Governor's Task Force on Veterans' Services

Final Report
December 2008

Governor Theodore R. Kulongoski

THEODORE R. KULONGOSKI
GOVERNOR

TASK FORCE ON VETERANS' SERVICES

December 10, 2008

Dear Governor Kulongoski:

The Task Force on Veterans' Services is pleased to submit to you its final report and recommendations as required by Executive Order 08-08. It is the result of a thorough review and assessment of existing federal, state, and local education, employment, health care, housing, and retirement policies. As directed, each policy cluster was examined through the lens of currently serving veterans, recently separated veterans, and aging veterans.

After an internal evaluation of existing policies, programs, and procedures, the Task Force travelled throughout Oregon hosting town halls regarding veterans' services. In all, the Task Force held twenty-four open forums and contacted over five hundred thirty Oregonians. Everyone that came to participate was welcomed so that we could develop an informed opinion of what works and what may need improvement. At each stop, we would meet with local leaders, tour veterans' facilities, and meet with groups associated with veterans' concerns.

Following the town hall tour, the Task Force weighed input and developed a framework of draft recommendations. These proposals were vetted through discussions with Congressional staffs, Legislative members, and statewide advocacy groups. The draft proposals have unanimous support in principle – although various interests favor distinct delivery mechanisms.

Overall, the Task Force found that the "veterans' landscape" is undergoing fundamental reshaping. First, aging veterans are living longer which impacts the type and price of care. Second, critically wounded veterans from ongoing conflicts often require complex and evolving treatments that were not expected. And third, the impact of the continuing wars in Afghanistan and Iraq is real and significant. Though dramatic progress has been made in the past few years, the VA access and support is still behind legitimate need.

Given Oregon's unique relationship with the National Guard, the Task Force spent considerable time assessing the impact of existing veterans' policies on the National Guard and Reserve. We found that ongoing conflicts have literally "rewritten the book" in terms of rational expectations. Sustained long-term deployment requirements, changes in warfare, and the transformation of National Guard and Reserve from a "strategic reserve" into an "operational reserve" have dramatically impacted the National Guard and Reserves.

Future study is required on the synergies found in melding veterans' programming with National Guard and Reserve readiness. Since many National Guard/Reserve members are

concurrently serving and eligible for veterans' services, the Task Force recognizes the need for continued policy maturation. This is especially important in terms of health care and mental health care services.

With submission of this report, the Task Force turns our findings, conclusions, and recommendations over to you for your consideration and prioritization. The Task Force recognizes the distinct but complimentary function of the executive and legislative branches in considering our advice and making policy choices within the current budget and political climate. We believe that the existence of this Task Force and the process directed by you has already opened dialogue and begun to make a difference.

The Task Force wants to express our continuing and deep appreciation for the outstanding support and cooperation from the agencies, organizations, and veterans' advocacy groups that assisted in this process. Of special note are the following: Tom Mann, who ODVA Director Jim Willis graciously provided for this enterprise – he was the architect of this report; Committee Chairs: Mic Alexander, Mike Burton, and Dan Estes, who worked hard to ensure each "veteran cohort" was represented in both form and function; and finally, the ODVA staff as a whole – they went above and beyond.

We close this by thanking all the veterans that have served our America, our Oregon, and our communities. Our nation is indebted to them for their service and sacrifice. They, their families, their employers have carried the burden so that we can live in freedom and peace.

Sincerely,

Paul L. Evans
Task Force Chair

Mike Burton
Reintegration Committee Chair

J. Michael Alexander
Post-Separation Committee Chair

Daniel D. Estes
Aging Veterans Committee Chair

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EXECUTIVE SUMMARY

Introduction

Governor Theodore Kulongoski established the Task Force on Veterans' Services through Executive Order 08-08 in March 2008. EO 08-08 was crafted to provide a vehicle for open dialogue and development of a shared strategy for veterans' services and benefits. After nearly seven years of sustained military operations in two major conflicts, the politics of veterans' care had begun to become splintered with traditional veteran advocate allies competing with one another. Without sustained intervention, this splintering is likely to continue because of the mounting pressures on the military and veterans' community.

Since 2001, the United States has implemented a new philosophy in warfare execution: instead of active-duty military units fighting the nation's conflicts as in the past, today the strategic reserve of National Guard and Reserve units are thrown directly into combat to supplement a smaller active-duty force. Today's force includes women in combat – to date more than 192,000 women have served in OEF/OIF. Further, significant logistical and maintenance duties have been contracted out to private-sector companies meaning that there are fewer support troops needed so more troops are seeing combat. Also, due to personnel shortfalls, service members are being ordered to serve repeated tours of duty and are involuntarily kept in service (stop loss) or returned to military service during their inactive reserve commitment. These shifts in force management have created a host of unanticipated (or ignored) consequences; outcomes that will incur irrefutable long-term costs for society unless mitigated through targeted policies.

For most of the past eight years, investment in veterans' care was not a priority for the President and Congress. Congressional Research Services estimates eventual cost of the Afghanistan and Iraq Wars will be $1 trillion; private economists estimate upwards of $3 trillion when equipment replacement, health care, transition, and opportunity costs are factored in. In context, these expenditures have contributed to escalating deficit spending since 2001 and increased the national debt to nearly $10 trillion. This accumulation of debt will undoubtedly constrain public policy choices.

With scare resources on the horizon for both national and state action, EO 08-08 empowered a process that brought interests together so that consensus could be built around the value of specific programming. Available resources must be stretched to the frontier of rational limits; there is not sufficient anticipated revenue to remedy every unmet need. Accordingly, EO 08-08 directed that this Task Force conduct a comprehensive review of all policies related to veterans and report specific recommendations for action.

One of the challenges of assessing veterans' policy is the size of the population and its diversity of experience. Nationally, 23.5 million men and women have served in the United States Armed Forces. Latest census data estimates that 350,000 Oregonians are veterans with service that extends from the 1930s to current day. In simplest terms, there are at least two types of "qualified veterans:" those that have completed service, and those that are still serving (in the National Guard and/or Reserves). The complexities of a 70-year span of experience required a tailored approach.

Process – A Tailored Approach

EO 08-08 established a 27-member Task Force. These men and women were invited to participate based upon their abilities, experience, and/or professional capacities. As a group, the Task Force included veterans of past and current conflicts, policy experts, elected/appointed political figures, and citizens-at-large. The following members serve as the Task Force on Veterans' Services:

- Paul Evans – Governor's Veterans' Policy Advisor (Task Force Chair)
- Erinn Kelley-Siel, DHS – Child & Family Services Administrator
- President Peter Courtney, Oregon State Senate
- Representative Jeff Barker, Oregon House of Representatives
- Jim Willis, ODVA – Director
- Dr. Bruce Goldberg, DHS – Director
- Brigadier General Mike Caldwell, OMD – Deputy Director
- Victor Merced, OHCS – Director
- Tino Ornelas, ODVA Advisory Board – Chair
- Dr. Jim Tuchschmidt, Portland VA Medical Center – Chief Executive Office
- Dr. Mike Burton, PSU Extended Studies – Vice Provost
- Jim Booker, Employment Department – Veterans' Program Coordinator
- Commissioner Martha Schrader, Clackamas County Commission
- Mic Alexander, Veteran
- Jerry Lorang, Veteran and former Director Portland VA Regional Office
- Michelle Kochosky, OMD Family Support – Coordinator
- Michelle Nelson, Veteran OEF/OIF (Currently deployed to OIF)
- Dan Estes, Marion County – Senior Policy Advisor
- Krissa Caldwell, CCWD – Deputy Commissioner
- Colonel Scott McCrae (Ret.), Oregon Reintegration Team – Director
- Amy Goodall, Health Policy Advocate
  (Formerly of Oregon Medical Association)
- Debbie Koreski, Oregon House of Representatives – Speaker's Office
- Jim Keller, Oregon House of Representatives – Minority Leader's Office
- Councilor Jacqueline L. Moir, City of Keizer
- Bob Plame, Disabled Veteran
- Kevin O'Reilly, Disabled Veteran
- Jack Heims, Portland VA Medical Center

Michelle Nelson left the Task Force early due to her deployment to Iraq as part of the Oregon Air National Guard.

Task Force members were assigned to one of three committees based upon cohort experience. These committees: Reintegration, Post-Separation to Retirement, and Aging/Retirement Care ensured cohort specific needs were identified and included in policy discussions. Five "core" public policy spheres (education, employment, health care, housing, and aging care) were then reviewed through the "lens" of these specific work groups. It should be noted that as a whole, these five core areas reflect the vast majority of public expenditures in veterans' benefits, compensation, and health.

Once formed, the Task Force determined that a formal presentation schedule was needed to accommodate discussions on the following: revenue mechanics, education, workforce readiness, housing, homelessness, drug and dependency issues, employment, post-conflict reintegration (the Oregon Reintegration Team), health care, TRICARE, veterans administration (federal, state, and county programming), and other lesser known subjects. The Task Force met weekly throughout April and May (2008). These formal presentations provided a foundation for continued dialogue and policy review.

After receiving the "formal" presentations of existing policies, procedures, and protocols, the Task Force implemented a 24-community outreach effort to validate lessons learned. This travel included tours/visits to specific veterans' programs, semi-private conversations with community leaders, and public town hall forums for an open exchange of ideas. The following communities were included in this effort:

- Portland (Veterans' Benefit Administration, Regional Office)
- Burns/Hines
- Bend – (Veterans Health Administration, Community Based Outpatient Clinic, Central Oregon Veterans' Outreach)
- Florence
- Philomath
- Portland (Veterans Health Administration, VA Medical Center/PSU)
- Beaverton/Hillsboro
- Myrtle Point
- Roseburg (Veterans Health Administration, VA Medical Center)
- Eugene (Vet Center)
- Astoria/Warrenton (Veterans Health Administration, Camp Rilea – Community Based Outpatient Clinic)
- La Grande (Veterans Health Administration, CBOC)
- Pendleton
- Madras
- Medford (Veterans Health Administration, Domiciliary)
- Grants Pass
- Gold Beach
- The Dalles/Hood River (Oregon Veterans' Home)
- Clackamas Community College
- Ashland (Southern Oregon University – Campus Veterans' Outreach facility)
- Klamath Falls (Kingsley Field tour/visit)
- Salem
- Albany
- Coos Bay
- Ontario

More than 400 people participated in the community town hall meetings throughout the state. In each of the communities listed above Task Force members met with local leaders, local media, visited facilities, and held forums with the public. Town halls were advertised in the mainstream media; attendees were self-selected.

A number of stakeholders who participated in Task Force committee meetings and the Task Force tour should be recognized as well. Senator Ron Wyden provided staff, including Juine Chada, John Michaels, Kathleen Cathey, Wayne Kinney and Fritz Graham; Congressman Peter DeFazio provided Frank Van Cleave; Congressman Greg Walden provided Troy Ferguson and John Howard; Congressman David Wu provide Ajah Maloney-Capps; Congressman Earl Blumenauer provided Elanna Schlichting; Oregon State Senate President Peter Courtney provided Sasha Pollack; Lt. Col Chaplain Daniel Thompson, Barry Vertner and others from the Oregon National Guard Reintegration Team participated; and Oregon Housing and Community Services provided Pegge McGuire, Bruce Buchanan and Jack Duncan. Each of these participants was instrumental in the Task Force process.

Following the community town hall tour, Task Force members met twice to share experiences and lessons learned from the discussions and to prioritize draft recommendations. The findings and recommendations that follow reflect the consensus of the voting membership of the task force.

Findings

The Task Force believes sufficient evidence warrants the following claims of fact:

1. Oregon has outperformed most other states in terms of VA benefit assistance. In 2006 Oregon ranked 3rd in VA Pension ($751 million); 6th in VA Compensation ($937 million) received. The state/county Veteran Service Officer (VSO) outreach network yields incontestable value.

2. Substantial amounts of federal aid (in benefit & compensation payments and health programming) are consistently unrealized because of a systemic failure of state, regional, and local public agencies to ask customer/clients veteran's status. Note: only 80,000 of 351,000 (22%) Oregon veterans identified through Census are "in the system."

3. A substantial amount of Federal housing/homeless-to-work assistance remains unclaimed (under maximized) because of widespread lack of awareness of availability as well as training for agency personnel on program procedure/s.

4. Existing transportation systems for veteran mobility to/from health care and employment/workforce programming are insufficient to current and projected need/s.

5. Expansion of VSO outreach should be extended to every public university and community college campus to assist veterans in realizing the new GI Bill (and to more efficiently cover underserved population need/s).

6. Existing Reintegration Summit collaborative strategies should be expanded in scope to provide regional "mini-summits" on a bi-monthly basis; regional constructs could coordinate efforts through current model.

7. Existing Oregon statute incentivizing TRICARE patient load increases has been misinterpreted and is insufficient to public goal/s. Amending language to "fix" statute has been reviewed.

8. Existing access for mental health services in remote/rural areas of the state is insufficient for the current and projected needs of veterans and families. Incentives for providers warrant urgent study.

9. Existing facilities for women veterans (especially those with children) are insufficient for current and projected need/s. The opportunities presented at the Eastern Oregon Training Center and the state psychiatric hospital in Salem warrant further study and may be a win/win for the nation, state, and community.

10. The Oregon Veterans' Home is at a crossroads in terms of long-term maintenance and sustainability; the establishment of a permanent maintenance fund warrants further study and may preserve a model facility.

11. Existing reintegration programming is improving the health and welfare of returning veterans' and families; existing efforts are not sufficiently coordinated to successfully preserve the force (National Guard/Reserve) and/or meet the current and projected need/s of veterans' and families.

12. Future expansion of skilled nursing home facilities for veterans should maximize federal support services; development opportunities through creative partnerships should be explored and implemented.

Recommendations

The Task Force recommends the following for action in the 2009-2011 Biennium:

Administrative/Policy Expansion

- Increase state VSO coverage by 18 positions (9 – 2009, 9 – 2010).
- Expansion of Reintegration Team/Programming to meet the projected needs of 2009 deployment of forces.
- Increase both Military Department and Veterans' Department "Emergency Relief Fund/s."

Legislative Action

- Refer amendment to Oregon Constitution deleting 30-year limit on Oregon Department of Veterans' Affairs home loan program.
- Grant automatic state residency for any/all veterans attending an Oregon university, public institution, and/or community college. Note: new GI Bill may pay for out-of-state costs; old GI Bill does not pay those costs.
- Develop and sustain a state recognition program for businesses/employers that hire veterans at a rate above average; implement a public information campaign encouraging employers to hire veterans.
- Expand reintegration efforts throughout the State of Oregon on the Clackamas Community College/Oregon Reintegration Team model.
- Empower/recognize mini-summit regions as representatives of Oregon reintegration efforts; provide small funding grants for development of tailored solutions. Create Internet bulletin board for information dissemination.
- Allocate resources and require closer cooperation for enhanced transportation capacities for veterans living in remote/rural areas.

Congressional Action

- Memorial to Congress urging transportation system enhancements for veteran's health care access.
- Memorial to Congress urging full funding of categories 1-8 within the Veterans Health Administration facilities.
- Memorial to Congress urging funding/implementation of a 90-day "soft-landing" plan associated with post-conflict reintegration efforts for National Guard and Reservists. Note: this supports recent proposals from the Commission on the National Guard and Reserve.
- Memorial to Congress urging the Veterans Administration to simplify and expand the VA "Fee-Basis" system.
- Memorial to Congress urging expansion of Department of Labor DVOP (Disabled Veterans Outreach Program) and LVER (Local Veterans Employment Representative) programming; restoration of previous levels of service.
- Memorial to Congress urging it to authorize states authority to develop home loan programming that mirrors federal programming.

On top of the previously listed items, the Task Force recommends the following "low hanging fruit" proposals for action within the next 100 days:

- Simplify existing procedures and expand the number of days a qualified veteran is allowed to stay at state parks without charge.
- Establish annual Oregon Military Families Appreciation Day.
- Pass a resolution of support for the Oregon "Hire Vets" program.
- Direct the Oregon Justice Department to assist in the research and development of Veterans' Courts (Oregon House of Representatives Interim Veterans' Affairs committee working on this initiative).
- Increase emphasis on educational campaign within all public agencies (especially the Oregon Military Department and Oregon Department of Veterans' Affairs) on military sexual trauma (MST), Post Traumatic Stress Disorder (PTSD), and traumatic brain injury (TBI) initiatives.
- Fund/coordinate a public information campaign on suicide prevention (especially among vets); Reintegration Team, ODVA, and partners are asking for help.
- Fund/coordinate a public information campaign on MST prevention/assistance and domestic violence.
- Public support for hiring/retention of veterans' efforts throughout state; support for emerging "compact idea."

Endgame conclusions

This Task Force served as both means and ends. Though veterans across the nation are struggling daily with the impact of their service, few states have made this issue a priority. No other state has been as innovative in its approach, or as consistent in its support. Oregon has pioneered post-conflict reintegration efforts for the National Guard and continues to set the agenda for other states to follow. Unfortunately, the personal challenges facing our veterans from all conflicts are vast; too many problems have been ignored for far too long. Transportation costs are unpredictable; medical care is costly; and the federal government has largely neglected the evolving reality for veterans and families. Recent increases in VA expenditures have come too little, too late, and will not keep pace with need/s.

The Task Force achieved its primary mission: to bring people around the table and have a rational dialogue about what should be done. Although inherently and primarily a federal issue, veterans' care impacts us all. The State of Oregon can, with relative ease, make local changes that improve the lives of 351,000 veterans and their families. Additionally, the state can send a clear message to Congress and the next Administration that change is warranted in terms of education, employment, health care, housing, and retirement. Key leaders can utilize nationalizing agents such as the National Governor's Association, the National Conference of State Legislatures, and other advocacy forums to move policy in the opening months of the next Congress.

Overall, this Task Force adjusted its approach as information and trends became available. After the initial presentations, work groups replaced committee structure, but the spirit remained. Towards the end of this process, committees functioned less as decision-makers than as reminders of perspective and need. And while the two-tiered assessment was not fully implemented as envisioned, it maintained focus on the divergent but equally important needs of the veteran cohorts.

Throughout this process, the Task Force members took the mission seriously – and spent enormous amounts of time and energy to complete this task. Committee chairs Mic Alexander, Mike Burton, and Dan Estes kept faith with their charge and manifested extraordinary leadership and dedication. As a group, the chairs helped lead their peers through the complex waters of multi-tiered policy. And each of them avoided the trap of accepting the "easy way" by merely parroting the wishes (often expressed with great enthusiasm and zeal) of legacy advocacy groups. This was not easy.

Within the small world that is veterans' policy, it is often the loudest voices that garner the most attention: but this was not the case in this process. Opinions were sought from legacy groups but proposals for action were reviewed with a keen eye towards the entire veteran community. Every person, every group, and every idea that was presented to the Task Force was given equal consideration. It was vital for a comprehensive product to result. The balance of this effort makes the final recommendations more powerful; it does not advance nor retard any singular interest group or established agenda. Veterans of every era had at least one (and often more) champion in policy discussions throughout the process.

On a final note, the staff of the Oregon Department of Veterans' Affairs should be commended for making this project possible. With scare resources, Director Jim Willis, Deputy Director Paula Brown and their Public Information team performed the improbable – on time, on target.

Reintegration

The Reintegration efforts in Oregon has been one of rapid evolution to meet with the changing needs of veterans, both National Guardsmen and returning service members who have separated from active duty. For definitional terms, reintegration refers to the processes faced by a returning soldier in his/her re-entry to civilian life in the first three years. Issues covered in other analysis: healthcare, education, family, and employment will only be referenced in this document. Nationally, according to the Veterans Health Administration about half of the Operation Enduring Freedom/ Operation Iraqi Freedom soldiers have separated from service, approximately 900,000.

Most of Oregon's reintegration issues concern National Guardsmen; Oregon does not have an active duty military base, such as Ft. Lewis, so does not routinely see active duty veterans. The first alert of the need for a reintegration effort came from military family members coping with not only the absence of loved ones and the associated fears, but life issues such as the "Dear Mortgage holder" letter. The alerts became alarms as injured soldiers returned home with both visible and invisible wounds. A few of these soldiers coalesced into a force that requested a formalized effort on the part of the Oregon National Guard to address their needs. The Reintegration Team was formed under the lead of COL Scott McCrae (Ret) with full support of Guard senior leadership. The team familiarized themselves with all resources, created an excellent website, an 800 number, and then divided the state up to assure the returning soldier's pulse regarding ease of reintegration was being taken. Many other states have created models based upon Oregon's reintegration team. The Yellow Ribbon Program formulizes the mode nationally.

The state, federal, local and charitable organizations supporting the returning veteran's needs also required an organizational structure. Through the coordination of the ONG, Veterans Healthcare Administration, and Congresswomen Hooley, the Oregon Summit was created as a semi-annual meeting of all leaders of the organization, and is held at the Anderson Readiness Center. It now hosts more than 100 attendees with updates on clinical issues, such as traumatic brain injury (TBI), and political updates, such as the presentations by state legislators, and finally, breakouts for discussion groups regarding healthcare, education, family, and employment.

As of this writing, returning Guardsmen are typically being demobilized at Fort Lewis for a period of three to five days. This is after seven to 14 days of logistics in Kuwait. While at Ft. Lewis, soldiers self-report physical and mental health issues, including TBI and PTSD. Those reporting issues are normally kept longer, which the Task Force learned is why many of these returning soldiers are not self-reporting. These soldiers want to return home and will not risk being put on medical hold while the rest of their unit goes home, While demobilizing at Ft. Lewis, these Guardsmen are under federal Title 10 active duty orders, which means they receive active army pay and benefits. During this period, they are briefed on everything from healthcare to education. Retention of information is very low. The Guardsmen then are brought to Oregon for two to three days where additional briefings including the services of the Reintegration Team, ceremonies, and reunification with family. From this point, they are Released from Active Duty (REFRAD) and returned to Title 32, inactive duty training with the State of Oregon. The Task Force learned that this is not enough time for a soldier to decompress after a combat tour and is a reason many of these veterans are finding it difficult to actually reintegrate back to their jobs, families, and lives.

For the next 90 days units conduct some reintegration actives during monthly drill weekends to reconnect with their fellow OEF/OIF combatants and have their pulse taken by their leadership. At 90-120 days, soldiers undergo Post Deployment Health Re-Appraisal (PDHRA) where they are again assessed for physical and mental health issues in coordination with VA, ODVA, and other resources.

Pre-mobilization has improved to inform the soldier and his/her family of what to expect and what benefits/resources are available while deployed. Soldiers returning out of sync from the rest of their unit due to injuries get their needs attended at Madigan Army Medical Center. ONG monitors their recovery process.

Active duty military members participate in the Transition Assistant Program (TAP), a weeklong program at active installations. However, these soldiers already have come home from their combat tour as a unit, have had significant decompression time, and are leaving service in most cases not directly after their combat tour but some time down the road. For those not separating, support is found on base especially for their families. Healthcare is provided by the facility's medical center. If the separating veteran allows notification (DD214), the ODVA is alerted of his/her arrival in the state and welcoming information is sent and follow-ups are made. The VHA contacts all separating service members, whether active or reserve component. Through word of mouth, these veterans are discovering the Reintegration team website and 800 number.

The Task Force discovered that eight different organizations claim to know all the resources in the state for support of Veteran care. A secondary finding was that no one group actually knew everything. And a final finding was that what is available is a constantly moving target. About half of those agencies offer 24x7 hot line 800 number capability. It is the impression of the Task Force that only ONG and ODVA come close to knowing the resources. During multiple town halls, the Task Force also heard the theme of veterans seeking information, often false, from one another; this was particularly true at college campuses. The Task Force also heard of Squad/Team Leader being perceived as a particular source of information regarding resources.

To help, the Department of Defense has provided staff to facilitate reintegration (Joint Family Service Assistant Program). They are monitored by the family program director under the ONG Yellow Ribbon Program. Department of Defense components are comprised of a Red Cross Liaison, two outreach counselors, one Military One Source person, and a children's program. In addition they have funded uniformed service member to attach to the OEF/OIF team at the Portland VA Medical Center.

Other governmental agencies have also provided specific outreach personnel. The Vet Centers have each hired OEF/OIF veterans to provide the information. Each VA Medical Center has an OEF/OIF coordinator and two have poly-trauma care case managers. The ODVA trialed a VSO on the campus of Portland State University with impressive results. As has been aforementioned, the ONG has four Reintegration Specialists scattered throughout the state and in Salem they have education, employment and family coordinators. It should also be noted that the VA's homeless outreach staff, the suicide prevention coordinators and case managers frequently interact with this population. The State Employment Department also has OEF/OIF specialists.

Finally, regarding information flow, a few local areas have mimicked the Oregon Summit by pulling together interested personnel to share their knowledge of resources. The Eugene area's Vet Net is the longest standing. County Commissioner Martha Schrader in Clackamas County initiated a group there. The Tigard Armory has been the home of monthly meetings of primarily 501-C-3 organizations and a small group meets in Washington County.

The Reintegration Team has learned much since it stood up to help returning veterans. More must be done to educate veterans and their families regarding the services that exist. The Task Force determined that there is not necessarily a lack of resources, but rather the gap exists in connecting soldiers/veterans and their families to those resources. The Task Force is committed to continuing the work of the Reintegration Team to further identify and fill these gaps.

Findings

1. That the current process of reintegrating soldiers into the civilian community is seriously deficient. More time in Title 10 status is necessary for a proper soldier and family reintegration.

2. Family education, preparation, and treatment are much improved but still lacking. Family members cannot receive VA treatment without the veteran enrolled and seeking care. Counselors in the community are either scarce or ill trained. VHA has well-trained and caring staff.

3. The GI Bill of 2008 remedies some of the problems of financing a soldier's entry or re-entry into higher education. Details of the entire program are not readily understood.

4. Overall, resource information is not centrally located or well known and sometimes comes from sources not fully informed.

5. No formalized system of bringing resource providers together to insure a centralized, successful semi-annual Oregon Summit.

6. Soldiers are frequently unemployed at time of enlistment or deployment (35%). Excellent resources exist for training, vocational rehabilitation or employment counseling, but again, these opportunities are not well known.

7. Homelessness is a potential threat to new veterans. As more come home, the difficulties dealing with PTSD, TBI, marital crises, family crises, employment crises, and often try to self medicate; homelessness can come on rapidly. VA is well prepared to deal with all these issues, however getting the veteran to seek that help is problematic. As one soldier said, "Uncle Sam screwed me over once, why would I trust him again."

Recommendations

1. The Oregon Legislature draft a Joint Memorial urging Congress to establish and fund a comprehensive reintegration program that includes maintaining National Guardsmen on Title 10 Orders for 90-120 days after deployment.

2. Provide funding for 18 additional Veteran Service Officers to be located on the each of Oregon community college and university campuses.

3. ODVA create an electronic "bulletin Board" where all personnel in all agencies can add and read about new resources, changing of staff, new laws and other information.

4. The Oregon Legislature create a Reintegration Task Force to continue to work with state agencies and partner with local and federal government to create mini-summits regionally throughout the state.

5. Increase staffing for Reintegration/Yellow Ribbon Team.

Veterans' Families

As a state without an active-duty military base, the families of Oregon's service members often find themselves separated by distance and without the type of support system active-duty units provide for families of deployed soldiers. This separation can create issues with communication and service delivery. Further, unlike the active-duty military culture, National Guard and Reserve families do not live the military lifestyle 24-hours a day in their normal lives, thus many do not even know to seek services from existing National Guard family support programs.

The current conflict is unlike previous conflicts and is putting greater strain on families. Multiple deployments create uncertainty and place tremendous burdens on the spouse left behind to raise the children as a single parent. For many National Guard and Reserve service members, deployment means a reduction in family income for the deployment period, placing strains on family budgets – to the point of welfare or bankruptcy for some families. While in Iraq and Afghanistan, soldiers receive instant communication via email from their spouses, which is both good and bad. On the one hand, this type of communication with family helps keep service members connected to home and raises morale. On the other, the problems at home are shared daily with the service member who already is burdened with stress of combat. Conversely, the spouse at home who does not receive the expected email or phone call on time only assumes the worst if their soldier is late from patrol. Also, the effects of the current conflict are even more severe when the service member returns home. Large numbers of soldiers are experiencing Post Traumatic Stress Disorder with symptoms ranging from anger, depression and anxiety to hyper-vigilance, self-medication with alcohol and drugs and suicidal ideation. Suicide among OEF/OIF veterans is at alarming rates. And many families also have to learn to adjust to physical disabilities, such as Traumatic Brain Injury, amputation, and a host of other medical problems. Family conflict unfortunately also includes domestic violence perpetrated by veterans against their spouse and/or children as a result of PTSD and other conditions.

The Task Force took a hard look at Oregon's Reintegration process. While the state's Reintegration team was the first of its kind in the nation and is the national model for reintegrating service members back into life after the military, the Task Force found gaps that could even further support soldiers and families in the continuum from pre-deployment to post-deployment and beyond.

One of the keys to helping families cope when a service member is called for deployment is pre-deployment services. The idea is simple: Educate families about what to expect during the deployment; provide a list of services that will help support families and explain how families can access these services; build relationships between the family support program personnel and the family members who are to be left behind; create contact lists for follow up; and provide contact information between families to create a self-supporting system. During a town hall meeting in Medford, the wife of an Afghanistan veteran said she wished she had had this type of information and briefing before her husband left and certainly before he came home, because he was not the same man that he had been before his deployment and she was unprepared for how he returned. This is a common statement from spouses of returning service members, according to county and state veteran service offices.

Staying in contact with family members during the deployment, providing them support and education also is fundamental to ensuring families receive the services they need. The Task Force was surprised to learn that the gap that exists is not in available services, but rather in connecting family members and soldiers to those services. The state's family support program manager told the Task Force that they continually invite family members to meetings, but many families simply to do not come. Unfortunately, by the time a family does come forward to ask for assistance, they are in crisis. Proactive outreach will have to be a component during the continuum of service delivery.

The post-deployment process also is a challenge. While active duty service members return to their bases as a group and are given time to decompress from their combat tours before resuming their regular duties, National Guard and Reserve troops are sent home, given a week of briefings and then are released back into the lives they left 12 to 18 months earlier. This has been a recipe for disaster. The Reintegration Team readily acknowledges that the "Death by PowerPoint" briefing process usually ends in the soldiers simply throwing away all the materials provided to them. In fact, the Task Force was told that a recycling bin is kept by the door for this purpose. The fact is soldiers returning from combat tours are not ready to absorb the plethora of information they need directly after deployment. The Task Force has come to the conclusion that more time is needed for soldiers to decompress after their deployments and this time should include family members who would attend briefings with their soldiers.

Because Oregon does not have an active-duty military base, it is unique and thus faces unique challenges in working with service members and their families. However, numerous services exist to support families during the continuum from pre-deployment through post-deployment. The Oregon Reintegration Team and the Family Support Program exist solely to facilitate services to veterans and their families. The Oregon Department of Veterans Affairs and the County Veteran Service Officers provide claims services to ensure veterans and their families receive the benefits that they have earned. The federal Veterans Health Administration provides counseling, mental health, health care, and social services to veterans. While counseling cannot be given directly to family members, it can be provided in conjunction with the veterans' counseling, providing a doorway to help. Military One Source and the Red Cross also provide services, as do private sector groups who have offered pro-bono counseling and medical care for soldiers and their families. Clergy and emergency first responders are being trained in PTSD and what to expect when working with returning OEF/OIF combat soldiers. Many positive and proactive steps are being taken to support Oregon military families. The keys to successfully providing services to families will be communicating consistently with families, and families taking the initiative to accept the services that will be offered.

Findings

1. Resources for families abound, but are frequently unknown to other providers. At one count, eight different agencies are claiming to be the "one stop" for all information, but in reality only two, the National Guard Reintegration Team and the ODVA know most of them. Military families do not know all of resources and misinformation from word of mouth compounds the problem.
2. Insufficient emergency funds exist for family situations despite the wonderful efforts of ODVA, the Guard itself, Salvation Army, the National Veteran Service Organizations, and religious based organizations. Many of these are not known in the caring community.
3. While a few communities, notably Eugene, have organized "mini reintegration summits" to assure communication of resources, such mini-summits need to be expanded regionally statewide.
4. Rural areas, whether for veterans or all citizens, are underserved for mental health needs.
5. Many military families do not seek support or resources until they are in crisis.

Recommendations

1. A one-stop "Bulletin Board" type resource should be created and hosted by either ODVA or the Reintegration Team to provide a clearinghouse of information for service members and their families.
2. The Emergency Financial Assistance Program at ODVA should be increased.
3. Mini-summits should minimally occur regionally throughout Oregon on an on-going basis. Furthermore these should be a feeder to the Oregon Summit to assure all needs, rural to urban, are represented.
4. Work to expand eligibility programs for "whole family" initiatives.
5. Develop/fund feasibility study for Veterans' Courts
6. Establish Oregon Military Families Appreciate Day
7. Develop/fund tailored suicide prevention public information campaign

Veterans' Healthcare

As the Task Force toured the state, health care was the top issue of discussion at nearly every town hall meeting. There was consensus that the VA medical system provides quality care; however, accessing that care was perceived as bureaucratic and difficult. For veterans living in rural and remote Oregon, accessing their VA health care can be quite difficult due to distance and weather. Mental Health is lacking throughout the state; where mental health exists, demand is outpacing the supply of providers due to difficulties in recruiting, particularly in rural areas. Veterans in rural and remote Oregon want more money spent on VA contract health care so they can see local providers instead of traveling great distances to a VA facility. Many veterans have had significant difficulty with having their emergency health care paid for by the VA when their emergency brings them to a private hospital, according to state and county veteran service officers. Lastly, older veterans feel they were promised health care as part of their agreement to serve their country; however, the VA health care system limits access based on income, so many of these veterans are found to be over-income and not allowed access to the system.

In Oregon, the Veterans Health Administration has two main hospitals (Portland and Roseburg); a rehabilitation center in White City; Community Based Outpatient Clinics in 10 communities with plans for expansion (Bend, Brookings, Eugene, Klamath Falls, La Grande, North Bend, Ontario, Portland, Salem, Warrenton); and four Vet Centers (Eugene, Grants Pass, Portland, Salem). The system is set up so that specialty care is provided at the two main hospitals (as well as the Vancouver, WA campus), while primary care is provided through the CBOCs. The Vet Centers specialized in readjustment and Post Traumatic Stress Disorder counseling. Access is free to any honorably discharged veteran The Task Force was made aware of a demand for a Vet Center in Bend, which is currently being served on a part time basis by traveling counselors from Salem and Eugene. Vet Centers also have a contract program for rural areas such as Tillamook, Astoria, The Dalles and La Grande.

VHA has established priority groups for VA health care. There are eight groups; however, group 8 has not accepted new enrollees since January 2003. The following outlines the priority groups and their eligibility:

Priority	Description
Priority 1:	• Veterans with VA-rated service-connected disabilities 50% or more disabling • Veterans determined by VA to be unemployable due to service-connected conditions
Priority 2:	• Veterans with VA-rated service-connected disabilities 30% or 40% disabling
Priority 3:	• Veterans who are Former Prisoners of War (POWs) • Veterans awarded a Purple Heart medal • Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty • Veterans with VA-rated service-connected disabilities 10% or 20% disabling • Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"
Priority 4:	• Veterans who are receiving Veterans who are receiving aid and attendance or housebound benefits from VA • Veterans who have been determined by VA to be catastrophically disabled

Priority 5:	• Nonservice-connected veterans and noncompensable service-connected veterans rated as 0% disabled by VA and whose annual income and net worth are below the VA pension benefitsVA national income threshold • Veterans receiving VA pension benefits • Veterans eligible for Medicaid programs

Priority 6:	• World War I veterans
	• Compensable 0% service-connected veterans
	• Veterans exposed to Ionizing Radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki
	• Project 112/SHAD participants
	• Veterans who served in a theater of combat operations after November 11, 1998 as follows:
	  ○ Veterans discharged from active duty on or after January 28, 2003, who were enrolled as of January 28, 2008 and veterans who apply for enrollment after January 28, 2008, for 5 years post discharge
	  ○ Veterans discharged from active duty before January 28, 2003, who apply for enrollment after January 28, 2008, until January 27, 2011

Priority 7:	• Veterans with income and/or net worth above the VA national income threshold and income below the geographic income threshold who agree to pay copays

Priority 8:	• Veterans with income and/or net worth above the VA national income threshold and the geographic income threshold who agree to pay copays
	  ○ Subpriority a: Noncompensable 0% service-connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date
	  ○ Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date
	  ○ Subpriority e**: Noncompensable 0% service-connected veterans applying for enrollment after January 16, 2003
	  ○ Subpriority g**: Nonservice-connected veterans applying for enrollment after January 16, 2003

As is evident by the groupings, the system is complex. Some groups pay co-pays for their care while others do not. For example, group one has all its health care needs paid for by the VA, while other groups only have their service-connected health care paid for by the VA, while their non-service connected issues require co-pays. Some health care is not available unless the veteran is service-connected for that particular disability, such as dental care. Older veterans routinely complain they cannot get hearing aids from the VA because they are not service-connected for hearing loss. Many veterans voiced frustration regarding access to the care they wanted and confusion over paying for medication, being prescribed medications by private physicians that are not on the VA formulary, and not understanding why some of their VA health care is free and other VA health care is not. Currently, all veterans in groups 1-7 are covered by VA health care, but co-pay levels are different. Those veterans enrolled in group 8 before its closure still are enrolled in the system.

To obtain VA health care, veterans must enroll by filling out an application. According to the Portland VA Medical Center, only 30 percent of Oregon's 351,000 veterans are enrolled in VA health care. All Operation Enduring Freedom and Operation Iraqi Freedom are given five years of free VA health care for any condition that was incurred or aggravated while the soldier was deployed. This ensures that these troops receive their needed health care while they are waiting for their disability claims to be approved. (Most veterans have to wait to be officially "Service-Connected" for their disability before being allowed access to VA health care related to that disability. This can take between 6 months and two years).

At nearly every town hall meeting, at least one veteran raised the issue of the VA contracting veterans' care in their local community. Known as the Fee Basis system, the VA spends millions of dollars allowing veterans to access medical care locally with private providers. However, the rules for Fee Basis are complicated and veterans are frustrated that the VA does not provide more local contract service, especially in rural and remote areas. As noted above, veterans must travel to one of the two main hospitals for specialty care – no matter where they live. (Oregon veterans in Eastern Oregon can travel to Walla Walla or Boise for their specialty care) This creates hardships that result in veterans not seeking the care they need and have earned through their service. Fee Basis also is responsible for paying medical bills incurred outside the VA system due to veteran emergencies. However, the rules regulating payment for emergency care are confusing and extremely strict. One veteran was denied payment for an emergency visit to his local hospital because he had Personal Injury Protection insurance on his vehicle. Another veteran was denied payment because he was late in alerting the VA he was in the hospital – he missed his 72-hour window because he was unconscious. While there is an appeal process within the Fee Basis system, it is a lengthy process, and while in appeal veterans are being billed by the private physician/hospital for payment. While Fee Basis is a federal issue, the Task Force agreed with the many veterans who voiced concern regarding the program and believes Congress needs to review the Fee Basis system, provide more funding, and provide relief for veteran emergency visits to non-VA facilities.

Aside from VA health care, military retirees and National Guardsmen have the option of a federal health care insurance benefit called TRICARE, which is administered by TriWest Healthcare Alliance. TriWest is the DoD contractor administering TRICARE throughout a 21-state west region, to include Oregon.

According to Triwest Health Alliance, in Oregon alone, TriWest has built a network of 9,247 total network providers, including 1,030 behavioral health providers available to help meet the healthcare needs of active duty, Reserve Component and retired military members and their families. Coverage for TRICARE beneficiaries is based on eligibility, the sponsor's status and location: TRICARE Prime (similar to a civilian HMO option—a primary care manager directs the beneficiary's care); TRICARE Extra (equivalent of a PPO option—care is received from TRICARE-network providers); TRICARE Standard (allows for care from providers who accept TRICARE but are outside of the TRICARE network). TRICARE Reserve Select is a premium-based TRICARE plan for members of the National Guard and Reserves and their families who are not eligible for other TRICARE coverage. TRICARE For Life, managed by Wisconsin Physicians Service, offers coverage to beneficiaries who are eligible for both TRICARE and Medicare.

Veterans are mixed about their experiences with TRICARE. Some are completely satisfied, while others say they cannot find a doctor in their area that will accept TRICARE. There is indeed a barrier keeping doctors from accepting TRICARE patients or at least a large number of these patient; the TRICARE reimbursement is the same as Medicare, which means doctors can actually lose money by treating TRICARE patients. Last Legislative Session, the Legislature passed a bill to help incentivize doctors to take TRICARE by offering them a tax credit to see TRICARE patients. Unfortunately, the bill was flawed and a technical fix must be passed during the 2009-2011 Legislative Session to correctly implement the tax credit.

Veterans from every era need access to VA health care. Veterans from the most recent conflict are suffering from Traumatic Brain Injury, Post Traumatic Stress Disorder, suicidal ideation, amputations, and host of orthopedic conditions. Women veterans care – especially the newer category of care for female combat veterans – also is a focus of the VA. Not surprisingly, there has been a rise in the rate of PTSD episodes among the Vietnam generation, which has been triggered by events since 9/11. These veterans also are beginning to age and have begun to seek health care related to Agent Orange exposure (Prostate Cancer, Lung Cancer, Type II Diabetes, etc…); they also are seeking hearing aids and looking for VA health care to take over from their employer-provided insurance now that they are retiring. The Korea and World War II generation is reaching the age where more concentrated health care is needed, including skilled nursing care at facilities such as the Oregon Veterans' Home. All veterans need their prescriptions filled regularly.

The Task Force realizes that most of the gaps identified require federal action. This is not surprising given VA health care is a federal program. However, in working closely with the Portland, Roseburg, Walla Walla and Boise VA Medical Centers, Vet Centers, and Clinics the Task Force believes that all have a better understanding of the pressures on the VA health care system and the concerns veterans have regarding access and the complicated system that exists.

Findings

1. Though VA and its partner, the Vet Centers, serve our veterans well, equity of access is an issue for those in more rural settings, including Fee Basis care.
2. Tri-West has difficulty locating providers in all areas due to the low reimbursement rate that is tied to Medicare.
3. The VA funding cycle always is two-years behind the current budget year due to congressional processes, resulting in uncertain VA funding.
4. The VA health care system is complicated and frustrated veterans who do not always understand their benefits.
5. For rural and remote Oregon, distance and travel issues can prohibit veterans from accessing their VA health benefits.

Recommendations

1. The Oregon Legislature draft a Joint Memorial urging Congress to simplify and broaden the eligibility of Fee Basis care for our Oregon veterans living in rural and remote areas.
2. The Oregon Legislature draft a Joint Memorial urging Congress to fund all groups (1-8) of veterans so that every veteran has access to VA health care.
3. Work with the Oregon Congressional Delegation to increase TRICARE reimbursement rates.
4. Draft legislation to correct a small error in the existing TRICARE incentive program.
5. Work to increase flexibility in partnerships in remote and rural areas.
6. The State should encourage mental health professionals to work in support of Oregon veterans and their families, especially in rural and remote areas.

Veterans' Transportation

As the Task Force discussed health care issues with veterans across the state, an ancillary issue developed that required the Task Force to address it separately. Veterans told the Task Force that finding reliable and consistent transportation to bring them to and from VA medical appointments – especially appointments for specialty care at VA Medical Centers – is a pressing concern. For veterans living in rural and remote Oregon, the lack of transportation can mean veterans forego health care altogether.

To grasp the issue, it is important to understand the VA health care system and how veterans access care. The VA has large medical centers in Portland, Roseburg, and Walla Walla that provide the system's specialty care. Primary care and some mental health is provided through Community Based Outpatient Clinics located in Bend, Brookings, Eugene, Klamath Falls, La Grand, North Bend, Ontario, Portland, Salem and Warrenton. New clinics are planned for Hillsboro and The Dalles. The VA has Post Traumatic Stress Disorder treatment facilities called Vet Centers in Eugene, Grants Pass, Portland and Salem, and there is a Domiciliary in White City.

Veterans enrolled in VA health care are assigned a primary care doctor from the Community Based Outpatient Clinic (CBOC) nearest them. If the veteran needs any specialty care –from orthopedics to ophthalmology and including surgery – the veteran must travel to one of the large medical centers. It is important to note that the majority of veterans with service-connected conditions require some level of specialty care, so most will need to access the larger VA medical facilities at some point.

Veterans told the Task Force that those living close to a CBOC or in Portland or Roseburg have little trouble finding transportation to these facilities. However, for veterans living significant distances from these facilities, transportation becomes *the* issue and determines whether a veteran receives health care or goes without. It does not matter how exceptional our doctors, hospitals or health care may be. If a veteran cannot access them, it is without value.

Veterans are not without some transportation options; the Disabled American Veterans (DAV) operates a van system that picks up veterans at designated locations, transports them to VA facilities, and then returns them to their hometown. There are 26 vans in service throughout the state and all have volunteer drivers. The Task Force learned that while a vital program, there are three shortfalls with this system. First, there are not enough vans to accommodate the need statewide. Second, in a shortsighted and cruel irony, the vans are not allowed to transport wheelchair-bound veterans. Third, the system is short of volunteer drivers; many of the current volunteers are aging veterans themselves and DAV is having trouble finding younger replacements. The DAV system is very important to veteran transportation, but is insufficient to be considered a statewide veteran transportation system.

In Oregon, there is an urban-rural split. This is evident when examining veteran transportation. In many urban areas, there is public transportation for veterans to use to access VA health care. However, in rural and remote Oregon comprehensive public transportation is lacking and veterans have trouble even accessing their assigned CBOC more or less driving hours to the VA medical center. Further, weather complicates veteran transportation in Central and Eastern Oregon during the winter months. Simply put, there are times of the year that the one road to the VA medical facility is closed due to weather. It goes without saying that the medical needs of our veterans are not seasonal and do not cease for inclement weather.

It would be easy to disregard this transportation issue by saying that the veteran chose to live in an area without access to VA medical care and thus needs to find his or her own transportation to the VA. However, the Task Force takes a different view. Veterans have earned their benefits – including health benefits – through their service to country. These benefits should be delivered equally to all veterans regardless of any factor, including location. Thus the Task Force believes that the federal government and the State of Oregon should study the issue of veteran transportation and find creative solutions to develop a comprehensive statewide transportation system that is reliable and can transport any veteran to and from his or her medical appointments, regardless of that veteran's condition or disability. This is an

issue of seeming triviality to the larger picture of veterans' services, but has such a visible and personal impact to our veterans. If we do nothing else, fixing the way we transport veterans to and from their health care is a significant and immediate improvement in their daily lives.

Interestingly, there are willing partners in this effort, as well as existing programs that do not directly service veterans but do provide medical transport. The Task Force learned that the local bus system in Astoria was willing to add a route to the local CBOC on Camp Rilea to help veterans access their health care. The week after the Task Force's visit to Astoria/Warrenton, the bus system began this new route. The Task Force believes that other public transportation system could be asked to create similar routes to local VA facilities.

While in Albany, the Task Force learned there is a statewide medical transport system for Department of Human Service clients. Task Force members discussed whether this existing system could be used, enhanced or expanded to include veteran transportation to CBOCs, Vet Centers, and VA hospitals.

The Task Force also discussed the existing DAV system and if there were ways to provide state support to bolster and expand that program.

Findings

1. Many Oregon veterans, especially in rural and remote Oregon, are in need of regular and reliable transportation to and from their VA medical appointments.

2. The DAV van system is a vital component for veteran transportation; however, it is not sufficient to be considered a comprehensive statewide system, especially when it cannot accommodate wheelchair-bound veterans.

3. Drive time to VA specialty care, Vet Centers, and other facilities can be two hours or more from many locations around the state, creating a hardship for veterans and their families who have to drive literally hundreds of miles for their health care, even a basic appointment, sometimes no more than 15 minutes in length. This also speaks to the lack of available health care providers that serve veterans in the more rural parts of our state.

4. During times of inclement weather veterans in parts of Oregon may not be able to access VA care.

Recommendations

1. Establish a Task Force to examine and recommend options for a statewide veterans' transportation system that uses strategic partnerships to create a reliable network – public and private – to help our veterans access their health care.

2. Urge the United States Congress to fund a statewide veterans' transportation system.

3. Restructure VA transportation funding streams.

Women Veterans

During the course of the Task Force's work, the group learned of the special needs women veterans have and their struggles having these needs met in a way they deemed appropriate. Unlike during the Vietnam War where only 7,500 women served, mostly as nurses, the current conflict as seen 192,000 women serve, many in combat. The paradigm of women veterans has shifted from women serving strictly in support positions to women in combat, suffering combat injuries including amputations, Traumatic Brain Injury (TBI), Post Traumatic Stress Disorder (PTSD), and a host of orthopedic conditions. Women also are the victims of Military Sexual Trauma (MST) (as are men) which "is rampant," according to the United State Army. The Task Force learned that there is a serious shortage of beds dedicated solely to women veterans, and no facilities that also take women veterans with their children, creating a significant barrier for some women veterans to obtain the care they need. Intentionally providing women-focused veteran services is a top priority of the Task Force.

Women's Health Care

Women make up approximately 15 percent of the current armed forces. Nationally, there are 1.4 million woman veterans who constitute about seven percent of the VA health care clientele. In Oregon, women veterans constitute about five percent of the VA health care system.

The VA health care system provides specific care to women veterans; however, the nation was largely unprepared to provide for the high number of women serving in this conflict – especially in combat – and the special needs they would have when they returned home.

Traditionally, women have not suffered from combat-related Post Traumatic Stress Disorder in large numbers. While PTSD was seen in women who had been sexually assaulted (addressed later in this paper), female combat-related PTSD is relatively new for health care providers. While the treatment of PTSD is not gender specific, mothers and wives coming home with PTSD creates a unique and different dynamic that must be addressed in treatment plans. Further, severe PTSD or Depression and/or Anxiety can create suicidal ideation, which is a significant problem from the current conflict.

Like their male counterparts, women combat veterans are more comfortable around other combat veterans. However, in some cases, they are more comfortable around other women – and if those other women are combat veterans, all the better. Given their combat experiences, some women are not comfortable discussing their situation with male veteran service officers or male health care providers. However, the system is not geared toward ensuring a female provider is always available to provide care for a female veteran. As only a small percentage of the total veteran population, the system has been geared toward the male veteran. The current conflict changes that paradigm as well.

The Task Force learned from the Portland VA Medical Center that efforts are on going to provide specific women's care. A private female waiting room is being created, and female providers are being assigned to female veterans. The VA Regional Office also has embraced this paradigm shift by recognizing female combat PTSD, Traumatic Brain Injury, and other combat-related injuries by providing disability compensation for these injuries. Six years into the Global War on Terrorism, the Task Force believes tremendous strides have been made in understanding the unique needs of female combat veterans. However, more work needs to be done.

As noted previously, there is a serious shortage of inpatient or residential mental health/PTSD treatment beds dedicated to female veterans. The Task Force was told no beds for separate women's programs exist in VISN 20, consisting of Oregon, Washington, Idaho, and Alaska. No government facility takes women with their children, creating a catch-22: Seek treatment and find somewhere for the children to stay, or take care of the children and forego treatment. The Task Force believes Oregon can lead the way in addressing this problem with innovative federal-state partnerships that could become a national model.

As the current conflict continues, more and more women combat veterans will be returning to Oregon with health care needs that require different handling than their male counterparts. The Task Force is encouraged with how the VA Health Care system is addressing the issue and believes that female veterans will be able to find appropriate health care within the current system.

Military Sexual Trauma

"Military sexual trauma" (MST) is the term that the Department of Veterans Affairs uses to refer to sexual assault or repeated, unsolicited, threatening acts of sexual harassment that occurred while the veteran was in the military. These acts often result in Post Traumatic Stress Disorder, Depression and/or Anxiety all with the potential of suicidal ideation. Sexual assault is any sort of sexual activity between at least two people in which someone is involved against his or her will -- they may be coerced into participation (e.g., with threats), not capable of consenting to participation (e.g., when intoxicated), or physically forced into participation. The sexual activity involved can include many different experiences such as unwanted touching, grabbing, oral sex, anal sex, sexual penetration with an object, and/or sexual intercourse. Sexual harassment that falls into the category of MST involves repeated, unsolicited and threatening verbal or physical contact of a sexual nature. Examples of this include implied faster promotions or better treatment in exchange for being sexually cooperative or negative consequences for refusing to be sexually cooperative.

In 2002 the Department of Defense conducted a large study of sexual victimization among active duty populations and found that 54 percent of women and 23 percent of men reported having experienced sexual harassment in the previous year. Rates of attempted or completed sexual assault were 3 percent for women and 1 percent for men. According to a Veterans Administration report in 2007, 59,345 male veterans and 57,637 female veterans screened positive for some sexual trauma during service. The United States Army reports 2.6 soldiers out of every 1,000 reported sexual assault in 2007, but admitted that the vast majority of cases go unreported. Rates of military sexual trauma are typically even higher among veterans using VA healthcare. In one study, 23 percent of female users of VA healthcare reported experiencing at least one sexual assault while in the military.

Although sexual trauma occurs more frequently among women than among men, the disproportionate ratio of men to women in the military means that within the VA system, there are actually slightly more men than women who report experiencing MST.

While there is little empirical data comparing experiences of military sexual trauma with experiences of sexual harassment and assault that occur outside of military service, there are aspects of MST that may make these experiences qualitatively different for victims. For example, because sexual trauma associated with military service most often occurs in a setting where the victim lives and works, many victims must continue to interact and work closely with their perpetrators on an ongoing basis after the trauma. In some cases, victims may need to rely on their perpetrators (or associates of their perpetrator) to authorize medical and psychological care or provide for other basic needs. This may leave them at risk for additional victimization and often increases their sense of helplessness and powerlessness. There may also be career-related consequences for victims in that perpetrators are frequently peers or supervisors with the power to influence work evaluations and decisions about promotions. Even if this is not the case, victims may face the difficult choice of either continuing military careers in which they are forced to have frequent contact with their perpetrators or sacrificing career goals in order to protect themselves from future victimization. In a case documented by the Oregonian, a female victim chose to go AWOL (Absent Without Leave) rather than continue in a unit with her perpetrator, resulting in military judicial punishment for the victim.

Most military groups are characterized by high unit cohesion, particularly during combat. Although this level of solidarity is typically a positive aspect of military service, the dynamics it creates may amplify the difficulties of responding to sexual harassment and assault. This makes MST most akin to incest, because a "family" member attacked and the trust for them to support and defend is demolished. For example, the high value placed on

organizational cohesion may make it taboo to divulge any negative information about a fellow service member. As a result, many victims are reluctant to report sexual trauma and may struggle to identify even to themselves that what occurred was an assault. Those who choose to report to those in authority often feel that they are not believed or, even worse, find themselves blamed for what happened. They may be encouraged to keep silent and their reports may be ignored. This type of invalidating experience can often have a negative impact on the victim's post-trauma adjustment.

In Oregon, every VA facility offers MST services. All men and women in the VA are screened for MST. The four Vet Centers in the State also offer counseling for MST. The services for veterans are there; however, the difficulty lies in having MST victims come forward, even after many years (sometimes decades) have passed.

The Task Force heard moving personal testimony of a woman who had been raped by her superior officer, and this tragedy was multiplied by her inability to report it, having to remain in the same squadron, and an understanding that any report would have deleterious impact on her career. Another example was a young woman who had joined the Army to escape a sexual abusive family situation only to find herself in a tent of 300 co-ed soldiers, in nighttime black out conditions, being raped. She later became Portland VA Medical Center's first homeless OEF/OIF Veteran and is well on her road to recovery. If this were not traumatic enough, an Iraqi hostile stepped in front of her vehicle during a convoy and she was ordered by her commander not to stop and to run over the Iraqi, which she did. This resulted in more severe PTSD.

The VA Health Care system continues to be concerned about the specifics of women's health care. The Task Force is encouraged by the dedication showed by the VA to focus on women's issues and believes that whatever gaps exist can be addressed internally by the Veterans Health Administration.

Findings

1. There are a significant number of female combat veterans who are experiencing the same combat injuries and disabilities as their male counterparts, creating a paradigm shift in how the nation addresses women veterans' health care

2. The Veterans Health Administration is addressing the special needs of women combat veterans

3. MST and specific (non coed) inpatient or residential female PTSD treatment are not available in this state or in the region.

4. No program exists in the VA national system that allows children to accompany their mother into treatment, which is often the stumbling block for seeking care. Senator Patty Murray (Washington) and Senator Wyden (Oregon) have co-sponsored a bill, currently in committee, that addresses MST and provides pilot money to care for children.

Recommendation

1. Establish a Task Force to explore reprogramming of the Eastern Oregon Training Center and other available facilities in Salem into a network of in-residence care for women veterans and families.

2. Develop/fund a Military Sexual Trauma public information campaign.

3. Expand mental health access for women veterans living in remote/rural areas.

Veterans' Employment

Regardless of what era a veteran served, the Task Force learned veterans face common issues when looking for employment once they leave the military. For many Oregon veterans who serve in the National Guard and Reserves, this current conflict has resulted in an even more complicated employment landscape due to multiple deployments and injuries, such as Traumatic Brain Injury, Post Traumatic Stress Disorder, and orthopedic issues.

Helping veterans find employment after service is a long-standing benefit. At the end of World War II, an intensive effort to help veterans obtain employment was implemented. One of the first initiatives, Local Veterans Employment Representatives, was established by the U.S. Department of Labor and housed in state workforce agencies. The LVERs, as they are called, were veterans themselves who had been trained to help other veterans navigate the civilian job market. Today, LVERs continue to help veterans by offering services, such as help creating a civilian resume, job searching, networking with veteran-friendly employers, and using the tools of state Employment Departments to match veterans to jobs.

A second veteran-employment program provides a deeper level of service. Disabled Veterans Outreach Program (DVOP) is similar to the LVER program only DVOPs target veterans with significant barriers to employment, such as disability or training needs. DVOPs work with the veteran to overcome these barriers and find suitable employment. Task Force members met several DVOP and LVERs while touring the state and heard their concerns at leadership and town hall meetings. Due to federal budget cuts in their programs, Oregon's DVOP and LVER contingent has been significantly reduced, resulting in fewer veterans receiving these specialized employment services that is vital to help them obtain employment after service.

Veterans of the current conflict are facing serious challenges. The disruption of life caused by the Global War on Terror (GWOT) makes finding or holding a job very difficult and yet once a veteran returns from the conflict in the Middle East that is precisely what is expected. Regular military veterans may initially find it difficult to transition from military "institutional" thinking and adapt to civilian language and protocols. Guardsmen and Reservists may find decompressing from their combat experience overwhelming and finding a job just a week after returning home may be too much to ask.

One of the most important things the Task Force learned is that returning veterans come home focused on returning to a "normal" life, but some do not want anyone to know they have a problem getting back to "normal." This obviously interferes with their ability to obtain and maintain employment.

Several factors work together to make reintegration a problem for returning veterans including stress, pride, fear and bureaucracy. Stress can cause a host of problems including procrastination to the point of crisis. Pride or the "I can hack it" mentality puts problems on the soldier they weren't meant to bear. Fear keeps them from looking "weak" to others (especially peers, spouse and leaders). And perceived (and maybe sometimes real) bureaucracy keeps vets from even trying to get the benefits they have earned.

Due to this reality, the Task Force and every agency involved with veterans has realized that veterans issues are interconnected; a veteran returning from Iraq needs a job, but that veteran also may need health care, mental health screening, housing, education, and other tools before the veteran is ready to enter the job market.

That being said, gains have been made in helping veterans transition out of the military and in stabilizing employment. The Oregon National Guard is working closely with local government officials, the Employment Department, the Oregon Department of Veterans' Affairs, the U.S. Veteran's Administration, education representatives and local private groups to help veterans access benefits, learn how to look for work and get training, but more needs to be done.

Oregon is in a unique situation during this current conflict. Many of its veterans are National Guard and Reserve service members who are both veterans and still serving in the Guard/Reserves. This means that while needing employment, they could be called back into service for deployment at any time. For employers, this creates a dilemma – hire a veteran who will be a good employee and risk them being taken away for up to 18 months or hire a civilian who may not be as good of an employee, but at least will not be leaving for a long period of time. There also is the issue of returning service members regaining their job with their employer once they return home from deployment. Under federal law (Uniformed Services Employment and Re-Employment Rights Act), deployed service members have a right to their job or a similar position upon returning home. However, the Task Force learned that some employers are not honoring this right.

Aside from the National Guard and Reserve, Oregon also has a large component of active-duty service members returning home. According to the Oregon Department of Veterans' Affairs, as many as 300-500 of these active-duty service members come home to Oregon each month. The Oregon Department of Veterans' Affairs, the Employment Department and the Oregon Military Department's Reintegration Team do significant outreach to these veterans; however, only a small percentage are finding their way to a DVOP or LVER for assistance.

Veterans bring important skills from their military experience, transferable skills that can save businesses in training and recruitment costs. The National HireVets First initiative lists 10 critical skills most employers want to see in a newly hired employee, skills most veterans gain while in service. The skills include:

1) Early Responsibility
2) Leadership
3) Teamwork
4) Diversity
5) Healthy & Drug Free
6) Performance Under Pressure
7) Integrity
8) Technical Training
9) Can Do Attitude
10) Respect for Organization

Veterans clearly are a sound hire for private business and government agencies. To help veterans compete in the job market, the Oregon Legislature recently passed an amended "preference" law with the intent to provide enough preference points to veterans in civil service hiring during the initial application phase to warrant that veteran receiving an interview. While there is no guarantee or requirement that a veteran be hired, providing a mechanism to allow veterans to interview should help veterans increase their chances at finding employment. Veterans' preference is not a new concept. Since the time of the Civil War, veterans of the Armed Forces have been given some degree of preference in appointments to Federal (and state) jobs. Recognizing their sacrifice, Congress enacted laws to prevent veterans seeking Federal employment from being penalized for their time in military service. A system was designed to recognize the economic loss suffered by citizens who have served their country in uniform, restore veterans to a favorable competitive position for Government employment, and acknowledge the larger obligation owed to disabled veterans. However, veterans' preference is a limited benefit, expiring after 15 years, meaning older veterans may not be able to take advantage of the preference points.

The 2005 Legislature provided $54,000 of special funding to help veterans with transportation related costs. It was administered by the Oregon Employment Department LVERs and DVOPs and served 748 veterans over the course of the biennium at an average cost of $72 per veteran; 397 (53%) of those served had obtained employment by the end of the biennium.

The need still exists. A projected 3,500 Oregon National Guard (ORNG) troops will be returning in 2010. Based on the experiences of soldiers from past deployments, many will need help with transportation related to job search. Providing these funds again would help veterans meet job related transportation needs and make the difference for those who require a bus pass or gas voucher to get to an interview or maintain attendance for the first critical weeks of a job before the first paycheck arrives.

Older veterans also have their own unique set of circumstances. For many, the downturn in the economy has meant retraining to become marketable for a job in a different field. Older veterans may not have the computer or other technical skills necessary in today's job market and may need vocational training. Otherwise stable veterans are finding themselves downsized, out of work and unable to keep in the job market due to their age, lack of experience in the particular field, and lack of technical skills. Like recent veterans, older veterans need the assistance of DVOPs and LVERs to help them navigate today's job market and program dollars to get the training they need.

Findings

The Task Force recorded the following employment-related findings:

1. Veteran employment issues often times intersect with other veteran needs

2. Cuts in DVOP and LVER programs have significantly affected employment services to veterans.

3. Existing transportation system and funding for veterans mobility to/from employment/workforce programming are insufficient to current and projected needs.

4. Many eligible veterans do not seek employment services for a number of reasons

5. Employers are wary of hiring veterans who may be re-deployed or are injured physically or emotionally

6. Employers do not always abide by the USERRA law

7. Older veterans are in need of employment services due to the economic downturn

Recommendations

1. A Joint Memorial to the U.S. Congress should be drafted to urge Congress to increase Local Veteran Employment Representative/Disabled Veteran Outreach Program (LVER/DVOP) staff funding

2. The Legislature should support the development of a public education campaign supporting Oregon "HireVets" program.

3. The Legislature should support the development of a state recognition program for employers that hire veterans, support veterans, and veteran-owned businesses.

4. The State should facilitate the creation of a private sector veterans' employment compact to provide employment to returning veterans.

5. The Legislature should examine veteran transportation issues related to veterans finding and maintaining employment and the associated costs.

6. The Legislature should examine eliminating the 15-year limitation on the use of the veterans' preference.

Veterans' Education

Since the end of World War II, the United States has provided programs to help veterans with education and training. The GI Bill of 1944 provided college education for millions of the veterans of WWII. The program literally transformed American society. The GI's who exercised their educational benefits after WWII became the architects of the US economic boom of the 1950's and 60's. In Oregon, there were so many veterans who took advantage of the GI Bill the State created a special college just for veterans*.

During the next 60 years, the country continued to provide educational benefits to its veterans. In addition, Oregon through the Military Department offered supplemental benefits for National Guard members. A major shift in the educational benefits occurred in 1984 with the passage of the Montgomery GI Bill (named for Rep. "Sonny" Montgomery of Alabama). Prior to the passage of this legislation, education benefits were available to veterans as a direct benefit and were available on the assumption that a draft was in place. Accessing these benefits was a fairly simple process: Veterans and active duty military members received a letter of eligibility and funding was paid to the school up to the amount provided. In 1984, the Montgomery Bill (Chapter 30) changed that as the nation ended the draft and moved towards an all-volunteer force. Foremost with the Montgomery GI Bill was an "enrollment fee" of $1,200 to be paid upfront by the military member ($100 a month for 12 months). For many this was a deterrent to the program. Also, the living expense allowance in the previous GI Bill was eliminated, creating a further deterrent to those eligible.

Montgomery GI Bill – Active Duty

The Montgomery GI Bill – Active Duty, called "MGIB" for short, provides up to 36 months of education benefits to eligible veterans for:

- College
- Technical or Vocational Courses
- Correspondence Courses
- Apprenticeships/Job Training
- Flight Training
- High-tech Training
- Licensing and Certification Tests
- Entrepreneurship Training
- Certain Entrance Examinations

Who is Eligible?

A veteran may be eligible if the veteran has an Honorable Discharge; AND has a high school diploma or GED or in some cases 12 hours of college credit; AND the veteran meets one of the following categories:

Category I

- Entered active duty for the first time after June 30, 1985
- Had military pay reduced by $100 a month for first 12 months
- Continuously served for three years, OR two years if that is what the veteran enlisted for, OR two years if the veteran entered the Selected Reserve within a year of leaving active duty and served four years (2 by 4 program)

Category II

- Entered active duty before January 1, 1977
- Served at least one day between 10/19/84 and 06/30/85, and stayed on active duty through 06/30/88 (or 06/30/97 if you entered the Selected Reserve within one year of leaving active duty and served four years)
- On 12/31/89, you had entitlement left from Vietnam-Era GI Bill

Category III

- Not eligible under MGIB under Category I and II
- On active duty on 09/30/90 AND separated involuntarily after 02/02/91,
- OR involuntary separated on or after 11/30/93,
- OR voluntarily separated under either Voluntary Separation Incentive (VSI) or Special Separation Benefit (SSB) program
- Before separation, you had military pay reduced by $1,200

Category IV

- On active duty on 10/09/96 And you had money remaining in a VEAP account on that date AND you elected MGIB by 10/09/97
- OR entered full-time National Guard duty under Title 32, USC, between 07/01/85 and 11/28/89 And you elected MGIB during the period 10/09/96 through 07/08/97
- Had military pay reduced by $100 a month for 12 months or made a $1,200 lump-sum contribution

How Much Does VA Pay?

The monthly benefit paid to a veteran is based on the type of training the veteran takes, length of service, category, and if the Department of Defense put extra money in your MGIB fund (called "kickers"). The veteran usually has 10 years after discharge to use the MGIB benefits, but the time limit can be less in some cases, and longer under certain circumstances.

New GI Bill

After 24 years of the Montgomery GI Bill, lawmakers have determined that veterans need a better education benefit and have created the new GI Bill, which is similar to the original GI Bill of 1944. The recently passed new GI Bill (Chapter 33) has eliminated the enrollment fee and does provide allowances for living expenses. It is expected that these changes will encourage more veterans to use their educational benefits. A head-to-head comparison of the old and new GI Bills shows the differences:

The following table highlights the differences between the Montgomery GI Bill and the Post 9/11 GI Bill. As noted below, some details still are being developed.

	Montgomery GI Bill (MGIB) Chapter 30	**Post 9/11 GI Bill Chapter 33**
Payment Rate for Full-Time Student	Annually set - nationwide - monthly payment rate. The payment rate is **$1,321** for the 2008-2009 academic year. **Note:** Generally speaking, this payment rate is enough to cover most high cost on-campus and online courses.	A payment indexed to the full time in-state undergraduate tuition rate for public colleges and universities. Paid per term. This tuition payment is limited to the in-state tuition rate for the most expensive state run college of university in the state of enrollment. **Note**: This new tuition payment rate is not enough to cover the cost of attending online classes at most colleges. This will result in veterans paying as much as $1,000 a course out of pocket.
Additional expense payments	No additional payments for expenses.	**Living Expenses** - stipend based on local BAH for E-5 with dependents – paid monthly. **Important note:** This stipend is not paid to those still on active duty and veterans attending distance learning (online) courses. Up to a $1,000 a year for books and fees.
Eligibility Requirements	Entered military after June 30, 1985 and paid the $1,200 enrollment fee.	Active-duty service for more than 90 days since Sept. 11, 2001.
VEAP-era Eligibility	No - Except those who elected to convert in the past.	Yes – those who meet the eligibility criteria above.
Benefit Expiration	10 Years after last separation or discharge.	15 Years your last period of active duty of at least 90 consecutive days.
Transfer benefits to families	Limited - Currently Limited to Army re-enlistees for critical MOS only.	Yes - open to active duty service members with six years service who agree to reenlist. However, the eligibility details are still being worked out.
Enrollment fee	Yes - **$1,200**	None. **Note:** If a member paid the $1,200 MGIB enrollment and switches to the Post 9/11, they will receive a refund of their fees once they have used all 36 months of their Post 9/11 benefits.

Programs Covered	The Montgomery GI Bill can be used to pay for many different programs including the following: • College, Business Technical or Vocational Courses • Distance Learning including Online and Correspondence Courses • Certification Tests • Apprenticeship/Job Training (Veterans and Reserve Only) • Flight Training These programs can be completed at any education or training institution.	Under the Post 9/11 GI Bill you may receive educational and training assistance for the following: • College, Business Technical or Vocational Courses • Distance Learning including Online and Correspondence Courses • Certification Tests • Flight Training However under the Post 9/11 these programs are only covered if offered **by a college or university**. Those who were previously eligible for the MGIB, MGIB-SR (1606), or REAP (1607) may continue to receive educational assistance for MGIB approved programs not offered by colleges and universities (i.e. flight, correspondence, APP/OJT, preparatory courses, and national tests). **Note:** This seemingly minor detail can have a huge impact on your education and training options in the future. Especially for those service members who choose to decline the MGIB.

On the surface the new Post 9/11 GI Bill seems to answer all shortcomings of the MGIB. However, as noted in the table, there are some limitations, especially in the area of tuition payment rates and housing stipends.

While these changes might bring a higher percentage of veterans to their education benefits, the Task Force found that there is a considerable amount of confusion on the part of veterans as to what their eligibility is and how to apply for those benefits. A brief glimpse of the range of benefits offers an example to the complexity of navigating those benefits:

Montgomery GI Bill – Active Duty	$47,556 max over 36 months
Montgomery GI Bill – Select Reserve	$11,844 max over 36 months
Veterans Educational Assistance Program (VEAP)	VEAP is available if you elected to make contributions from your military pay. The Government matches your contributions on a $2 for $1 basis. Benefit entitlement is 1 to 36 months depending on the number of monthly contributions.

Reserve Educational Assistance Program (REAP)	Members may be eligible after serving 90 consecutive days on active duty after September 11, 2001. **Institutional Training** **Training Time** **Consecutive service of 90 days but less than one year** **Consecutive service of 1 year +** **Consecutive service of 2 years +** Full time $440.40 $660.60 $880.80 3/4 time $330.30 $495.45 $660.60 1/2 time $220.20 $330.30 $440.40 Less than 1/2 time More than 1/4 time $220.20** $330.30** $440.40** 1/4 time or less $110.10** $165.15** $220.20 **

Post 9/11 GI Bill (for training pursued on or after August 1, 2009)	Determined by length of creditable active duty service. • Amount of tuition and fees charged, not to exceed the most expensive in-State undergraduate tuition at a public institution of higher education (paid to school). • Monthly housing allowance equal to the basic allowance for housing payable to a military E-5 with dependents, in same zip code as school (paid to you) • Yearly books and supplies stipend of up to $1000 per year (paid to you) • 36 months general entitlement
Guard Officer Leader Detachment (GOLD) program	On campus military science instruction. All courses are fully accredited and applicable towards fulfilling academic requirements for a baccalaureate degree.
Voyager	Financial aid benefit that is available to honor and support Oregon residents who served in the National Guard or Reserves on active duty in a combat zone since 9/11/2001. Award is a fee remission for tuition amounts not covered by other military benefits.
State of Oregon Veteran Educational Aid	$150 mo. (full time) or $100 (part time)
Vocational Rehab	A veteran who is eligible for an evaluation under Chapter 31 must complete an application and meet with a Vocational Rehabilitation Counselor (VRC). If the VRC determines that an employment handicap exists as a result of a service-connected disability, the veteran is found entitled to services. The VRC and the veteran will then continue counseling to select a track of services and jointly develop a plan to address the rehabilitation and employment needs of the veteran.

As is evident, there is any number of educational programs available for veterans; however, according to the Department of Veterans Affairs, only 5,813 Oregon veterans are using their GI Bill, a small percentage of those eligible.

Navigating the maze for matriculation into college or eligible training programs is an arduous path for most and veterans are no exception. The veteran's education benefits maze makes this even more daunting. The Task Force found that many veterans do not wish to enter college or training programs immediately upon discharge, but rather wait up to several years before starting. There are several reasons for this: 1) veterans often are not "ready" for college or to enter a training program, that is, they have trouble transitioning from a military environment to a college environment; 2) they often cannot afford college and want to work for awhile; 3) they see no value in attending college; 4) they are unaware that they have benefits; or, 5) they do not know how to get started.
Each of these creates a barrier to increase the number of veterans that could access educational benefits

Overcoming the Barriers

The Task Force found that the universities and colleges in Oregon have made attempts to recruit and accommodate veteran students to their campuses. But these efforts have been scattered and when successful have been so mostly because of a dedicated campus official or student who spearheads the effort.

Notable among the successful programs to reach out to veterans is Clackamas Community College (CCC) and Linn-Benton Community College (LBCC). Clackamas Community College initiated a diverse veteran's services team, which includes staff from the County, members of the Oregon National Guard, and providers of services from the community college. The team established an $180,000 Military Family Scholarship Endowment. The endowment has assisted returning veterans' families with educational expenses at the college. The services provided at CCC are available at a Veteran's Education and Training Center. The concept behind this center is recognition that soldiers

returning from deployment face numerous challenges reintegrating into civilian life. The center will feature a dedicated staff, a "Rapid Response" team that meets with veterans during demobilization and a "One-stop" resource center for referrals to other needed services.

LBCC has also created a veterans team and "gap" funding to get veterans started prior to benefit being approved. Representatives from LBCC told the Task Force during its Albany town hall that it plans to create a veteran center on campus that would be a one-stop shop for veterans and a comfortable place for veterans to congregate. LBCC is reaching out and will be meeting with the CVSO and others to determine what type of services could be offered of campus to student veterans. The school also is intent on providing pre-deployment and reintegration services. Currently, LBCC is providing tuition-free education to Gold Star families, and has in the past provided tuition waivers to bridge the gap between when a service member returns and when their GI Bill kicked in. Linn-Benton says it is committed to helping reintegrate service members via its education opportunities.

These programs, and there are others, have been successful for several reasons:

- They recognize that returning veterans need help navigating the benefits maze.
- They recognize that returning veterans need to be in an environment in which they can feel comfortable.
- They recognize that merely advising on education benefits is not enough. For veterans to be successful and stay in college they often have other needs such as family, housing, and medical requirements that need attention.
- They have grouped veteran services into a central service function –"one-stop" shops.
- They know that veterans should be getting benefits advice from an accredited Veteran's Services Officer (VSO).

It is particularly important to understand the role that an accredited Veteran's Service Officer plays. Accredited Veteran Service Officers are subject matter experts in federal veterans law and act as advocates for veterans by filing claims for benefits for veterans. In their work, VSOs not only help fill out complicated VA paperwork, but they perform legal, medical and military research to create evidence to prove veterans eligibility for VA benefits. A VSO's job is to ensure a veteran receives the maximum amount of benefits the veteran has earned due to his/her service. There are VSOs at the national level (VFW, American Legion, Military Order of the Purple Heart, Disabled American Veterans, AMVETS, Paralyzed Veterans of America), state service officers who work for the Oregon Department of Veterans' Affairs, and County Veteran Service Officers who work for counties throughout Oregon.

The VSO, then, is the key to veteran's receiving their benefits. The VA benefits system is quite complex. While it protects veterans' rights, it also protects the taxpayer against fraud. However, due to its complexity and bureaucratic nature, many veterans simply give up trying to obtain their benefits – especially if they try to obtain these benefits without the help of a VSO.

Economic Impact

While not a primary motivation, the economic impact of providing education benefits for veterans should not be overlooked. In 2007, the federal VA paid $1.2 billion to Oregon veterans in the form of disability compensation, pension, health care benefits, and education benefits. It is anticipated that the New GI Bill will exponentially increase federal dollars coming to Oregon community colleges and universities, especially those who cater to veterans. As was the case after World War II, Oregon can expect to see a significant financial and social impact due to the new GI Bill.

Findings

1. The New GI Bill will bring more federal education dollars to Oregon with more veterans being able to attend state colleges and universities.

2. Many veterans are unaware of the full extent of their military education benefits and need help navigating the process and bureaucracy. Veteran Service Officers can help veterans with the process and bring more federal education dollars to Oregon.

3. There may be non-traditional partnership that can be created to provide further assistance to veteran students.

Recommendations

Political leaders at both the state and federal level have recognized the importance of education and have acted to ensure veterans receive sufficient education benefits to achieve their education goals. However, many veterans do not use their benefits for a number of reasons. The Task Force believes more can be done to encourage veterans to use their education benefits – especially the new GI Bill – by creating systems that are less bureaucratic and more conducive to meeting veterans' needs. A key to this will be outreach by Veteran Service Officers who can manage the VA bureaucracy for the veteran. The Task Force recommends the following:

1. To enable veterans to obtain the direct advice for education benefits and at the same time receive assistance in obtaining other benefits and coordination of those benefits, the Task Force recommends that 18 Veteran's Services Officers be assigned to permanent on-campus sites at all Oregon Community Colleges and Universities.

2. The Task Force further recommends that the Oregon University System allocate space at the colleges in the OUS system to create a "one-stop" office where veteran's can seek services. The Task Force recommends that the various community colleges make every effort to locate a VSO and one-stop offices on their campuses.

3. Amend SB 1066 to eliminate the eligibility date so that all eligible veterans, dependents and survivors qualify, and include community colleges.

4. Allow automatic state residency for any veteran attending an Oregon public college or university.

5. Create pilot childcare, housing and transition programs at Eastern Oregon University and Portland State University.

Veterans' Housing

Veterans face many of the same housing problems as the population at large, but obviously have more particularized issues, and some additional means for assistance. The general subject of "housing" can encompass many areas, including homelessness, transitional housing, home loans, and assisted living and nursing home care. The Task Force has grappled with each of these issues as it relates to state policy and local implementation.

Homelessness and Transitional Housing

Homelessness is an urgent problem facing many of our citizens, a large percentage of whom are veterans. The number of homeless in Oregon is not easily determined. The statistics in most communities are determined by a "one night count" on a nationally identified day in January. On that date, volunteers count individuals using shelter services; individuals turned away from shelters; and, in some communities, a "street count" is also performed. According to the National Alliance to End Homelessness, there were an average of 16,221 homeless people in Oregon during 2007 – about 4.5 out of every 1000 people and the state ranked sixth in the nation for homelessness. Almost 7,000 of these individuals are estimated to be veterans, according to the Oregon Housing and Community Services Department. The most common reasons for homelessness are:

- Poverty
- Lack of affordable housing
- Economic downturns
- Difficulties in utilizing the available service delivery systems
- Addictions
- Mental Illness
- Abuse (domestic violence)

There are many programs aimed at assisting the homeless, some directed generally, and some more focused on veterans. Oregon Housing and Community Services is the State housing finance agency, providing financial and program support to create and preserve opportunities for quality, affordable housing for lower income Oregonians. The agency also administers Federal and state anti-poverty, homeless and energy assistance community service programs. OHCS addresses a continuum of housing needs, including immediate disaster response; stabilization of traditional housing, assisted living, and other similar facilities; and the long-term impact of homelessness through development and preservation of affordable housing, home ownership, down payment assistance, education and other services to help the more disadvantaged acquire suitable housing. Its Housing Resource Division essentially performs banking type functions, while the Community Resources Division provides logistical support or rapid response programs and community stabilization. Many of its programs are administered through partnerships such as collaboration with other state agencies, private sector partners, community development corporations, community action programs, public and Indian housing authorities, the Oregon food bank, and other similar organizations. There is a potential for similar collaboration with veterans services to hopefully marshal resources to assist the homeless.

There are also private sector facilities that are helping the homeless in general, and veterans in particular. Central City Concern, a nonprofit organization in the Portland area, was established in 1979 and operates an affordable housing program integrated with health care, addiction treatment, mental health, and employment services. Central City has 20 residential buildings, most in downtown Portland, which provide more than 1,300 units for homeless individuals. More than 70 percent of these units are alcohol and drug free community housing. Central City also has a particular building, the Henry Building, which has 50 units specifically reserved for veterans under the Federal veterans' grant per diem program. The Henry Building is part of a transitional housing program, which allows up to two years of residency as veterans prepare for independence. To be eligible, a veteran must have received an honorable discharge, be homeless, and have a motivation to complete the program. These units are always filled with veterans and have a substantial waiting list. The representative from Central City, Rachel Post, emphasized the importance of having specialized

veterans programs, and of housing veterans in the same facility where they can share common experiences. Ms. Post also noted that many of the veterans in the program have been homeless for some time and thus are among the "chronic homeless" as opposed to the "episodic homeless." It was apparent that many of the homeless veterans are from the Vietnam-era, and also suffer from many of the problems associated with that conflict, including substance abuse and Post Traumatic Stress Disorder. Central City offered an excellent model for a well-coordinated program to help the homeless reintegrate into society in a meaningful fashion.

The Task Force also received a presentation from Mark Jolin, the executive director of JOIN, another private nonprofit organization aimed at assisting the homeless. JOIN is more focused on directly relieving homelessness, supporting the efforts of homeless individuals to get into permanent housing, and working consistently with the chronically homeless. This organization perhaps exemplifies the concept of "outreach." Although rather small, JOIN now has six outreach workers who try to find and assist anyone without a home. These workers literally go out on the street and find people living under bridges, in caves, in vehicles, and in other desperate circumstances. Mr. Jolin estimated that perhaps 20 percent of the homeless people he serves are veterans, most from the Vietnam era, and most of whom have been homeless for 10 - 15 years or longer, and would certainly be characterized as "chronically homeless." These Vietnam-era veterans present a particular problem because most of them who are still homeless have obviously been unsuccessful in reintegrating into society, are aging rapidly, and are very difficult to reach or help. Some also choose to be homeless. They also may have exhausted many of their veterans' benefits. He indicated that aggressive outreach to these veterans is important, and it would be very helpful if many of the administrative hurdles to participation in programs, and acceptance into housing facilities, could be alleviated. He accentuated this need for outreach through the example of a Korean War veteran who was found living in his vehicle. His mental faculties were failing and he could not bring himself to leave his vehicle. This individual had veterans' benefits, could afford to get into some form of housing, but was just unable to get himself out of his car. One of the outreach specialists from JOIN physically went to this veteran, encouraged him to leave his vehicle, obtained housing for him, and generally assisted him in regaining some level of normalcy.

The federal VA also has a homeless Grant Per Diem program provides money to community agencies that provide shelter and programs to veterans. The program will grant up to 65 percent of the cost for construction or purchase of a facility to accommodate a veteran homeless program. The VA also provide per diem for grant recipients and other organizations that apply. Per Diem is paid for each veteran sheltered.

The VA also has other homeless initiatives, such as a partnership with the US Department of Housing and Urban Development to provide case-managed Section 8 housing for veterans in need of more maintenance. HUD VASH, as it is called, is a voucher program that is provided to 10,000 veterans across the nation.

As indicated in the introductory portion of this record, the Task Force conducted a great many visits to outlying communities. The issue of homelessness and housing came up at a number of meetings with local leaders and during public town halls. Some communities did not identify veterans as a specific category relating to their homeless population. Other communities do. Of particular interest was the Central Oregon Veterans Outreach, an organization located in Bend. COVO is a nonprofit corporation formed by veterans and aimed solely toward assisting veterans in the Central and Eastern Oregon areas. Relieving homelessness is only a portion of the multifaceted mission of COVO, which also seeks to generally assist veterans through an initial intake assessment; helping in the VA benefits and claims process; addressing mental, emotional and social health issues and making appropriate referrals; providing emergency and transitional sustenance; providing job training and employment services; and crisis intervention. However, there is a decided focus on taking care of homelessness.

COVO has determined that, at any given time, there are at least 1,500 homeless veterans in Central and Eastern Oregon. Despite this number, COVO is the only private organization in the 18 Counties East of the Cascades that is veteran specific, and provides beds specifically for veterans. In addition to veterans seeking beds in organized shelters, there is substantial evidence that a number of veterans, perhaps 300, many from the Vietnam-era, are living in tents

in National Forests. More than 200 of these have full or part-time work at minimum wage, but cannot afford housing in Central Oregon. Of that number, almost 10 percent, despite their own situations, volunteer for Habitat Humanity, building homes for others, according to COVO. Homelessness in Central and Eastern Oregon is not limited to Vietnam-era veterans. Anecdotal evidence at least suggests that peacetime veterans are also among the homeless, and some of the younger Gulf War and Afghan war veterans are also finding themselves displaced. A high percentage of veterans in our State have been hospitalized for mental health reasons, including acute psychiatric disorders and substance abuse.

One of COVO's initial efforts to assist homeless veterans has been the acquisition of a residential facility, the "Home of the Brave," within the city of Bend. The down payment for the facility was obtained through a grant from the City of Bend, utilizing Federal funds. The ongoing mortgage costs are covered by a grant from the Disabled American Veteran's Association. The facility houses veterans, all of whom previously suffered from substance abuse and/or PTSD or other emotional or psychiatric problems. Many of the home's day-to-day expenses are paid through the federal VA veteran's per diem program, as also utilized by Central City. COVO hopes to acquire another home to house a similar number of veterans whose disabilities are primarily physical, with an eye toward reintegrating them into independent living. COVO also would like to acquire up to 72 low-income units to assist veterans and their immediate families, to include families of Guard and Reserve personnel who are on deployment.

All of the facilities available to homeless veterans are extremely important. Central City and COVO are perhaps good models for public/private collaborations providing a fully integrated spectrum of valuable services. Transitional housing – moving veterans from homelessness and substance abuse to independence – is needed in every region of the state. Organizations such as the Union Gospel Mission and other shelters provide a safety net for homeless veterans; however, the Task Force envisions a more comprehensive and coordinated effort to identify homeless veterans and provide them the services and shelter they need to regain independence if they so choose.

Home Loans

There are two home loan programs specifically for veterans – the federal VA Home Loan Program and the Oregon Department of Veterans' Affairs Home Loan Program. While many veterans confuse the two, calling them both "VA home loans," there are important differences between the two programs that affect Oregon veterans.

The federal VA Home Loan is a lifetime benefit to honorably discharged veterans. It offers a zero-down loan that includes discounts for disabled veterans. There is no limit on the number of federal VA Home Loans a veteran uses during his lifetime.

The Oregon Department of Veterans Affairs offers home loans to veterans who have been honorably discharged within the past 30 years (25 years in some cases), and served 210 consecutive days on active duty. The Department home loan requires a down payment, but offers a low interest rate – usually lower than any other rate available. Veterans are limited to two loans during their eligibility period.

The Task Force heard from veterans who believe that the State home loan program should be structured more like the federal VA home loan with lifetime eligibility, and active-duty requirements of more than 178 days instead of 210 days to accommodate Oregon National Guard and Reserves who have been called to active duty. To do this, three things must happen. First, the time restriction of the Oregon home loan is due to federal IRS tax code restrictions on the type of bonds used to finance the home loan. Thus, federal law must be changed to allow the state home loan program to use these bonds without timeframe conditions. Second, the Oregon Constitution mandates a 30-year time limit on the loan, as well as the 210 consecutive active duty day requirement, thus Oregon Constitution must be amended. Lastly, to allow a veteran to use the Oregon home loan more than twice, Oregon Revised Statute must be amended. Loosening these restrictions would result in more Oregon veterans being eligible to obtain Department home loans.

Assisted Living and Nursing Home Care

As with the general population, there is an overriding need for senior veteran centers with multiple levels of care, from retirement homes, to assisted living, to nursing home/Alzheimer facilities. Currently our state has a single Oregon Veteran's Home skilled nursing facility with 151 beds in The Dalles. According to a census conducted by the federal VA, Oregon needs 800 skilled nursing beds, meaning that many of Oregon most vulnerable veterans cannot access the skilled nursing homes they need. The state hopes to build one or more additional veterans' homes and/or develop non-traditional partnerships to create this bed space. Veterans' Homes provide a great service to veterans in that the cost for care usually is about 60 percent that of a commercial nursing home. The Oregon Veterans Home provides for veterans who pay for their care through private pay, insurance, Medicare/Medicaid, and federal VA per diem. A veteran rated 70 percent service-connected disabled or more has his/her nursing home care paid for by the VA.

Unfortunately, the VA does not pay for assisted living care. There is no program specifically for veterans moving to assisted living, which may be a need for a good number of Oregon veterans during the next 15 years. Veterans transitioning to assisted living seemingly are on their own.

Findings

1. Homelessness presents a significant problem for veterans. Veterans make up a large percentage of Oregon's homeless population, and, on any given day, as many as 7,000 Oregon veterans are homeless. Many have substance abuse and or mental health issues.

2. The response to veteran homelessness and housing is inconsistent throughout the state. In some areas veteran organizations have made significant attempts to provide housing and programs for veterans, while in others, veteran homelessness is not looked upon as a separate issue from general homelessness.

3. Veteran homelessness is exacerbated by long waiting lists for Section 8 housing throughout the state. Transitional housing -- moving a veteran from inpatient care to self-sufficiency -- also is lacking.

4. Providing housing, workforce development, substance abuse and mental health counseling, and employment training and opportunities, will help reduce veteran homelessness.

5. Substantial amounts of Federal housing/homeless-to-work assistance remains unclaimed or underutilized because of widespread lack of awareness of availability of such funds, as well as lack of training for agency personnel on program procedures.

6. The Oregon Housing and Community Service Department has grants available to build housing. However, funds must be provided locally to run the facility once it is built. The VA also has programs to help build housing. Local government and veteran organizations need to be educated on how to apply for these grants.

7. The Oregon Veterans' Home is at a crossroads in terms of long-term maintenance and sustainability. The establishment of a permanent maintenance fund warrants further study and may preserve a model facility. Oregon also needs to expand the availability of Veterans' Home for veterans needing skilled nursing and Alzheimer/Dementia care.

8. Future expansion of skilled nursing home facilities for veterans should maximize Federal support services. Development opportunities through creative and non-traditional partnerships should be explored and implemented.

9. Resources will be needed to address the issue of homeless veterans, as well as an aggressive outreach program.

10. Existing opportunities for veteran home ownership should be expanded where possible.

Recommendations

1. In order to better inform veterans of the availability of general benefits, and housing benefits in particular, require all public agencies to ask whether customers/clients/users or members of the family are veterans, and whether they would like additional information about veterans' benefits.

2. Refer a Constitutional Ballot Measure deleting the 30-year limitation on an ODVA home loan and changing the number of days of consecutive service required for the home loan from 210 to 178, defining a veteran as per ORS 408.225.

3. Eliminate the ODVA loan use limit, currently set at two during their eligibility period.

4. Provide funding for a maintenance budget for the Oregon Veterans' Home and for the establishment of additional facilities for aging veterans.

5. Provide funding for tiered investments in programs such as COVO and Central City, which provide potential transition for homeless veterans back into the work force.

6. Pass a Joint Memorial urging the United States Congress to amend federal IRS tax code to allow state home loan programs to offer home loans without time restrictions (eliminate 25-year restriction on use of Qualified Veteran Mortgage Bonds).

7. Work to gain greater flexibility in VA Housing funding for student housing, homelessness, and aging housing programs.

8. Develop/fund partnership incentives for local housing options.

Aging Veterans and Retirement

As veterans age and plan for retirement and beyond, the main benefit they seek is VA health care. However, when the aging veteran does see a veteran service officer to apply for VA health care, many times that veteran also is eligible for other benefits, including disability compensation or pension. Unfortunately, many of these veterans have missed out on decades of benefits they could have been receiving because they never sought information about their benefits after service.

The Task Force met with many aging veterans from the World War II and Korean War generations, as well as retiring veterans from the Vietnam generation. While particularly true of the WWII generation, many of these veterans never applied for VA benefits either because they thought someone had it worse than they did and the veteran did not want to take someone else's benefit, or they had a bad experience with government and did not want to re-engage the government system. That being said, today veterans older than 60 are coming forward to seek health care benefits out of need.

Anecdotally, the most common benefit these aging veterans seek is VA health care for hearing loss; they want hearing aids. Exposure to gunfire, explosions, unmuffled engines and other long-term sources of hearing damage are experiences that most veterans share. The second most common benefit they seek is health care to replace their employer-based health care after retirement. For geriatric veterans, family members often seek benefit information for assisted living or nursing home care.

A source of great frustration for many veterans is the confusion surrounding health care coverage. The aging veterans who are coming forward to seek VA health care say that as part of their enlistment they were promised VA health care for life. However, that original benefit was eliminated some years ago and today every veteran – regardless of era – has to apply for VA health care and meet the conditions of one of the priority groups. This often is an unhappy surprise to the veteran who is seeking benefits for the first time in 60 years. Under the current system, not all retired or aging veterans will qualify for VA health care, and many veterans do not understand why.

To be eligible for VA health care, the veteran must meet one of a handful of criteria, including:

- Having a service-connected disability
- Be receiving VA Pension
- Be a former POW
- Purple Heart Recipients
- Radiation Exposed Veterans
- Project SHAD Veterans
- Veteran Income Below VA's National Income Threshold

Given these criteria, many aging veterans find that they must first have their condition service connected or officially tied to their service before they can receive VA health care. The Task Force learned that veteran service officers routinely file claims on behalf of aging veterans just so the veteran can access the VA health care system. The Task Force also learned that veteran service officers often find that the aging veteran has conditions other than the one for which he/she is seeking VA health care. For example, a WWII veteran came to see a veteran service officer so he could get VA health care. The veteran wanted hearing aids. Unfortunately, the veteran was over income for VA purposes and did not fit into any category making him eligible for VA health care. However, this veteran had been in combat, had documented combat noise exposure and exhibited serious Post Traumatic Stress Disorder symptomology, yet had never filed a claim for benefits. The veteran service officer filed a new claim for all the conditions, eventually won the claim, and the veteran was allowed into the VA health care system (and did get his hearing aids). Unfortunately, the process took more than six months to complete, during which time the veteran could not access VA health care. This story is routine among veteran service officers and very frustrating for aging veterans who believe that VA health care is an entitlement due to their service, not a benefit for which they must apply and qualify.

Like VA health care, VA-paid nursing home care also is not automatic, and the VA does not pay for assisted living. To qualify for VA-paid nursing home, the veteran must either:

- Need the care due to the veteran's service-connected disability
- Have a disability rated 60 percent service-connected and have been awarded Individual Unemployability
- Have a disability rated 60 percent service-connected and be considered permanently and totally disabled (P&T)
- Have a combined rating of at least 70 percent service-connected disabilities

Aging veterans in need of nursing care who do not meet these criteria will not receive VA funding for their nursing home care. And, as stated above, the VA does not pay for assisted living, which is perhaps the largest growing need for the aging veteran population, particularly amongst WWII and Korea veterans.

As is evident from this discussion, the Task Force learned there are several gaps in providing VA health care to retired and aging veterans.

Also as noted earlier, many retiring and aging veterans never have sought their full benefits, which only is discovered when one of these veterans meets with a veteran service officer and that officer recognizes this oversight.

According to a federal VA census, the State of Oregon needs 800 skilled nursing home beds to accommodate its veteran population. Currently, there is one Veterans' Home in Oregon, located in The Dalles. This facility has 150 beds and provides skilled nursing along with a dementia/Alzheimer's unit. The advantage of the Veterans' Home is that it costs about 60 percent of what a commercial nursing home would cost the veteran. However, there is not a dedicated maintenance budget to preserve the Home's operations. We risk going backwards in our ability to deliver quality care to a growing population if this flagship facility loses any function or capacity. Oregon needs an additional 650 dedicated veteran beds to meet the need and a second Veterans' Home is being developed. However, even a second Home will not meet the total need. The Task Force recognizes that there are opportunities for creative partnerships that could help create beds for veterans in conjunction with a new Veterans' Home and supports the exploration and implementation of these partnerships.

When a veteran passes away, surviving spouses have burial benefits and potential widow benefits. Like all benefits, the widow must apply and the easiest way to do so is for the widow to visit a veteran service officer. Benefits include burial at a national cemetery; free headstone or grave marker; compensation if the veteran's death was directly or indirectly caused by his/her service-connected disability; and widow's pension if the widow is extremely low income (less than $625 a month). Military retirees also can purchase the Survivor Benefit Plan (SBP) at the time of their retirement, which will provide the surviving spouse a monthly income after the veteran's death. The Task Force heard from widows who all said the amount provided by the VA benefit was too small to sustain them. This is a difficult situation. A 100 percent disabled veteran who had been receiving $2,600 a month for his disability can leave the widow with no VA benefits at all if the death does not fit into the right category. The most a widow will receive in compensation is $1, 091 due to a service-connected death, and can receive no more than $625 a month for widow's pension. The Task Force believes this amount is insufficient to support these widows and believes Congress should increase these amounts.

In Oregon, the largest cohort of veterans in the state is the Vietnam-era veteran. This means as the system continues to care for WW II veterans in their mid-80s and Korean War veterans in their late 70s, the pressure on the system still is to come from the Vietnam veterans moving into their early and mid 60s and will be sustained during the next 20 years.

Findings

1. Many retired and aging veterans are seeking VA benefits for the first time decades after their service.

2. Retired and aging veterans believe that VA health care is an entitlement due to their service and not a benefit for which they have to apply. However, that entitlement no longer exists, and can create great frustration and a sense of betrayal if discovered for the first time when a need for health care and contact with the VA arises.

3. Due to VA health care enrollment rules, many retired and aging veterans are not eligible for VA health care or paid skilled nursing care.

4. VA widows compensation and pension is not sufficient to sustain these widows.

5. More skilled nursing beds dedicated to veterans are needed in Oregon.

Recommendations

1. Urge Congress to fund all priority groups of VA health care, which will include all retired and aging veterans.

2. Work with Congressional delegation to increase widow benefits

3. Fund maintenance budget of existing Veterans' Home in The Dalles, and make sure that maintenance is part of any conversation about an additional future Veterans' Home.

4. Support non-traditional partnerships to create dedicated veteran skilled nursing beds.

Future Considerations

While the Task Force's role has been to review the current veterans' service delivery environment in Oregon, Task Force members recognize several issues that will play themselves out in the future and will impact state policy.

Multiple Deployments

As Oregon National Guardsmen, Reservists, and active duty personnel deploy to combat zones for their second, third and sometimes fourth rotation, the human toll both to the veteran and the veterans' family exponentially increases. While a soldier may be able to manage the stress of one combat tour and all that comes with it, multiple combat tours are resulting in long-term physical, emotional, and societal consequences for Oregon veterans and their families. According to the Army Surgeon General Mental Health Advisory Team noted that the percentage of soldiers with Depression, Anxiety and/or acute stress increased from 12 percent to 19 percent to 27 percent on consecutive tours.

The current conflict is unlike any before, especially for Oregon soldiers. While the National Guard and Reserves traditionally have been a strategic reserve component, today's Guard and Reserve make up about 45 percent of the entire active duty force fighting in the current conflict. The Task Force believes that this will continue to be the rule for the future: National Guard and Reserve units will continue to supplement active duty units in combat. For Oregon, this is especially poignant in that the state does not have an active-duty base, but does have significant Guard and Reserve resources. To date there have been 7,000 National Guard mobilizations and 4,000 Reserve activations. Another 3,000 Oregon Guardsmen will deploy early next year. For many of those deploying in 2009, this will be their second or third tour of duty.

Unlike active duty service members who live a military lifestyle at all times and have on-base family support systems built into their communities, National Guard and Reserve volunteers arrive in combat from a very different environment, and return from combat not to a military lifestyle, but back into their communities as civilians. For the National Guard and Reserve, their combat experience is quite different than that of an active-duty soldier. The same holds true for military families of the Guard and Reserve. While active-duty families have an entire military base full of support while a soldier is deployed, National Guard and Reserve families are spread out, disconnected, and often are unaware of the family support programs available to them. Oregon is seeing a high rate of Post Traumatic Stress Disorder, depression, anxiety and suicidal ideation in National Guard and Reserve veterans. While it is not known if a contributing factor relates to National Guardsmen and Reservists being civilians thrown into combat and then returned to their civilian lives, anecdotal evidence suggests there is a link.

While changes in force deployment have taken place, so has the technology linking families to deployed soldiers in theater. Internet, cell phones, instant messaging, and other technologies mean that families can be connected in real-time across the world. This is both good and bad for the deployed soldier and his or her family. On the one hand, having this type of contact with family builds morale and can reduce the loneliness of long deployments. On the other hand, the deployed soldier is made aware of all the problems at home the he or she is absolutely incapable of managing while in combat, thus adding stress to their condition. The Task Force heard that in additions to getting "Dear John" letters from home, soldiers are getting "Dear Mortgage Holder" emails from their spouses.

Families also can suffer from this instant communication. If a soldier is going on a four-hour patrol and tells his wife he will contact her when he returns, but after four-five-six hours he does not contact her, the spouse is left panicked that something may have happened to her husband because he did not connect with her when he said he would. Chances are that the patrol ran long, or some other event superceded the soldier's ability to call home. Hours later when he does call, his wife is upset, he is then upset – who knows what he saw or had to do on patrol – and the relationship is strained. Even with all this communication, reports indicate that divorce rates for OEF/OIF veterans is two to three times the norm of military families.

The strain of multiple combat tours is evident with our National Guard and Reserve veterans. As many Oregon National Guard and Reserve veterans have committed suicide since returning home as have died due to combat. This is a stunning development and clearly shows that more must be done to support these troops through the continuum of pre-deployment through post-deployment reintegration.

Championing Veterans' Causes

During World War II, nearly every family in America was affected directly by the conflict by having someone in the family serving in the military. The Vietnam War affected about 40 percent of American families. Today, OEF/OIF is called the "One Percent War" in that only about 1.5 percent of American families have had a family member serve in the conflict.

Veterans look to policymakers to understand and relate to their experiences. They especially look to policymakers at the local and national level that are veterans like themselves. After World War II, Korea, and even Vietnam, there were veterans who ran for office and clearly understood the conditions of the combat veteran. However, a decade from now, the current OEF/OIF veterans will find that there will be very few policymakers with their experience simply because so few have born the burden of this conflict.

From a veterans' policy perspective, this is troubling. While it is true that non-veterans can and do support veteran public policy issues, there is no substitute for the experience of a veteran – especially combat veteran – when it comes to truly understanding the needs of the veteran community.

During this time of war, every policymaker across the nation is behind veterans' issues – it is both publicly and politically popular to do so. However, when the wars end and time passes, veterans will need champions – especially in the budget process to fund VA benefits – who understand the unique situation veterans face and honor their service to country. Veterans are concerned that the current generation of combat veterans from OEF/OIF will not result in a large enough pool from which future elected officials will rise. The fear is that non-veteran policymakers will see veterans as a special interest group instead of a group of men and women who voluntarily sacrificed when their nation called and have earned their benefits through blood, sweat, and tears.

History has shown that promises made to veterans can and will be broken when politically expedient (e.g. Lifetime VA Health Care for all WWII veterans). Ensuring that Oregon's veterans are not forgotten once the wars are over is an important public policy issue – a trust the State and nation cannot break. Veterans who are policymakers tend to keep these issues on the front burner; a loss of these veterans in the public policy arena could result in degrading the current positive opinion of the veteran community.

Military Gender Transformation

During the Vietnam War, about 7,500 women served in the military, mostly as nurses. During OEF/OIF, more than 185,000 women have served in theater – many in combat, earning Combat Action Ribbons, Bronze Stars and other combat awards. And like their male counterparts, they are coming home injured both physically and emotionally.

Due to the dynamics of an "asymmetric" or unconventional conflict, soldiers are seeing combat regardless of their specific military occupational specialty (MOS). In other words, it doesn't matter whether a soldier is trained as an infantryman or mechanic, chances are that soldier will see some type of combat Iraq or Afghanistan. This holds true for female soldiers, which is a paradigm shift from a military that traditionally has limited women to non-combat support roles. While women still do not serve in the infantry, they are serving as military police, intelligence officers, convoy truck drivers other jobs that place them directly in harms way.

Because women are handling themselves so well in combat, it is likely that there will be a further shift in military thinking as to what jobs women can and cannot do in the future. This in turn will mean more and more women veterans suffering the same types of injuries and debilitating conditions as men. It also means providing appropriate services to women veterans (in sufficient quantity) that address their unique physical and emotional needs. Currently, the system is not prepared for a large influx of women combat veterans needing care; the current system was created for a male-dominated military. More female veteran service officers are needed, as well as more specific female care programs. There also is a significant lack of residential in-patient mental health care specifically designed for women. Non-traditional partnerships will be needed to develop a system that accommodates not only the woman veteran but also that veteran's children (one cannot expect a single mother to seek treatment if there is no place for their children).

Caring for our women veterans is a vital issue – one that needs to be addressed intensely in the short term to ensure that these women are provided for in the long term.

TRICARE for National Guard

Traditionally the health care insurance for military retirees, TRICARE has expanded to cover National Guard and Reserve families when the soldier is called to active duty, as well as allowing National Guard and Reserve families to purchase a TRICARE plan any time while they serve. Providing a means for National Guardsmen and Reservists to have health insurance for themselves and their families is an important component of maintaining a healthy force, and ensuring Oregonians have health care.

According to TriWest Health Alliance (which manages TRICARE in the Western Region), Oregon has a network of 9,247 total healthcare providers, including 1,030 behavioral health providers, as well as other medical disciplines. These numbers are impressive, but may be misleading in terms of state coverage. Veterans told the Task Force in all parts of the state that finding a doctor who will accept TRICARE payments is difficult if not impossible. This is consistent with testimony presented to the Legislature during the 2007 Legislative Session requesting tax incentives for doctors to encourage them to accept TRICARE payments. The Task Force recognizes the apparent contradiction between the TriWest figures and the experience of veterans and believes the explanation lies in how TriWest counts providers. While the Task Force believes the numbers provided by TriWest are accurate, the Task Force does not believe these figures truly reflect the number of doctors available to veterans and National Guard and Reservists throughout Oregon. The Task Force believes that there remains a demonstrated shortage of Oregon MDs and DOs who will accept TRICARE as a payment for service. To be fair, this is due in part because TRICARE is designed to provide payment for military retirees' health care, which they obtain from a military base. Oregon has no active duty military base that its retirees (and now Guard and Reserve) can access for health care. Thus, TRICARE must establish a network of providers who accept their payment in the private sector market – a much more difficult task than simply paying a military hospital to care for military retirees.

The main reason behind private sector physicians' reluctance to accept TRICARE is the low reimbursement rate for work performed. The TRICARE reimbursement rate is directly tied to the Medicare rate. Doctors who accept TRICARE and those who do not both told the Task Force that the reimbursement rate is so low that it may not be worth a provider's time to accept the payment. This has an impact on the benefit provided to National Guard and Reserve families – if a family cannot find a provider who takes TRICARE it is no benefit at all.

Although a federal program, the State has tried to help take care of veterans and National Guard/Reserve families by providing a tax incentive for health care providers who accept TRICARE payments. This is not the State's responsibility; however, the Task Force sees this as the right thing to do to ensure a healthy force and keep faith with our veterans and military families. Also, more must be done to establish a working network of providers – especially MDs – who take TRICARE for Oregon veterans and military families. The Task Force believes that the federal government has a significant role to play in raising TRICARE rates. If the current fighting force is 45-50 percent National Guard and Reserve, the federal government must take care of these soldiers and their families by providing an adequate benefit. The Task Force has found Oregon's congressional delegation very receptive to working on this issue in the coming year.

In the mean time, Oregon must press ahead. More than 11,000 Oregon Guardsmen and Reservists already have deployed and another 3,000 Guardsmen will deploy in January 2009. The TRICARE benefit is an important component in the health care continuum and must be made to work seamlessly for our veterans and military families.

VA Prescription Services

As discussed in the Health Care section of this report, VA health care is a complex system of priority groups, co-pays and means testing. The Task Force believes that all priority groups should be fully funded, thus keeping the promise made to generations of veterans that they would receive a lifetime of VA health care in return for their service. However, the Task Force also understands the financial and budgetary realities that have led the VA to establish priority groups, means testing, co-pays, and other cost-saving measures. There clearly is tension between promises made to veterans regarding their access to VA health care and the cost of providing that care as was evident during several of the Task Force's town hall meetings.

Currently, the federal government has an $11 trillion deficit, and the Task Force knows that fully funding VA health care may not be possible under these hard budgetary times. However, the Task Force learned during its work that a major piece of veteran health care is prescription drugs. If the federal government would fully fund or creatively provide a discount prescription drug benefit to ALL veterans, this would be a significant step in the right direction.

While touring the state, the Task Force learned that access to medication was a concern for veterans, especially aging veterans. Their concerns focused on four issues: Formulary, coordination with non-VA providers, complexity of the co-pay and cost. Most veterans had some degree of misinformation regarding the current system.

Many veterans complained they could not get medications not listed on the VA formulary, a listing of drugs approved based on evidence-based medicine. VA has expanded its formulary and has an immediate exception policy where in fact 85 percent of exceptions are approved.

Others complained that they want their private physician's prescription to be continued. Co-managed care occurs in what is approaching 10 percent of VA patients. The outside physician sends in the medical records to the VA where they are entered into the electronic record and reviewed by the patient's primary care provider (with whom he/she ahs a separate relationship). If agreeable to the prescription regimen, the VA provider will order the medications. The VA cannot accept responsibility for veterans who have not-enrolled in their system of care. VA doctors do not order drugs to be filled outside the system, because there is no way to monitor compliance or to deal with the paperwork. Again the VA system is totally electronic.

The cost of the co-pay varies on the patient's condition and disability and priority group rating. The co-pay is currently at $8 for conditions not covered by their eligibility.
The Task Force believes this, like the Fee Basis system, could be simplified.

This issue will continue to escalate as Vietnam-era veterans – Oregon's largest cohort – grow older and need increasingly larger amounts of prescription medication. Ensuring they can access that medication through the VA health care system is not only the right thing to do, but can take pressure off other systems, both private and public. If the federal government would fully fund or creatively provide a discount prescription drug benefit to ALL veterans, this would be a significant step in the right direction.

Task Force Recommendations

Administrative

State and local agencies should ask customers if they are veterans and if they would like their contact information sent to a veteran specialist who will provide more information about veteran benefits

The Task Force was surprised to learn that few if any state or local agencies ask if a customer is a veteran. The largest gap the Task Force found in the veterans' service delivery system is identifying veterans and then connecting those veterans to existing services and benefits. By asking customers if they are veterans and proactively providing veteran information to them, the Task Force believes this gap can be significantly addressed. Of Oregon's 351,000 veterans, only 39,241 are receiving disability compensation. Only 30 percent of Oregon veterans are enrolled in VA health care. Even with these low numbers, Oregon veterans receive $1.2 billion in federal VA benefits. By not connecting more veterans to their benefits (including education benefits), Oregon is leaving as much as $4 billion of federal money on the table. The Task Force believes that all state and local agencies should ask if their clients are veterans so that veteran benefits information can be provided.

Wherever possible, state agencies should reconfigure data management system to share information that encourages caseworkers to connect veterans to available services

The Task Force found that sharing veteran client information between state agencies would help veterans access services more efficiently and effectively. Currently, the state is using the OPUS system for information sharing, but the system does not identify clients as veterans. OPUS should be expanded to all state agencies that offer services and identify if a client is a veteran so that veteran-specific benefits can be delivered in a coordinated manner.

Education

Place State Veteran Service Officers on all State university and community college campuses to help facilitate the implementation of the new GI Bill and provide outreach to college-bound veterans

The Oregon Department of Veterans' Affairs and Portland State University entered into an agreement to launch a pilot project to do outreach to veteran students. A veteran service officer was placed on the PSU campus and immediately began connecting with veterans regarding their benefits. Many of the more than 100 veterans the VSO met did not know they had GI Bill eligibility, disability compensation benefits, or access to vocational rehabilitation. This pilot project proved that a VSO on campus could help facilitate benefits to veterans who otherwise would not access these benefits. With the passage of the new GI Bill, VSOs on campus would ensure that post-9/11 veterans understand and maximize this benefit, bringing in federal education dollars to Oregon schools.

Waiver "out-of-state" tuition for veterans seeking access to education (when programs do not automatically provide it)

While the new GI Bill may address the out-of-state tuition issue by treating all veterans equally no matter where they attend college, veterans using the Montgomery GI Bill, Vocational Rehabilitation, or state education benefits still are being charged out-of-state tuition rates. The Task Force learned that recruiting students to attend state universities and colleges is competitive. Ohio has given state residency to out-of-state veterans attending their colleges, granting in-state tuition rights in a bid to draw more veterans to their state. The Task Force believes Oregon should follow Ohio's example and bring as many veteran students to the state as possible. In-state tuition rates create a strong incentive to consider coming to an Oregon school.

Create a pilot project at Eastern Oregon University and Portland State University to provide veteran childcare, housing and transition programs within the context of one-stop veteran centers.

With the passage of the new GI Bill, which provides extensive education benefits to veterans, Oregon universities and colleges should see an influx of new veteran students on their campuses after August 2009. The Task Force has seen how veterans on campus already gravitate to one another based on their shared experiences. The Task Force believes that this natural gravitation should be encouraged and facilitated through one-stop veteran centers on campus, where veterans can go for services. The Task Force proposes creating pilot projects at EOU and PSU to create a model that eventually would be spread throughout the higher education system.

Employment

Increase DVOP/LVER staffing throughout Oregon through restoration of previous budget reductions

The Disabled Veteran Outreach Program and the Local Veterans Employment Representative provide veterans with hands-on employment support, including networking, job searching, resume writing, interview skills, and more. Unfortunately, these programs have been scaled back at the same time the nation is at war and creating more veterans and disabled veterans. The Task Force believes this is counterintuitive and the federal government should restore previous budget reductions and fully fund the needed cadre of DVOP and LVERs in Oregon.

Develop and fund a public information campaign supporting the "HireVets First" initiative

The HireVets First initiative is a Federal campaign to maximize the benefits of business partnerships on behalf of transitioning military personnel. HireVets works with employers to encourage them to hire veterans. The Task Force believes the state should invest in a public information campaign supporting the HireVets program. The campaign would be a force multiplier in encouraging businesses to hire veterans. This program is particularly important in Oregon where National Guard and Reserve veterans return home after deployment and need to immediately return to a civilian job. Facilitating a veteran's smooth transition and reintegration to employment is a top priority for the Task Force.

Develop and fund a state recognition program for employers that hire and retain veterans, support veterans, and veteran-owned businesses

The Task Force would like to recognize those Oregon businesses that hire veterans, support veterans, as well as veteran-owned businesses. The Task Force learned that other states have created a window decal identifying these businesses and those businesses have responded positively by displaying these decals prominently. The Task Force also believes that such a program will encourage business to hire and support veterans as well. This positive program will help educate communities about the need for veteran employment.

The State should encourage and facilitate a private-sector veterans' employment compact

Businessman Harvey Platt of Platt Electric has been one of Oregon's most faithful veteran employers. Mr. Platt told the Task Force that he was prepared to create a compact of private-sector businesses that would commit to hiring a returning veteran who was displaced from another compact member. The Task Force would like to encourage as many private-sector businesses to join this compact, creating an employment safety net for returning veterans.

The Legislature should examine veteran transportation issues related to veterans finding and maintaining employment and the associated costs

A barrier to veteran employment is the cost of transportation to job interviews and work. Currently, the Oregon Employment Department as limited funds to help veterans with these transportation costs. However, the funds are insufficient to meet the demand. This issue will continue, especially in areas without public transportation.

The Legislature should examine eliminating the 15-year limitation on the use of the veterans' preference

Current statute limits the use of the veterans' preference to 15 years after service. The Task Force determined that due to the changing economy veterans need a lifetime preference.

Health Care

Urge Congress to fully fund Veterans Health Administration priority groups 1-8

To help control costs, the Veterans Health Administration created priority groups for veterans' health care. Priority groups are based upon level of disability and veteran status (POW, Purple Heart, etc…). The last category, priority group 8, is for veterans whose income is above a means test line for Group 7. However, priority group 8 has been closed to new applications since 2003. In other words, no new veterans have been given access to VA health care via priority group 8 for five years. The Task Force believes this breaks faith with many generations of veterans who were promised a lifetime of VA health care in return for their service. The Task Force strongly believes that the federal government must fully fund all categories of VA health care for all veterans.

Urge Congress to expand and simplify the VA "Fee Basis" contract health care service program

Fee Basis is the name of the VA program that contracts for private health care services outside the VA health care system. Millions of dollars are spent yearly on Fee Basis service; however, veterans at every town hall meeting told the Task Force that the Fee Basis system is inadequate, complicated, confusing, and not supportive of veterans. In its defense, the VA manages Fee Basis based upon federal law and regulations. However, those laws, regulations and VA policy can result in veterans not obtaining the authority to seek outside treatment as they think appropriate. This is especially difficult for Oregon veterans living in rural and remote areas who have to travel literally hundreds of miles for a VA appointment. The Task Force believes that Congress must address the Fee Basis system, expand Fee Basis for rural and remote Oregon and other such areas nationally, and simplify the regulations and rules implementing Fee Basis so that veterans can understand their benefit.

Increase the TRICARE reimbursement Rate

The Task Force learned from the medical community that the TRICARE reimbursement they receive is tied to Medicare and is too low for doctors to accept. The Task Force believes that Legislature should urge Congress to increase the TRICARE reimbursement rate so that doctors will accept the insurance for our military families and retirees.

Correct Minor Error In State TRICARE Tax Credit Incentive

During the 2007 Regular Legislative Session, the Legislature passed a measure providing a one-time tax credit to physicians who accepted TRICARE. Unfortunately, language in the bill has been interpreted to mean only physicians who accept *new* TRICARE patients instead of all physicians treating TRICARE patient. The intent of the legislation was to provide the tax credit to all physicians treating TRICARE patients. The Task Force believes this housekeeping fix will correct this small error in the original legislation.

Create non-traditional partnerships in remote and rural areas, especially for mental health services

With tightening resources and increasing needs, the Task Force believes that more creative strategic partnerships should be created to provide services for veterans in remote and rural parts of the state. This is especially true for mental health services, which are extremely limited in these parts of the state. Partnerships could include federal, state and local government, businesses, non-profit organizations, service clubs, individuals and more.

The State should encourage mental health professionals to work in support of Oregon veterans and their families, especially in rural and remote areas

The shortage of mental health providers in rural and remote areas is not a new issue. However, the need is more severe for returning service members suffering from Post Traumatic Stress Disorder, Depression, Anxiety and other mental health conditions. The Task Force believes it is important to ensure these veterans receive the same level of care as veterans in urban areas.

Housing

Create greater flexibility in VA housing funding for student housing, homelessness, and aging housing programming

The federal VA provides money for a number of housing initiatives (homeless grant per diem, veterans' home grant per diem, veterans' home construction funds, etc…); however, the rules to use this money can be narrow and not allow for the flexibility needed at the local level. The Task Force learned that more flexibility would allow VA funds to be used more effectively to help veterans. Ideas such as providing veteran student housing on college campuses and partnerships with the Oregon Community Housing and Development Department may do more to provide for our veterans than the one-size-fits-all funding the VA currently provides.

Urge the Oregon Legislature to place a Constitutional Amendment on the ballot to eliminate the 30-year restriction on ODVA Home Loans and revise the definition of veterans to be consistent with statute

The Oregon Constitution limits the Oregon Department of Veterans' Affairs Home Loan to veterans who have served within the past 30 years. These veterans have had to serve more than 210 consecutive days of active duty. These rules keep thousands of Oregon veterans from accessing an ODVA home loan. The Task Force believes the Oregon home loan program should not have a time limit and should be available to any veteran who meets the definition of veteran in ORS 408.225.

Urge Congress to eliminate the time restriction on state home loans

Under IRS tax code, Qualified Veteran Mortgage Bonds – the bonds used to fund state veteran home loan programs – limit veteran borrowing to the first 25 years after service. By contrast, the federal VA home loan program provides a lifetime benefit. The limitation on state home loan programs keeps thousands of Oregon veterans from accessing an ODVA home loan. The Task Force believes the state home loan program should mirror the federal VA home loan program, which is a lifetime benefit and urges Congress to eliminate the time restriction.

Develop and fund partnership incentives for local housing options

The Task Force learned that homeless housing and transitional housing are lacking in every part of the state. In some parts of the state, HUD housing has a three-year waiting list! The Task Force believes more can be done to create strategic partnerships to provide this type of housing. The Task Force looks to the Central Oregon Veterans Outreach and Portland's Central City Concern as models.

Families

Expand eligibility for program expenditures for "whole family" initiatives

The Task Force learned that federal VA dollars only can be spent on the veteran and not the veteran's dependents. For example, a veteran can obtain mental health counseling from the VA, but the wife and/or children living with that affected veteran cannot separately seek this care. The Task Force believes the VA should expand its eligibility laws and rules to include the whole family in VA benefits. Another example is the single mother veteran who cannot access a VA facility for care because she has no place to place her children. Together with state, local and private entities, the VA should work to expand programming to manage whole families, not just veterans, because the entire family is affected by the veteran's condition.

Increase funds for the ODVA and OMD Emergency Grant programs

To help bridge the gap for veterans and National Guardsmen in financial crisis, both the Oregon Department of Veterans' Affairs and the Oregon Military Department created emergency grant funds for health and welfare emergencies. Both programs have successfully helped keep veterans and Guardsmen employed, in their homes, and provided with food, and medical care. By giving these short-term emergency funds, veterans and Guardsmen are kept from more severe crises that require them to seek state services, such as housing, food stamps, Oregon Health Plan and more. However, the need is greater than the funds; each quarter the funds are depleted within the first 30 days without replenishment for another two months. More money is needed to meet demand.

Develop and fund feasibility study for creation of Veterans' Courts

Based on the Buffalo, NY model, the Chairman of the House Interim Committee on Veterans Affairs and Task Force member Representative Jeff Barker has begun exploring the concept of Veterans' Courts in Oregon. Like the Drug Court and Mental Health Court, Veterans' Courts would adjudicate cases involving veterans with a multi-disciplinary team approach, providing services veterans need based upon their situation. These courts would be trained to recognize veteran-specific issues, such as PTSD and TBI and how these conditions relate to their transgression.

Develop and fund tailored suicide prevention public information campaign

Since the wars in Afghanistan and Iraq began, an equal number of Oregon National Guardsmen and Reservists have committed suicide as have died in combat.

Nationally, the military, policymakers and the media all have recognized that suicide among OEF/OIF veterans is at a catastrophic rate. The Task Force believes that a tailored suicide prevention public information campaign aimed at OEF/OIF veterans and their spouses is needed immediately. There are three suicide coordinators within the federal VA medical system in Oregon. The Reintegration Team has been providing suicide information and intervention to National Guard member. The Oregon Department of Veterans' Affairs has done the same with veterans. The Task Force believes more must be done in light of this epidemic.

Establish an Oregon Families Appreciation Day

The Task Force believes that Oregon should honor its military families by recognizing the sacrifices they have made to support their service member. Events would be organized in support of the day and military families would be connected and recognized during the celebrations.

Reintegration

Acknowledge the overall impact of the Reintegration Team

Oregon was the first state to establish an official reintegration team. That team went forward and created the national model for reintegration efforts. In fact the program is so popular other states, such as Minnesota and Georgia, have adopted it completely. The Task Force believes the State should recognize the efforts of the Reintegration Team, commend it for its innovation, and encourage it to continue its groundbreaking work.

Create a Task Force to develop and implement a regional reintegration model

The Task Force learned during its work that the current state reintegration model and semi-annual summit should be regionalized throughout the state. Exactly what that would look like is fluid. However, a new Task Force will design the model and then implement it in conjunction with the federal VA, congressional offices, local government, and existing veterans organizations and 501c3 community groups.

Increase the staffing level for the Reintegration/Yellow Ribbon Team

More than 11,000 Oregon National Guard and Reservists have deployed in OEF/OIF. Another 3,000 more are scheduled to deploy in January 2009. As many as 500 active duty veterans return to Oregon each month. As the numbers grow, demand on the Reintegration Team grows. Simply put, the Team needs more staff to meet the growing need for reintegration services, including family support, employment, benefits, suicide intervention and more.

Urge Congress to develop and fund a 90-day "soft landing" reintegration process for returning National Guard and Reserve soldiers

Currently, a National Guard or Reserve soldier returning from deployment could leave the combat zone and be back at his or her regular job in 10 days. This has proved not to be enough time for the soldier to decompress after a combat tour and is resulting in crises ranging from self-medicating with alcohol and drugs to suicide. To help soldiers properly readjust, the Task Force is urging Congress to implement a 90-day soft landing reintegration program in which National Guard and Reservists would be left on Title 32 active duty orders and allowed to decompress for up to 90 days upon returning home. This window would allow the reintegration team to provide the services and benefits veterans need to seamlessly reintegrate back into their lives instead of being dropped back into their lives as they are today.

Retirement

Develop and fund a permanent maintenance budget for the Oregon Veterans' Home

Built in 1997, the 151-bed Veterans' Home is in need of maintenance and repair. To date, the legislature has contributed $1 of General Fund to the home, which today is worth approximately $21 million. The Task Force believes it is time for the Legislature to commit itself to this state asset by contributing to the long-term maintenance of the home.

Expansion of in-residence care for aging veterans

During its last census, the federal VA determined that Oregon needs approximately 800 in-residence skilled nursing beds for its veteran population. Currently, Oregon has 151 beds at its Veterans' Home. A second veterans' home is needed to help provide for these veterans. As Oregon largest cohort of veterans – Vietnam era – ages, even more beds may be needed.

Support the exploration of non-traditional partnerships for future investments

The Task Force supports the exploration of non-traditional partnerships between the Oregon Department of Veterans' Affairs and other entities to provide skilled nursing and Alzheimer/Dementia beds for aging veterans. These non-traditional partnerships may be able to be implemented long before a new veterans' home can be built, providing more immediate solutions for veterans in need of skilled nursing beds.

Transportation

Urge Congress to develop and fund a statewide veterans transportation network

The Task Force learned that a significant difficulty for veterans across the state is transportation to and from VA medical appointments. Oregon does have a network of Disabled American Veteran Vans that provide veteran transportation. However, there are not enough vans to cover the state, vans are driven by aging veterans, new volunteers are difficult to find, and these vans cannot transport wheelchair-bound veterans. Oregon needs a consistent and dependable statewide transportation system to transport its veterans – many of whom live in remote and rural areas – to and from their VA medical appointments.

Create a Veterans' Transportation Task Force

The Task Force learned that throughout Oregon there are many existing transportation districts, local bus lines, Department of Human Service medical transportation programs, and more. However, none is connected and none routinely and purposefully provide services to veterans. The Task Force could not grapple with this enormous task in the time allotted and believe a separate Task Force focused on the veteran transportation issue is warranted, with a specific eye to rural and remote veterans.

Restructure VA Transportation Funding Stream

Unlike other areas of the country, Oregon is a sprawling state. A veteran who lives in remote or rural Oregon literally has to drive hours to reach some VA medical appointments. The Task Force heard anecdotal stories of transportation hardships at nearly every town hall meeting throughout Oregon. The VA's transportation funding stream does not adequately address states like Oregon that have remote and rural areas. Whether the VA regionalizes spending strategies, provides more money for remote/rural areas or creates public private partnership, the VA must address how it will provide for veterans who do not live in close proximity to the VA health care facilities they use for their health care.

Women Veterans

Establish a Task Force on feasibility of transitioning the Eastern Oregon Training Center and other potential sites into a network of in-residence care for women veterans and children

According to the Veterans Health Administration, there are no in-residence beds dedicated to women in this region. This has created a crisis for women veterans who need this type of care. The Task Force also learned that a barrier for women to seek the care they need is a lack of a place to leave their children should they enter treatment. The Task Force was approached by the Eastern Oregon Training Center with the idea of repurposing the training center. In meeting with EOTC, the Task Force determined that the facility might have a use for a variety of veteran-related services, including women veterans. However, the Task Force did not have enough time to flush out enough details to make a final decision, but believes a new Task Force should be created to continue this work.

Develop a Military Sexual Trauma (MST) Public Information Campaign

According to a recent Army Times article, the Army has admitted that Military Sexual Trauma is at an all-time high. The article called the problem "rampant." Unfortunately, military culture is not conducive to providing a secure environment for victims to report these incidents. That being said, the Oregonian recently reported that more than 100,000 men and woman reported MST in the past year. MST causes Post Traumatic Stress Disorder, depression, anxiety and other emotional and mental conditions. The Task Force believes that the Oregon Military Department, along with the Oregon Department of Veterans' Affairs, must develop a public information campaign that reaches out to victims, as well as works to change the culture of Oregon's military establishment regarding MST.

Expand mental health access for women living in remote and rural Oregon

It is well known that there is a shortage of mental health access in remote and rural Oregon. However, the shortage becomes critical for women veterans returning from combat tours in Iraq and Afghanistan. The Task Force believes the Legislature should examine creative ways to incentivize providers to work in remote and rural Oregon and partner with the federal VA to provide mental heath care to women veterans.

Appendix

What is VBA?

One part of the US Department of Veterans Affairs.

US DVA

Veterans Health Administration
- 200,000 employees
- < 50% of total US DVA budget

Veterans Benefits Administration

13,000 employees

>50% of total US DVA budget

National Cemetery Administration

< 2500 employees

< 5% of total US DVA budget

VBA Regional Office Portland, OR

- One of 58 regional offices across the country
- Approx 190 employees
- 30,000 Claims decisions each year
- Over $½ Billion distributed to 45,000 vets and dependents in Oregon last year

VBA Benefits

- Compensation – Live and Death
- Pension – Live and Death administered out of Pension Maintenance Center in St. Paul, MN
- Vocational Rehabilitation and Employment
- Education (GI Bill) administered out of Muskogee, OK
- Loan Guaranty administered out of Denver, Co. (Oregon State Home Loan Program is better in today's market)

Critical Partners with VBA in Oregon

- ODVA and County Service Officers
- National Service Organizations – DAV, American Legion, Amvets, VFW, PVA, MOPH, etc.
- Reintegration Team
- Homeless Programs
- VHA
- Anyone, anywhere who wants to help vets

Are these gaps in service?

- 350,000+ vets in Oregon only 45,000 receive benefits?
- Limited access to VA computer network for accredited ODVA and County Veteran Service Officers
- Vets/widows/widowers entitled to benefits while in nursing homes are underserved, misled or misinformed regarding benefits entitlement?
- Iraq/Afghanistan (recently released) vets represent about 10% of claims filed?
- Timeliness of claims processing?
- Appeals processing (procedures and timeliness)?

Ok, now it is your turn

- Define more clearly known gaps, or identify other gaps in service that relate to VBA's work in Oregon.
- Present questions that I can deliver to the Regional Office before the visit on June 4.
- Ask questions during the visit on June 4.
- Bring questions from Town Hall meetings to me or to the Regional Office for their response.

What is a veteran?

- Name the 7 uniformed services whose former members are considered veterans as defined by Title 38.

- I will give you the first 5
- Army, Navy, Air Force, Marines, Coast Guard.

The other two

- Public Health Service
- National Oceanic and Atmospheric Administration

Veterans Running Awards as of End of FY 2007												
Number of Veterans by State, Territory and Other by Combined Degree of Disability												
	CDD											
State, Territory and Other	0	10	20	30	40	50	60	70	80	90	100	Grand Total
Grand Total by CDD	13,783	786,429	431,994	346,136	274,503	172,682	197,960	178,748	125,035	67,151	250,017	2,844,438
US States Totals	13,490	776,787	425,734	340,917	270,161	169,879	194,255	175,865	122,814	65,977	243,935	2,799,814
Alabama	230	16,229	9,732	8,161	6,706	3,976	4,437	3,940	2,802	1,355	5,803	**63,371**
Alaska	47	2,761	1,887	1,669	1,462	1,148	1,140	886	615	300	646	**12,561**
Arizona	337	17,818	9,725	7,884	6,117	3,928	4,594	4,198	2,929	1,524	6,347	**65,401**
Arkansas	123	7,286	4,697	3,884	3,265	2,341	3,013	2,895	2,214	1,342	4,417	**35,477**
California	1,543	69,179	35,230	28,914	22,062	14,007	15,226	14,811	9,566	5,156	19,894	**235,588**
Colorado	248	15,205	8,658	7,031	5,746	3,562	3,825	2,785	1,998	1,168	6,049	**56,275**
Connecticut	159	6,799	3,063	2,328	1,713	1,098	1,147	1,101	669	348	1,743	**20,168**
Delaware	58	2,489	1,436	1,079	862	543	557	398	270	165	704	**8,561**
District Of Columbia	44	1,255	628	577	395	277	263	205	148	56	447	**4,295**
Florida	941	67,474	35,239	27,363	20,599	13,080	15,279	13,237	9,601	4,971	19,406	**227,190**
Georgia	372	27,920	16,870	13,028	10,721	6,276	6,962	5,608	4,100	2,220	8,184	**102,261**
Hawaii	144	4,250	2,466	1,785	1,492	946	938	881	606	302	1,500	**15,310**
Idaho	67	4,696	2,817	2,163	1,791	1,109	1,273	1,184	754	402	1,316	**17,572**
Illinois	443	19,519	10,754	8,069	6,102	3,827	3,968	3,745	2,498	1,355	5,231	**65,511**
Indiana	241	15,768	8,283	6,179	4,903	2,893	3,381	2,488	1,837	916	3,402	**50,291**
Iowa	112	7,013	3,573	2,869	2,324	1,385	1,631	1,329	937	541	1,771	**23,485**
Kansas	114	7,760	4,434	3,268	2,530	1,437	1,571	1,295	902	452	2,211	**25,974**
Kentucky	199	10,634	6,612	5,302	4,518	2,869	3,422	2,931	2,165	1,256	4,942	**44,850**
Louisiana	169	9,597	5,622	4,480	3,608	2,474	2,612	2,921	1,961	1,078	3,539	**38,061**
Maine	68	4,997	2,688	2,356	1,867	1,234	1,518	2,044	1,362	701	2,400	**21,235**
Maryland	303	14,411	8,487	7,122	5,631	3,267	3,457	2,446	1,723	954	4,402	**52,203**
Massachusetts	293	17,524	7,242	6,396	4,097	2,830	3,226	3,635	2,099	875	4,362	**52,579**
Michigan	464	20,098	10,482	8,298	6,281	3,788	4,288	3,957	2,510	1,303	5,343	**66,812**
Minnesota	210	18,356	7,594	5,574	4,592	2,803	3,195	2,949	2,161	1,171	4,714	**53,319**
Mississippi	126	7,175	4,554	3,419	2,655	1,635	2,097	1,422	1,168	577	2,951	**27,779**
Missouri	248	16,088	8,948	6,999	5,592	3,272	4,007	3,434	2,380	1,065	4,278	**56,311**
Montana	50	3,980	2,256	1,922	1,537	1,011	1,114	1,091	710	379	1,226	**15,276**
Nebraska	53	10,385	3,986	3,002	2,549	1,591	1,917	1,344	1,229	701	1,885	**28,642**
Nevada	130	8,013	4,309	3,484	2,693	1,572	1,840	1,778	1,140	645	2,258	**27,862**
New Hampshire	57	4,495	2,340	1,821	1,499	859	963	867	596	308	1,122	**14,927**
New Jersey	302	15,897	6,808	5,373	3,909	2,734	2,879	2,677	1,979	1,186	4,335	**48,079**
New Mexico	107	6,052	3,440	2,763	2,352	1,698	2,121	3,418	2,047	935	2,823	**27,756**
New York	794	33,904	14,968	12,339	8,834	5,834	6,208	6,095	3,976	1,927	9,627	**104,506**
North Carolina	388	25,805	17,162	13,924	11,619	7,313	8,348	7,265	5,335	3,254	10,788	**111,201**

Veterans Running Awards as of End of FY 2007

Number of Veterans by State, Territory and Other by Combined Degree of Disability

	CDD											
State, Territory and Other	**0**	**10**	**20**	**30**	**40**	**50**	**60**	**70**	**80**	**90**	**100**	**Grand Total**
North Dakota	25	2,730	1,245	975	747	491	577	420	307	173	680	**8,370**
Ohio	529	26,506	15,526	11,178	8,266	4,981	5,210	4,272	2,906	1,498	6,742	**87,614**
Oklahoma	151	11,661	7,114	5,944	5,463	3,620	5,052	4,821	3,559	2,103	6,774	**56,262**
Oregon	196	9,898	5,512	4,677	4,079	2,725	3,225	3,437	2,481	1,441	4,887	**42,558**
Pennsylvania	634	28,350	14,545	11,578	8,468	5,285	5,954	5,495	3,473	1,783	7,515	**93,080**
Rhode Island	47	2,924	1,390	1,068	804	562	673	733	467	200	862	**9,730**
South Carolina	191	13,847	8,535	6,759	5,541	3,503	3,874	3,539	2,712	1,656	6,055	**56,212**
South Dakota	32	2,983	1,688	1,329	1,089	724	764	721	511	289	908	**11,038**
Tennessee	346	16,840	10,774	8,152	6,426	3,937	4,373	3,518	2,554	1,461	6,595	**64,976**
Texas	949	61,244	35,904	29,513	25,235	15,817	20,329	17,984	13,383	7,276	19,882	**247,516**
Utah	63	4,522	2,618	2,071	1,634	1,130	1,164	1,033	679	403	1,243	**16,560**
Vermont	33	1,577	876	673	551	351	460	350	262	134	600	**5,867**
Virginia	400	28,574	18,441	15,934	12,783	7,531	8,366	6,477	4,439	2,280	6,649	**111,874**
Washington	342	23,372	12,930	11,133	9,150	5,764	6,284	6,497	4,189	2,336	6,765	**88,762**
West Virginia	85	4,993	3,097	2,575	2,142	1,627	1,825	2,126	1,661	762	2,745	**23,638**
Wisconsin	260	14,009	7,378	5,681	4,479	2,805	3,254	2,841	2,026	1,154	4,368	**48,255**
Wyoming	23	1,925	1,171	852	681	409	454	341	218	140	599	**6,813**
Puerto Rico	156	4,119	2,692	2,153	1,790	1,287	1,599	1,402	978	527	4,082	**20,785**
Philippines	48	603	398	426	382	255	791	445	566	258	790	**4,962**
Other Territories and Countries	89	4,909	3,164	2,635	2,167	1,257	1,311	1,032	676	388	1,208	**18,836**
No Zip Code	0	11	6	5	3	4	4	4	1	1	2	**41**

Source: VA Veterans Benefits Administration, Office of Performance, Analysis & Integrity

VHA – Oregon Medical Services

Welcome

To care for him who shall have borne the battle and his widow and orphan.
Abraham Lincoln

Governor's Task Force
5 June, 2008
Jack Heims, MSW, FACHE

Portland VAMC Main Campus

VHA – Oregon Medical Services

Our Organization

The Department of Veterans Affairs is comprised of

- **Veterans Benefits Administration** – provides compensation and pension, education, life insurance, loan guaranty, & vocational rehabilitation & employment
- **National Cemetery Service** – provides burial services to veterans and their spouses
- **Veterans Health Administration** – provides medical, surgical, mental health & long term care services to veterans

Note: Military hospitals for active duty personnel are part of the Department of Defense, for example - Walter Reed

VHA

OUR MISSION

Honor America's veterans by providing exceptional health care that improves their health and well-being.

OUR VISION

To be a patient-centered integrated health care organization for veterans providing excellent health care, research, and education; an organization where people choose to work; an active community partner; and a back-up for National emergencies.

Roseburg Facility

OUR VALUES

Trust, Respect, Excellence, Compassion, Commitment

VHA – Oregon Medical Services

WHO WE ARE

The Oregon Facilities are part of VA Northwest Network VISN 20, which is comprised of the largest geographical land mass of any VISN within the Department of Veterans Affairs

The Veterans Health Administration (VHA) is divided into 22 Veterans Integrated Service Networks (VISN's)

VHA – Oregon Medical Services

PORTLAND VA MEDICAL CENTER

149 inpatient & 72 nursing home beds

Referral Center

Full Continuum of Care

Acute Medicine, Surgery, Psychiatry, Neurology, Rehabilitation, Emergency, Primary, Specialty, Transplant, Ophthalmology, Optometry, Cardiology, Endocrinology, Rheumatology, Geriatrics, Hemodialysis, Endoscopy, Chemotherapy, ENT, Orthopedics, Podiatry, General Surgery, Urology, Dental, Psychology, PTSD, Substance Abuse, Opioid Substitution,, Nuclear Medicine, Imaging, Path & Lab, Audiology, etc.

Portland VAMC Main Facility

Support VISN 20, Willamette National Cemetery, and two Vet Centers

VHA – Oregon Medical Services

VANCOUVER FACILITY

The Vancouver campus includes a 72-bed Nursing Skilled Care Unit/Comprehensive Rehabilitation Unit, Primary Care Clinic, Mental Health Clinic, Substance Abuse Treatment, Dental, Prosthetics, Community Nursing Home, Home and Community Based Care, Transitional Lodging Unit, Transplant Lodging Unit, Telephone Care, Warehouse, Laundry and VISN 20 Administrative Offices.

A Single Room Occupancy Enhanced-Use Lease (EUL) exists on the campus along with the Clark County Center for Community Health (EUL)

VHA – Oregon Medical Services

Roseburg VA Medical Center & Southern Oregon Rehabilitation Center & Clinics

Roseburg VA Medical Center

- Inpt PTSD, SA
- Not all Specialties
- surgical capabilities
- Primary MH and Primary Care

SORCC (White City)

- Primarily Rehab with 425 Beds
- Primary MH and Primary Care

VHA – Oregon Medical Services

Additional Medical Care Coverage provided by Community Based Outpatient Clinics

FT Current CBOCs

- Bandon
- Bend (expanded)
- Brookings
- Eugene (expanded)
- Klamath Falls
- Ontario
- Portland East
- Salem
- Warrenton

Planned FT or PT Clinics

- West Portland (12/08)
- Burns
- Grants Pass
- The Dalles (9/08)
- Lincoln County (FY09)
- Ore City Area (FY09)
- Bandon Relocate to North Bend

VHA – Oregon Medical Services

FY07 OREGON VITAL STATISTICS

Veterans Served	100,157
Veteran Pop.	305,387
Outpatient Visits	837,410
Budget	$427 m
Staff	3653

Hospital Beds	237
NH Beds	127
Dom Beds	472
Total Beds	836

VHA – Oregon Medical Services

RESEARCH

- **151 Active Research Investigators**
- **Research and Education Foundation**
- **NW VA Cancer Research Center**
- **National Center For Rehabilitative Auditory Research (NCRAR)**
- **Mental Illness Research Education & Clinical Center (MIRECC)**
- **Parkinson's Disease Research, Education & Clinical Center (PADRECC)**
- **Alcohol Research Center**
- **MS Center of Excellence**
- **NW Hepatitis C Center of Excellence**
- **Methamphetamine Research Center**
- **Center for the Study of Chronic, Comorbid Mental, and Physical Disorders**
- **Agency for Healthcare Research and Quality (AHRG) Decision & Science Center**

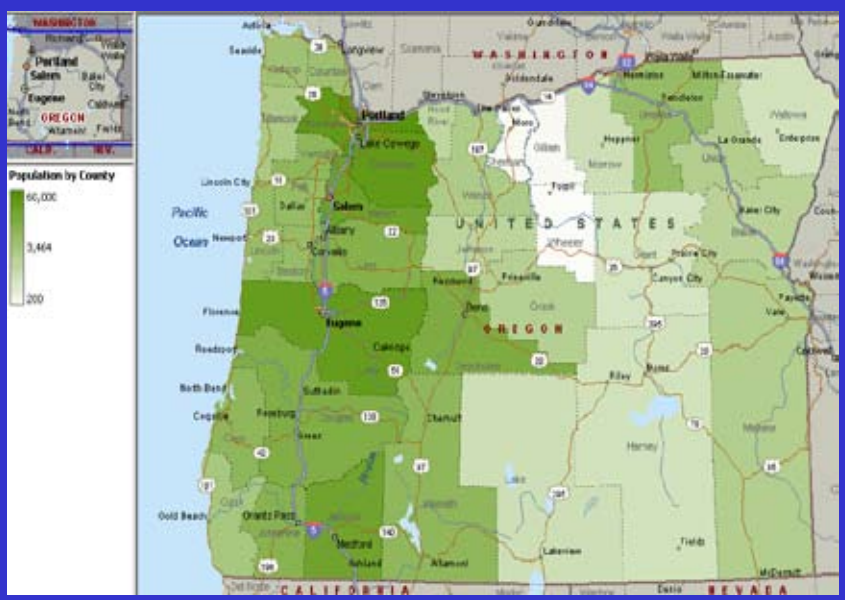
VHA – Oregon Medical Services

EDUCATION

- Primary academic affiliate is Oregon Health & Science University
- 138 affiliation agreements with 55 educational institutions
- 133.93 funded house officers in 33 different specialties

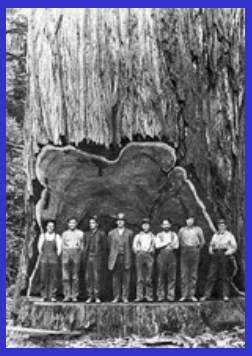
VHA – Oregon Medical Services

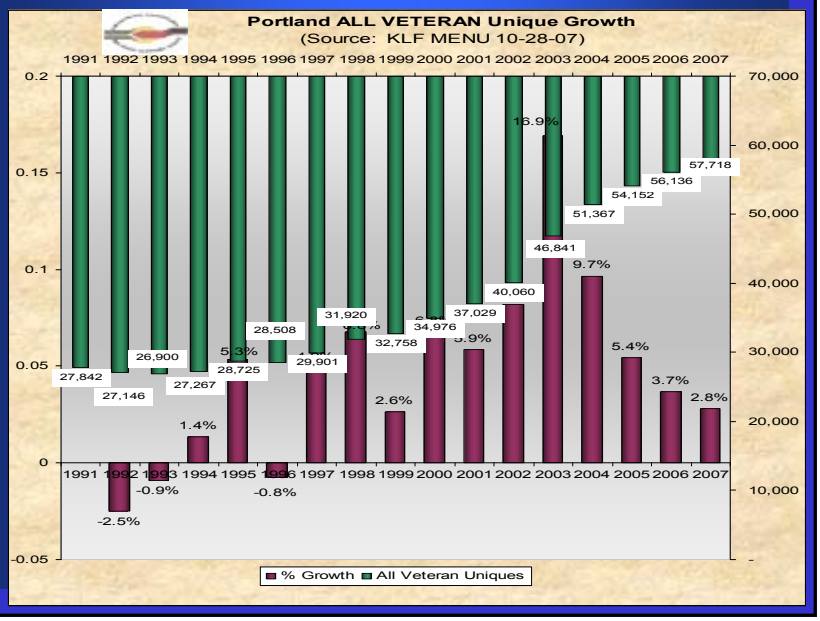
OREGON VETERAN POPULATION BY COUNTY



VHA – Oregon Medical Services

EXAMPLE OF ACCESS & GROWTH





VHA – Oregon Medical Services

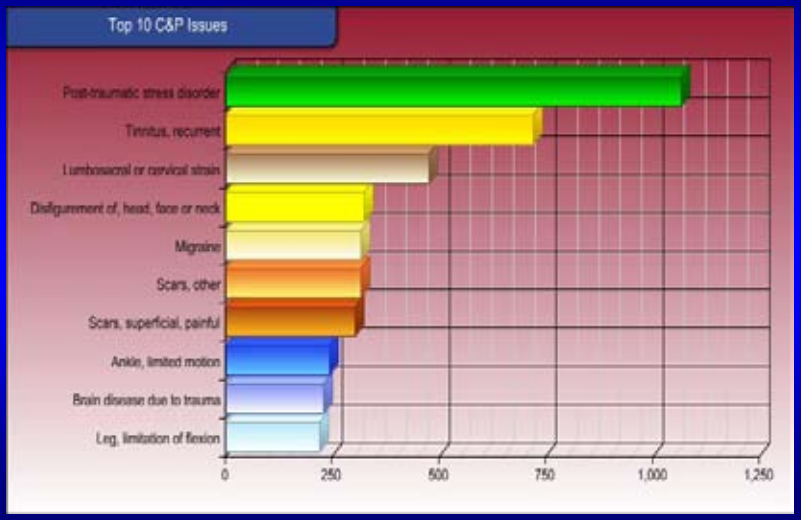
OIF/OEF VETERANS

- 48% are Active Duty, 52% are Reserve/National Guard
- 88% are men, 12% are women
- 65% Army; 12% Air Force; 12% Navy; 12% Marine
- 34% were deployed multiple times
- 52%, largest age group, is 20-29 years old
- 69% of those who filed disability claims received service-connected disability compensation award
- As of March 2008, Oregon Facilities have enrolled approximately 5000 OIF/OEF veterans

VHA – Oregon Medical Services

OIF/OEF VETERANS

Veterans Tracking Application, March 5, 2008



VHA – Oregon Medical Services

NATIVE AMERICAN PARTNERSHIPS

- Continued sponsorship of Camp Chaparral, now in its 14th year
- Provision of VA staff to tribal clinics to assist with Post Traumatic Stress Disorder issues, to include training over 200 attendees
- Development of MOUs in Portland and Walla Walla to provide a mechanism for specialty care referrals and prescription support
- Provision of technical assistance in the development of electronic medical records at Warm Springs

VHA – Oregon Medical Services

Eligibility, Co-Pays, Fee, CHAMPVA

- Eight levels of eligibility (See Handout)
- Co-Pays depending on priority levels, Income, Special Programs and can be waived in certain circumstances (See Handout)
- Generally Fee Cards allow, in certain cases, for veterans to access non-VA services in rural parts of the state. These are on decline due to efforts to bring care closer to where veterans live
- Sometimes we contract (purchase) specialty care in the community when our ability to meet demand outstrips our supply
- CHAMPVA for spouses and Dependents, Few Oregon providers accept it. (See Handout)

VHA – Oregon Medical Services

OUT OF NETWORK CARE

VA may authorize payment of emergent inpatient care at non-VA facilities only when certain criteria is met. Care must be:

- **For emergent treatment of a service connected disability**
- **For emergent treatment for any condition for a veteran rated permanently and totally disabled by VA regional office**
- **For female veterans if notified within 72 hours, and**
- **A few other conditions**

VHA – Oregon Medical Services

OUT OF NETWORK CARE

If neither of these criteria are met, VA may consider inpatient claims for payment if the following is met:

- **Veteran is enrolled in VA healthcare and has received treatment at a VA within the past 24 months**
- **VA is notified within 90 days of the admission**
- **Veteran has no other insurance**

Under these conditions, payment is made only until medically stable.

Each case is reviewed based on eligibility and medical documentation and can be appealed.

If the veteran has other insurance, then VA does not pay

VHA – Oregon Medical Services

SUMMARY

Meeting the physical and emotional needs of all our Veterans is a complex undertaking

Oregon Facilities have and are continuing to improve access and meet unprecedented growth

OEF/OIF Veterans are increasing, bringing New challenges such as TBI

VHA – Oregon Medical Services

THANK YOU For Your Service to Our Veterans

At Portland VAMC

Data Source: CHIPS database

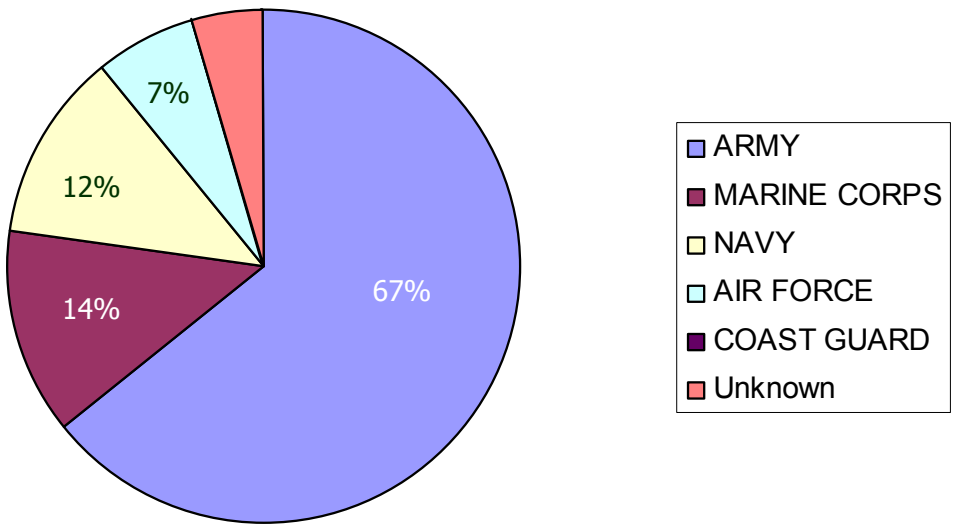
	Outpatients	OEF/OIF	%
FY01	39,917	87	0.2
FY02	42,182	59	0.1
FY03	48,448	105	0.2
FY04	53,624	383	0.7
FY05	56,550	826	1.5
FY06	58,835	849	1.4
FY07	59,710	800	1.3
TOTAL UNIQUES	113,395	3,118	2.7

D

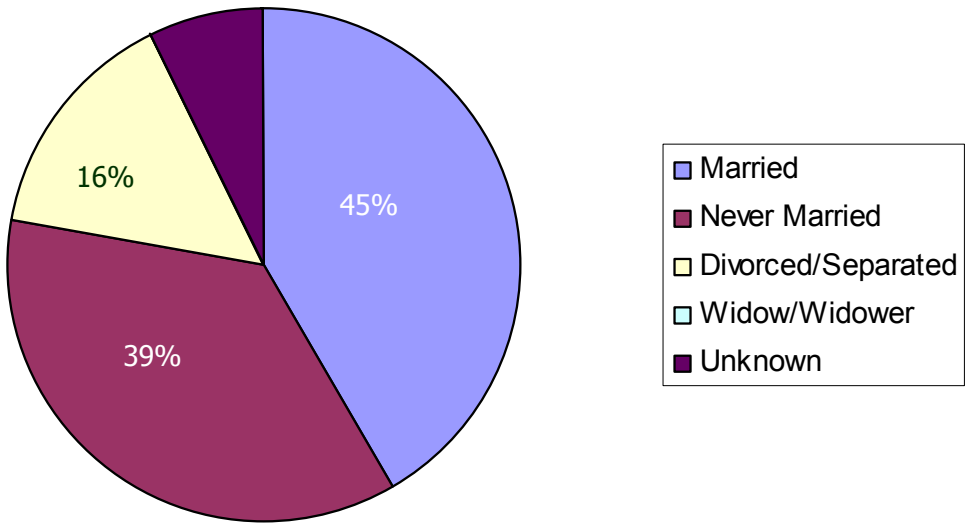
FY01-FY07: 3,118 OIF/OEF

Sex	
Male	2,835
Female	283
Average Age	30 (8.3)
Median	27
Range	17-64
Ethnicity	
Caucasian	923
Other	88
Unknown	2,107
Service Connected	
SC	1,770
Average SC %	44%

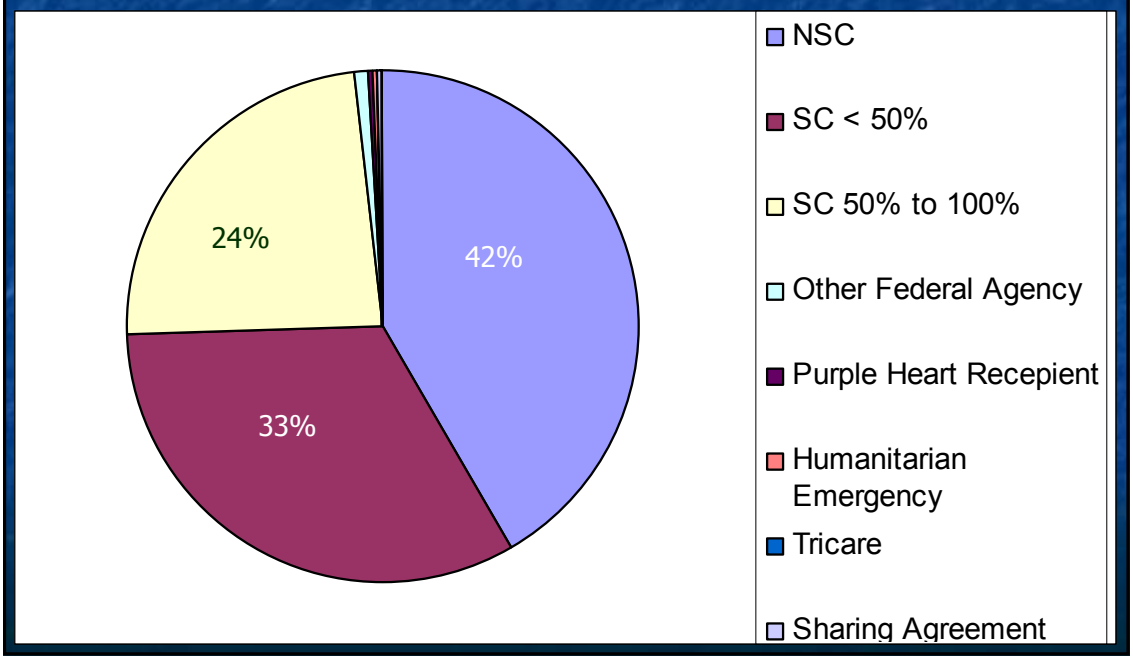
PVAMC OEF/OIF: Service Component



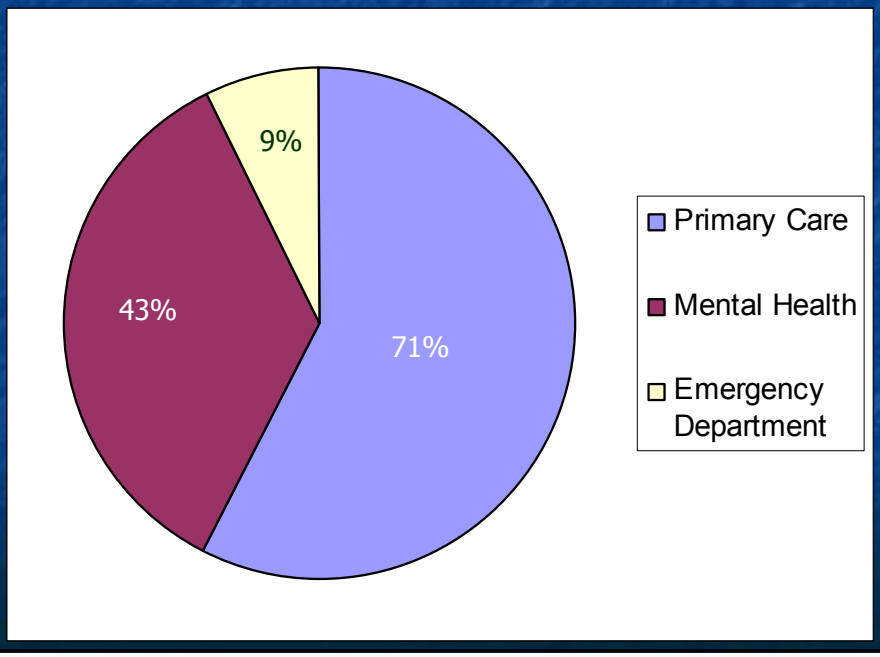
PVAMC OEF/OIF: Marital Status



PVAMC OEF/OIF: Eligibility



PVAMC OEF/OIF: Clinic Stops



Portland VA Medical Center and the OEF/OIF program

Victoria Koehler, MSW, LCSW
OEF/OIF Program Manager

April 19, 2008

Portland VA Medical Center

3710 SW U.S. Veterans Hospital Road
Portland, OR 97239
Phone: (503) 220-8262 or (800) 949-1004

Vancouver Campus
1601 E Fourth Plain Blvd.
Vancouver WA 98661
Phone: 360-696-4061

Community Based Outpatient Clinics
- Eastside Portland
- Salem
- Bend
- Camp Rilea

Who is Eligible for VA Healthcare?

Eligibility is a three-step process

1. **Character of Discharge**
2. **Length of service**
3. **Enrollment priority group**

Character of Discharge

Types to Qualify

- **Honorable Discharge**
- **General Discharge**
- **Discharge under Honorable Conditions**

Length of Service

- **Active Duty after September 8, 1980 then at least 24 months service.**

Length of Service Exceptions:

- **Reservists and National Guard who were activated by federal order and completed the term**
- **Discharged or released from active duty for a hardship, convenience of the government, or medical**
- **VA service-connected disability**
- **Active duty before September 8, 1980**

How to enroll at VA

- Portland or Vancouver enrollment office
- Complete 10-10ez, application for health benefits
- Bring copy of DD-214

Enrollment Priority Groups

Group 1: Service-Connected (SC) 50% or greater

Group 2: Service-Connected (SC) 30% or 40%

Group 3: Service Connected (SC) 10% or 20%, or:
- POW, Purple Heart, Discharged due to disability

Group 4: Aid & Attendance or Housebound

Group 5: Non SC & 0% non-compensable service-connected with income & assets below VA threshold
- In receipt of non-service connected pension

Enrollment Groups (continued)

Group 6: Service in Combat Location After November 11, 1998
- Exposed to herbicides in Vietnam
- Exposed to Ionized Radiation
- Participation in Project SHAD
- Compensable 0% Service Connected

Group 7: Income and/or net worth above VA threshold and below geographic income threshold who agree to copay

Group 8: Income over geographic income threshold who do not fall within Groups 1-7 and applied before January 16, 2003. Group 8 applying after January 16, 2003 are not eligible for enrollment for VA health care

Co-payments

Group 1: **NO** copay for meds or treatment

Group 2: **NO** copay for treatment, copay for non-service connected medications unless income below VA threshold

Group 3: POWs **NO** copay for meds or treatment. All others **NO** copay for treatment, copay for meds unless income below VA threshold

Group 4: **NO** copay for treatment or medication

Group 5: **NO** copay for treatment, copay for meds unless income below VA threshold

Group 6: Copay for treatment and meds unless for conditions related to exposure to herbicides, ionized radiation, project SHAD

Group 7 & 8: Copay for treatment and meds

OEF/OIF Enrollment

- All combat veterans including guard and reserve members who served in theater after November 11, 1998
- No co-payments for five years from date of discharge for conditions potentially related to active duty, regardless of income.
- May be subject to co-payments after five years

Verifying OEF/OIF

- DD214 stating service in Iraq or Afghanistan
- In receipt of Expeditionary Medal, Iraq or Afghanistan Service Medal
- In receipt of Combat Infantry Badge or Combat Action Badge (CIB/CAB)

OEF/OIF Case Management Program

- Transition from DOD to VA care
- Advocacy with VBA
- Case Management
- Access to appropriate care
- Reintegration support
- Outreach
- Community Referral

OEF/OIF Program Referrals

- MTF
- PDHRA
- CBHCO
- National VA Medical Centers
- TBI
- Polytrauma Clinic

The Vet Center

- **individual and group counseling**
- **marriage and family counseling**
- **80% counselors are combat veterans**
- **no fee for service**

8383 N.E. Sandy Blvd. Suite #110
Portland, OR 97220
Phone: (503)-273-5370

Mandy Martin
GWOT Outreach Worker

- Other Vet Center locations in Salem, Eugene and Grants Pass

Questions??

- Victoria.koehler@va.gov
- 503.220.8262 x57044

Thank you for your Service!!

GEOGRAPHIC DISTRIBUTION OF VA EXPENDITURES FOR FY 07
OREGON
Expenditures in $000s

County/ Congressional District	Veteran Population *	Total Expenditures	Compensation & Pension	Education & Vocational Rehabilitation	Insurance & Indemnities	Construction	Medical Care	General Operating Expenses	$/Vet	%of Vets	% of Dollars
BAKER	1,889	$ 7,384	$ 3,718	$ 184	$ 79	$ -	$ 3,404	$ -	$ 2,065	0.54%	0.31%
BENTON	6,447	$ 18,405	$ 10,346	$ 2,331	$ 824	$ -	$ 4,904	$ -	$ 1,966	1.83%	3.87%
CLACKAMAS	35,904	$ 86,080	$ 42,319	$ 3,334	$ 2,451	$ -	$ 37,977	$ -	$ 1,272	10.21%	5.58%
CLATSOP	4,267	$ 15,306	$ 7,845	$ 313	$ 368	$ -	$ 6,781	$ -	$ 1,912	1.21%	0.53%
COLUMBIA	5,640	$ 16,924	$ 9,284	$ 678	$ 124	$ -	$ 6,838	$ -	$ 1,766	1.60%	1.14%
COOS	8,729	$ 40,222	$ 23,164	$ 1,079	$ 314	$ -	$ 15,666	$ -	$ 2,777	2.48%	1.82%
CROOK	2,102	$ 6,917	$ 3,735	$ 126	$ 176	$ -	$ 2,880	$ -	$ 1,837	0.60%	0.21%
CURRY	3,476	$ 15,382	$ 9,507	$ 122	$ 264	$ -	$ 5,489	$ -	$ 2,770	0.99%	0.22%
DESCHUTES	15,646	$ 36,796	$ 21,648	$ 1,599	$ 994	$ -	$ 12,556	$ -	$ 1,486	4.45%	2.68%
DOUGLAS	14,167	$ 100,387	$ 45,969	$ 1,628	$ 845	$ -	$ 51,418	$ 527	$ 3,360	4.03%	2.77%
GILLIAM	210	$ 577	$ 311	$ 7	$ 52	$ -	$ 207	$ -	$ 1,507	0.06%	0.01%
GRANT	813	$ 2,656	$ 1,609	$ 33	$ 59	$ -	$ 954	$ -	$ 2,019	0.23%	0.06%
HARNEY	1,007	$ 3,021	$ 1,706	$ 61	$ 32	$ -	$ 1,222	$ -	$ 1,755	0.29%	0.10%
HOOD RIVER	1,538	$ 3,391	$ 2,222	$ 120	$ 143	$ -	$ 906	$ -	$ 1,523	0.44%	0.20%
JACKSON	23,988	$ 101,772	$ 44,341	$ 2,195	$ 1,990	$ 3,585	$ 48,454	$ 1,207	$ 1,940	6.82%	3.70%
JEFFERSON	1,902	$ 5,274	$ 3,105	$ 88	$ 36	$ -	$ 2,045	$ -	$ 1,679	0.54%	0.15%
JOSEPHINE	10,783	$ 40,673	$ 22,993	$ 1,020	$ 592	$ -	$ 16,069	$ -	$ 2,227	3.07%	1.72%
KLAMATH	8,020	$ 35,729	$ 21,536	$ 1,205	$ 427	$ -	$ 12,562	$ -	$ 2,836	2.28%	2.03%
LAKE	931	$ 3,808	$ 2,434	$ 23	$ 20	$ -	$ 1,331	$ -	$ 2,638	0.26%	0.04%
LANE	35,257	$ 112,444	$ 62,406	$ 6,091	$ 2,318	$ -	$ 41,629	$ -	$ 1,943	10.02%	10.17%
LINCOLN	6,032	$ 21,748	$ 12,187	$ 314	$ 253	$ -	$ 8,993	$ -	$ 2,072	1.72%	0.54%
LINN	11,697	$ 38,049	$ 22,864	$ 1,874	$ 731	$ -	$ 12,579	$ -	$ 2,115	3.33%	3.13%
MALHEUR	2,842	$ 7,982	$ 3,648	$ 236	$ 147	$ -	$ 3,952	$ -	$ 1,366	0.81%	0.40%
MARION	25,750	$ 79,262	$ 46,618	$ 2,929	$ 1,565	$ -	$ 28,150	$ -	$ 1,924	7.32%	4.92%
MORROW	1,034	$ 2,688	$ 1,176	$ 61	$ 57	$ -	$ 1,393	$ -	$ 1,196	0.29%	0.10%
MULTNOMAH	50,361	$ 234,926	$ 77,919	$ 22,151	$ 3,747	$ 11,673	$ 97,721	$ 21,715	$ 1,987	14.32%	36.73%
POLK	6,914	$ 18,542	$ 10,831	$ 1,004	$ 542	$ -	$ 6,164	$ -	$ 1,712	1.97%	1.68%
SHERMAN	279	$ 1,021	$ 614	$ 26	$ 15	$ -	$ 366	$ -	$ 2,291	0.08%	0.04%
TILLAMOOK	2,990	$ 12,604	$ 7,497	$ 207	$ 209	$ -	$ 4,691	$ -	$ 2,577	0.85%	0.35%
UMATILLA	6,880	$ 25,764	$ 12,512	$ 632	$ 231	$ -	$ 12,389	$ -	$ 1,910	1.96%	1.06%
UNION	2,566	$ 8,688	$ 4,494	$ 415	$ 214	$ -	$ 3,565	$ -	$ 1,913	0.73%	0.69%
WALLOWA	930	$ 3,023	$ 1,766	$ 46	$ 57	$ -	$ 1,154	$ -	$ 1,949	0.26%	0.08%
WASCO	2,978	$ 9,000	$ 4,608	$ 230	$ 171	$ -	$ 3,991	$ -	$ 1,625	0.85%	0.39%
WASHINGTON	38,274	$ 88,950	$ 45,095	$ 6,716	$ 3,241	$ -	$ 33,898	$ -	$ 1,354	10.88%	11.17%

GEOGRAPHIC DISTRIBUTION OF VA EXPENDITURES FOR FY 07
OREGON
Expenditures in $000s

County/ Congressional District	Veteran Population *	Total Expenditures	Compensation & Pension	Education & Vocational Rehabilitation	Insurance & Indemnities	Construction	Medical Care	General Operating Expenses	$/Vet	%of Vets	% of Dollars
WHEELER	214	$ 563	$ 300	$ 6	$ 13	$ -	$ 244	$ -	$ 1,431	0.06%	0.01%
YAMHILL	9,238	$ 23,570	$ 12,124	$ 833	$ 500	$ -	$ 10,113	$ -	$ 1,402	2.63%	1.40%
OREGON (Totals)	**351,697**	**$ 1,229,527**	**$ 604,448**	**$ 59,917**	**$ 23,800**	**$ 15,258**	**$ 502,656**	**$ 23,449**	$ 1,889	100.00%	100.00%
TOTAL CONG. DIST (01)		$ 212,875	$ 84,069	$ 23,467	$ 5,132	$ 5,867	$ 75,497	$ 18,842			
TOTAL CONG. DIST (02)		$ 290,654	$ 149,339	$ 7,981	$ 5,311	$ 3,585	$ 123,231	$ 1,207			
TOTAL CONG. DIST (03)		$ 195,375	$ 82,039	$ 8,077	$ 3,378	$ 5,806	$ 93,202	$ 2,872			
TOTAL CONG. DIST (04)		$ 333,989	$ 179,276	$ 12,494	$ 5,193	$ -	$ 136,499	$ 527			
TOTAL CONG. DIST (05)		$ 196,602	$ 109,695	$ 7,896	$ 4,785	$ -	$ 74,227	$ -			
OREGON (Totals)		**$ 1,229,494**	**$ 604,418**	**$ 59,915**	**$ 23,798**	**$ 15,258**	**$ 502,656**	**$ 23,449**			

Notes:

* Veteran population estimate as of September 30, 2007 by the VA Office of the Actuary (VetPop 2007).

1. Expenditures are rounded to the nearest thousand dollars: "$1" = $1,000; "$0" < $500; and "$ -" = 0.
2. Expenditures presented at the county level for compensation, pension, education and vocational rehabilition reflect the dollar values of actual payments made to individuals.
3. The Compensation & Pension cetegory includes expenditures for the following programs: veterans' compensation for service-connected disability; dependency and indemnity compensation for service-connected deaths; veterans' pension for nonservice-connecte
4. Medical Care category includes medical services, medical administration, facility maintenance, educational support, research support, and other overhead items. Medical Care does not include construction or other non-medical support expenditures.
5. Total expenditures by sum of counties may be slightly different from those calculated by sum of 110th Congressional Districts. The differences are resulted from rounding.

Order Code RL34598

CRS Report for Congress

F

Veterans Medical Care: FY2009 Appropriations

July 29, 2008

Sidath Viranga Panangala
Analyst in Veterans Policy
Domestic Social Policy Division

Congressional Research Service

Prepared for Members and Committees of Congress

Veterans Medical Care: FY2009 Appropriations

Summary

The Department of Veterans Affairs (VA) provides benefits to veterans who meet certain eligibility rules. Benefits to veterans range from disability compensation and pensions to hospital and medical care. The VA provides these benefits through three major operating units: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), and the National Cemetery Administration (NCA). The VHA is primarily a direct service provider of primary care, specialized care, and related medical and social support services to veterans through the nation's largest integrated health-care system.

On February 4, 2008, the President submitted his FY2009 budget proposal to Congress. The Administration is requesting a total of $39.2 billion (excluding collections) for VHA. This is a 5.3% increase (or $2.0 billion) over the FY2008 enacted level. Including total available resources (including medical collections) the Administration's budget would provide $41.1 billion for VHA.

On March 7, 2008, the House (H.Con.Res. 312) and Senate (S.Con.Res. 70) reported its respective budget resolutions. After negotiations between the House and Senate, the House agreed to an amended version of S.Con.Res. 70 (Conference Report; H.Rept. 110-659). The conference agreement provides $48.2 billion for FY2009 for discretionary veterans' programs, including medical care, and provides $45.1 billion in mandatory funding for veterans programs.

On June 24, the House Appropriations Committee marked up the Military Construction and Veterans Affairs Appropriations bill (H.R. 6599; H.Rept. 110-775) for FY2009. The House Appropriations Committee recommended $40.8 billion (excluding collections) for VHA, a $1.6 billion increase over the Administration's FY2009 request and $3.6 billion over the FY2008 enacted amount.

On July 17, 2008, the Senate Appropriations Committee marked up its version of the FY2009 Military Construction and Veterans Affairs and Related Agencies Appropriations bill (S. 3301; S.Rept. 110-428). The Senate Appropriations Committee recommended $41.1 billion (excluding collections) for VHA for FY2009. This is a 4.8% increase over the FY2009 request, and $294 million above the House Appropriations Committee-recommended amount.

H.R. 6599 and S. 3301 *did not* include any bill language authorizing fee increases as requested by the Administration's budget proposal for the VHA for FY2009. The House and Senate Committees are directing the VA to increase Priority Group 8 enrollment in FY2009, and have provided additional funding to accomplish this. With escalating gasoline prices, the House and Senate Appropriations Committees have also included report language to increase the mileage reimbursement rate, and has provided additional funding in their respective bills for this purpose.

This report will track the FY2009 appropriations process, and will be updated as legislative activities warrant.

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Veterans Medical Care: FY2009 Appropriations

Most Recent Developments

On July 17, 2008, the Senate Appropriations Committee marked up its version of the FY2009 Military Construction and Veterans Affairs and Related Agencies Appropriations bill (S. 3301 and S.Rept. 110-428). The Senate Appropriations Committee recommended $41.1 billion (excluding collections) for the Veterans Health Administration (VHA) for FY2009 (see **Table 1**). This is a 4.8% increase over the FY2009 request. S. 3301 *did not* include any bill language authorizing fee increases as requested by the Administration's budget proposal for the VHA for FY2009.

On June 24, 2008, the House Committee on Appropriations, approved its version of the Military Construction and Veterans Affairs Appropriations bill, FY2009 (H.R. 6599 and H.Rept. 110-775). This bill recommends a total of $40.8 billion for VHA (see **Table 1**), a $1.6 billion increase over the Administration's FY2009 request and $3.6 billion over the FY2008 enacted amount. H.R. 6599 *did not* include any bill authorizing fee increases as requested by the Administration's budget proposal for the VHA for FY2009.

This report provides a brief background on the veterans health care system, followed by a discussion of the FY2009 VHA budget request, and House and Senate Appropriation Committee action. The report concludes with a discussion of major VHA budget issues.

Table 1. VA and VHA Appropriations, FY2008-FY2009
($ thousands)

	FY2008 request	FY2008 House	FY2008 Senate	FY2008 enacted	FY2009 request	FY2009 House Committee (H.Rept. 110-775)	FY2009 Senate Committee (S.Rept. 110-428)
Total Department of Veterans Affairs (VA)	$83,903,751	$87,696,839	$87,501,280	$87,595,142	$90,761,057	$93,685,057	$94,792,750
Total Veterans Health Administration (VHA)	$34,612,671	$37,122,000	$37,213,220	$37,201,220	$39,178,503	$40,783,270	$41,078,232
Total Discretionary	$39,416,501	$43,209,589	$43,014,030	$43,107,892	$44,764,132	$47,688,132	$48,049,825
Total Mandatory	$44,487,250	$44,487,250	$44,487,250	$44,487,250	$45,996,925	$45,996,925	$46,742,925

Sources: S.Rept. 109-286; H.Rept. 109-464; H.Rept. 110-186; S.Rept. 110-85; Congressional Record, vol.153 (December 17, 2007), pp.H16249-H16431; H.Rept. 110-775; and S.Rept. 110-428.

Note: Does not include funding included in the Supplemental Appropriation Act, 2008 (P.L. 110-252).

Background

The Department of Veterans Affairs (VA) provides a range of benefits and services to veterans who meet certain eligibility rules, including disability compensation and pensions, education, training and rehabilitation services, hospital and medical care, assistance to homeless veterans,[1] home loan guarantees, and death benefits that cover burial expenses.[2] The VA carries out its programs nationwide through three administrations and the board of veterans appeals (BVA). The Veterans Health Administration (VHA) is responsible for health-care services and medical research programs.[3] The Veterans Benefits Administration (VBA) is responsible, among other things, for providing compensations, pensions, and education assistance.[4] The National Cemetery Administration (NCA)[5] is responsible

[1] For detailed information on homeless veterans programs, see CRS Report RL34024, *Veterans and Homelessness*, by Libby Perl.

[2] For a detailed description on eligibility for veterans disability benefits programs, see CRS Report RL33113 *Veterans Affairs: Basic Eligibility for Disability Benefit Programs*, by Douglas Reid Weimer.

[3] For a detailed description of veterans' health-care issues, see CRS Report RL33993, *Veterans' Health Care Issues*, by Sidath Viranga Panangala.

[4] For a detailed description of veterans' benefits issues, see CRS Report RL33985, *Veterans'*
(continued...)

for maintaining national veterans cemeteries; providing grants to states for establishing, expanding, or improving state veterans cemeteries; and providing headstones and markers for the graves of eligible persons, among other things.

The VA's budget includes both mandatory and discretionary spending accounts. Mandatory funding supports disability compensation, pension benefits, vocational rehabilitation, and life insurance, among other benefits and services. Discretionary funding supports a broad array of benefits and services, including medical care. In FY2008, discretionary budget authority accounted for about 49% of the total VA budget authority of approximately $88 billion, with about 86% of this discretionary funding going toward supporting VA health-care programs.

The Veterans Health Care System

The VHA operates the nation's largest integrated direct health-care delivery system.[6] The VA's health-care system is organized into 21 geographically defined Veterans Integrated Service Networks (VISNs). Although policies and guidelines are developed at VA headquarters to be applied throughout the VA health-care system, management authority for basic decision making and budgetary responsibilities are delegated to the VISNs.[7]

Recently, VA's Inspector General (IG) for Health Care Inspections has stated that the current VISN management structure is ineffective. According to the IG's statement "VHA has an organizational bias in favor of local decision makers over national leaders which impedes the provision of one standard of excellent medical care for all eligible veterans. The lack of a standard organizational structure leads to differences in financial systems, medical data systems, and management and committee structures from VISN to VISN."[8]

Congressionally appropriated medical care funds are allocated to the VISNs based on the Veterans Equitable Resource Allocation (VERA) system, which

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[4] (...continued)
Benefits: Issues in the 110th Congress, by Carol D. Davis (Coordinator).

[5] Established by the National Cemeteries Act of 1973 (P.L. 93-43).

[6] Established on January 3, 1946, as the Department of Medicine and Surgery by P.L. 79-293, succeeded in 1989 by the Veterans Health Services and Research Administration, renamed the Veterans Health Administration in 1991.

[7] Jian Gao, Ying Wang and Joseph Engelhardt, "Logistic Analysis of Veterans' Eligibility-Status Change," *Health Services Management Research*, vol. 18, (August 2005), p. 175.

[8] U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies Appropriations, *Military Construction, Veterans Affairs, and Related Agencies Appropriations for FY2009*, hearings, 110th Congress, 2nd sess., February 2008, p. 295.

generally bases funding on patient workload.[9] Prior to the implementation of the VERA system, resources were allocated to facilities primarily on the basis of their historical expenditures. Unlike other federally funded health insurance programs, such as Medicare and Medicaid, which finance medical care provided through the private sector, the VHA provides care directly to veterans.

In FY2008, VHA operated 153 medical centers, 135 nursing homes, 795 ambulatory care and community based outpatient clinics (CBOCs),[10] 6 independent outpatient clinics, and 232 Readjustment Counseling Centers (Vet Centers). [11] The VHA also pays for care provided to veterans by private-sector providers on a fee basis under certain circumstances. Inpatient and outpatient care is also provided in the private sector to eligible dependents of veterans under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).[12] In addition, the VHA provides grants for construction of state-owned nursing homes and domiciliary facilities, and collaborates with the Department of Defense (DOD) in sharing health-care resources and services.

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[9] About 90% of the VHA appropriation is allocated through VERA. Networks also receive appropriated funds not allocated through VERA for such things as prosthetics, homeless programs, readjustment counseling, and clinical training programs. VA facilities could also retain collections from insurance reimbursements and copayments, and use these funds for the care of veterans.

[10] Data on the number of CBOCs differ from source to source. Some count outpatient clinics located at VA hospitals while others count only freestanding CBOCs. The number represented in this report excludes clinics located in VA hospitals. On June 26, 2008, VA announced that it would be establishing 44 new CBOCs in FY2008 and FY2009. The new CBOCs are to be located in: Marshall County, and Wiregrass, AL; Matanuska-Susitna Borough area, AK; Ozark, and White County, AR; East Bay-Alameda County area, CA; Summerfield, FL; Baldwin County, Coweta County, Glynn County, and Liberty County, GA; Miami County, and Morgan County, IN; Wapello County, IA; Lake Charles, Leesville, Natchitoches, St. Mary Parish, and Washington Parish, LA; Lewiston-Auburn area, ME; Douglas County, and Northwest Metro, MN; Franklin County, MO; Rio Rancho, NM; Robeson County, and Rutherford County, NC; Grand Forks County, ND; Gallia County, OH; Altus, Craig County, Enid, and Jay, OK; Giles County, Maury County, and McMinn County, TN; Katy, Lake Jackson, Richmond, Tomball, and El Paso County, TX; Augusta County, Emporia, and Wytheville, VA; and Greenbrier County, WV.

[11] On July 9, 2008, VA announced that it would be establishing 39 new Vet Centers. The new Vet Centers are to be located in the following counties: Madison, AL; Maricopa, AZ; Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, and San Diego, CA; Fairfield, CT; Broward, Palm Beach, Pasco, Pinellas, Polk, and Volusia, FL; Cobb, GA; Cook, and DuPage, IL; Anne Arundel, Baltimore, and Prince George's, MD; Macomb and, Oakland, MI; Hennepin, MN; Greene,MO; Onslow, NC; Ocean, NJ; Clark, NV; Comanche, OK; Bucks, and Montgomery, PA; Bexar, Dallas, Harris, and Tarrant, TX; Virginia Beach, VA; King, WA; and Brown, WI. VA plans to have the 39 sites fully operational by the end of December 2009.

[12] For further information on CHAMPVA, see CRS Report RS22483, *Health Care for Dependents and Survivors of Veterans*, by Sidath Viranga Panangala and Susan Janeczko.

The Veteran Patient Population

During FY2008, the VHA had an estimated total enrolled veteran population of 7.9 million and provided medical care to about 5.2 million unique veteran patients (see **Tables 2** and **3**).[13] According to VHA estimates, the number of unique veteran patients is estimated to increase by approximately 69,000, from 5.189 million in FY2008 to 5.258 million in FY2009. As shown in **Table 3**, there would be a 1.6% increase in the total number of unique patients (both veterans and non-veterans), from 5.681 million in FY2008 to approximately 5.771 million in FY2009. This includes veterans from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). In FY2009, VHA estimates that it would treat 333,275 OIF and OEF veterans, an increase of 39,930 patients, or 13.6%, over the FY2008 level. In FY2009, VA would be treating over 513,000 non-veterans, an increase of over 21,000, or 4.3%, over the FY2008 level.[14]

The total number of outpatient visits, including visits to Vet Centers, reached 63 million during FY2007 and is projected to increase to approximately 65 million in FY2008 and 70.4 million in FY2009.[15] In FY2008, the VHA estimates that it will spend approximately 63.7% of its medical services obligations on outpatient care.[16]

[13] "Enrolles" are veterans who have enrolled in the VA health care system. "Unique patients" are those receiving medical care who are counted only once. In any given year, some enrollees do not seek any medical care, either because they do not become sick or because they rely on other health care systems, such as private health insurance, for care.

[14] Non-veterans include CHAMPVA patients, reimbursable patients with VA affiliated hospitals and clinics, care provided on a humanitarian basis, and employees receiving preventive occupational immunizations.

[15] This number excludes outpatient care provided on a contract basis and outpatient visits to readjustment counseling centers. U.S. Department of Veterans Affairs, *FY2009 Budget Submission, Medical Programs and Information Technology Programs*, Vol. 2 of 4.

[16] Ibid., p.1C-20.

Table 2. Number of Veterans Enrolled in the VA Health Care System

Priority Groups	FY2006 Actual	FY2007 Actual	FY2008 Estimate	FY2009 Estimate
1	912,787	977,389	957,792	977,773
2	522,829	545,196	566,829	584,605
3	996,063	1,023,256	1,047,724	1,063,512
4	241,716	244,159	250,920	260,106
5	2,538,228	2,413,796	2,461,855	2,468,941
6	265,253	312,256	274,482	278,437
Subtotal Priority Groups 1-6	*5,476,876*	*5,516,052*	*5,559,302*	*5,633,374*
7	218,248	202,049	615,581	625,570
8	2,177,314	2,115,344	1,738,801	1,728,535
Subtotal Priority Groups 7-8	*2,395,562*	*2,317,393*	*2,354,382*	*2,354,105*
Total Enrollees	**7,872,438**	**7,833,445**	**7,913,684**	**7,987,479**

Source: U.S. Department of Veterans Affairs, *FY2009 Budget Submission, Medical Programs and Information Technology Programs*, Vol. 2 of 4.

Note: See **Appendix A** for the Priority Groups and their eligibility criteria.

Table 3. Number of Patients Receiving Care from VA

Priority Groups	FY2006 Actual	FY2007 actual	FY2008 Estimate	FY2009 Estimate
1	768,537	820,410	815,432	832,622
2	342,023	358,270	374,182	386,660
3	568,740	590,860	605,066	616,123
4	177,563	181,572	200,001	207,994
5	1,645,781	1,544,328	1,657,210	1,672,504
6	134,425	155,939	143,483	145,666
Subtotal Priority Groups 1-6	3,637,069	3,651,379	3,795,374	3,861,569
7	197,901	173,149	373,285	380,934
8	1,195,612	1,191,161	1,020,644	1,015,616
Subtotal Priority Groups 7-8	1,393,513	1,364,310	1,393,929	1,396,550
Subtotal Unique Veteran Patients[a]	*5,030,582*	*5,015,689*	*5,189,303*	*5,258,119*
Non-Veterans[b]	*435,488*	*463,240*	*492,117*	*513,232*
Total Unique Patients	**5,466,070**	**5,478,929**	**5,681,420**	**5,771,351**

Source: U.S. Department of Veterans Affairs, *FY2009 Budget Submission, Medical Programs and Information Technology Programs*, Vol. 2 of 4.

a. Unique veteran patients include Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans. These patients numbered: 155,272 in FY2006 and 205,628 in FY2007 and are estimated to be 293,345 in FY2008 and 333,275 in FY2009.

b. Non-veterans include CHAMPVA patients, reimbursable patients with VA- affiliated hospitals and clinics, care provided on a humanitarian basis, and employees receiving preventive occupational immunizations.

Eligibility for Veterans' Health Care

"Promise of Free Health Care"

To understand some of the issues discussed later in this report, it is important to understand eligibility for VA health care, the VA's enrollment process, and its enrollment priority groups. Unlike Medicare or Medicaid, VA health care is not an entitlement program. Contrary to numerous claims made concerning "promises" to military personnel and veterans with regard to "free health care for life," not every veteran is automatically entitled to medical care from the VA.[17] Prior to eligibility reform in 1996, provisions of law governing eligibility for VA care were complex and not uniform across all levels of care. All veterans were technically "eligible" for hospital care and nursing home care, but eligibility did not by itself ensure access to care.

The Veterans' Health Care Eligibility Reform Act of 1996, P.L. 104-262, established two eligibility categories and required the VHA to manage the provision of hospital care and medical services through an enrollment system based on a system of priorities.[18] P.L. 104-262 authorized the VA to provide all needed hospital care and medical services to veterans with service-connected disabilities, former prisoners of war, veterans exposed to toxic substances and environmental hazards such as Agent Orange, veterans whose attributable income and net worth are not greater than an established "means test," and veterans of World War I. These veterans are generally known as "higher priority" or "core" veterans (see **Appendix A**, discussed in more detail below).[19] The other category of veterans are those with no service-connected disabilities and with attributable incomes above an established means test (see **Appendix C**).

P.L. 104-262 also authorized the VA to establish a patient enrollment system to manage access to VA health care. As stated in the report language accompanying P.L. 104-262, "the Act would direct the Secretary, in providing for the care of 'core' veterans, to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment system would operate."[20]

Furthermore, P.L. 104-262 was clear in its intent that the provision of health care to veterans was dependent upon the available resources. The committee report accompanying P.L. 104-262 states that the provision of hospital care and medical

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[17] For a detailed discussion of "promised benefits," see CRS Report 98-1006, *Military Health Care: The Issue of "Promised" Benefits*, by David F. Burrelli.

[18] U.S. Congress, House Committee on Veterans Affairs, *Veterans' Health Care Eligibility Reform Act of 1996*, report to accompany H.R. 3118, 104th Cong. 2nd sess., H.Rept. 104-690 p. 2.

[19] Ibid., p.5.

[20] Ibid., p.6.

services would be provided to "the extent and in the amount provided in advance in appropriations Acts for these purposes. Such language is intended to clarify that these services would continue to depend upon discretionary appropriations."[21]

VHA Health-Care Enrollment

As stated previously, P.L. 104-262 required the establishment of a national enrollment system to manage the delivery of inpatient and outpatient medical care. The new eligibility standard was created by Congress to "ensure that medical judgment rather than legal criteria will determine when care will be provided and the level at which care will be furnished."[22]

For most veterans, entry into the veterans' health-care system begins by completing the application for enrollment. Some veterans are exempt from the enrollment requirement if they meet special eligibility requirements.[23] A veteran may apply for enrollment by completing the Application for Health Benefits (VA Form 10-10EZ) at any time during the year and submitting the form online or in person at any VA medical center or clinic, or mailing or faxing the completed form to the medical center or clinic of the veteran's choosing.[24] Once a veteran is enrolled in the VA health-care system, the veteran remains in the system and does not have to reapply for enrollment annually. However, those veterans who have been enrolled in Priority Group 5 (see **Appendix A**, discussed in more detail below) based on income must submit a new VA Form 10-10EZ annually with updated financial information demonstrating inability to defray the expenses of necessary care.[25]

Veteran's Status. Eligibility for VA health care is based primarily on "veteran's status" resulting from military service. Veteran's status is established by active-duty status in the military, naval, or air service and an honorable discharge or release from active military service. Generally, persons enlisting in one of the armed forces after September 7, 1980, and officers commissioned after October 16, 1981, must have completed two years of active duty or the full period of their initial service obligation to be eligible for VA health-care benefits. Servicemembers discharged at any time because of service-connected disabilities are not held to this requirement. Also, reservists that were called to active duty and who completed the term for which

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[21] Ibid., p.5.

[22] Ibid., p.4.

[23] Veterans do not need to apply for enrollment in the VA's health-care system if they fall into one of the following categories: veterans with a service-connected disability rated 50% or more (percentages of disability is based upon the severity of the disability; those with a rating of 50% or more are placed in Priority Group 1); less than one year has passed since the veteran was discharged from military service for a disability that the military determined was incurred or aggravated in the line of duty, but the VA has not yet rated; or the veteran is seeking care from the VA only for a service-connected disability (even if the rating is only 10%).

[24] VA Form 10-10EZ is available at [https://www.1010ez.med.va.gov/sec/vha/1010ez/#Process].

[25] 38 C.F.R. §17.36 (d)(3)(iv) (2007).

they were called, and who were granted an other than dishonorable discharge, are exempt from the 24 continuous months of active duty requirement. National Guard members who were called to active duty by federal executive order are also exempt from this two-year requirement if they (1) completed the term for which they were called, and (2) were granted an other than dishonorable discharge.

When not activated to full-time federal service, members of the reserve components and National Guard have limited eligibility for VA health-care services. Members of the reserve components may be granted service-connection for any injury they incurred or aggravated in the line of duty while attending inactive duty training assemblies, annual training, active duty for training, or while going directly to or returning directly from such duty. In addition, reserve component service members may be granted service-connection for a heart attack or stoke if such an event occurs during these same periods. The granting of service-connection makes them eligible to receive care from the VA for those conditions. National Guard members are not granted service-connection for any injury, heart attack, or stroke that occurs while performing duty ordered by a governor for state emergencies or activities.[26]

After veteran's status has been established, the VA next places applicants into one of two categories. The first group is composed of veterans with service-connected disabilities or with incomes below an established means test. These veterans are regarded by the VA as "high priority" veterans, and they are enrolled in Priority Groups 1-6 (see **Appendix A**). Veterans enrolled in Priority Groups 1-6 include

- veterans in need of care for a service-connected disability;[27]
- veterans who have a compensable service-connected condition;
- veterans whose discharge or release from active military, naval, or air service was for a compensable disability that was incurred or aggravated in the line of duty;
- veterans who are former prisoners of war (POWs);
- veterans awarded the Purple Heart;
- veterans who have been determined by VA to be catastrophically disabled;
- veterans of World War I;
- veterans who were exposed to hazardous agents (such as Agent Orange in Vietnam) while on active duty; and
- veterans who have an annual income and net worth below a VA-established means test threshold.

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[26] 38.U.S.C. §101(24); 38 C.F.R. §3.6(c).

[27] The term "service-connected" means, with respect to disability, that such disability was incurred or aggravated in the line of duty in the active military, naval, or air service. The VA determines whether veterans have service-connected disabilities and, for those with such disabilities, assigns ratings from 0 to 100% based on the severity of the disability. Percentages are assigned in increments of 10%.

The VA looks at applicants' income and net worth to determine their specific priority category and whether they have to pay copayments for nonservice-connected care. In addition, veterans are asked to provide the VA with information on any health insurance coverage they have, including coverage through employment or through a spouse. The VA may bill these payers for treatment of conditions that are not a result of injuries or illnesses incurred or aggravated during military service. **Appendix B** provides information on what categories of veterans pay for which services.

The second group of veterans is composed of those who do not fall into one of the first six priority groups — primarily veterans with nonservice-connected medical conditions and with incomes and net worth above the VA-established means test threshold. These veterans are enrolled in Priority Group 7 or 8.[28] **Appendix C** provides information on income thresholds for VA health-care benefits.

Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans. The National Defense Authorization Act (NDAA), FY2008 was signed by the President (P.L. 110-181) on January 28, 2008. This Act extended the period of enrollment for VA health care from two to five years for veterans who served in a theater of combat operations after November 11, 1998 (generally, OEF and OIF veterans who served in a combat theater).

According to the VA, currently enrolled combat veterans will have their enrollment eligibility period extended to five years from their most recent date of discharge. New servicemembers discharged from active duty on or after January 28, 2003, could enroll for a period of up to five years after their most recent discharge date from active duty. Veterans who served in a theater of combat, and who never enrolled, and were discharged from active duty between November 11, 1998 and January 27, 2003, may apply for this enhanced enrollment opportunity through January 27, 2011.

Generally, new OEF and OIF veterans are assigned to Priority Group 6, unless eligible for a higher Priority Group, and are not charged copays for medication and/or treatment of conditions that are potentially related to their combat service. Veterans who enroll in the VA health care system under this extended enrollment authority will continue to be enrolled even after the five-year eligibility period ends. At the end of the five-year period, veterans enrolled in Priority Group 6 may be re-enrolled in Priority Group 7 or 8, depending on their service-connected disability status and income level, and may be required to make copayments for nonservice-connected conditions. The above criteria apply to National Guard and Reserve personnel who were called to active duty by federal executive order and served in a theater of combat operations after November 11, 1998.

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[28] The VA considers a veteran's previous year's total household income (both earned and unearned income, as well as his/her spouse's and dependent children's income). Earned income is usually wages received from working. Unearned income includes interest earned, dividends received, money from retirement funds, Social Security payments, annuities, and earnings from other assets. The number of persons in the veterans family will be factored into the calculation to determine the applicable income threshold. 38 C.F.R. § 17.36(b)(7) (2006).

Priority Groups and Scheduling Appointments. The VHA is mandated to provide priority care for non-emergency outpatient medical care for *any* condition of a service-connected veteran rated 50% or more, or for a veteran's service-connected condition.[29] According to VHA policies, patients with emergency or urgent medical needs must be provided care, or must be scheduled to receive care as soon as practicable, independent of service-connected status and whether care is purchased or provided directly by the VA. Veterans who are service-connected 50% or more need to be scheduled to be seen within 30 days of the desired date for any condition.

Veterans who are rated less than 50% service-connected disabled, and who require care for a service-connected condition, need to be scheduled to be seen within 30 days of the desired date. When VHA staff are in doubt as to whether the request for care is for a service-connected condition, they are required to assume, on behalf of the veteran, that the veteran is entitled to priority access and schedule within 30 days of the desired date.[30]

Veterans in other priority groups are to be scheduled to be seen within 120 days of the desired date. According to VHA policies, all outpatient appointment requests must be acted on as soon as possible, but no later than seven calendar days from the date of the request. The VHA also requires that priority scheduling of any veteran must not affect the medical care of any other previously scheduled veteran. Furthermore, VHA guidelines state that veterans with service-connected conditions cannot be prioritized over other veterans with more acute health-care needs.[31]

Funding for the VHA

The VHA is funded through multiple appropriations accounts that are supplemented by other sources of revenue. Although the appropriations account structure has been subject to change from year to year, the appropriation accounts used to support the VHA traditionally include medical care, medical and prosthetic research, and medical administration. In addition, Congress also appropriates funds for construction of medical facilities through a larger appropriations account for construction for all VA facilities. In FY2004, "to provide better oversight and [to] receive a more accurate accounting of funds," Congress changed the VHA's appropriations structure.[32] The Department of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act, 2004 (P.L. 108-199, H.Rept. 108-401), funded VHA through four accounts: (1) medical services, (2) medical administration, (3) medical facilities, and (4) medical and prosthetic research. Provided below are brief descriptions of these accounts.

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[29] VHA Directive 2006-055, October 11, 2006.

[30] Ibid.

[31] Ibid.

[32] U.S. Congress, Conference Committees, *Consolidated Appropriations Act, 2004,* conference report to accompany H.R. 2673, 108th Cong., 1st sess., H.Rept. 108-401, p. 1036.

Medical Services

The medical services account covers expenses for furnishing inpatient and outpatient care and treatment of veterans and certain dependents, including care and treatment in non-VA facilities; outpatient care on a fee basis; medical supplies and equipment; salaries and expenses of employees hired under Title 38, United States Code; and aid to state veterans homes. In its FY2008 budget request to Congress, the VA requested the transfer of food service operations costs from the medical facilities appropriations to the medical services appropriations. The House and Senate Appropriations Committees have concurred with this request.[33]

In its FY2009 budget request to Congress, the Administration requested the consolidation of the medical services and medical administration account. While the House Appropriations Committee did not concur with this request, the Senate Appropriations Committee has consolidated the medical services and medical administration accounts (see discussion under Senate Committee Action below).

Medical Support and Compliance (Previously Medical Administration)

The medical support and compliance account provides funds for the expenses in the administration of hospitals, nursing homes, and domiciliaries, billing and coding activities, public health and environmental hazard program, quality and performance management, medical inspection, human research oversight, training programs and continuing education, security, volunteer operations, and human resources.

Medical Facilities

The medical facilities account covers, among other things, expenses for the maintenance and operation of VHA facilities; administrative expenses related to planning, design, project management, real property acquisition and deposition, construction, and renovation of any VHA facility; leases of facilities; and laundry services.

Medical and Prosthetic Research

This account provides funding for VA researchers to investigate a broad array of veteran-centric health topics, such as treatment of mental health conditions, rehabilitation of veterans with limb loss, traumatic brain injury and spinal cord injury, organ transplantation, and the organization of the health-care delivery system. VA researchers receive funding not only through this account but also from the DOD, the National Institutes of Health (NIH), and private sources.

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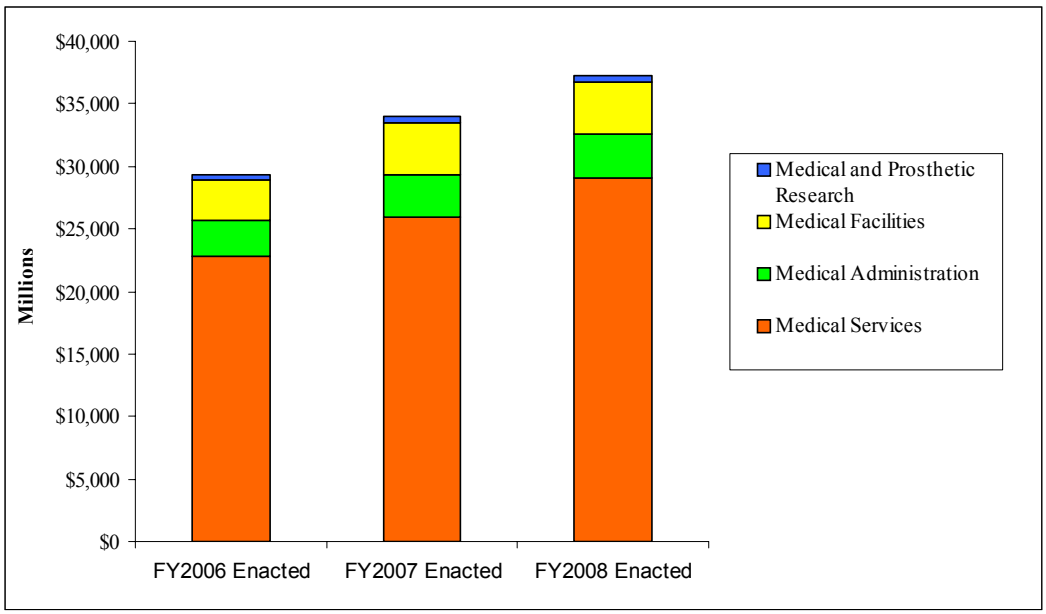
[33] The cost of food service operations support hospital food service workers, provisions, and supplies related to the direct care of patients.

As seen in **Figure 1**, the total level of funding for VHA increased between FY2006 and FY2008, and most of this increase has been due to the increase in spending on medical services. As a percentage of total VHA funding, spending on medical facilities, medical administration, and medical and prosthetic research has been fairly stable (see **Appendix D** for FY2005 and FY2006 VHA funding levels).

Figure 1. VHA Funding FY2006-FY2008



Source: Chart prepared by CRS based on H.Rept. 109-95; S.Rept. 109-105; H.Rept. 109-305; H.Rept. 109-359; H.Rept. 109-464; H.Rept. 109-494; S.Rept. 109-286; P.L. 110-5; H.Rept. 110-64; S.Rept. 110-37; H.Rept. 110-60; *Congressional Record*, vol. 153, (May 24, 2007), H5786-H5787; H.Rept. 110-186; S.Rept. 110-85; *Congressional Record*, vol. 153, (September 7, 2007), S11271-S11278; and *Congressional Record*, vol.153 (December 17, 2007), pp.H16249-H16431.

Medical Care Collections Fund (MCCF)

In addition to direct appropriations for the above accounts, the Committees on Appropriations include medical care cost recovery collections when considering the amount of resources needed to provide funding for the VHA. The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), enacted into law in 1986, gave the VHA the authority to bill some veterans and most health-care insurers for nonservice-connected care provided to veterans enrolled in the VA health-care system, to help defray the cost of delivering medical services to veterans.[34] This law also established means testing for veterans seeking care for nonservice-connected conditions. However, P.L. 99-272 did not provide the VA with specific authority to retain the third-party payments it collected and VA was required to deposit these third-party collections in the General Fund of the U.S. Treasury.

[34] Veterans' Health-Care and Compensation Rate Amendments of 1985;100 Stat. 372, 373, 383.

The Balanced Budget Act of 1997 (P.L. 105-33) gave the VHA the authority to retain these funds in the Medical Care Collections Fund (MCCF). Instead of returning the funds to the Treasury, the VA can use them for medical services for veterans without fiscal year limitations.[35] To increase the VA's third-party collections, P.L. 105-33 also gave the VA the authority to change its basis of billing insurers from "reasonable costs" to "reasonable charges."[36] This change in billing was intended to enhance VA collections to the extent that reasonable charges result in higher payments than reasonable costs.[37] In FY2004, the Administration's budget requested consolidating several medical existing collections accounts into one MCCF. The conferees of the Consolidated Appropriations Act of 2004 (H.Rept. 108-401) recommended that collections that would otherwise be deposited in the Health Services Improvement Fund (former name), Veterans Extended Care Revolving Fund (former name), Special Therapeutic and Rehabilitation Activities Fund (former name), Medical Facilities Revolving Fund (former name), and the Parking Revolving Fund (former name) should be deposited in MCCF.[38] The Consolidated Appropriations Act of 2005; (P.L. 108-447, H.Rept. 108-792) provided the VA with permanent authority to deposit funds from these five accounts into the MCCF. The funds deposited into the MCCF would be available for medical services for veterans. These collected funds do not have to be spent in any particular fiscal year and are available until expended.

The conferees of the FY2006 Military Construction, Military Quality of Life and Veterans Affairs Appropriations Act (P.L. 109-114, H.Rept. 109-305) required the VA to establish a revenue improvement demonstration project. The purpose of this pilot project is to provide a "comprehensive restructuring of the complete revenue cycle including cash-flow management and accounts receivable."[39] The conferees included this provision because the Appropriations Committees were concerned that the VHA was collecting only 41% percent of the billed amounts from third-party insurance companies. Currently, the VHA has established a pilot Consolidated Patient Account Center (CPAC) in VISN 6. There are eight VA medical centers under the CPAC management initiative. In a report issued in June 2008, the

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[35] For a detailed history of funding for VHA from FY1995 to FY2004, see CRS Report RL32732, *Veterans' Medical Care Funding FY1995-FY2004*, by Sidath Viranga Panangala.

[36] Under "reasonable costs," the VA billed insurers based on its average cost to provide a particular episode of care. Under "reasonable charges," the VA bills insurers based on market pricing for health-care services.

[37] U.S. Government Accountability Office (GAO), *VA Health Care: Third-Party Charges Based on Sound Methodology; Implementation Challenges Remain*, GAO/HEHS-99-124, June 1999.

[38] For a detailed description of these former accounts, see CRS Report RL32548, *Veterans' Medical Care Appropriations and Funding Process*, by Sidath Viranga Panangala.

[39] U.S. Congress, Conference Committees, *Military Construction, Military Quality of Life and Veterans Affairs Appropriations Act, 2006*, conference report to accompany H.R. 2528, 109th Congress, 1st session, H.Rept. 109-305, p. 43.

Government Accountability Office (GAO) stated that VA had ineffective controls over medical center billings.[40]

As shown in **Table 4**, MCCF collections increased by 45%, from $1.5 billion in FY2003 to $2.2 billion in FY2007. During this same period, first-party collections increased by 33.6%, from $685 million to $915 million. In FY2007, first-party collections represented approximately 41% of total MCCF collections.

Table 4. Medical Care Collections, FY2003-FY2007

($ in thousands)

	FY2003 Actual	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 Actual
First-party pharmacy copayments[a]	$576,554	$623,215	$648,204	$723,027	$760,616
First-party copayments for inpatient and outpatient care	104,994	113,878	118,626	135,575	150,964
First-party long-term care copayments[b]	3,461	5,077	5,411	4,347	3,699
Third-party insurance collections	804,141	960,176	1,055,597	1,095,810	1,261,346
Enhanced use leasing revenue[c]	234	459	26,861	3,379	1,692
Compensated work therapy collections[d]	38,834	40,488	36,516	40,081	43,296
Parking fees[e]	3,296	3,349	3,443	3,083	3,136
Compensation and pension living expenses[f]	376	634	2,431	2,075	1,904
MCCF Total	**$1,531,890**	**$1,747,276**	**$1,897,089**	**$2,007,377**	**$2,226,653**

Sources: Table prepared by CRS based on data provided by the VA, and U.S. Department of Veterans Affairs, *FY2009 Budget Submission, Medical Programs and Information Technology Programs*, Vol. 2 of 4, pp. 1C-11.

Notes: The following accounts were not consolidated into the MCCF until FY2004: enhanced use leasing revenue, compensated work therapy collections, parking fees, and compensation and pension living expenses. Collection figures for these accounts for FY2003 are provided for comparison purposes.

a. In FY2002, Congress created the Health Services Improvement Fund (HSIF) to collect increases in pharmacy copayments (from $2 to $7 for a 30-day supply of outpatient medication) that went into effect on February 4, 2002. The Consolidated Appropriations Resolution, 2003 (P.L. 108-7) granted the VA the authority to consolidate the HSIF with the MCCF and granted permanent authority to recover copayments for outpatient medications.

[40] For details on whether medical centers under the CPAC initiative had more effective controls over third-party billings and collections, see U.S. Government Accountability Office, *VA Health Care: Ineffective Controls over Medical Center Billings and Collections Limit Revenue from Third- Party Insurance Companies,* GAO-08-675, June 2008.

b. Authority to collect long-term care copayments was established by the Millennium Health Care and Benefits Act (P.L. 106-117). Certain veteran patients receiving extended care services from VA providers or outside contractors are charged copayments.

c. Under the enhanced-use lease authority, the VA may lease land or buildings to the private sector for up to 75 years. In return the VA receives fair consideration in cash and/or in-kind. Funds received as monetary considerations may be used to provide care for veterans.

d. The compensated work therapy program is a comprehensive rehabilitation program that prepares veterans for competitive employment and independent living. As part of their work therapy, veterans produce items for sale or undertake subcontracts to provide certain products and/or services, such as providing temporary staffing to a private firm. Funds collected from the sale of these products and/or services are deposited into the MCCF.

e. The Parking program provides funds for construction and acquisition of parking garages at VA medical facilities. The VA collects fees for use of these parking facilities.

f. Under the compensation and pension living expenses program, veterans who do not have either a spouse or child would have their monthly pension reduced to $90 after the third month a veteran is admitted for nursing home care. The difference between the veteran's pension and the $90 is used for the operation of the VA medical facility.

FY2008 Budget Summary[41]

On February 5, 2007, the President submitted his FY2008 budget proposal to Congress. The total amount requested by the Administration for the VHA for FY2008 was $34.6 billion, a 1.93% increase in funding compared with the FY2007 enacted amount. The total amount of funding that would have been available for the VHA under the President's budget proposal for FY2008, including collections, was approximately $37.0 billion (see **Table 5** and **Appendix E**). For FY2008, the Administration requested $27.2 billion for medical services, a $1.2 billion, or 4.8%, increase in funding over the FY2007 enacted amount. The Administration's budget proposal also requested $3.4 billion for medical administration, $3.6 billion for medical facilities, and $411 million for medical and prosthetic research (see **Table 5** and **Appendix E**). As in FY2003, FY2004, FY2005, FY2006, and FY2007, the Administration' FY2008 budget request included several cost-sharing proposals.

House Action

On June 6, 2007, the House Appropriations Committee recommended $37.1 billion for the VHA for FY2008, a 9.3% increase over the FY2007 enacted amount of $34.0 billion and 7.3% above the President's request. The Military Construction and Veterans Affairs appropriations bill for FY2008 (H.R. 2642, H.Rept. 110-186) was reported out of committee on June 11.

[41] For a detailed description of VA Medical Care Appropriations for FY2008, see CRS Report RL34063, *Veterans' Medical Care: FY2008 Appropriations*, by Sidath Viranga Panangala.

On June 15, 2007, the House passed H.R. 2642.[42] As amended, H.R. 2642 provided $29.0 billion for medical services. The MILCON-VA appropriations bill, as amended, also provided: $3.5 billion for the medical administration account, $68.6 million above the FY2008 request and $82.6 million above the FY2007 enacted amount; $4.1 billion for medical facilities, a 14% increase over the President's request; and $480 million for medical and prosthetic research, a 17% increase over the President's request of $411 million (see **Table 5**).

Senate Action

On June 14, 2007, the Senate Appropriations Committee approved its version of the MILCON-VA appropriations bill. The bill was reported to the Senate on June 18 (S. 1645, S. Rept.110-85). S. 1645, as reported, provided a total of $37.2 billion for the VHA.

On September 6, 2007, the Senate passed H.R. 2642 with an amendment in the nature of a substitute to reflect the Senate Appropriations Committee-approved measure (S. 1645, S. Rept.110-85). As amended by the Senate, H.R. 2642 provided $29.1 billion for medical services — a $3.2 billion (12.3%) increase over the FY2007 enacted amount and $1.9 billion over the FY2008 budget request — and $3.5 billion would have been available for medical administration, $75 million above the FY2008 Administration's request. H.R. 2642, as passed by the Senate, provided $4.1 billion for medical facilities — a 14.0% increase over the FY2008 request and 1.7% less than the FY2007 enacted amount — and $500 million for medical and prosthetic research — a 12% increase over the FY2007 enacted amount, a 22.0% increase over the FY2008 request, and 4.2% above the House-passed amount (see **Table 5**).

Consolidated Appropriations Act for FY2008

At the end of 2007, Congress passed the Consolidated Appropriations Act for FY2008 (H.R. 2764), an omnibus measure that combined the 11 outstanding appropriations bills for FY2008.[43] H.R. 2764 was passed by the House on December 17, 2007; the Senate passed the measure the next day, December 18, with an amendment (McConnell Amendment — adding funding for the Iraq war). The House agreed to the McConnell Amendment on December 19. The bill was signed into law (P.L. 110-161) on December 26. Division I of H.R. 2764 included the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2008 (MILCON-VA Appropriations Act).

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[42] H.R. 2642 as passed by the House on June 15, 2007, was not enacted into law. Provisions in this bill were amended and later incorporated into the Consolidated Appropriations Act, 2008 (H.R. 2764, P.L. 110-161). H.R. 2642 subsequently became the vehicle for the Supplemental Appropriations Act, 2008 (P.L. 110-252).

[43] The only appropriations bill that passed as a stand alone measure was the Department of Defense Appropriations Act, 2008 (H.Rept. 110-434), which was signed into law on November 13, 2007 (P.L. 110-116).

The MILCON-VA Appropriation Act provided $37.2 billion for VHA for FY2008, which is $2.6 billion above the Administration's request for FY2008 (see **Table 5**). Of this amount $2.6 billion (the amount above the Administration's request) was designated as contingent emergency funding, and was to be available for obligation only after the President submitted a budget request to Congress. On January 17, 2008, the President submitted a budget request to Congress, requesting this additional amount and designating it as an emergency requirement.

FY2009 VHA Budget

On February 4, 2008, the President submitted his FY2009 budget proposal to Congress. The Administration is requesting a total of $39.2 billion (excluding collections) for VHA. This is a 5.3% increase, or a $2.0 billion increase, over the FY2008 enacted level. Including total available resources (including medical collections) the Administration's budget would provide $ 41.1 billion for VHA. The President's FY2009 budget submission also proposes to abolish the medical administration account and consolidate these activities in the medical services account. Under this account structure the Administration is requesting $34.1 billion for the medical services account which is approximately $5 billion above the FY2008 enacted amount (**Table 5**). The VHA is estimating an overall medical inflation rate of 4.63% for FY2009. The major cost drivers for VHA medical care are increases in costs of goods and services beyond the control of the VHA, as well as increases in utilization of services by existing patients, and increases in intensity of care (more complex care).

The President's budget proposal also requests $4.7 billion for the medical facilities account, an increase of $561 million over the FY2008 enacted level. The Administration's budget proposal for FY2009 requests $442 million for the medical and prosthetic research account, a 7.9% decrease ($38 million) below the FY2008 enacted level. According to the Senate Committee on Veterans' Affairs, the President's proposal would result in the loss of 49 full time positions and 294 research projects.[44]

As in FY2003, FY2004, FY2005, FY2006, FY2007, and FY2008. the Administration included several cost-sharing proposals. These legislative proposals are discussed in detail in the key budget issues section at the end of this report.

[44] Senate Committee on Veterans Affairs (majority), *Views and Estimates Letter for FY2009,* to the Senate Committee on the Budget, February 22, 2008.

FY2009 Congressional Budget Resolution[45]

On March 7, 2008, the House (H.Con.Res. 312) and Senate (S.Con.Res. 70) reported their respective budget resolutions.[46] The House budget resolution provided $48.2 billion in funding for discretionary veterans programs and $45.1 billion in mandatory spending for FY2009. The House budget resolution also rejected health care enrollment fees and prescription drug copayment increases as proposed by the President. Similar to the House amounts, the Senate budget resolution provided $48.2 billion for discretionary veterans programs including health care, and $45.1 billion for mandatory programs. The House passed its budget resolution on March 13 and the Senate passed its version the following day. After negotiations between the House and Senate, the House agreed to an amended version of S.Con.Res. 70 (Conference Report; H.Rept. 110-659). The Senate adopted H.Rept. 110-659 on June 4 and the House adopted the conference agreement the next day. The conference agreement provides $48.2 billion for FY2009 for discretionary veterans' programs, including medical care. This amount is $4.9 billion more than the FY2008 enacted level, and $3.3 billion more than the President's budget proposal for FY2009. The conference agreement also provides $45.1 billion in mandatory funding for veterans programs.

House Committee Action

On June 12, 2008, the House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, marked up a draft Military Construction and Veterans Affairs Appropriations bill. On June 24, the House Appropriations Committee marked up the Military Construction and Veterans Affairs Appropriations bill (H.R. 6599; H.Rept. 110-775), for FY2009 (MILCON-VA Appropriations bill). The House Appropriations Committee recommended $40.8 billion for VHA, a $1.6 billion increase over the Administration's FY2009 request, and $3.6 billion over the FY2008 enacted amount. This amount includes $31billion for the medical services account. The committee did not concur with the President's proposed account structure of consolidating the medical administration account with the medical services account. The House Appropriations Committee-recommended amount for the medical services account is 6% above the FY2008 enacted amount (**Table 5**). The Committee has included bill language stipulating that VA must spend not less than $3.8 billion on specialty mental health care, including Post-traumatic Stress Disorder (PTSD).

The Committee also recommended $4.4 billion for the medical support and compliance account (previously known as the medical administration account). This amount is 25% above the FY2008 enacted amount. H.R. 6599 also provides approximately $5 billion for the medical facilities account, a $368 million increase over the Administration's request, and $929 million above the FY2008 enacted level. This increase includes funding for non-recurring maintenance. The Committee is

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[45] For a detailed analysis of the FY2009 budget resolution see CRS Report RL34419, *The Budget for Fiscal Year 2009,* by D. Andrew Austin.

[46] H.Rept. 110-543 and S. Prt. 110-039.

directing the VHA to use these funds to address life/safety and suicide prevention deficiencies in mental health wards. Lastly, the House MILCON-VA appropriations bill provides $500 million for the medical and prosthetic research account, a 13.1 % increase over the FY2009 request, and a 4.2 % increase over the FY2008 enacted amount (**Table 5**).

Construction Projects. The MILCON-VA appropriations bill (H.R. 6599) recommends $923 million for the construction major account, a 58% increase over the FY2009 request and a 13 % decrease from the FY2008 enacted level. H.R. 6599 also provides $991.5 million for the construction minor projects account, an increase of 200% over the FY2009 request and 57% above the FY2008 enacted amount. In total (excluding grants for construction of state veterans cemeteries), the Committee has recommended $2.1 billion for VA construction projects, including construction projects identified under the Capital Asset Realignment for Enhanced Services (CARES) initiative, and grants for construction of state extended care facilities. This level of funding is a 108% increase in funding over the FY2009 request, and 11.5% over the FY2008 enacted amount (**Table 6**).

Senate Committee Action

On July 17, 2008, the Senate Appropriations Committee marked up its version of the FY2009 Military Construction and Veterans Affairs and Related Agencies Appropriations bill (S. 3301, S.Rept. 110-428). The Senate Appropriations Committee recommended $41.1 billion (excluding collections) for VHA for FY2009 (see **Table 5**). This is a 4.8% increase over the FY2009 request, and $294 million above the House Appropriations Committee-recommended amount. The Senate Appropriations Committee concurred with the President's proposal to merge the medical services account with the medical administration account. The Committee has stated that the "current account structure has created bureaucratic confusion at the medical center level often slowing effective delivery of health care."[47] The Committee recommends merging the medical services account with the medical administration account in order to provide more spending flexibility to medical center directors.

Under the proposed new account structure the Committee is recommending $35.6 billion for the medical services account, a 4.4% ($1.5 billion) increase over the FY2009 request. S. 3301, as marked up by the Committee, also provides $5.0 billion for medical facilities. This is a 21% increase compared to the FY2008 enacted amount, 6.4% above the FY2009 request, and $68 million below the House Committee-recommended amount (see **Table 5**).

The Senate marked up MILCON-VA appropriations bill also provides $527 million for the medical and prosthetic research account. This is a 19.2% increase over the FY2009 request and 9.8% above the FY2008 enacted amount.

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[47] U.S. Congress, Senate Committee on Appropriations, *Military Construction, and Veterans Affairs, and Related Agencies Appropriations Bill, 2009*, report to accompany S. 3301, 110th Cong., 2nd sess., S.Rept. 110-428, p.40.

Construction Projects. The Committee recommended bill (S. 3301) provides $1.2 billion for the construction major projects account, a 109% increase over the FY2009 request and 32% above the House Appropriations Committee-recommended amount. S. 3301 also provides $729 million for the construction minor projects account, a 26% decrease from the House Committee recommended amount (see **Table 6**). In total, S. 3301 provides $2.2 billion for VA construction projects (excluding grants for state veterans cemeteries), including projects identified under the CARES initiative.

Major Areas of Committee Interest

Priority Group 8 Veterans. The Veterans Health Care Eligibility Reform Act of 1996 (P.L. 104-262) included language that stipulated that medical care to veterans will be furnished to the extent appropriations were made available by Congress on an annual basis. Based on this statutory authority, the Secretary of Veterans Affairs announced on January 17, 2003 that VA would temporarily suspend enrolling Priority Group 8 veterans.[48] Those who were in VA's health care system prior to January 17, 2003 were not to be affected by this suspension.

The House Appropriations Committee, in its report to accompany H.R. 6599 (H.Rept. 110-775) states that the VA "should do everything possible to increase access to medical care for all our veterans, but not in a manner that will negatively impact the medical care [provided to] currently enrolled patients."[49] The Committee is directing the VA to increase Priority Group 8 enrollment by 10%, and has provided $568 million above the Administration's request for this purpose.

Likewise the Senate Appropriations Committee has included $350 million within the medical services account so that the VA could "raise the income threshold to an amount commensurate with the increased level of funding" in order to enroll more Priority Group 8 veterans.[50]

Beneficiary Travel Milage Reimbursement. In general, the beneficiary travel program reimburses certain veterans for the cost of travel to VA medical facilities when seeking health care. P.L. 76-432, passed by Congress on March 14, 1940, mandated VA to pay either the actual travel expenses, or an allowance based upon the mileage traveled by any veteran traveling to and from a VA facility or other place for the purpose of examination, treatment, or care. P.L. 85-857, signed into law on September 2, 1958, authorized VA to pay necessary travel expenses to any veteran traveling to or from a VA facility or other place in connection with vocational

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[48] Department of Veterans Affairs, "Enrollment — Provision of Hospital and Outpatient Care to Veterans Subpriorities of Priority Categories 7 and 8 and Annual Enrollment Level Decision; Final Rule," *68 Federal Register* 2670, January 17, 2003.

[49] U.S. Congress, House Committee on Appropriations, *Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2009*, report to accompany H.R. 6599, 110th Cong., 2nd sess., H.Rept. 110-775, p.39.

[50] U.S. Congress, Senate Committee on Appropriations, *Military Construction, and Veterans Affairs, and Related Agencies Appropriations Bill, 2009*, report to accompany S. 3301, 110th Cong., 2nd sess., S.Rept. 110-428, p.50.

rehabilitation counseling or for the purpose of examination, treatment, or care. However, this law changed VA's travel reimbursement into a discretionary authority by stating that VA "may pay" expenses of travel.

Due to rapidly increasing costs of the beneficiary travel program, on March 12, 1987, VA published final regulations that sharply curtailed eligibility for the beneficiary travel program.[51] Under these regulations beneficiary travel payments to eligible veterans were paid when specialized modes of transportation, such as ambulance or wheelchair van, were medically required. In addition, payment was authorized for travel in conjunction with compensation and pension examinations, as well as travel beyond a 100-mile radius from the nearest VA medical care facility. It also authorized the VA to provide transportation costs, when necessary, to transfer any veteran from one health care facility (either a VA or contract care facility) to another in order to continue care paid for by the VA. The following transportation costs were not authorized under these regulations:

- Cost of travel by privately owned vehicle in any amount in excess of the cost of such travel by public transportation unless public transportation was not reasonably accessible or was medically inadvisable.

- Cost of travel in excess of the actual expense incurred by any person as certified by that person in writing.

- Cost of routine travel in conjunction with admission for domiciliary care, or travel for family members of veterans receiving mental health services from the VA except for such travel performed beyond a 100-mile radius from the nearest VA medical care facility.

Travel expenses of all other veterans were not authorized unless the veterans were able to present clear and convincing evidence to show the inability to pay the cost of transportation; or except when medically-indicated ambulance transportation was claimed and an administrative determination was made regarding the veteran's ability to bear the cost of such transportation.[52]

The Veterans' Benefits and Services Act of 1988 (P.L. 100-322, section 108), in large part restored VA travel reimbursement benefits. It required that if VA provides any beneficiary travel reimbursement under Section 111 of Title 38 U.S.C. in any given fiscal year, then payments must be provided in that year in the case of travel for health care services for all the categories of beneficiaries specified in the statute. In order to limit the overall cost of this program, the law imposed a $3 one-way deductible applicable to all travel, except for veterans otherwise eligible for beneficiary travel reimbursement who are traveling by special modes of transportation such as ambulance, air ambulance, wheelchair van, or to receive a

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[51] Veterans Administration, "Transportation of Claimants and Beneficiaries," final regulations, 52 FR 7575-01, March 12, 1987. These regulations became effective on April 13, 1987.

[52] Ibid.

compensation and pension examination. In order to limit the overall impact on veterans whose clinical needs dictate frequent travel for VA medical care, an $18-per-calendar-month cap on the deductible was imposed for those veterans who are pre-approved as needing to travel on a frequent basis.

Veterans may qualify for travel reimbursement if (1) they have a service-connected disability rated 30% or more; (2) they are traveling for treatment of a service-connected disability; (3) they receive a VA pension; (4) their income does not exceed the maximum annual VA pension rate; or (5) traveling for a scheduled compensation or pension examination; (6) they are participating in an authorized Vocational Rehabilitation Program.

The FY2008 Appropriations Act (P.L. 110-161) provided funding for VA to increase the beneficiary travel mileage reimbursement rate from 11 cents per mile to 28.5 cents per mile. The increase went into effect on February 1, 2008. While increasing the payment, VA, as mandated by law, also increased proportionately the deductible amounts applied to certain mileage reimbursements. The new deductibles are $7.77 for a one way trip, $15.54 for a round trip, with a maximum of $46.62 per calendar month. However, these deductibles can be waived if they cause a financial hardship to the veteran.

VA regulation with respect to waiving deductibles. Under current regulations 38 CFR 17.144 (b) when it is determined that charging a deductible would cause a severe financial hardship to the veteran, the VA could waive the deductible requirement. Currently, VA determines severe financial hardship as (1) annual income for the year immediately preceding the application for benefits does not exceed the maximum annual rate of pension which would be payable if the person were eligible for pension; or (2) the person is able to demonstrate that due to circumstances such as loss of employment, or incurrence of a disability, income in the year of application will not exceed the maximum annual rate of pension which would be payable if the person were eligible for pension.

With gasoline prices at record high levels, the House and Senate Appropriations Committees have included report language to further increase the mileage reimbursement rate. The House Appropriations Committee has provided an additional $100 million to increase the beneficiary travel reimbursement mileage rate to 41.5 cents per mile from the current rate of 28.5 cents per mile. The Senate Appropriations Committee has included an additional $138 million above the Administration's request to raise the mileage reimbursement rate to 50.5 cents per mile, which raises VA's reimbursement rate to conform with the General Services Administration's (GSA) rate at which federal employees are reimbursed when using private automobiles for official business.

Table 5. VHA Appropriations by Account, FY2007-FY2009

($ in thousands)

Program	FY2007 Enacted	FY2008 Request	FY2008 House	FY2008 Senate	FY2008 Enacted	FY2009 Request	FY2009 House Committee (H.Rept. 110-775)	FY2009 Senate Committee (S.Rept. 110-428)
Medical Services	$25,518,254	$27,167,671	$29,031,400	$29,104,220	$27,167,671	$34,075,503	$30,854,270	$35,590,432
Emergency appropriations — U.S. Troop Readiness, Veterans' Care, Katrinia Recovery (P.L. 110-28)	$400,778[a]	—	—	—	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	$1,936,549	—	—	—
Subtotal Medical Services	***$25,919,032***	***$27,167,671***	***$29,031,400***	***$29,104,220***	***$29,104,220***	***$34,075,503***	***$30,854,270***	***$35,590,432***
Medical Support and Compliance (Previously Medical Administration)	$3,177,968	$3,442,000	$3,510,600	$3,517,000	$3,442,000	—	$4,400,000	—
Emergency appropriations — U.S. Troop Readiness, Veterans' Care, Katrinia Recovery (P.L. 110-28)	$250,000	—	—	—	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	$75,000	—	—	—
Subtotal Medical Support and Compliance (Previously Medical Administration)	***$3,427,968***	***$3,442,000***	***$3,510,600***	***$3,517,000***	***$3,517,000***	**—**	***$4,400,000***	—
Medical Facilities	$3,569,533	$3,592,000	$4,100,000	$4,092,000	$3,592,000	$4,661,000	$5,029,000	$4,961,000
Emergency appropriations — U.S. Troop Readiness, Veterans' Care, Katrinia Recovery (P.L. 110-28)	$595,000	—	—	—	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	$508,000	—	—	—
Subtotal Medical Facilities	***$4,164,533***	***$3,592,000***	***$4,100,000***	***$4,092,000***	***$4,100,000***	***$4,661,000***	***$5,029,000***	***$4,961,000***
Medical and Prosthetic Research	$413,980	$411,000	$480,000	$500,000	$411,000	$442,000	$500,000	$526,800
Emergency appropriations — U.S. Troop Readiness, Veterans' Care, Katrinia Recovery (P.L. 110-28)	$32,500	—	—	—	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	$69,000	—	—	—
Subtotal Medical and Prosthetic Research	***$446,480***	***$411,000***	***$480,000***	***$500,000***	***$480,000***	***$442,000***	***$500,000***	***$526,800***
Total VHA appropriations (without collections)	**$33,958,013**	**$34,612,671**	**$37,122,000**	**$37,213,220**	**$37,201,220**	**$39,178,503**	**$40,783,270**	**$41,078,232**
Medical care cost collections (MCCF)	$2,329,000	$2,414,000	$2,414,000	$2,414,000	$2,414,000	$1,879,000	$2,544,000	$2,544,000
Total VHA appropriations (with collections)	**$36,287,013**	**$37,026,671**	**$39,536,000**	**$39,627,220**	**$39,615,220**	**$41,057,503**	**$43,327,270**	**$43,622,232**

Sources: Table prepared by the Congressional Research Service based on H.Rept. 109-464; H.Rept. 109-494; S.Rept. 109-286; P.L. 110-5; H.Rept. 110-64; S.Rept. 110-37; H.Rept. 110-60; *Congressional Record*, vol. 153,(May 24, 2007), H5786-H5787; H.Rept. 110-186; S.Rept. 110-85; *Congressional Record*, vol. 153, (September 7, 2007), S11271-S11278; *Congressional Record*, vol. 153 (December 17, 2007),H16249-H16431; H.Rept. 110-775; and S.Rept. 110-428.

Note: FY2008 enacted does not include funding included in the Supplemental Appropriation Act, 2008 (P.L. 110-252).

a. P.L. 110-161 (H.R. 2764) transferred $66 million from the FY2007 medical services account to the construction major, projects account for FY2007.

Table 6. Appropriations for VA Construction Projects, FY2008-FY2009

($ in thousands)

	FY2008 Request	FY2008 House	FY2008 Senate	FY2008 enacted	FY2009 Request	FY2009 House Committee (H. Rept. 110-775)	FY2009 Senate Committee (S.Rept. 110-428)
Construction, major projects[a]	$727,400	$1,410,800	$727,400	$727,400	$581,582	$923,382	$1,217,747
Contingent emergency (P.L.110-161)	—	—	—	341,700	—	—	—
Subtotal construction, major projects	***727,400***	***1,410,800***	***727,400***	***1,069,100***	***581,582***	***923,382***	***1,217,747***
Construction, minor projects[b]	233,396	615,000	751,398	233,396	329,418	991,492	729,418
Contingent emergency (P.L.110-161)	—	—	—	397,139	—	—	—
Subtotal construction, minor projects	***233,396***	***615,000***	***751,398***	***630,535***	***329,418***	***991,492***	***729,418***
Grants for construction of state extended care facilities[c]	85,000	165,000	250,000	85,000	85,000	165,000	250,000
Contingent emergency (P.L.110-161)	—	—	—	80,000	—	—	—
Subtotal Grants for construction of state extended care facilities	***85,000***	***165,000***	***250,000***	***165,000***	***85,000***	***165,000***	***250,000***
Total	**$1,045,796**	**$2,190,800**	**$1,728,798**	**$1,864,635**	**$996,000**	**$2,079,874**	**$2,197,165**

Sources: Table prepared by CRS based on H.Rept. 110-186; S.Rept. 110-85; *Congressional Record*, vol. 153, (September 7, 2007), S11271-S11278; *Congressional Record*, vol.153 (December 17, 2007), H16249-H16431; H.Rept. 110-775; and S.Rept. 110-428.

Note: This table excludes grants for construction of state veterans cemeteries.

a. This account provides funds for constructing, altering, extending, and improving any VA facility, including planning, assessments of needs, architectural and engineering services, CARES projects, and site acquisition, where the estimated cost of a project is *$10 million or more* or where funds for a project were made available in a previous major project appropriation. Emphasis is placed on correction of safety code deficiencies in existing VA medical facilities.

b. This account provides funds for constructing, altering, extending and improving any VA facility, including planning, architectural and engineering services, CARES projects, and site acquisition, where the estimated cost of a project is *less than $10 million*. VA medical center projects that need minor improvements costing $500,000 or more are funded from this account.

c. This account provides grants to states to acquire or construct state nursing home and domiciliary facilities, and to remodel, modify, or alter existing hospitals, nursing homes, and domiciliary facilities in state homes. A grant may not exceed 65% of the total cost of the project. P.L. 102-585 granted permanent authority for this program, and P.L. 104-262 added Adult Day Health Care as another level of care that may be provided by state homes. This is a no-year account.

Key Budget Issues

In its FY2009 budget request, the Administration has put forward several legislative proposals. These proposals are similar to previous ones included in the Administration's budget requests for FY2003, FY2004, FY2005, FY2006, FY2007, and FY2008 and rejected by Congress each year.[53] Similar to the FY2008 budget proposals, revenue from the proposals in the FY2009 budget request would not be deposited in the Medical Care Collections Fund (MCCF), but would be classified as mandatory receipts to the Treasury. None of these proposals have received any consideration by the House and Senate Appropriation Committees.

The President's FY2009 budget request includes three major policy proposals:

- Assess a tiered annual enrollment fee for all Priority 7 and 8 veterans based on the family income of the veteran.
- Increase pharmaceutical copayments from $8 to $15 (for each 30-day prescription) for all enrolled veterans in Priority Groups 7 and 8.
- Bill veterans receiving treatment for nonservice-connected conditions for the entire copayment amount.

A detailed description of these budget proposals follows.

Assess an Annual Enrollment Fee

The Administration is proposing a tiered annual enrollment fee, which is structured to charge $250 for Priority 7 and 8 veterans with family incomes from $50,000 to $74,999; $500 for those with family incomes from $75,000 to $99,999; and $750 for those with family incomes equal to or greater than $100,000. The VA has estimated that this proposal would contribute more than $129 million to the Treasury annually, beginning in FY2010, and will increase revenue by $1.1 billion over 10 years.

Increase Pharmacy Co-payments

The Administration proposes increasing the pharmacy copayments from $8 to $15 for all enrolled Priority Group 7 and Priority Group 8 veterans whenever they obtain medication from the VA on an outpatient basis for the treatment of a

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[53] In FY2003, the VA proposed a $1,500 deductible for all Priority Group 7 veterans for nonservice-connected disabilities. For proposals included in FY2004, FY2005, FY2006, FY2007,and FY2008, see CRS Report RL32548, *Veterans' Medical Care Appropriations and Funding Process*, by Sidath Viranga Panangala; CRS Report RL32975, *Veterans' Medical Care: FY2006 Appropriations*, by Sidath Viranga Panangala; CRS Report RL33409, *Veterans' Medical Care: FY2007 Appropriations*, by Sidath Viranga Panangala; and CRS Report RL34063, *Veterans' Medical Care: FY2008 Appropriations*, by Sidath Viranga Panangala.

nonservice-connected condition. The Administration put forward this proposal in its FY2004, FY2005, FY2006, FY2007, and FY2008 budget requests as well, but did not receive any approval from Congress. At present, veterans in Priority Groups 2-8 pay $8 for a 30-day supply of medication, including over-the-counter medications.[54]

The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) authorized the VA to charge most veterans $2 for each 30-day supply of medication furnished on an outpatient basis for treatment of a nonservice-connected condition. The Veterans Millennium Health Care and Benefits Act of 1999 (P.L. 106-117) authorized the VA to increase the medication copayment amount and establish annual caps on the total amount paid, to eliminate financial hardship for veterans enrolled in Priority Groups 2-6.[55] When veterans reach the annual cap, they continue to receive medications without making a copayment.

On November 15, 2005, the VHA issued a directive stating that effective January 1, 2006, the medication co-payment will be increased to $8 for each 30-day supply of medication furnished on an outpatient basis for treatment of a nonservice-connected condition, and that the annual cap for veterans enrolled in Priority Groups 2-6 will be $960.[56] There is no cap for veterans in Priority Groups 7 and 8 (see **Appendixes B** and **C**). The VA estimates that if the current proposal to raise the copayment were enacted, it would contribute $355 million to the Treasury in FY2009 and will increase revenue by $3.7 billion over 10 years.

Impact of Fee Proposals. According to the VA, in FY2009, as many as 444,000 veterans would choose not to enroll in the VA health care system and 146,000 unique veteran patients would not seek VA health care if enrollment fees are imposed and pharmacy copays are increased.

Third-Party Offset of First-Party Debt

The Administration is requesting that Congress amend the VA's statutory authority by eliminating the practice of reducing first-party copayment debts with third-party

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[54] The following veterans are exempt from paying copayments: veterans receiving a pension for a nonservice-connected disability from the VA; veterans with incomes below $11,181 (if no dependents) and $14,643 (with one dependent plus $1,909 for each additional dependent); veterans receiving care for conditions such as Agent Orange or Military Sexual Trauma, and combat veterans within five years of discharge; and veterans who are former POWs.

[55] This law allowed the VA to increase the copayment amount for each 30-day or less supply of medication provided on an outpatient basis (other than medication administered during treatment) for treatment of a nonservice-connected condition. Accordingly, the VA increased the copayment amount from $2 to $7. The medication copayment charge for each subsequent calendar year after 2002 is established by using the prescription drug component of the Medical Consumer Price Index. When an increase occurs, the copayment increases in whole dollar amounts. The amount of the annual cap increases $120 for each $1 increase in the copayment amount.

[56] VHA Directive 2005-052, *Implementation of Medication Copayment Changes*, November 15, 2005.

health insurance collections. The VA asserts that this proposal would align the VA with the DOD health-care system for military retirees and with the private sector.

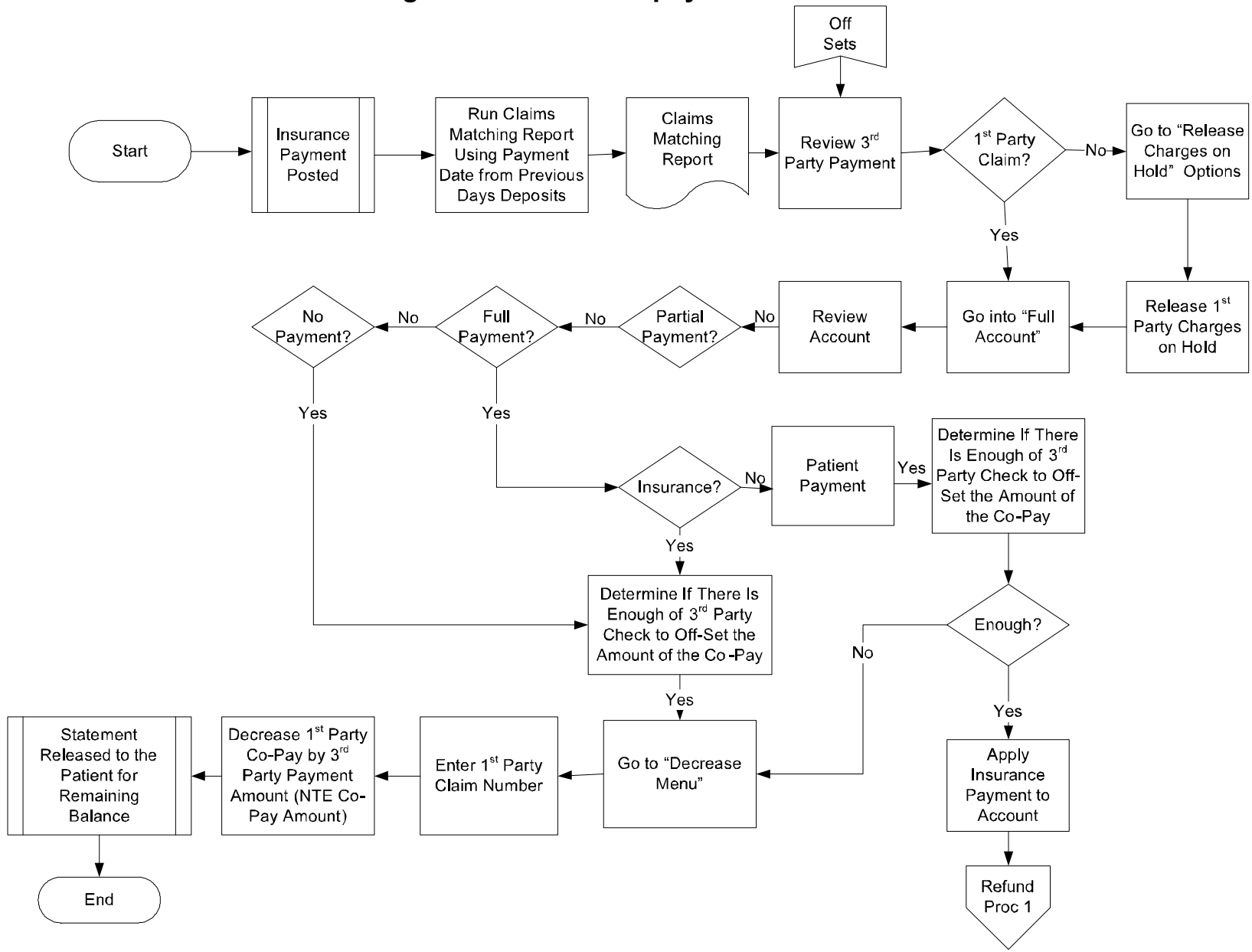
With the enactment of P.L. 99-272 in 1986, Congress authorized the VA to collect payments from third-party health insurers for the treatment of veterans with nonservice-connected disabilities; it also established copayments from veterans for this care.[57] Under current law, the VA is authorized to collect from third-party health insurers to offset the cost of medical care furnished to a veteran for the treatment of a nonservice-connected condition.[58] If the VA treats an insured veteran for a nonservice-connected disability, and the veteran is also determined by the VA to have copayment responsibilities, the VA will apply the payment collected from the insurer to satisfy the veteran's copayment debt related to that treatment.

Under the current copayment billing process, in cases where the cost of a veteran's medical care for a nonservice-connected condition appears to qualify for billing under reimbursable insurance and copayment, the VA medical facilities sends the bill to the insurance provider. The veteran's copayment obligation is placed on hold for 90 days pending payment from the third-party payer. If no payment is received from the third-party payer within 90 days, a bill is sent to the veteran for the full copayment amount. However, when insurers reimburse the VA after the 90-day period, the VA must absorb the cost of additional staff time for processing a refund if the veteran has already paid the bill. On all insurance policies, the entire amount of the claim payment is applied first to the copayment. The veteran is then billed only for the portion of the copayment not covered by the insurance reimbursement and the portion of the copayment for services not covered by the veteran's insurance plan (see **Figure 2**).

[57] Consolidated Omnibus Budget Reconciliation Act of 1985, 100 Stat. 372, 373, 383.

[58] 38 U.S.C. §1729; 38 U.S.C. §1710; and 38 U.S.C. 1722A.

Figure 2. Present Copayment Process



Source: Department of Veterans Affairs.

Under the Administration's proposal, veterans receiving medical care services for treatment of nonservice-connected disabilities will receive a bill for their entire copayment, and the copayment will not be reduced by collection recoveries from third-party health plans. This proposal would apply to all veterans who make copayments.

According to VA estimates, this proposal will increase revenue by $44 million in FY2009 and $415 million over 10 years. The House and Senate Appropriations Committees have not addressed this issue because it is an issue in the purview of the authorizing committees.

Appendix A. Priority Groups and Their Eligibility Criteria

Priority Group 1
Veterans with service-connected disabilities rated 50% or more disabling
Priority Group 2
Veterans with service-connected disabilities rated 30% or 40% disabling
Priority Group 3
Veterans who are former POWs
Veterans awarded the Purple Heart
Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
Veterans with service-connected disabilities rated 10% or 20% disabling
Veterans awarded special eligibility classification under Title 38, U.S. C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"
Priority Group 4
Veterans who are receiving aid and attendance or housebound benefits
Veterans who have been determined by the VA to be catastrophically disabled
Priority Group 5
Nonservice-connected disabled veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds
Veterans receiving VA pension benefits
Veterans eligible for Medicaid benefits
Priority Group 6
Compensable 0% service-connected disabled veterans
World War I veterans
Mexican Border War veterans
Veterans solely seeking care for disorders associated with
— exposure to herbicides while serving in Vietnam; or
— ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
— for disorders associated with service in the Gulf War; or
— for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.
Priority Group 7
Veterans who agree to pay specified copayments who have income and/or net worth *above* the VA Means Test threshold and income *below* the HUD geographic index

— Subpriority a: Noncompensable 0% service-connected disabled veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date — Subpriority c: Nonservice-connected disabled veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date. — Subpriority e: Noncompensable 0% service-connected disabled veterans not included in Subpriority a above — Subpriority g: Nonservice-connected disabled veterans not included in Subpriority c above
Priority Group 8 Veterans who agree to pay specified copayments with income and/or net worth *above* the VA Means Test threshold and the HUD geographic index — Subpriority a: Noncompensable 0% service-connected disabled veterans enrolled as of January 16, 2003 and who have remained enrolled since that date — Subpriority c: Nonservice-connected disabled veterans enrolled as of January 16, 2003 and who have remained enrolled since that date — Subpriority e: Noncompensable 0% service-connected disabled veterans applying for enrollment after January 16, 2003

Source: Department of Veterans Affairs.

Note: Service-connected disability means with respect to disability, that such disability was incurred or aggravated in the line of duty in the active military, naval, or air service.

Appendix B. Veterans' Payments for Health-Care Services, by Priority Group

	Copayments				Insurance Billing	Humanitarian Emergency Billing
	Inpatient		Out-patient	Medication[a]		
	Geographic Means Test Copayment	VA Means Test				
Priority Group 1	No	No	No	No	Yes, but only if care was for nonservice-connected condition	No
Priority Groups 2, 3,[b] 4[c]	No	No	No	Yes, but only for veterans with less than 50% service connected disability and medication is for nonservice-connected condition. Former POWs are exempt from all medications copayments	Yes, but only if care was for nonservice-connected condition	No
Priority Group 5	No	No	No	Yes	Yes, but only if care was for nonservice-connected condition	No
Priority Group 6 (WWI, and 0% service-connected compensable)	No	No	No	Yes	Yes, but only if care was for nonservice-connected condition	No
Priority Group 6 (Veterans receiving care for exposure or experience)[d]	No	No[d]	No[d]	No[d]	Yes, but only if care was for nonservice-connected condition	No
Priority Group 7a	Yes	No	Yes	Yes, but only if care was for nonservice-connected condition	Yes, but only if care was for nonservice-connected condition	No

	Copayments				Insurance Billing	Humanitarian Emergency Billing
	Inpatient		Out-patient	Medication[a]		
	Geographic Means Test Copayment	VA Means Test				
Priority Group 7c	Yes	No	Yes	Yes, but only if care was for nonservice-connected condition	Yes, but only if care was for nonservice-connected condition	No
Priority Group 8a	No	Yes	Yes	Yes, but only if care was for nonservice-connected condition	Yes, but only if care was for nonservice-connected condition	No
Priority Group 8c	No	Yes	Yes	Yes, but only if care was for nonservice-connected condition	Yes, but only if care was for nonservice-connected condition	No

Source: Table prepared by CRS based on information from the Department of Veterans Affairs.

Notes: Priority Group 7a and 7c veterans have income above the VA Means Test threshold but below the Geographic Means Test threshold and are responsible for 20% of the inpatient copayment and 20% of the inpatient per diem copayment. The geographic means test copayment reduction does not apply to outpatient and medication copayment, and veterans will be assessed the full applicable copayment charges. Note that reduced inpatient copayments can apply to veterans in Priority Groups 4 and 6 based on the income of the veteran.

Priority Group 8a and 8c veterans have income above the VA Means Test threshold and above the Geographic Means Test threshold. Veterans enrolled in this priority group are responsible for the full inpatient copayment and the inpatient per diem copayment for care of their nonservice-connected conditions. Veterans in this priority group are also responsible for outpatient and medication copayments for care of their nonservice-connected conditions.

a. An annual medication copayment cap has been established for veterans enrolled in Priority Groups 2-6. Medication will continue to be dispensed after copayment cap is met. An annual copayment cap has not been established for veterans enrolled in Priority Groups 7 or 8.
b. Veterans in receipt of a Purple Heart are in Priority Group 3. This change occurred with the enactment of the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) on Nov. 30, 1999.
c. Priority Group 7 veterans who are determined to be catastrophically disabled and who are placed in Priority Group 4 for treatment are still subject to the copayment requirements as a Priority Group 7 veteran.
d. Priority Group 6 — veterans claiming exposure to Agent Orange; veterans claiming exposure to environmental contaminants; veterans exposed to Ionizing Radiation; combat veterans within two years of discharge from the military; veterans who participated in Project 112/SHAD; veterans claiming military sexual trauma; and veterans with head and neck cancer who received nasopharyngeal radium treatment while in the military are subject to copayments when their treatment or medication is not related to their exposure or experience. The initial registry examination and follow-up visits to receive results of the examination are not billed to the health insurance carrier and are not subject to copayments. However, care provided that is not related to exposure, if it is nonservice-connected, will be billed to the insurance carrier and copayments can apply.

Appendix C. Financial Income Thresholds for VA Health-Care Benefits, Calender Year 2008

Veterans with —	Free VA prescriptions and travel benefits for veterans with incomes of —	Free VA inpatient and outpatient care for veterans with incomes of —
No dependents	$11,181 or less	$28,429 or less
1 dependent	$14,643 or less	$34,117 or less
2 dependents	$16,552 or less	$36,026 or less
3 dependents	$18,461 or less	$37,935 or less
4 dependents	$20,370 or less	$39,844 or less
For each additional dependent, add:	$1,909	$1,909

Source: Department of Veterans Affairs.

Appendix D. VHA Appropriations for FY2005 and FY2006

($ in thousands)

Program	FY2005 Request	FY2005 House	FY2005 Senate	FY2005 Enacted	FY2006 Request	FY2006 House	FY2006 Senate	FY2006 Enacted
Medical services	—	$19,498,600	$19,498,600[a]	$19,316,995	$19,995,141	$20,995,141	$21,331,011	$21,322,141
Supplemental appropriations (P.L. 108-324)	$38,283	—	—	38,283	—	—	—	—
Supplemental appropriations	975,000[b]	975,000[c]	1,500,000[d]	1,500,000[e]	—	—	—	—
Emergency appropriations	—	—	—	—	1,977,000[f]	—	1,977,000[g]	1,225,000[h]
Emergency appropriations- Gulf Coast Hurricanes (P.L. 109-148)	—	—	—	—	198,265	—	—	198,265
Emergency appropriations-Avian Flu Pandemic (P.L. 109-148)	—	—	—	—	27,000	—	—	27,000
Subtotal medical services	***1,013,283***	***20,473,600***	***20,998,600***	***20,855,278***	***22,197,406***	***20,995,141***	***23,308,011***	***22,772,406***
Medical administration	—	4,705,000	4,705,000	4,667,360	4,517,874	4,134,874	2,858,442	2,858,442
Supplemental appropriations (P.L. 108-324)	1,940	—	—	1,940	—	—	—	—
Subtotal medical administration	***1,940***	***4,705,000***	***4,705,000***	***4,669,300***	***4,517,874***	***4,134,874***	***2,858,442***	***2,858,442***
Medical facilities	—	3,745,000	3,745,000	3,715,040	3,297,669	3,297,669	3,297,669	3,297,669
Supplemental appropriations (P.L. 108-324)	46,909	—	—	46,909	—	—	—	—
Subtotal medical facilities	***46,909***	***3,745,000***	***3,745,000***	***3,761,949***	***3,297,669***	***3,297,669***	***3,297,669***	***3,297,669***
Medical and prosthetic research	384,770	384,770	405,593	402,348	393,000	393,000	412,000	412,000
Information technology	—	—	—	—	—	—	1,456,821	—
Medical care[i]	26,748,600	—	—	—	—	—	—	—
Total VHA appropriations (without collections)	**28,195,502**	**28,308,370**	**28,854,193**	**29,688,875**	**30,405,949**	**28,820,684**	**31,332,943**	**29,340,517**
Medical care cost collection (MCCF)[j]	2,002,000	2,002,000	2,002,000	1,985,984	2,170,000	2,170,000	2,170,000	2,170,000
Total: VHA (appropriations and collections)	**$30,197,502**	**$31,310,370**	**$30,856,193**	**$31,674,859**	**$32,575,949**	**$30,990,684**	**$33,502,943**	**$31,510,517**

Source: Table prepared by the Congressional Research Service based on H.Rept. 108-674; S.Rept. 108-353; H.Rept. 109-95; S.Rept. 109-105; H.Rept. 109-305; H.Rept. 109-359; and House Appropriations Committee data.

Notes: Appropriation amounts for FY2005 adjusted to account for the 0.8% across-the-board reduction in most discretionary accounts as called for in Division J, Section 122 (a)(1) of P.L. 108-447. Supplemental appropriations for FY2005 are not subject to the 0.8% across-the-board reductions. Appropriation amounts for FY2006 *are not* subject to any cross-the-board reductions as stipulated in Division B, Title III, Section 3801(c)(2) of P.L. 109-148.

a. This amount includes $1.2 billion designated as an emergency requirement.
b. On June 30, 2005, the Administration requested an additional $975 million for medical services for FY2005.
c. On June 30, 2005, the House passed H.R. 3130.
d. On June 29, 2005, the Senate passed an amendment to H.R. 2361, the Department of the Interior, Environment, and Related Agencies Appropriations bill, 2006 to add $1.5 billion in emergency funds for medical services.
e. On August 2, 2005, the FY2006 Department of the Interior, Environment, and Related Agencies appropriations bill (H.R. 2361, P.L. 109-54) was signed into law.
f. On July 14, 2005, the Administration requested an additional $1.977 billion for medical services for FY2006.
g. On July 21, 2005, the Senate Committee on Appropriations reported H.R. 2528 favorably out of committee (S.Rept. 109-105) and designated this amount as an emergency appropriation.
h. On November 18, 2005, the House and Senate adopted the conference report (H.Rept. 109-305) to accompany H.R. 2528 and designated this amount as an emergency appropriation.
i. This amount includes funding for medical services, medical administration, and medical facilities.
j. Medical Care Cost Collection Fund (MCCF) receipts are restored to the VHA as an indefinite budget authority equal to the revenue collected, estimated to be $1.985 billion in FY2005, $2.17 billion in FY2006, and $2.33 billion in FY2007.

Appendix E. VHA Appropriations for FY2007 and FY2008

($ in thousands)

Program	FY2007 request	FY2007 House	FY2007 Senate	FY2007 enacted	FY2008 request	FY2008 House	FY2008 Senate	FY2008 enacted
Medical services	$25,512,000	$25,412,000	$28,689,000	$25,518,254	$27,167,671	$29,031,400	$29,104,220	$27,167,671
Emergency appropriations — U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability (P.L. 110-28)	—	414,982	454,131	400,778[a]	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	—	—	—	1,936,549
Subtotal medical services	***25,512,000***	***25,826,982***	***29,143,131***	***25,919,032***	***27,167,671***	***29,031,400***	***29,104,220***	***29,104,220***
Medical administration	3,177,000	3,277,000	—	3,177,968	3,442,000	3,510,600	3,517,000	3,442,000
Emergency appropriations (P.L. 110-28)	—	256,300	250,000	250,000	—	—	—	—
Contingent emergency (P.L. 110-161)								75,000
Subtotal medical administration	***3,177,000***	***3,533,300***	***250,000***	***3,427,968***	***3,442,000***	***3,510,600***	***3,517,000***	***3,517,000***
Medical facilities	3,569,000	3,594,000	3,569,000	3,569,533	3,592,000	4,100,000	4,092,000	3,592,000
Emergency appropriations (P.L. 110-28)	—	595,000	595,000	595,000	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	—	—	—	508,000
Subtotal medical facilities	***3,569,000***	***4,189,000***	***4,164,000***	***4,164,533***	***3,592,000***	***4,100,000***	***4,092,000***	***4,100,000***
Medical and prosthetic research	399,000	412,000	412,000	413,980	411,000	480,000	500,000	411,000
Emergency appropriations (P.L. 110-28)	—	35,000	30,000	32,500	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	—	—	—	69,000
Subtotal medical and prosthetic research	***399,000***	***447,000***	***442,000***	***446,480***	***411,000***	***480,000***	***500,000***	***480,000***
Total VHA appropriations (without collections)	**32,657,000**	**33,996,282**	**33,999,131**	**33,958,013**	**34,612,671**	**37,122,000**	**37,213,220**	**37,201,220**
Medical care cost collection (MCCF)	2,329,000	2,329,000	2,329,000	2,329,000	2,414,000	2,414,000	2,414,000	2,414,000
Total: VHA (appropriations and collections)	**$34,986,000**	**$36,325,282**	**$36,328,131**	**$36,287,013**	**$37,026,671**	**$39,536,000**	**$39,627,220**	**$39,615,220**

Sources: Table prepared by the Congressional Research Service based on H.Rept. 109-95; S.Rept. 109-105; H.Rept. 109-305; H.Rept. 109-359; H.Rept. 109-464; H.Rept. 109-494; S.Rept. 109-286; P.L. 110-5; H.Rept. 110-64; S.Rept. 110-37; H.Rept. 110-60; *Congressional Record*, vol. 153, (May 24, 2007), H5786-H5787; H.Rept. 110-186; S.Rept. 110-85; *Congressional Record*, vol. 153, (September 7, 2007), S11271-S11278; and *Congressional Record*, vol. 153 (December 17, 2007), H16249-H16431.
Note: FY2008 enacted does not include funding included in the Supplemental Appropriation Act, 2008 (P.L. 110-252).

a. P.L. 110-161 (H.R. 2764) transferred $66 million from the FY2007 medical services account to the construction major, projects account for FY2007.

Housing, Homelessness, and Community Services

Pegge McGuire
Community Resources Division Administrator
Oregon Housing and Community Services

G

General Housing Information

- Homelessness statistics in most communities are determined by a “one night count”. Annually, on a nationally identified day in January, volunteers count:
  - Individuals using shelter services
  - Individuals turned away from shelters
  - In some communities, a “street count” is also performed

Oregon's Homeless Population

- Approximately 13,000 people in Oregon are homeless on any given night
- Almost 7,000 of these individuals are veterans
  - Reasons most commonly cited for homelessness are:
    - Poverty
    - Lack of affordable housing
    - Economic downturns-either resulting in elimination of services impacting people in poverty, or increasing unemployment rates
    - Difficulties in navigating service delivery systems conflicts/gaps in the system

G

Rent Burdened Households

A unit is considered affordable if it costs no more than 30% of the renter's income a household is considered severely rent burdened they pay more than 50% of their income for rent and utilities.

In Oregon, the Fair Market Rent (FMR) for a two-bedroom apartment is $721. In order to afford this level of rent and utilities, without paying more than 30% of income on housing, a household must earn $2,405 monthly or $28,856 annually. **Assuming a 40-hour work week, 52 weeks per year, this level of income translates into a Housing Wage of $13.87.**

In Oregon, a minimum wage worker earns an hourly wage of $7.95. In order to afford the FMR for a two-bedroom apartment, a minimum wage earner must work 70 hours per week, 52 weeks per year. Or, a household must include 1.7 minimum wage earner(s) working 40 hours per week year-round in order to make the two bedroom FMR affordable.

In Oregon, the estimated mean (average) wage for a renter is $12.52 an hour.

Monthly Supplemental Security Income (SSI) payments for an individual are $637 in Oregon. **If SSI represents an individual's sole source of income, $191 in monthly rent is affordable, while the FMR for a one-bedroom is $603.**

Source:National Low Income Housing Coalition

Affordable Housing

- **Federal Rent Subsidies**
  - Project Based
  - Housing Choice
    - Special Programs/Populations
- **Unsubsidized**
  - Substandard
  - Manufactured Dwelling Parks
- **Other**
  - Specialized Funding Sources (OAHTC, Etc.)

G

Public Housing Authorities

- **Essential Services:** Provide decent and safe housing and related programs to lower-income families and individuals throughout Oregon. **Population Served:** Collectively, Oregon's housing Authorities serve over 92,800 people, including more than 42,500 children of striving families, 6,000 elderly, and 7,500 disabled.
- **Limited Housing:** Subsidized housing is in limited supply. There are 28,500 households on housing authority waiting lists. The wait after application can be as long as two to three years.
- **Public Housing:** Oregon housing authorities own and operate public housing for households whose income is below 50% of area median income. Residents pay a portion of their income to the housing authority for rent and utilities. **Section 8-Housing Choice Vouchers:** A household whose income is below 50% of median selects a suitable housing unit in the open market and pays a portion of the rent to the owner, based on household income. The balance of the monthly rent is subsidized by the housing authority. All units and rental rates are subject to approval by the housing authority.
- **Other Housing:** Housing is developed for households earning at or below 80% of median income. It is available, depending on circumstances, for the disabled, elderly, farmworkers, families, and others.
- **Family Stabilization:** Oregon's housing authorities operate a number of programs designed to stabilize families: family self-sufficiency, drug elimination, family counseling etc.

Preserving and Revitalizing Oregon's Assisted Housing

- Of the nearly 170,000 Extremely Low Income Households in Oregon, 108,000 (64%) spend more than 50% of their income for housing.
- About 23,300 Oregon households live in project based federally assisted housing.
- Oregon had a net loss of 1000+ subsidized units between 1995-2003

Source: Community Development Law Center

What We Do Matters!

G

Why the Stock of Assisted Housing is At Risk

- Expiring Contracts, Use Agreements
- Escalating market values-properties more valuable to owners for a different use/population
- Aging owners
- Owners tired of dealing with federal bureaucracy
- Aging physical assets- insufficient funds/and or owner attention to maintain properties to decent standards
- Federal budget constraints and reduction in federal commitment to fund preservation activities.

What We Do Matters!

Source: Community Development Law Center

Importance of Preserving this Assisted Housing

- Serves the poorest Oregonians; those least able to compete in private market
- Once project-based assistance is lost, it will not be replaced; many generations of low-income Oregonians will be affected
- Preservation, on average, is substantially less expensive than new construction

Source: Community Development Law Center

Who Are We?

- **OHCS is the state housing finance agency, providing financial and program support to create and preserve opportunities for quality, affordable housing for lower income Oregonians.**
- **The agency also administers federal and state antipoverty, homeless and energy assistance community service programs.**
- **Think:**
  - **Housing Resource Division = Banking Functions**
  - **Community Resources Division = Logistical Support for Rapid Response Programs and Community Stabilization**

We Address Housing as a Continuum of Needs

- **Immediate/Disaster Response** (Homeless/Emergency Shelter, Rental Assistance, Energy Assistance Payments, Food, Incidentals, etc.)
- **Stabilization** (Transitional Housing, Assisted Living, Case Management, Information and Referral, Incidentals, Volunteer Service Systems Assistance, Manufactured Dwelling Park Resident and Owner Services and Park Closure Response, FH Information, etc.)
- **Long-Term Impact** (Development and Preservation of Affordable Housing, Home Ownership, Down Payment Assistance, Home Buyer Education, Weatherization, Housing Rehab, Asset Building, Tenant Readiness)

Community Resources Division

- **Programs for populations who are at or below 60% of Area Median Income**
  - Emergency Housing and Shelter Assistance
  - Rental Housing Assistance
  - USDA Commodities and Food Programs
  - Energy Assistance
  - Weatherization
- **Programs Without Income Qualification Requirements**
  - Manufactured Dwelling Park Community Relations
  - Oregon Volunteers!
  - Fair Housing Information and Assistance (Reasonable Accommodation and Accessible Design and Construction Requirements)

Oregon Volunteers!

- **Promotes and supports AmeriCorps, volunteerism and civic engagement to strengthen Oregon communities.**
- **Goals**
  - AmeriCorps: High quality AmeriCorps programs continue to help meet local needs identified by communities.
  - Volunteerism: More Oregon residents are mobilized to meet local needs identified by communities.
  - Civic Engagement: Increase citizen involvement among Oregon residents to build connections within and across communities.

G

Housing Resources Division

- The Housing Division offers multiple programs for both multifamily rental housing and single-family homeownership.
- The multifamily programs fund the development of new units or acquisition of existing properties that range from housing for persons with special needs to housing for lower income, working Oregonians.
- The multifamily developments are funded through a combination of programs that include low interest loans, grants and tax incentives.
- The Single-Family Finance Section provides permanent, lower interest financing for qualified homebuyers and also works with local partners in providing homeownership education programs and manages the Community Development Block Grant Program for housing rehabilitation and the Regional Housing Centers.

Our Programs are Administered Through Partnerships

- Collaboration with Other State Agencies
- Private Sector Partners
- Community Development Corporations
- Community Action Programs
- Public and Indian Housing Authorities
- Oregon Food Bank
- Others

Possibilities for Collaboration for Vet Services ??

- **Clinic Space in Senior Housing Projects?**
  - Pro-Bono doctors could administer approved health services to Vets (Tricare or not)
- **Expansion of Statewide College Curriculum on:**
  - Energy Efficiency
  - Renewable Energy
  - Western Climate Initiative Activities
  - (Special Vet preference access)
- **Gatekeeper Partnerships**
  - VSO's at CAP agencies
  - Visiting Housing Sites
  - Train the Trainer-Partner agency case managers can pre-prep Vet's prior to referrals to VSO's (limiting follow-up for benefits claims and expanding services to Vet's who may otherwise fail to follow-up on benefits access)
- **Joint Partnerships on Development**
  - Federal legislation may need revision to allow
  - Set asides in affordable housing projects/ALFs for Vets

GIS MAP of OHCS Partners

G

Community Action Organizations

- Community Action Agencies (CAAs), formerly called Community Action Programs (CAPs), came into existence with President Johnson's "War on Poverty" and the adoption of the Economic Opportunity Act of 1964. Oregon statutes designate the CAPs as our anti-poverty advisory network.
- Each Community Action Agency uses a community-based needs assessment to develop advocacy and service priorities that provide services designed specifically for their own community. The activities and services vary by agency, depending on the needs of the community, local resources, and the opportunities for collaboration and partnership with business, private non-profit organizations and state and local government.

Services Offered By Community Action Agencies

- Advocacy
- Affordable Housing Development
- Commodity Distribution
- Child Care
- Community Development
- Domestic Violence Victims Assistance
- Economic Development
- Emergency Food & Shelter
- Employment Training
- Energy Assistance and Weatherization
- Family Shelters
- Food Banks
- Food Gleaning
- Head Start
- Homeless Shelters
- Housing Rehabilitation
- Information & Referral Service
- In-Home Care
- Lifespan Respite Care – Warmline
- Life Skills Training
- Migrant/Farmworker Service
- Neighborhood Centers
- Parent Training
- Public Transportation
- Second Chance Renters Program
- Self-Help Programs
- Self-Sufficiency Programs
- Senior Services
- Transportation

Tracking Those Using Our Services

- Disproportionate Impact:
  - Communities of Color
  - Individuals with Disabilities
- OPUS
- Partner Input
- Voluntary Dis

What We Do Matters!

Oregon Housing and Community Services

www.ohcs.oregon.gov

CENTRAL CITY concern

Providing pathways to self-sufficiency through active intervention in poverty and homelessness

Presented by Rachel Post, L.C.S.W., Director of Supportive Housing & Employment

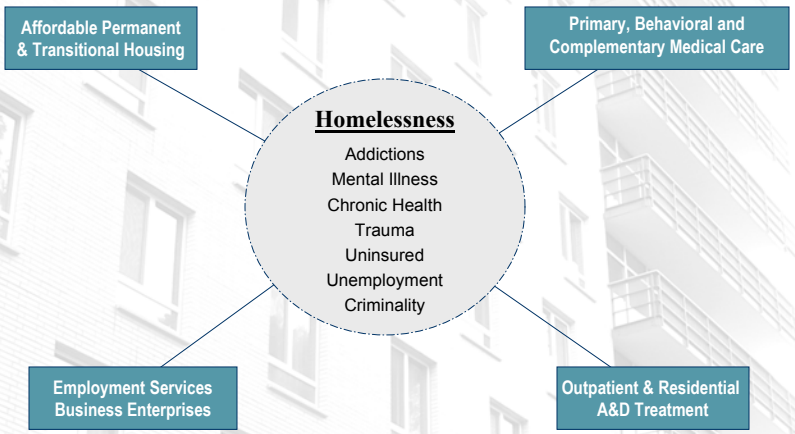
About CCC

- Since 1979
- Affordable housing integrated with Healthcare, Addictions Treatment, Mental Health, and Employment Services
- Over 15,000 low-income and homeless individuals access services annually
- 501(c)3 Non-profit organization

8NW8

Residents in the community room

The Continuum of Care



H

CCC – Housing

- 20 residential buildings with 1,337 units
  - 962 (72%) are Alcohol and Drug Free Community (ADFC) housing
    - 379 transitional and 583 permanent ADFC units
  - 375 non ADFC (low barrier) SRO units
  - 165 Shelter Plus Care vouchers
  - 176 units under renovation

The Estate – renovation completed in December 2007

CCC Health and Recovery Services

- Old Town Clinic (OTC)
  - Medical and psychiatric care to homeless clients
  - Opened in 1983; CCC assumed management in 2001
  - Federally Qualified Health Center
  - Member of the Coalition of Community Health Clinics

8NW8, and Old Town Clinic staff and client (inset)

H

Homeless Veterans

- Nationally veterans are estimated to make up 23% of the homeless population
- In Dec. 2004, Portland's 10 Yr. Plan "Home Again" estimated 17,000 individuals homeless in Mult. County
- Given above estimate of 23%, this means about 4,000 homeless vets locally, however the National Coalition of Homeless Veterans places that estimate at 7,000.

Health & Recovery Services to Veterans

2007 Veterans Served:

Alcohol & Drug Treatment	77
Detox Center	134
Primary Medical Care	201
Psychiatric Outpatient Care	50
Total Visits (combined)	**5,298**

Some clients – in multiple service areas – may be counted more than once.

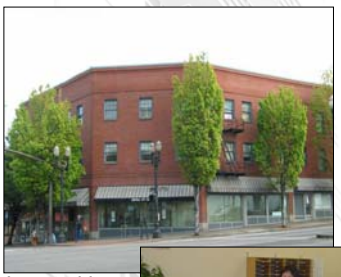
H

WorkSource: Employment Services

Features a variety of employment support services specifically for homeless and low income clients

2,400 served in 24,000 visits in FY 06/07

555 Veterans (23%)



Located in the Shoreline

WorkSource staff

WorkSource – Veteran Programs

Homeless Veteran Reintegration Project

- 800 unduplicated individuals served since FY 04/05
- More than 400 employment placements
- Average wage of $10.66/hour
- Compensated work therapy: 62
- 736 housing placements (Shelters, Per Diem, Permanent Housing)
- Over 800 referrals to VA medical and benefits
- Referrals from White City, VA Medical, TPI/Clark Center, Salvation Army Harbor Light, Faith-based organization

WorkSource – Veteran Programs

Veterans Grant Per Diem Program

- 154 served in 50 units since inception in 2/05
- 87 employment placements
- $11.56 per hour
- 33 Compensated Work Therapy
- 55 exits to permanent housing
- 45 exits to transitional housing
- 13,500 visits
- 88 secured disability benefits

WorkSource Supported Employment

- 150 units of Transitional ADFC housing
- Majority have histories of incarceration
- Over half w/ co-occurring mental health disorders
- 44% meet definition of chronically homeless
- Since June 2007, 140 placements in permanent housing and 117 employed at exit
- 78% remain in perm. housing, clean and sober and employed 1 year post exit.
- Funding: HUD McKinney, HUD Emergency Shelter Grant, City General Funds

WorkSource Supported Employment

Uses the Individual Placement and Support model, a SAMHSA evidence based practice

- Team approach: case managers, employment spec.
- Assertive engagement and outreach
- Competitive work
- Rapid job search
- Continuous work-based assessment
- Follow along supports
- Client preferences and assisted job search
- Services provided in community rather than office

Benefits and Entitlement Specialist Team

- Initiated in 2007 to speed access to SSI/DI Medicaid/Medicare benefits.
- MOU with SSA and Oregon DDS to expedite applications for disability.
- Goal of application to award 120 days
- The first award was made 16 days after application submitted.
- Uses the national SOAR model

H

Order Code RL34024

CRS Report for Congress

Veterans and Homelessness

I

May 31, 2007

Libby Perl
Analyst in Social Legislation
Domestic Social Policy Division

Prepared for Members and
Committees of Congress

Veterans and Homelessness

Summary

The current conflicts in Iraq and Afghanistan have brought renewed attention to the needs of veterans, including the needs of homeless veterans. The Department of Veterans Affairs (VA) estimates that it has served approximately 300 returning veterans in its homeless programs and has identified over 1,000 more as being at risk of homelessness. Both male and female veterans are overrepresented in the homeless population, and as the number of veterans increases due to the current wars, there is concern that the number of homeless veterans could rise commensurately.

Congress has created numerous programs that serve homeless veterans specifically, almost all of which are funded through the Veterans Health Administration. These programs provide health care and rehabilitation services for homeless veterans (the Health Care for Homeless Veterans and Domiciliary Care for Homeless Veterans programs), employment assistance (Homeless Veterans Reintegration Program and Compensated Work Therapy program), transitional housing (Grant and Per Diem and Loan Guarantee programs) as well as other supportive services. Through an arrangement with the Department of Housing and Urban Development (HUD), approximately 1,000 veterans currently use dedicated Section 8 vouchers for permanent housing, with supportive services provided through the VA. These are referred to as HUD-VASH vouchers. In FY2007, it is estimated that approximately $270 million will be used to fund homeless veterans programs.

Several issues regarding veterans and homelessness have become prominent, in part, because of the current conflicts. One issue is the need for permanent supportive housing for low-income and homeless veterans. With the exception of HUD-VASH vouchers, there is no source of permanent housing specifically for veterans. In FY2007, the Veterans Benefits, Health Care, and Information Technology Act (P.L. 109-461) authorized funding for additional HUD-VASH vouchers; however, they have not been funded. In the 110th Congress, S. 1084, the Homes for Heroes Act, would create no fewer than 20,000 HUD-VASH vouchers. The bill would also provide funds through HUD for the acquisition, rehabilitation, and construction of permanent supportive housing for very low-income veterans and their families.

A second emerging issue is the concern that veterans returning from Iraq and Afghanistan who are at risk of homelessness may not receive the services they need. In the 110th Congress, S. 1384, a bill to amend Title 38 of the United States Code, would institute a demonstration program in which the VA and Department of Defense would work together to identify returning members of the armed services who are at risk of homelessness. Another emerging issue is the needs of female veterans, whose numbers are increasing. Women veterans face challenges that could contribute to their risks of homelessness. They are more likely to have experienced sexual abuse than women in the general population and are more likely than male veterans to be single parents. Few homeless programs for veterans have the facilities to provide separate accommodations for women and women with children.

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Veterans and Homelessness

Introduction

The wars in Iraq and Afghanistan have brought renewed attention to the needs of veterans, including the needs of homeless veterans. Homeless veterans initially came to the country's attention in the 1970s and 1980s, when homelessness generally was becoming a more prevalent and noticeable phenomenon. The first section of this report defines the term "homeless veteran," discusses attempts to count homeless veterans, and the results of studies regarding the characteristics of homeless veterans.

At the same time that the number of homeless began to grow, it became clear through various analyses of homeless individuals that homeless veterans are overrepresented in the homeless population. The second section of this report summarizes the available research regarding the overrepresentation of both male and female veterans, who are present in greater percentages in the homeless population than their percentages in the general population. This section also reviews research regarding possible explanations for why homeless veterans are overrepresented.

In response to the issue of homelessness among veterans, the federal government has created numerous programs to fund services and transitional housing specifically for homeless veterans. The third section of this report discusses nine of these programs. The majority of programs are funded through the Department of Veterans Affairs (VA). Within the VA, the Veterans Health Administration (VHA), which is responsible for the health care of veterans, operates all but one of the programs for homeless veterans. The Veterans Benefits Administration (VBA), which is responsible for compensation, pensions, educational assistance, home loan guarantees, and insurance, operates the other. In addition, the Department of Labor operates one program for homeless veterans. In FY2007, approximately $270 million will fund the majority of programs for homeless veterans.

Several issues regarding homelessness among veterans have become prominent since the beginning of the conflicts in Iraq and Afghanistan. The fourth section of this report discusses three of these emerging issues. The first is the need for permanent supportive housing for homeless and low-income veterans. A second issue is ensuring that an adequate transition process exists for returning veterans to assist them with issues that might put them at risk of homelessness. Third is the concern that adequate services might not exist to serve the needs of women veterans. This report will be updated when new statistical information becomes available and to reflect programmatic changes.

Overview of Veterans and Homelessness

Homelessness has always existed in the United States, but only in recent decades has the issue come to prominence. In the 1970s and 1980s, the number of homeless persons increased, as did their visibility. Experts cite various causes for the increase in homelessness. These include the demolition of single room occupancy dwellings in so-called "skid rows" where transient single men lived, the decreased availability of affordable housing generally, the reduced need for seasonal unskilled labor, the reduced likelihood that relatives will accommodate homeless family members, the decreased value of public benefits, and changed admissions standards at mental hospitals.[1] The increased visibility of the homeless was due, in part, to the decriminalization of actions such as public drunkenness, loitering, and vagrancy.[2]

Homelessness occurs among families with children and single individuals, in rural communities as well as large urban cities, and for varying periods of time. Depending on circumstances, periods of homelessness may vary from days to years. Researchers have created three categories of homelessness based on the amount of time that individuals are homeless.[3] First, the transitionally homeless are those who have one short stay in a homeless shelter before returning to permanent housing. In the second category, those who are episodically homeless frequently move in and out of homelessness but do not remain homeless for long periods of time. Third, the chronically homeless are those who are homeless continuously for a period of one year or have at least four episodes of homelessness in three years. Chronically homeless individuals often suffer from mental illness and/or substance abuse disorders. Although veterans experience all types of homelessness, they are thought to be chronically homeless in higher numbers than nonveterans.[4]

Homeless veterans began to come to the attention of the public at the same time that homelessness generally was becoming more common. News accounts chronicled the plight of veterans who had served their country but were living (and dying) on the street.[5] The commonly-held notion that the military experience

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[1] Peter H. Rossi, *Down and Out in America: The Origins of Homelessness* (Chicago: The University of Chicago Press, 1989), 181-194, 41. See, also, Martha Burt, *Over the Edge: The Growth of Homelessness in the 1980s* (New York: Russell Sage Foundation, 1992), 31-126.

[2] *Down and Out in America*, p. 34; *Over the Edge*, p. 123.

[3] See Randall Kuhn and Dennis P. Culhane, "Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization: Results from the Analysis of Administrative Data," *American Journal of Community Psychology* 26, no. 2 (April 1998): 210-212.

[4] Martha R. Burt, Laudan Y. Aron et al., *Homelessness: Programs and the People They Serve, Technical Report*, Urban Institute, December 1999, p. 11-1, available at [http://www.huduser.org/Publications/pdf/home_tech/tchap-11.pdf]. Of homeless male veterans surveyed, 32% reported being homeless for 13 or more months, versus 17% of non-veteran homeless men.

[5] Marjorie J. Robertson, "Homeless Veterans, An Emerging Problem?" in *The Homeless in*

(continued...)

provides young people with job training, educational and other benefits, as well as the maturity needed for a productive life, conflicted with the presence of veterans among the homeless.[6]

Definition of "Homeless Veteran"

Although the term "homeless veteran" might appear straightforward, it contains two layers of definition.[7] First, the definition of "veteran" for purposes of Title 38 benefits (the Title of the United States Code that governs veterans benefits) is a person who "served in the active military, naval, or air service" and was not dishonorably discharged.[8] In order to be a "veteran" who is eligible for benefits according to this definition, at least four criteria must be met. (For a detailed discussion of these criteria see CRS Report RL33113, *Veterans Affairs: Basic Eligibility for Disability Benefit Program*, by Douglas Reid Weimer.)

Second, veterans are considered homeless if they meet the definition of "homeless individual" established by the McKinney-Vento Homeless Assistance Act (P.L. 100-77).[9] According to McKinney-Vento, a homeless individual is (1) an individual who lacks a fixed, regular, and adequate nighttime residence, and (2) a person who has a nighttime residence that is:

- a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
- an institution that provides a temporary residence for individuals intended to be institutionalized; or
- a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings.

Counts of Homeless Veterans

The Department of Veterans Affairs. The exact number of homeless veterans is unknown, although attempts have been made to estimate their numbers. In every year since 1994, the VA has included estimates of the number of homeless veterans receiving services in its "Community Homelessness Assessment, Local

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[5] (...continued)
Contemporary Society, ed. Richard J. Bingham, Roy E. Green, and Sammis B. White (Newbury Park, CA: Sage Publications, 1987), 66.

[6] Ibid., pp. 64-65.

[7] The United States Code defines the term as "a veteran who is homeless" as defined by the McKinney-Vento Homeless Assistance Act. 38 U.S.C. §2002(1).

[8] 12 U.S.C. §101(2).

[9] 38 U.S.C. §2002(1). The McKinney-Vento definition of homeless individual is codified at 42 U.S.C. 11302(a).

Education and Networking Groups" (CHALENG) report to Congress.[10] The estimates are made as part of the CHALENG process, through which representatives from each local VA medical center coordinate with service providers from state and local governments and nonprofit organizations to determine the needs of homeless veterans and plan for how to best deliver services.

Each VA medical center estimates the greatest number of veterans who are homeless on any given day in the previous fiscal year. This is a point-in-time estimate rather than an estimate of the total number of veterans who are homeless at some time during the year. Various sources are used to arrive at the estimates, and include Department of Housing and Urban Development (HUD) point-in-time counts, previous Census estimates, VA client data, VA staff impressions, or combinations of sources.[11] In its most recent CHALENG report, for FY2006, the VA estimated that there were 195,827 homeless veterans at a given point-in-time during the fiscal year.[12] Data regarding the entire homeless population vary; a point-in-time estimate of homeless individuals nationwide taken from a January 2005 count was 754,147. (For more information about attempts to count the homeless, see CRS Report RL33956, *Counting the Homeless: Homeless Management Information Systems*, by Libby Perl.)

The Department of Housing and Urban Development. In addition to the VA CHALENG process, HUD is engaged in an ongoing process to attempt to count the homeless, including homeless veterans, through its Homeless Management Information Systems (HMIS). Local jurisdictions called "Continuums of Care" (CoCs) — typically cities, counties, or combinations of both — collect and store information about homeless individuals they serve, and the information is aggregated in computer systems at the CoC level. In February 2007, HUD released its first Annual Homeless Assessment Report (AHAR) to Congress, in which it used HMIS data to estimate the number of sheltered homeless individuals nationwide during a three-month period, from February 1 to April 30, 2005.[13] These estimates did not include the homeless who were not residing in emergency shelters or transitional housing during the relevant time periods. The AHAR estimated that 18.7% of adults who were homeless during the three-month period were veterans (while 12.6% of the general population were veterans). Based on the data provided in the AHAR, this

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[10] For the most recent CHALENG report, see John Nakashima, Craig W. Burnette, James F. McGuire, and Amanda Sheely, *The Thirteenth Annual Progress Report on Public Law 105-114: Services for Homeless Veterans Assessment and Coordination* (Draft), U.S. Department of Veterans Affairs, April 15, 2007, Appendix 5, available at [http://www1.va.gov/homeless/docs/CHALENG_REPORT_FY2006_DRAFT.pdf] (hereafter *Thirteenth Annual CHALENG Report*). Congress required the VA to issue the report as part of the Veterans Benefits Improvement Act of 1994, P.L. 103-446 (38 U.S.C. §2065).

[11] *Thirteenth Annual CHALENG Report*, p. 12.

[12] Ibid., Appendix 5.

[13] U.S. Department of Housing and Urban Development, *The Annual Homeless Assessment Report to Congress*, February 2007, available at [http://www.huduser.org/Publications/pdf/ahar.pdf].

means that approximately 101,785 veterans were homeless during this time period.[14] The report noted, however, that 35% of records were missing information on veteran status.[15] In addition, because this number did not include unsheltered homeless individuals,[16] chronically homeless veterans may be underrepresented.

Characteristics of Homeless Veterans

Homeless male veterans differ from homeless men who are nonveterans in a variety of ways. According to data from several studies during the 1980s, homeless male veterans were more likely to be older and better educated than the general population of homeless men.[17] However, they were found to have more health problems than nonveteran homeless men, including AIDS, cancer, and hypertension.[18] They also suffered from mental illness and alcohol abuse at higher rates than nonveterans. A study published in 2002 found similar results regarding age and education. Homeless male veterans tended to be older, on average, than nonveteran homeless men.[19] Homeless veterans were also different in that they had reached higher levels of education than their nonveteran counterparts[20] and were more likely to be working for pay. They were also more likely to have been homeless for more than one year, and more likely to be dependent on or abuse alcohol. Family backgrounds among homeless veterans tended to be more stable, with veterans experiencing less family instability[21] and fewer incidents of conduct disorder,[22] while also being less likely to have never married than nonveteran homeless men.

Homeless women veterans have also been found to have different characteristics than nonveteran homeless women. Based on data collected during the late 1990s, female veterans, like male veterans, were found to have reached higher levels of education than nonveteran homeless women, and also more likely to have been

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[14] CRS estimate using 704,146 total homeless persons from February to April, 2005, 64.3% of whom were unaccompanied adults and 13% of whom were adults with children.

[15] *The Annual Homeless Assessment Report to Congress*, p. 31.

[16] Ibid., p. 32.

[17] "Homeless Veterans," pp. 104-105.

[18] Ibid., p. 105.

[19] Richard Tessler, Robert Rosenheck, and Gail Gamache, "Comparison of Homeless Veterans with Other Homeless Men in a Large Clinical Outreach Program," *Psychiatric Quarterly* 73, no. 2 (Summer 2002): 113-114.

[20] Veterans averaged 12.43 years of education completed, versus 11.21 for nonveterans.

[21] Family instability is measured by factors that include parental separation or divorce and time spent in foster care.

[22] Conduct disorder is measured by factors such as school suspensions, expulsions, drinking, using drugs, stealing, and fighting.

employed in the 30 days prior to being surveyed.[23] They also had more stable family backgrounds, and lower rates of conduct disorder as children.

Overrepresentation of Veterans in the Homeless Population

Research regarding homeless veterans, beginning in the 1980s, has found that both male and female veterans are overrepresented among the homeless and that, overall, veterans are more likely to be homeless than their non-veteran counterparts.[24] This has not always been the case, however. Although veterans have always been present among the homeless, the birth cohorts that served in the military more recently, from the Vietnam[25] and post-Vietnam eras, have been found to be overrepresented. Veterans of World War II and Korea are less likely to be homeless than their non-veteran counterparts.[26] (The same cohort effect is not as evident for women veterans.) Four studies of homeless veterans, two of male veterans and two of female veterans, provide evidence of this overrepresentation and increased likelihood of experiencing homelessness.

Overrepresentation of Male Veterans

Two national studies — one published in 1994 using data from 1986-1987, and the other published in 2001 using data from 1996 — found that male veterans were overrepresented in the homeless population. In addition, researchers in both studies determined that the likelihood of homelessness depended on the ages of veterans.[27] During both periods of time, the odds of a veteran being homeless was highest for veterans who had enlisted after the military transitioned to an all-volunteer force (AVF) in 1973. These veterans were age 20-34 at the time of the first study, and age 35-44 at the time of the second study.

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[23] Gail Gamache, Robert Rosenheck, and Richard Tessler, "Overrepresentation of Women Veterans Among Homeless Women," *American Journal of Public Health* 93, no. 7 (July 2003): 1133-1134 (hereafter "Overrepresentation of Women Veterans Among Homeless Women").

[24] See Gail Gamache, Robert Rosenheck, and Richard Tessler, "The Proportion of Veterans Among Homeless Men: A Decade Later," *Social Psychiatry and Psychiatric Epidemiology* 36, no. 10 (October 2001): 481 (hereafter "The Proportion of Homeless Veterans Among Men: A Decade Later"). "Overrepresentation of Women Veterans Among Homeless Women," p. 1134.

[25] Generally, the Vietnam era is defined as the period from 1964 to 1975. 38 U.S.C. §101(29)(B).

[26] Alvin S. Mares and Robert A. Rosenheck, "Perceived Relationship Between Military Service and Homelessness Among Homeless Veterans with Mental Illness," *The Journal of Nervous and Mental Disease* 192, no. 10 (October 2004): 715.

[27] See Robert Rosenheck, Linda Frisman, and An-Me Chung, "The Proportion of Veterans Among Homeless Men," *American Journal of Public Health* 84, no. 3 (March 1994): 466 (hereafter "The Proportion of Homeless Veterans Among Men"); "The Proportion of Veterans Among Homeless Men: A Decade Later," p. 481.

In the first study, researchers found that 41% of adult homeless men were veterans, compared to just under 34% of adult males in the general population. Overall, male veterans were 1.4 times as likely to be homeless as non-veterans.[28] Notably, though, those veterans who served after the Vietnam War were four times more likely to be homeless than nonveterans in the same age group.[29] Vietnam era veterans, who are often thought to be the most overrepresented group of homeless veterans, were barely more likely to be homeless than nonveterans (1.01 times). (See **Table 1** for a breakdown of the likelihood of homelessness based on age.)

In the second study, researchers found that nearly 33% of adult homeless men were veterans, compared to 28% of males in the general population. Once again, the likelihood of homelessness differed among age groups. Overall, male veterans were 1.25 times more likely to be homeless than nonveterans.[30] However, the same post-Vietnam birth cohort as that in the 1994 study were most at risk of homelessness; they were over three times as likely to be homeless as non-veterans in their age cohort. Younger veterans, those age 20-34 in 1996, were two times as likely to be homeless as nonveterans. And Vietnam era veterans were approximately 1.4 times as likely to be homeless as their nonveteran counterparts. (See **Table 1**.)

Overrepresentation of Female Veterans

Like male veterans, women veterans are more likely to be homeless than women who are not veterans. A study published in 2003 examined two surveys, one of mentally ill homeless women, and one of homeless persons generally, and found that 4.4% and 3.1% of those homeless surveyed were female veterans respectively (compared to approximately 1.3% of the general population).[31] Although the likelihood of homelessness was different for each of the two surveyed populations, the study estimated that female veterans were between two and four times as likely to be homeless as their non-veteran counterparts.[32] Unlike male veterans, all birth cohorts were more likely to be homeless than nonveterans. However, with the exception of women veterans age 35-55 (representing the post-Vietnam era), who were between approximately 3.5 and 4.0 times as likely to be homeless as nonveterans, cohort data was not consistent between the two surveys. (See **Table 1** for a breakdown of likelihood of homelessness by age cohort.)

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[28] "The Proportion of Homeless Veterans Among Men," p. 467.

[29] Ibid.

[30] "The Proportion of Homeless Veterans Among Men: A Decade Later," p. 483.

[31] "Overrepresentation of Women Veterans Among Homeless Women," p. 1133.

[32] Ibid., p. 1134.

Table 1. Results from Four Studies: Veterans as a Percentage of the Homeless Population and Likelihood of Experiencing Homelessness

Veteran Group	Veterans as a Percentage of the General Population[a]	Veterans as a Percentage of the Homeless Population	Odds Ratio (Likelihood of Homelessness among Veterans vs. Nonveterans)
Men (data 1986-87)[b]	33.6	41.2	1.38
Age 20-34	10.0	30.6	3.95
Age 35-44	36.9	37.2	1.01
Age 45-54	44.8	58.7	1.75
Age 55-64	69.9	61.7	0.69
> Age 64	46.3	37.4	0.71
Men (data 1996)[c]	28.0	32.7	1.25
Age 20-34	7.7	14.5	2.04
Age 35-44	13.8	33.7	3.17
Age 45-54	38.4	46.5	1.39
Age 55-64	48.7	45.8	0.89[f]
> Age 64	62.6	59.5	0.88[f]
Women (data 1994-98)[d]	1.3	4.4	3.58
Age 20-34	—	—	3.61
Age 35-44	—	—	3.48
Age 45-54	—	—	4.42
Age 55 and Older	—	—	1.54[f]
Women (data 1996)[e]	1.2	3.1	2.71
Age 20-34	—	—	1.60[f]
Age 35-44	—	—	3.98
Age 45-54	—	—	2.00[f]
Age 55 and Older	—	—	4.40

Sources: Robert Rosenheck, Linda Frisman, and An-Me Chung, "The Proportion of Veterans Among Homeless Men," *American Journal of Public Health* 84, no. 3 (March 1994): 466-469; Gail Gamache, Robert Rosenheck, and Richard Tessler, "The Proportion of Veterans Among Homeless Men: A Decade Later," *Social Psychiatry and Psychiatric Epidemiology* 36, no. 10 (October 2001): 481-485; Gail Gamache, Robert Rosenheck, and Richard Tessler, "Overrepresentation of Women Veterans Among Homeless Women," *American Journal of Public Health* 93, no. 7 (July 2003): 1132-1136.

a. Data are from the Current Population Survey.
b. Data are from four community surveys conducted during 1986 and 1987.
c. Data are from the National Survey of Homeless Assistance Providers and Clients (NSHAPC).
d. Data are from the Access to Community Care and Effective Services and Supports sample of women with mental illness.
e. Data are from the NSHAPC.
f. Not statistically significant.

Why Are Veterans Overrepresented in the Homeless Population?

As the number of homeless veterans has grown, researchers have attempted to explain why veterans are homeless in higher proportions than their numbers in the general population. Factors present both prior to military service, and those that developed during or after service, have been found to be associated with veterans' homelessness.

Most of the evidence about factors associated with homelessness among veterans comes from The National Vietnam Veterans Readjustment Study (NVVRS) conducted from 1984 to 1988.[33] Researchers for the NVVRS surveyed 1,600 Vietnam theater veterans (those serving in Vietnam, Cambodia, or Laos) and 730 Vietnam era veterans (who did not serve in the theater) to determine their mental health status and their ability to readjust to civilian life. The NVVRS did not specifically analyze homelessness. However, a later study, published in 1994, used data from the NVVRS to examine homelessness specifically.[34] Findings from both studies are discussed below.

Factors Present During and After Military Service. Although researchers have not found that military service alone is associated with homelessness,[35] it may be associated with other factors that contribute to homelessness. The NVVRS found an indirect connection between the stress that occurs as a result of deployment and exposure to combat, or "war-zone stress," and homelessness. Vietnam theater and era veterans who experienced war-zone stress were found to have difficulty readjusting to civilian life, resulting in higher levels of problems that included social isolation, violent behavior, and, for white male veterans, homelessness.[36]

The 1994 study of Vietnam era veterans (hereafter referred to as the Rosenheck/Fontana study) evaluated 18 variables that could be associated with homelessness. The study categorized each variable in one of four groups, according to when they occurred in the veteran's life: pre-military, military, the one-year

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[33] The NVVRS was undertaken at the direction of Congress as part of P.L. 98-160, the Veterans Health Care Amendments of 1993.

[34] Robert Rosenheck and Alan Fontana, "A Model of Homelessness Among Male Veterans of the Vietnam War Generation," *The American Journal of Psychiatry* 151, no. 3 (March 1994): 421-427 (hereafter "A Model of Homelessness Among Male Veterans of the Vietnam War Generation").

[35] See, for example, Alvin S. Mares and Robert Rosenheck, "Perceived Relationship Between Military Service and Homelessness Among Homeless Veterans With Mental Illness," *Journal of Nervous and Mental Disease* 192, no. 10 (October 2004): 715.

[36] Richard A. Kulka, John A. Fairbank, B. Kathleen Jordan, and Daniel S. Weiss, *Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study* (Levittown, PA: Brunner/Mazel, 1990), 142.

readjustment period, and the post-military period subsequent to readjustment.[37] Variables from each time period were found to be associated with homelessness, although their effects varied. The two military factors — combat exposure and participation in atrocities — did not have a direct relationship to homelessness. However, those two factors did contribute to (1) low levels of social support upon returning home, (2) psychiatric disorders (not including Post Traumatic Stress Disorder (PTSD)), (3) substance abuse disorders, and (4) being unmarried (including separation and divorce). Each of these four post-military variables, in turn, contributed directly to homelessness.[38] In fact, social isolation, measured by low levels of support in the first year after discharge from military service, together with the status of being unmarried, had the strongest association with homelessness of the 18 factors examined in the study.[39]

Post-Traumatic Stress Disorder (PTSD). Researchers have not found a direct relationship between PTSD and homelessness. The Rosenheck/Fontana study "found no unique association between combat-related PTSD and homelessness."[40] Unrelated research has determined that homeless combat veterans were no more likely to be diagnosed with PTSD than combat veterans who were not homeless.[41] However, the NVVRS found that PTSD was significantly related to other psychiatric disorders, substance abuse, problems in interpersonal relationships, and unemployment.[42] These conditions can lead to readjustment difficulties and are considered risk factors for homelessness.[43]

Factors that Pre-Date Military Service. According to research, factors that predate military service also play a role in homelessness among veterans. The

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[37] The first category consisted of nine factors: year of birth, belonging to a racial or ethnic minority, childhood poverty, parental mental illness, experience of physical or sexual abuse prior to age 18, other trauma, treatment for mental illness before age 18, placement in foster care before age 16, and history of conduct disorder. The military category contained three factors: exposure to combat, participation in atrocities, and non-military trauma. The readjustment period consisted of two variables: accessibility to someone with whom to discuss personal matters and the availability of material and social support (together these two variables were termed low levels of social support). The final category contained four factors: Post Traumatic Stress Disorder (PTSD), psychiatric disorders not including PTSD, substance abuse, and unmarried status.

[38] "A Model of Homelessness Among Male Veterans of the Vietnam War Generation," p. 424.

[39] Ibid., p. 425.

[40] "A Model of Homelessness Among Male Veterans of the Vietnam War Generation," p. 425.

[41] Robert Rosenheck, Catherine A. Leda, Linda K. Frisman, Julie Lam, and An-Me Chung, "Homeless Veterans" in *Homelessness in America*, ed. Jim Baumohl (Phoenix, AZ: Oryx Press, 1996), 99 (hereafter "Homeless Veterans").

[42] Robert Rosenheck, Catherine Leda, and Peggy Gallup, "Combat Stress, Psychosocial Adjustment, and Service Use Among Homeless Vietnam Veterans," *Hospital and Community Psychiatry* 42, no. 2 (February 1992): 148.

[43] "Homeless Veterans," p. 98.

Rosenheck/Fontana study found that three variables present in the lives of veterans before they joined the military had a significant direct relationship to homelessness. These were exposure to physical or sexual abuse prior to age 18; exposure to other traumatic experiences, such as experiencing a serious accident or natural disaster, or seeing someone killed; and placement in foster care prior to age 16.[44] The researchers also found that a history of conduct disorder had a substantial indirect effect on homelessness.[45] Conduct disorder includes behaviors such as being suspended or expelled from school, involvement with law enforcement, or having poor academic performance. Another pre-military variable that might contribute to homelessness among veterans is a lack of family support prior to enlistment.[46]

The conditions present in the lives of veterans prior to military service, and the growth of homelessness among veterans, have been tied to the institution of the all volunteer force (AVF) in 1973. As discussed earlier in this report, the overrepresentation of veterans in the homeless population is most prevalent in the birth cohort that joined the military after the Vietnam War. It is possible that higher rates of homelessness among these veterans are due to "lowered recruitment standards during periods where military service was not held in high regard."[47] Individuals who joined the military during the time after the implementation of the AVF might have been more likely to have characteristics that are risk factors for homelessness.[48]

Federal Programs that Serve Homeless Veterans

The federal response to the needs of homeless veterans, like the federal response to homelessness generally, began in the late 1980s. Congress, aware of the data showing that veterans were disproportionately represented among the homeless,[49] began to hold hearings and enact legislation in the late 1980s. Among the programs enacted were Health Care for Homeless Veterans, Domiciliary Care for Homeless Veterans, and the Homeless Veterans Reintegration Projects. Also around this time, the first (and only) national group dedicated to the cause of homeless veterans, the

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[44] "A Model of Homelessness Among Male Veterans of the Vietnam War Generation," p. 426.

[45] Ibid.

[46] Richard Tessler, Robert Rosenheck, and Gail Gamache, "Homeless Veterans of the All-Volunteer Force: A Social Selection Perspective," *Armed Forces & Society* 29, no. 4 (Summer 2003): 511 (hereafter "Homeless Veterans of the All-Volunteer Force: A Social Selection Perspective").

[47] Testimony of Robert Rosenheck, M.D., Director of Northeast Program Evaluation Center, Department of Veterans Affairs, Senate Committee on Veterans' Affairs, 103rd Cong., 2nd sess., February 23, 1994.

[48] "Homeless Veterans of the All-Volunteer Force: A Social Selection Perspective," p. 510.

[49] Senate Committee on Veterans Affairs, *Veterans' Administration FY1988 Budget, the Vet Center Program, and Homeless Veterans Issues*, 100th Cong., 1st sess., S.Hrg. 100-350, February 18 & 19, 1987, p. 2-6.

National Coalition for Homeless Veterans, was founded by service providers that were concerned about the growing number of homeless veterans.

While homeless veterans are eligible for and receive services through programs that are not designed specifically for homeless veterans, the VA funds multiple programs to serve homeless veterans. The majority of homeless programs are run through the Veterans Health Administration (VHA), which administers health care programs for veterans.[50] The Veterans Benefits Administration (VBA), which is responsible for compensation and pensions,[51] education assistance,[52] home loan guarantees,[53] and insurance, operates one program for homeless veterans. In addition, the Department of Labor (DOL) is responsible for one program that provides employment services for homeless veterans. In FY2007, funding of approximately $270 million is expected to be provided for homeless veterans programs,[54] nine of which are summarized in this section. **Table 2**, below, shows historical funding levels for the five homeless veterans programs that receive the most funding.

[50] For more information about the VHA, see CRS Report RL33993, *Veterans' Health Care Issues*, by Sidath Viranga Panangala.

[51] For more information about veterans benefits, see CRS Report RL33985, *Veterans Benefits: Issues in the 110th Congress*, coordinated by Carol Davis.

[52] For more information about educational assistance see CRS Report RL33281, *Montgomery GI Bill Education Benefits: Analysis of College Prices and Federal Student Aid Under the Higher Education Act*, by Charmaine Mercer and Rebecca R. Skinner.

[53] For more information about VA home loan guarantees see CRS Report RS20533, *VA-Home Loan Guaranty Program: An Overview*, by Bruce E. Foote and Meredith Peterson.

[54] The amount of funding is based on VA estimates of FY2007 obligations for its homeless programs and the amount appropriated for the Department of Labor's Homeless Veterans Reintegration Program.

Table 2. Funding for Selected Homeless Veterans Programs, FY1988-FY2007

(dollars in thousands)

Obligations (VA Programs)					Budget Authority (DOL Program)
Fiscal Year	Health Care for Homeless Veterans[a]	Domiciliary Care for Homeless Veterans	Compensated Work Therapy/ Therapeutic Residence	Grant and Per Diem Program	Homeless Veterans Reintegration Program
1988	$12,932	$15,000[b]	NA	NA	$1,915
1989	13,252	10,367	NA	NA	1,877
1990	15,000	15,000	NA	NA	1,920
1991	15,461[c]	15,750	—[c]	NA	2,018
1992	16,500[c]	16,500	—[c]	NA	1,366
1993	22,150	22,300	400	NA	5,055
1994	24,513	27,140	3,051	8,000	5,055
1995	38,585[d]	38,948	3,387	—[d]	107[e]
1996	38,433[d]	41,117	3,886	—[d]	0
1997	38,063[d]	37,214	3,628	—[d]	0
1998	36,407	38,489	8,612	5,886	3,000
1999	32,421	39,955	4,092	20,000	3,000
2000	38,381	34,434	8,068	19,640	9,636
2001	58,602	34,576	8,144	31,100	17,500
2002	54,135	45,443	8,028	22,431	18,250
2003	45,188	49,213	8,371	43,388	18,131
2004	42,905	51,829	10,240	62,965	18,888
2005	40,357	57,555	10,004	62,180	20,832
2006	56,998	63,592	19,529	63,621	21,780
2007[f]	$59,278	$72,702	$20,310	$92,180	$21,809

Sources: Department of Veterans Affairs Budget Justifications, FY1989-FY2008, VA Office of Homeless Veterans Programs, Department of Labor Budget Justifications FY1989-FY2008, House Appropriations Committee Tables, FY2007 budget.

a. Health Care for Homeless Veterans was originally called the Homeless Chronically Mentally Ill veterans program. In 1992, the VA began to use the title "Health Care for Homeless Veterans."
b. Congress appropriated funds for the DCHV program for both FY1987 and FY1988 (P.L. 100-71), however, the VA obligated the entire amount in FY1988. See VA Budget Summary for FY1989, Volume 2, Medical Benefits, p. 6-10.
c. For FY1991 and FY1992, funds from the Homeless Chronically Mentally Ill veterans program as well as substance abuse enhancement funds were used for the Compensated Work Therapy/Therapeutic Residence program.
d. For FY1995 through FY1997, Grant and Per Diem funds were obligated with funds for the Health Care for Homeless Veterans program. VA budget documents do not provide a separate breakdown of Grant and Per Diem Obligations.
e. Congress appropriated $5.011 million for HVRP in P.L. 103-333. However, a subsequent rescission in P.L. 104-19 reduced the amount.
f. The obligation amounts for FY2007 are estimates.

The Department of Veterans Affairs

The majority of programs that serve homeless veterans are part of the Veterans Health Administration (VHA), one of the three major organizations within the VA (the other two are the Veterans Benefits Administration (VBA) and the National Cemetery Administration).[55] The VHA operates hospitals and outpatient clinics across the country through 21 Veterans Integrated Service Networks (VISNs). Each VISN oversees between five and eleven VA hospitals as well as outpatient clinics, nursing homes, and domiciliary care facilities. In all, there are 157 VA hospitals, 750 outpatient clinics, 134 nursing homes, and 42 domiciliary care facilities across the country. Many services for homeless veterans are provided in these facilities. In addition, the VBA has made efforts to coordinate with the VHA regarding homeless veterans by placing Homeless Veteran Outreach Coordinators (HVOCs) in its offices in order to assist homeless veterans in their applications for benefits.

Health Care for Homeless Veterans. The first federal program to specifically address the needs of homeless veterans, Health Care for Homeless Veterans (HCHV), was initially called the Homeless Chronically Mentally Ill veterans program.[56] The program was created as part of an emergency appropriations act for FY1987 (P.L. 100-6) in which Congress allocated $5 million to the VA to provide medical and psychiatric care in community-based facilities to homeless veterans suffering from mental illness.[57] Through the HCHV program, VA medical center staff conduct outreach to homeless veterans, provide care and treatment for medical, psychiatric, and substance abuse disorders, and refer veterans to other needed supportive services.[58] Although P.L. 100-6 provided priority for veterans whose illness was service-connected, veterans with non-service-connected disabilities were also made eligible for the program. Within two months of the program's enactment, 43 VA Medical Centers had initiated programs to find and assist mentally ill homeless veterans.[59] The HCHV program is currently authorized through December 31, 2011.[60]

Program Data. The HCHV program itself does not provide housing for veterans who receive services. However, the VA was initially authorized to enter

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[55] For more information about the organization of the VA, see U.S. Department of Veterans Affairs, *Organizational Briefing Book*, May 2006, available at [http://www.va.gov/ofcadmin/ViewPDF.asp?fType=1].

[56] In 1992, the VA began to refer to the program by its new name. VA FY1994 Budget Summary, Volume 2, Medical Benefits, p. 2-63.

[57] Shortly after the HCHV program was enacted in P.L. 100-6, Congress passed another law (P.L. 100-322) that repealed the authority in P.L. 100-6 and established the HCHV program as a pilot program. The program was then made permanent in the Veterans Benefits Act of 1997 (P.L. 105-114). The HCHV program is now codified at 38 U.S.C. §§2031-2034.

[58] 38 U.S.C. §2031, §2034.

[59] Veterans Administration, Report to Congress of member agencies of the Interagency Council on Homelessness pursuant to Section 203(c)(1) of P.L. 100-77, October 15, 1987.

[60] The program was most recently authorized in the Veterans Benefits, Health Care, and Information Technology Act of 2006 (P.L. 109-461).

into contracts with non-VA service providers to place veterans in residential treatment facilities so that they would have a place to stay while receiving treatment. In FY2003, the VA shifted funding from contracts with residential treatment facilities to the VA Grant and Per Diem program (described later in this report).[61] Local funding for residential treatment facilities continues to be provided by some VA medical center locations, however. According to the most recent data available from the VA, 1,725 veterans stayed in residential treatment facilities in FY2005, with an average stay of about 64 days.[62] The HCHV program treated approximately 61,261 veterans in that same year.[63]

Domiciliary Care for Homeless Veterans. Domiciliary care consists of rehabilitative services for physically and mentally ill or aged veterans who need assistance, but are not in need of the level of care offered by hospitals and nursing homes. Congress first provided funds for Domiciliary Care program for *homeless* veterans in 1987 through a supplemental appropriations act (P.L. 100-71). Prior to enactment of P.L. 100-71, domiciliary care for veterans generally (now often referred to as Residential Rehabilitation and Treatment programs) had existed since the 1860s. The program for homeless veterans was implemented to reduce the use of more expensive inpatient treatment, improve health status, and reduce the likelihood of homelessness through employment and other assistance. Congress has appropriated funds for the DCHV program since its inception.

Program Data. Currently the DCHV program operates at 34 VA medical centers and has 1,833 beds available.[64] In FY2005, the number of veterans completing treatment was 5,394.[65] Of those admitted to DCHV programs, 92% were diagnosed with a substance abuse disorder, half were diagnosed with serious mental illness, and 46% had both diagnoses.[66] The average length of stay for veterans in FY2005 was 108.7 days, in which they received medical, psychiatric and substance abuse treatment, as well as vocational rehabilitation.

Compensated Work Therapy/Therapeutic Residence Program. The Compensated Work Therapy (CWT) Program has existed at the VA in some form since the 1930s.[67] In the most current version of the program, the VA enters into contracts with private companies or nonprofit organizations which then provide

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[61] FY2004 VA Budget Justifications, p. 2-163.

[62] Wesley J. Kasprow, Robert A. Rosenheck, Diane DiLello, Leslie Cavallaro, and Nicole Harelik, *Healthcare for Homeless Veterans 19th Annual Report*, U.S. Department of Veterans Affairs Northeast Program Evaluation Center, March 31, 2006, pp. 125-126.

[63] Ibid., p. 31.

[64] Sandra G. Resnick, Robert Rosenheck, Sharon Medak, and Linda Corwel, *Seventeenth Progress Report on the Domiciliary Care for Homeless Veterans Program*, U.S. Department of Veterans Affairs Northeast Program Evaluation Center, February 2006, p. 1.

[65] Ibid., p. 9.

[66] Ibid., p. 10.

[67] Senate Veterans Affairs Committee, report to accompany S. 2908, 94th Cong., 2nd sess., S.Rept. 94-1206, September 9, 1976.

disabled veterans with work opportunities.[68] Veterans must be paid wages commensurate with those wages in the community for similar work, and through the experience the goal is that participants improve their chances of living independently and reaching self sufficiency. Most CWT positions are semiskilled or unskilled, and include work in clerical, retail, warehouse, manufacturing, and food service positions.[69] In 2003, the Veterans Health Care, Capital Asset, and Business Improvement Act (P.L. 108-170) added work skills training, employment support services, and job development and placement services to the activities authorized by the CWT program. The VA estimates that approximately 14,000 veterans participate in the CWT program each year.[70] The CWT program is permanently authorized through the VA's Special Therapeutic and Rehabilitation Activities Fund.[71]

In 1991, as part of P.L. 102-54, the Veterans Housing, Memorial Affairs, and Technical Amendments Act, Congress added the Therapeutic Transitional Housing component to the CWT program. The purpose of the program is to provide housing to participants in the CWT program who have mental illnesses or chronic substance abuse disorders and who are homeless or at risk of homelessness.[72] Although the law initially provided that both the VA itself or private nonprofit organizations, through contracts with the VA, could operate housing, the law was subsequently changed so that only the VA now owns and operates housing.[73] The housing is transitional — up to 12 months — and veterans who reside there receive supportive services. As of September 2006, the VA operated 66 transitional housing facilities with 520 beds.[74]

Grant and Per Diem Program. Initially called the Comprehensive Service Programs, the Grant and Per Diem program was introduced as a pilot program in 1992 through the Homeless Veterans Comprehensive Services Act (P.L. 102-590). The law establishing the Grant and Per Diem program, which was made permanent in the Homeless Veterans Comprehensive Services Act of 2001 (P.L. 107-95), authorizes the VA to make grants to public entities or private nonprofit organizations to provide services and transitional housing to homeless veterans.[75] For the last four fiscal years (FY2004-FY2007) the Grant and Per Diem program has received more funding than any of the other eight VA programs that are targeted to homeless

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[68] The Compensated Work Therapy program was authorized in P.L. 87-574 as "Therapeutic and Rehabilitative Activities." It was substantially amended in P.L. 94-581, and is codified at 38 U.S.C. §1718.

[69] VA Veterans Industry/Compensated Work Therapy web pages, available at [http://www1.va.gov/vetind/].

[70] VA Fact Sheet, "VA Programs for Homeless Veterans," September 2006, available at [http://www1.va.gov/opa/fact/docs/hmlssfs.doc] (hereafter "VA Programs for Homeless Veterans").

[71] 38 U.S.C. §1718(c).

[72] The VA's authority to operate therapeutic housing is codified at 38 U.S.C. §2032.

[73] The provision for nonprofits was in P.L. 102-54, but was repealed by P.L. 105-114, Section 1720A(c)(1).

[74] "VA Programs for Homeless Veterans."

[75] The Grant and Per Diem program is codified at 38 U.S.C. §§2011-2013.

veterans (See **Table 2**). The Grant and Per Diem program is permanently authorized at $130 million (P.L. 109-461).

The program has two parts: grant and per diem. Eligible grant recipients may apply for funding for one or both parts. The grants portion provides capital grants to purchase, rehabilitate, or convert facilities so that they are suitable for use as either service centers or transitional housing facilities. The capital grants will fund up to 65% of the costs of acquisition, expansion or remodeling of facilities.[76] Grants may also be used to procure vans for outreach and transportation of homeless veterans. The per diem portion of the program reimburses grant recipients for the costs of providing housing and supportive services to homeless veterans. The supportive services that grantees may provide include outreach activities, food and nutrition services, health care, mental health services, substance abuse counseling, case management, child care, assistance in obtaining housing, employment counseling, job training and placement services, and transportation assistance.[77] Organizations may apply for per diem funds alone (without capital grant funds), as long as they would be eligible to apply for and receive capital grants.

Program Rules and Data. The per diem portion of the Grant and Per Diem program pays organizations for the housing that they provide to veterans at a fixed dollar rate for each bed that is occupied.[78] Organizations apply to be reimbursed for the cost of care provided, not to exceed the current per diem rate for domiciliary care. The per diem rate increases periodically; the FY2007 rate is $31.30 per day.[79] The per diem portion of the program also compensates grant recipients for the services they provide to veterans at service centers. Grantee organizations are paid at an hourly rate of one eighth of either the cost of services or the domiciliary care per diem rate, however organizations cannot be reimbursed for both housing and services provided to the same individual. Organizations are paid by the hour for each veteran served for up to eight hours per day. Any per diem payments are offset by other funds that the grant recipient receives. S. 1384, a bill to amend Title 38 of the U.S. Code, introduced on May 14, 2007, would remove from law this offset requirement.

According to the most recent data available from the VA, in FY2005 the Grant and Per Diem program funded more than 290 service providers. These providers had a total of 8,000 beds available and served approximately 15,000 homeless veterans.[80] According to a 2006 Government Accountability Office report, an additional 9,600

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[76] 38 U.S.C. §2011(c).

[77] 38 CFR §61.1.

[78] 38 CFR §61.33.

[79] U.S. Department of Veterans Affairs, Department of Geriatrics and Extended Care, Description of the State Veterans Home Program, available at [http://www1.va.gov/geriatricsshg/docs/FY07STATEVETHOMEPROGRAMHistory.doc].

[80] *Healthcare for Homeless Veterans 19th Annual Report*, p. 177.

Grant and Per Diem transitional beds are needed to meet the demand.[81] The VA has stated that it is in the process of increasing the number of available beds to 10,000.[82]

Grant and Per Diem for Homeless Veterans with Special Needs. In 2001, Congress created a demonstration program to target grant and per diem funds to specific groups of veterans (P.L. 107-95). These groups include women, women with children, the frail elderly, those veterans with terminal illnesses, and those with chronic mental illnesses. The program was authorized at $5 million per year for FY2003 through FY2005. The VA released grants in 2004; sixteen grants went to organizations to serve the chronically mentally ill, eight went to programs to serve women veterans, three to programs for the frail elderly, and two for the terminally ill.[83] P.L. 109-461, enacted on December 22, 2006, reauthorized the program for FY2007 through FY2011 at $7 million per year. In February 2007, the VA issued a notice of funding availability for new special needs grants.[84]

HUD-VASH. Beginning in 1992, through a collaboration between HUD and the VA, funding for approximately 2,000 Section 8 vouchers was made available for use by homeless veterans with severe psychiatric or substance abuse disorders.[85] Section 8 vouchers are subsidies used by families to rent apartments in the private rental market.[86] According to the VA, approximately 1,000 of these vouchers are still used by veterans.[87] Through the program, called HUD-VA Supported Housing (HUD-VASH), local Public Housing Authorities (PHAs) administer the Section 8 vouchers while local VA medical centers provide case management and clinical services to participating veterans. HUD distributed the vouchers to PHAs through three competitions, in 1992, 1993, and 1994. Prior to issuing the vouchers, HUD and the VA had identified medical centers with Domiciliary Care and Health Care for Homeless Veterans programs that were best suited to providing services. PHAs within the geographic areas of the VA medical centers were invited to apply for vouchers. In the first year that HUD issued vouchers, 19 PHAs were eligible to

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[81] Government Accountability Office, *Homeless Veterans Programs: Improved Communications and Follow-up Could Further Enhance the Grant and Per Diem Program*, September 2006, p. 12, available at [http://www.gao.gov/new.items/d06859.pdf].

[82] Testimony of Pete Dougherty, Director, Homeless Veterans Programs, Department of Veterans Affairs, House Appropriations Committee, Subcommittee on Military Construction and Veterans Affairs, *FY2008 Appropriations*, 110th Cong., 1st sess., March 8, 2007 (hereafter, "March 8, 2007 Testimony of Pete Dougherty").

[83] See VA Press Release, "VA Announces Homeless Program Awards," September 29, 2004, available at [http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1178].

[84] See *Federal Register* vol. 72, no. 35, February 22, 2007, pp. 8077-8082.

[85] The first announcement of voucher availability was announced in the Federal Register. See U.S. Department of Housing and Urban Development, "Invitation for FY1992 Section 8 Rental Voucher Set-Aside for Homeless Veterans with Severe Psychiatric or Substance Abuse Disorders," *Federal Register* vol. 57, no. 55, p. 9955, March 20, 1992.

[86] For more information about Section 8 in general, see CRS Report RL32284, *An Overview of the Section 8 Housing Programs*, by Maggie McCarty.

[87] "March 8, 2007 Testimony of Pete Dougherty."

apply, and by the third year the list of eligible VA medical centers and PHAs had expanded to 87.[88]

In 2001, Congress codified the HUD-VASH program (P.L. 107-95) and authorized the creation of an additional 500 vouchers for each year from FY2003 through FY2006.[89] However, funding was not provided for these vouchers. A bill enacted at the end of the 109th Congress (P.L. 109-461) also provided the authorization for additional HUD-VASH vouchers: 500 in FY2007, 1,000 in FY2008, 1,500 in FY2009, 2,000 in FY2010, and 2,500 in FY2011. Funding for additional vouchers was not requested by the President or provided by Congress in FY2007.

Program Evaluations. Long-term evaluations of the HUD-VASH program have shown both improved housing and improved substance abuse outcomes among veterans who received the vouchers over those who did not.[90] Veterans who received vouchers experienced fewer days of homelessness and more days housed than veterans who received intensive case management assistance or standard care through VA homeless programs alone.[91] Analysis also found that veterans with HUD-VASH vouchers had fewer days of alcohol use, fewer days on which they drank to intoxication, and fewer days of drug use.[92] HUD-VASH veterans were also found to have spent fewer days in institutions.[93]

Loan Guarantee for Multifamily Transitional Housing Program. The Veterans Programs Enhancement Act of 1998 (P.L. 105-368) created a program in which the VA guarantees loans to eligible organizations so that they may construct, rehabilitate or acquire property to provide multifamily transitional housing for homeless veterans.[94] Eligible project sponsors may be any legal entity that has experience in providing multifamily housing.[95] The law requires sponsors to provide

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[88] U.S. Department of Housing and Urban Development, "Funding Availability (NOFA) for the Section 8 Set-Aside for Homeless Veterans with Severe Psychiatric or Substance Abuse Disorders," *Federal Register* vol. 59, no. 134, p. 36015, July 14, 1994.

[89] 42 U.S.C. §1437f(o)(19).

[90] Robert Rosenheck, Wesley Kasprow, Linda Frisman, and Wen Liu-Mares, "Cost-effectiveness of Supported Housing for Homeless Persons with Mental Illness," *Archives of General Psychiatry* 60 (September 2003): 940 (hereafter "Cost-effectiveness of Supported Housing for Homeless Persons with Mental Illness"). An-Lin Cheng, Haiqun Lin, Wesley Kasprow, and Robert Rosenheck, "Impact of Supported Housing on Clinical Outcomes," *Journal of Nervous and Mental Disease* 195, no. 1 (January 2007): 83 (hereafter "Impact of Supported Housing on Clinical Outcomes").

[91] "Cost-effectiveness of Supported Housing for Homeless Persons with Mental Illness," p. 945.

[92] "Impact of Supported Housing on Clinical Outcomes," p. 85.

[93] Ibid.

[94] 38 U.S.C. §§2051-2054.

[95] U.S. Department of Veterans Affairs, *Multifamily Transitional Housing Loan Guarantee* (continued...)

supportive services, ensure that residents seek to obtain and maintain employment, enact guidelines to require sobriety as a condition of residency, and charge veterans a reasonable fee.[96] Veterans who are not homeless, and homeless individuals who are not veterans, may be occupants of the transitional housing if all of the transitional housing needs of homeless veterans in the project area have been met.[97]

Supportive services that project sponsors provide include outreach; food and nutritional counseling; health care, mental health services, and substance abuse counseling; child care; assistance in obtaining permanent housing; education, job training, and employment assistance; assistance in obtaining various types of benefits; and transportation.[98] Not more than 15 loans with an aggregate total of up to $100 million may be guaranteed under this program. The VA has committed loans to two projects and released a notice of funding availability for additional applications.[99] One project, sponsored by Catholic Charities of Chicago, opened in January 2007 with 144 transitional units for homeless veterans.[100] A second project in San Diego is also expected to provide 144 transitional housing units.[101] According to the VA, the agency has been slow to implement the program due to service providers' concerns that they may not be able to operate housing for such a needy population and still repay the guaranteed loans.[102]

Acquired Property Sales for Homeless Veterans. The Acquired Property Sales for Homeless Veterans program is operated through the Veterans Benefits Administration (VBA). The program was enacted as part of the Veterans Home Loan Guarantee and Property Rehabilitation Act of 1987 (P.L. 100-198). The current version of the program was authorized in P.L. 102-54 (a bill to amend Title 38 of the U.S. Code), and is authorized through December 31, 2008.[103]

Through the program, the VA is able to dispose of properties that it has acquired through foreclosures on its loans so that they can be used for the benefit of homeless veterans. Specifically, the VA can sell, lease, lease with the option to buy, or donate,

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[95] (...continued)
Program: Program Manual, April 6, 2007, p. 9, available at [http://www1.va.gov/homeless/docs/Loan_Guarantee_Program_Manual_4-6-07.pdf].

[96] 38 U.S.C. §2052(b).

[97] Ibid.

[98] *Multifamily Transitional Housing Loan Guarantee Program: Program Manual*, p. 10.

[99] The Notice of Funding Availability is available at *Federal Register* 71, no. 10, April 12, 2006, p. 18813.

[100] "March 8, 2007 Testimony of Pete Dougherty."

[101] Statement of Pete Dougherty, Director, Homeless Veterans Programs, Senate Veterans Affairs Committee, *Looking At Our Homeless Veterans Programs: How Effective Are They?*, 109th Cong., 2nd sess., March 16, 2006.

[102] "March 8, 2007 Testimony of Pete Dougherty."

[103] The program was most recently authorized in the Veterans Health Care, Capital Asset, and Business Improvement Act of 2003 (P.L. 108-170). The program is codified at 38 U.S.C. §2041.

properties to nonprofit organizations and state government agencies that will use the property only as homeless shelters primarily for veterans and their families. The VA estimates that over 200 properties have been sold through the program.[104]

The Department of Labor

The Department of Labor (DOL) contains an office specifically dedicated to the employment needs of veterans, the office of Veterans' Employment and Training Service (VETS). In addition to its program for homeless veterans — the Homeless Veterans Reintegration Program (HVRP) — VETS funds employment training programs for all veterans. These include the Veterans Workforce Investment Program and the Transition Assistance Program.

Homeless Veterans Reintegration Program. Established in 1987 as part of the McKinney-Vento Homeless Assistance Act (P.L. 100-77), the HVRP has two goals. The first is to assist veterans in achieving meaningful employment, and the second is to assist in the development of a service delivery system to address the problems facing homeless veterans. Eligible grantee organizations are state and local Workforce Investment Boards, local public agencies, and both for- and non-profit organizations.[105] Grantees receive funding for one year, with the possibility for two additional years of funding contingent on performance and fund availability.[106]

HVRP grantee organizations provide services that include outreach, assistance in drafting a resume and preparing for interviews, job search assistance, subsidized trial employment, job training, and follow-up assistance after placement. Recipients of HVRP grants also provide supportive services not directly related to employment such as transportation, provision of or assistance in finding housing, and referral for mental health treatment or substance abuse counseling. HVRP grantees often employ formerly homeless veterans to provide outreach to homeless veterans and to counsel them as they search for employment and stability. In fact, from the inception of the HVRP, it has been required that at least one employee of grantee organizations be a veteran who has experienced homelessness.[107]

Program Data. In program year (PY) 2004, from July 1, 2004 to June 30, 2005 (the most recent year for which information is available), HVRP grantees served a total of 12,516 homeless veterans, of whom 8,087, or 65%, were placed in employment.[108] Of those who became employed in PY2004, an estimated 64% were

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[104] "VA Programs for Homeless Veterans."

[105] Veterans Employment and Training Service Program Year 2007 Solicitation for Grant Applications, *Federal Register* vol. 72, no. 71, April 13, 2007, p. 18682.

[106] Ibid., p. 18679.

[107] "Procedures for Preapplication for Funds; Stewart B. McKinney Homeless Assistance Act, FY1988" *Federal Register* vol. 53, no. 70, April 12, 1988, p. 12089.

[108] U.S. Department of Labor, Office of the Assistance Secretary for Veterans' Employment and Training, *FY2005 Annual Report to Congress*, March 23, 2007, p. 9, available at [http://www.dol.gov/vets/media/FY2005_Annual_Report_To_Congress.pdf].

still employed after 90 days, and 58% after 180 days.[109] The percentage of HVRP participants placed in employment as well as the average wages they earn have both increased from PY2000. The percentage of participants placed in employment grew from 52.8% in PY2000, to 60.3% in PY2001 and PY2002, 62.7% in PY2003 and 65% in PY2004. The average wage has grown steadily from $8.73 per hour in PY2000 to $9.55 per hour in PY2004.

Stand Downs for Homeless Veterans. A battlefield stand down is the process in which troops are removed from danger and taken to a safe area to rest, eat, clean up, receive medical care, and generally recover from the stress and chaos of battle. Stand Downs for Homeless Veterans are modeled on the battlefield stand down and are local events, staged annually in many cities across the country, in which local Veterans Service Organizations, businesses, government entities, and other social service organizations come together for up to three days to provide similar services for homeless veterans. Items and services provided at stand downs include food, clothing, showers, haircuts, medical exams, dental care, immunizations, and, in some locations where stand downs take place for more than one day, shelter. Another important facet of stand downs, according to the National Coalition for Homeless Veterans, is the camaraderie that occurs when veterans spend time among other veterans.

Although stand downs are largely supported through donations of funds, goods, and volunteer time, the DOL VETS office allows HVRP grant recipient organizations to use up to $8,000 of their grants to fund stand downs. The VETS program also awards up to $8,000 to HVRP eligible organizations that have not received an HVRP grant. According to the most recent data available, $364,460 was used to serve 10,155 veterans at stand downs in FY2005.[110]

Incarcerated Veterans Transition Program Demonstration Grants. The Homeless Veterans Comprehensive Assistance Act of 2001 (P.L. 107-95) instituted a demonstration program to provide job training and placement services to veterans leaving prison.[111] By 2005, the program awarded $1.45 million in initial grants to seven recipients, and extended these seven grants through March 2006 with funding of $1.6 million.[112] Authorization for the program expired on January 24, 2006 and no additional funding has been provided. However, service providers encourage continued involvement in making arrangements for veterans leaving correctional facilities.[113] And in its report for 2006, the Advisory Committee on Homeless Veterans recommended that both the VHA and VBA be involved in

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[109] Ibid.

[110] Ibid., p. 12.

[111] 38 U.S.C. §2023.

[112] DOL VETS *FY2005 Annual Report to Congress*, p. 13.

[113] See National Coalition for Homeless Veterans, "FY2007 Public Policy Priorities," January 24, 2007, available at [http://www.nchv.org/content.cfm?id=24].

planning for veterans leaving prison.[114] S. 1384, introduced on May 14, 2007, would remove the program's demonstration status and authorize it through FY2011.

Emerging Issues

Permanent Supportive Housing

With the exception of Section 8 vouchers provided through the HUD-VASH program, the federal programs for homeless veterans offer funding only for transitional housing developments; they do not fund permanent supportive housing. The permanent supportive housing model promotes stability by ensuring that residents receive services tailored to their particular needs, including health care, counseling, employment assistance, help with financial matters, and assistance with other daily activities that might present challenges to a formerly-homeless individual. Although veterans are eligible for permanent supportive housing through HUD programs for the homeless, they are not prioritized above non-veteran homeless individuals. Some members of Congress, service providers, and the VA Advisory Committee on Homeless Veterans support the creation of permanent supportive housing dedicated to veterans. According to local government and community participants in the last five VA CHALENG surveys, permanent supportive housing is the number one unmet need of homeless veterans.[115]

At three recent Congressional hearings, witnesses and Committee Members discussed the issue of permanent supportive housing for veterans, including funding for additional HUD-VASH vouchers.[116] According to testimony, permanent housing is needed because veterans are not always served by housing for low-income households provided by HUD.[117] Limited resources are available to house low-income families, and veterans must compete with other needy groups including the elderly, disabled, and families with young children. Due to a lack of permanent housing options, when veterans complete programs that have transitional housing components, there is not always a place for them to go. Another concern is that, as Vietnam-era veterans age, there is a reduced chance that they will be able to find

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[114] U.S. Department of Veterans Affairs, Advisory Committee on Homeless Veterans, *Advisory Committee on Homeless Veterans Fourth Annual Report*, December 2006, p. 16 (hereafter *Advisory Committee on Homeless Veterans Fourth Annual Report*).

[115] *The Thirteenth Annual CHALENG Report*, p. 9.

[116] See House Appropriations Committee, Subcommittee on Military Construction and Veterans Affairs, *FY2008 Appropriations*, 110th Cong., 1st sess., March 8, 2007; Senate Committee on Banking, Housing and Urban Affairs, Subcommittee on Housing, Transportation, and Community Development, *Meeting the Housing Needs of Veterans*, 109th Cong., 2nd sess., August 2, 2006; Senate Veterans Affairs Committee, *Looking At Our Homeless Veterans Programs: How Effective Are They?*, 109th Cong., 2nd sess., March 16, 2006, S.Hrg. 109-533.

[117] Statement of Michael Blecker, Executive Director, Swords to Plowshares, submitted to the Senate Veterans Affairs Committee, *Looking At Our Homeless Veterans Programs: How Effective Are They?*, 109th Cong., 2nd sess., March 16, 2006, S.Hrg. 109-533.

employment and support themselves. Permanent supportive housing would serve that population.[118]

As discussed previously, the law currently authorizes the creation of additional HUD-VASH vouchers to provide permanent supportive housing for homeless veterans: 500 in FY2007, 1,000 in FY2008, 1,500 in FY2009, 2,000 in FY2010, and 2,500 in FY2011. Congress did not fund additional vouchers in its FY2007 appropriations law (P.L. 110-5). In the 110th Congress, legislation has been introduced that would provide additional permanent housing for homeless veterans. The Homes for Heroes Act (S. 1084) would create no fewer than 20,000 HUD-VASH vouchers. The bill would also authorize funds through HUD for the acquisition, rehabilitation, and construction of permanent supportive housing for very low-income veterans and their families. Services for residents would be provided through the VA.

Veterans of the Wars in Iraq and Afghanistan

As veterans return from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), just as veterans before them, they face risks that could lead to homelessness. To date, 300 OEF/OIF veterans have used VA services for homeless veterans, and the VA has classified 1,049 as being at risk of homelessness. The National Coalition for Homeless Veterans, in an informal survey of service providers, estimated that 1,260 veterans of the Iraq War have sought assistance from Grant and Per Diem programs in 2006.[119] Approximately 686,302 OEF/OIF troops have been separated from active duty since 2002.[120] If the experiences of the Vietnam War are any indication, the risk of becoming homeless continues for many years after service. After the Vietnam War, 76% of Vietnam era combat troops and 50% of non-combat troops who eventually became homeless reported that at least ten years passed between the time they left military service and when they became homeless.[121]

Among troops returning from Iraq, between 15% and 17% have screened positive for depression, generalized anxiety, and PTSD.[122] Veterans returning from

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[118] Testimony of Cheryl Beversdorf, Director, National Coalition for Homeless Veterans, before the House Appropriations Committee, Subcommittee on Military Construction and Veterans Affairs, *FY2008 Appropriations*, 110th Cong., 1st sess., March 8, 2007.

[119] Conversation with Cheryl Beversdorf.

[120] Since October 2003, DOD's Defense Manpower Data Center (DMDC) has periodically (every 60 days) sent VA an updated personnel roster of troops who participated in OEF and OIF, and who have separated from active duty and become eligible for VA benefits. The roster was originally prepared based on pay records of individuals. However, in more recent months it has been based on a combination of pay records and operational records provided by each service branch. The current separation data are from FY2002 through November 30, 2006.

[121] See "Homeless Veterans," p. 105.

[122] Charles W. Hoge, Carl A. Castro, Stephen C. Messer, and Dennis McGurk, "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *New England* (continued...)

Iraq also appear to be seeking out mental health services at higher rates than veterans returning from other conflicts.[123] There is some concern that the VA may not be able to meet demand. Access to VA health services could be a critical component of reintegration into the community for some veterans. The VA has multiple means of reaching out to injured veterans and veterans currently receiving treatment through the Department of Defense (DOD) to ensure that they know about VA health services. (For more information about these programs see CRS Report RL33993, *Veterans' Health Care Issues*, by Sidath Viranga Panangala.) However, for some veterans, health issues, particularly mental health issues, may arise later, and there is concern that they might not be aware of available VA health programs and services.[124] S. 1384, introduced on May 14, 2007, would institute a demonstration program in which the VA and DOD would work together to identify returning members of the armed services who are at risk of homelessness.

Another concern is that returning National Guard and Reserve troops may not be able to access services as readily as members of the Army or Marines. Members of the Guard and Reserve do not necessarily live near military bases, where some services for returning personnel are provided. They could be largely separated from support networks. For example, through the Transition Assistance Program (TAP), operated through the Departments of Labor, Defense, and Veterans Affairs, returning service personnel may attend employment workshops at military bases throughout the nation. In addition, veterans of the Guard and Reserve are half as likely to file claims for disability and pension benefits as those in the regular forces.[125]

Female Veterans

The number and percentage of women enlisted in the military has increased since previous wars. In FY2004, approximately 14.8% of enlisted troops in the active components of the military (Army, Navy, Air Force, and Marines) were female, up from approximately 3.3% in FY1974 and 10.9% in FY1990.[126] The

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[122] (...continued)
Journal of Medicine 351, no. 1 (July 1, 2004): Table 3.

[123] Charles W. Hoge, Jennifer L. Auchterlonie, and Charles S. Milliken, "Mental Health Problems, Use of Mental Health Services, and Attrition from Military Service After Returning from Deployment to Iraq or Afghanistan," *JAMA* 295, no. 9 (March 1, 2006): 1026, 1029.

[124] See, for example, Amy Fairweather, *Risk and Protective Factors for Homelessness Among OIF/OEF Veterans*, Swords to Plowshares' Iraq Veteran Project, December 7, 2006, p. 6, available at [http://www.swords-to-plowshares.org/Risk%20and%20Protective%20Factors%20for%20Homelessness%20among%20OIF%20Veterans.pdf].

[125] Veterans for America, Freedom of Information Act Request, "Compensation and Pension Benefit Activity Among 464,144 Veterans Deployed to the Global War on Terror," January 30, 2006, available at [http://www.veteransforamerica.org/files/vcs/CPGWOT.pdf].

[126] U.S. Department of Defense, Office of the Under Secretary of Defense, Personnel and Readiness, *Population Representation in the Military Services, FY2004*, May 2006, Appendix D, Table D-13, available at [http://www.defenselink.mil/prhome/poprep2004/

number of women deployed to war is also on the rise. To date, over 165,000 female troops have been deployed to Iraq and Afghanistan,[127] compared to 7,500 in the Vietnam War, and 41,000 in the Gulf War.[128] The number of women veterans can be expected to grow commensurately. According to the VA, there were approximately 1.2 million female veterans in 1990 (4% of the veteran population) and 1.6 million in 2000 (6%).[129] The VA anticipates that there will be 1.8 million female veterans in 2010 (8% of the veteran population) and 1.9 million (10%) in 2020. At the same time, the number of male veterans is expected to decline.[130]

Women veterans face challenges that could contribute to their risks of homelessness. Experts have found that female veterans report incidents of sexual assault that exceed rates reported in the general population.[131] The percentage of female veterans seeking medical care through the VA who have reported that they have experienced sexual assault ranges between 23% and 29%.[132] Female active duty soldiers have been found to suffer from PTSD at higher rates than male soldiers.[133] Experience with sexual assault has been linked to PTSD, depression, alcohol and drug abuse, disrupted social networks, and employment difficulties.[134] These factors can increase the difficulty with which women veterans readjust to civilian life, and could be risk factors for homelessness (see earlier discussion in this report).

Women veterans are estimated to make up a relatively small proportion of the homeless veteran population. Among veterans who use VA's services for homeless veterans, women are estimated to make up just under 4% of the total.[135] As a result, programs serving homeless veterans may not have adequate facilities for female

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[126] (...continued)
contents/contents.html].

[127] The Joint Economic Committee, *Helping Military Moms Balance Family and Longer Deployment*, May 11, 2007, p. 2, available at [http://www.jec.senate.gov/Documents/Reports/MilitaryMoms05.11.07Final.pdf].

[128] U.S. Department of Veterans Affairs.

[129] Robert A. Klein, *Women Veterans: Past, Present, and Future*, U.S. Department of Veterans Affairs, Office of the Actuary, May 2005, pp. 8-9, available at [http://www1.va.gov/vetdata/docs/Womenveterans5-10-05.doc].

[130] Ibid.

[131] Jessica Wolfe et al., "Changing Demographic Characteristics of Women Veterans: Results from a National Sample," *Military Medicine* 165, no. 10 (October 2000): 800.

[132] Anne G. Sandler, Brenda M. Booth, Michelle A. Mengeling, and Bradley N. Doebbeling, "Life Span and Repeated Violence Against Women During Military Service: Effects on Health Status and Outpatient Utilization," *Journal of Women's Health* 13, no. 7 (2004): 800.

[133] Laurel L. Hourani and Huixing Yuan, "The Mental Health Status of Women in the Navy and Marine Corps: Preliminary Findings from the Perceptions of Wellness and Readiness Assessment," *Military Medicine* 164, no. 3 (March 1999): 176.

[134] Maureen Murdoch et al., "Women and War: What Physicians Should Know," *Journal of General Internal Medicine* 21, no. s3 (March 2006): S7.

[135] *Healthcare for Homeless Veterans 19th Annual Report*, p. 32.

veterans at risk of homelessness, particularly transitional housing for women and women with children. Currently, eight Grant and Per Diem programs provide transitional housing for female veterans and their children.[136] The VA Advisory Committee on Homeless Veterans noted in its 2006 report that the Grant and Per Diem programs for women have been "slow to materialize" and recommended that the Special Needs grant be renewed and expanded.[137]

[136] Conversation with Cheryl Beversdorf, Director, National Coalition for Homeless Veterans, April 10, 2007 (hereafter "Conversation with Cheryl Beversdorf").

[137] *Advisory Committee on Homeless Veterans Fourth Annual Report*, p. 11.

Veteran's Programs

support business & promote employment

Contact: Jim Booker, State Veteran's Program Coordinator, 947-1845, Business & Employment Service Programs

Program Description

The US Secretary of Labor, through the Veterans' Employment and Training Services (USDOL-VETS), authorizes the funding of programs to meet the employment and training needs of service-connected special disabled veterans, service connected disabled veterans and other eligible veterans. DOL-VETS assists the public employment service (established by the Wagner-Peyser Act) to meet the requirement of providing the maximum level of employment and training opportunities for veterans.

Background / Enabling Legislation

Title 38 of the U.S. Code provides for the funding of a program grant by USDOL-VETS. There are two types of Employment Department veterans representative positions specified in Title 38. They are the Local Veterans Employment Representatives (LVERs) and Disabled Veteran Outreach Program representatives (DVOPs).

Funding Source

Veteran services are funded through the USDOL-VETS via a program grant. The grant pays for veteran representatives who are dedicated to serving eligible veterans and other eligible persons.

LVERs

LVERs are located in many WorkSource Oregon Employment Department (WSOED) field offices providing direct services to veterans. They also market veterans as a workforce solution to local employers and employer groups, provide guidance to Business and Employment Service (B &ES) staff on veterans' priority of service, and are responsible assuring that priority services to veterans are provided by field office staff.

DVOPs

DVOPs are located in many field offices around the state. Their time is spent focusing on veteran outreach, developing veteran service networks, and enhancing the employment prospects for special disabled veterans, disabled veterans and other eligible veterans. They work with any veteran needing more intensive employment services.

Budget

The current budget for the LVER and DVOP Program is $2,264,000. This program operates under Federal Fiscal Year of October 1 through September 30th of each year.

Staffing

The current LVER/DVOP budget supports a staffing level of 9.5 LVER FTE and 17.5 DVOP FTE. LVERs are located in 12 local offices and 16 offices have DVOPs stationed in them. Staff are directly supervised by field office managers and supervisors. Coordination and functional supervision for program services are provided by the state Veterans' Program Coordinator working out of the B&ES Program Section in Salem.

Services Provided

The veteran programs produced these outcomes for Program Year (PY) 2006, which runs July 1, 2006 to June 30, 2007*:

- Veterans registered
  47,845
- Obtained Employment[1]
  17,047
- Hires[2]
  5,412
- System Placements[3]
  22,459
- Referred to Supportive Services
  5,808

* Source: iMatchSkills OARS report Jul06-Jun 07

1. Credit taken when an individual goes to work without a direct referral but within 90 days of receiving a qualifying service. In most instances, this count is automated
2. ES registrant who goes to work as a result of a job referral (on an employer's job order)
3. The total of Hires plus obtained employment

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Veteran Services

Background

One of the most important things we have found out, over the past five years, is that returning veterans come home focused on returning to "normal" life but some do not want anyone to know they have a problem getting back to "normal."

Several factors work together to make reintegrating a problem for returning veterans including stress, pride, fear and bureaucracy. Stress can cause a host of problems including procrastination to the point of crisis. Pride or the "I can hack it" mentality puts problems on the soldier they weren't meant to bear. Fear keeps them from looking "weak" to others (especially peers, wife and leaders). And perceived (and maybe sometimes real) bureaucracy keeps vets from even trying to get the benefits they deserve. We are working to overcome these factors through the services we offer.

To meet the needs of veterans with various barriers to employment, WSOED is using every means possible to provide first class service.

We are educating employers about the advantages of hiring veterans through business and account representatives, staff that work hard to become industry experts to facilitate quality services to employers and by using information gleaned from the national Hire Vets First campaign. The Hire Vets First campaign is an effort by the U.S. Department of Labor to provide employers with access to on-line and print information about the advantages veterans offer as employees.

iMatchSkills

WorkSource Oregon Employment Department also employs an on-line job listing and job seeker registration system called iMatchSkills. This national award-winning interactive database offers businesses and job seekers twenty-four hour access to enter job listings or job seeker registration culminating in matching the appropriate job seeker to job listings. The system is available on-line for access even in remote locations like Iraq and features skill sets for military job titles. This secure system has built in veteran self-identification, and priority of service features. Veterans can contact LVER or DVOP staff for one-on-one registration guidance. LVERs and DVOPs can use the system to welcome and encourage veterans to contact them, search for jobs around the state that fit the veterans they are working with, set follow up reminders and communicate veteran's needs with other LVER/DVOPs. An interesting feature is the ability to link to our QualityInfo.org website for helpful labor market information.

QualityInfo.org enables job seekers, including veterans, to enter their occupational and skill experience to find labor market information, job availability, wage information, links to job listings, and training and apprenticeship information.

Business Representative System

Business Representatives are utilized to market veterans to the business community. The Business Representatives become experts, researching and understanding the needs of our business customers and reaching out to businesses to promote WSOED as a high quality solution for workforce needs. In doing so, our staff statewide is committed to assisting the veteran in securing the right kind of job based on the veteran's talents and challenges, matching the veteran to the employer's needs.

Our partnerships with education, other workforce and economic development entities give us vital links to training opportunities for veterans to pursue careers with new and expanding businesses. Our trained staff offers career advice on identifying and making the most of transferable skills to job opportunities in other industries. Evaluating the veteran's knowledge, skills and abilities allow them to make the best match with employer's needs.

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Marketing Services

WorkSource Oregon Employment Department and partners like Oregon Department of Veteran's Affairs (ODVA) and Community Solutions for Clackamas County (CSCC) make use of public service announcements, Governor's proclamations, job fairs and billboard and bus advertisements to promote hiring veterans to employers and to let veterans know about their benefits.

All WSOED offices make use of posters and brochure stands to alert veterans to the services available to them. Our brochures have been updated to reflect lessons learned from the Hire Vets First campaign such as emphasizing the soft skills veterans offer that other job seekers may lack.

The employer brochure emphasizes the benefits to businesses of hiring veterans. A veteran hiring success story adds power to the message and helpful websites provide even more resources. Local veteran representative contact information is also included.

The veteran's employment services brochure includes a job seeking veteran's success story, information about the LVERs and DVOPs, a list of services and helpful websites for veteran job seekers.

We also distribute giveaways such as bookmarks at job fairs, demobilization briefings and other public gatherings. Small, less likely to be discarded and likely to be used; they incorporate interview tips, 10 reasons to hire a vet and on-line resources.

Statewide Reintegration Network

WSOED became an integral part of the Oregon Military Department's Reintegration Team developed to bring the many resources a returning soldier might need under one umbrella, making access easier and less intimidating. The team coordinates debriefings for returning Oregon National Guard troops, a 24 hour-a-day resource access system, which includes a 1-800 number and public awareness outreach. Their coordinated efforts with employment, health care, law enforcement and education agencies provide the on-the-spot resources soldiers and their families need to make the transition to "normal" life.

Part of the plan to overcome the barriers mentioned above, includes a "go to the need" philosophy that puts soldiers at ease. The resources go to them in the form of demobilization briefings, job fairs, medical center visits and family support group briefings or are available by phone or website. Another method is the "Soldier Enhancement Days" where multiple federal, state and local resources are gathered approximately 90 days after units return and set up at a location nearest to where the veterans live to offer a "one-stop" where veterans can look for work, get legal advice, sign up for health benefits or attend a job fair.

The plan also involves, the Oregon National Guard, WSOED, the U.S Department of Labor, the U.S. Department of Veteran's Affairs, the Oregon Department of Veteran's Affairs and a host of other agencies banding together to make sure we get the right benefits to veterans with as little hassle as possible. Reintegration Summit meetings were convened to collect the lessons all the different agencies had learned and to create a unified plan to meet the needs of our returning soldiers. The meetings resulted in a memorandum of understanding (MOU) designed to enhance cooperation, encourage resource and information sharing and increase knowledge about veteran's needs.

Emergency Transition Assistance

The Oregon Legislature made significant contributions helping veterans with emergency funds, additional education benefits, home loans and job related transportation funds. The legislation came about primarily through the Oregon House Committee on Veteran's Affairs and the testimony of the Oregon Military Department, the Oregon Department of Veteran's Affairs (ODVA), and many military organizations and private citizens. One question asked by the House Committee drove the legislation passed, **"What are the gaps in veteran's benefits, what can we do that hasn't been done?"**

The Veteran's Transportation Fund, administered by WorkSource Oregon, provides gas vouchers or bus passes to help veterans looking for work, training or short-term education opportunities. Due to a sluggish economic recovery, some veterans in Oregon need help getting to interviews or to work until they can collect their first paycheck. The program ended in June 2007 and served 748 veterans, of whom 397 have been placed in jobs.

WorkSource Oregon Employment Department helped identify veterans who needed the Oregon Veterans' Emergency Financial Assistance Program (OVEFAP) help and referred them to ODVA to access the funds. The OVEFAP monies have prevented many veterans and their families who were in a temporary emergency financial situation from becoming homeless. Most were assisted with rent and/or mortgage payments, utility bills to avoid shut-off, school clothes and supplies for dependents, necessary medical equipment and other emergency needs.

Veterans Workforce Investment Program (VWIP) Grant

This grant will assist veterans, especially transitioning and combat veterans to obtain employment, employment related training and support services. The $750,000 grant from the U.S. Department of Labor will be used statewide and will build on a past successful VWIP marketing grant to make veterans aware of the services available to them, strengthen relationships between DVOP/LVERs and One-Stop partners, promote hiring veterans to employers and unions and demonstrate that the veterans helped will retain their employment. The grant is a cooperative effort between WorkSource Oregon, Community Solutions for Clackamas County and Labor's Community Service Agency with significant input from the Oregon Military Department.

Anticipated Program and Budget Changes in the Coming Year

Program changes
Our greatest challenge is to effectively reach recently returning veterans while continuing to serve past veterans under tighter budget constraints.

Budget Changes

The federal budget for the WSOED veteran programs continues to be a challenge. Funding for this program for FY 2007 was reduced by $93,000 from FY 2006. Coupled with inflation, negotiated salary increases and the cost of employee benefit packages, FY 2007 funding resulted in the reassignment of 8.5 LVER FTE from direct veteran services to other duties within WSOED. The veteran's representatives whose duties were reassigned are now supported by other funding and working to support other programs. The reduction of positions has been managed through attrition. Funding is provided to WSOED by DOL-VETS. United States Code (USC) Title 38 designates the state workforce agency as the recipient of the Jobs for Veterans Act grants.

USDOL-VETS allocates the funding based, in part, on a formula stipulated by Public Law 107-288 as it amends USC Title 38. The formula uses the Current Population Survey (CPS) and Local Area Unemployment Statistics (LAUS) provided by the Bureau of Labor and Statistics to determine the appropriate funding for States based upon working aged veterans.

The Funding Ratio:
The Total Number of Veterans Residing in the State that are Seeking Employment
Divided by
The Total Number of Veterans that are Seeking Employment in all States

In the past, we were able to pay for more positions than we had funding for through recaptured DOL-VETS money from other states. As the initial state funding remained essentially the same (not going up by more than a few thousand dollars) and our salaries and benefits as well as other costs went up we were able to afford less staff each year. The recapture money eventually went away as DOL-VETS received less money from Congress and other states used all of their allocations. Therefore, we were not able to continue to maintain the same level of staff and reductions were made.

Every effort was made to minimize the impact of the reassignment on service to veterans. Most offices affected retain a dedicated veteran's representative. Also, all Business and Employment Services staff are trained to be sensitive to the needs of veterans and are able to provide job seeking veterans with the service they need or connect them to those who can provide it. While they can not replace the dedicated veteran representatives, front line staff continue to offer valuable services to veterans.

Oregon Veteran's Employment Summit

Representatives from the Oregon National Guard, Oregon Employment Department (OED), Workforce Investment Act partners, apprenticeship training programs, and representatives from federal and state government met on April 2nd and 3rd at the Anderson Readiness Center in Salem to discuss ways to work with their local communities to help veterans find jobs.

Both US Representative Darlene Hooley (via a pre-recorded message) and Paul Evans, the Governor's Military and Veteran's Affairs Policy Advisor, welcomed the group and talked about current issues involving veterans, emphasizing the need of returning veterans for jobs and mentioning that veterans make great employees. They both noted that Oregon is recognized nationally as a model for helping National Guard veterans return to work and challenged the participants of the summit to work locally to serve veterans as well as they have served us.

From the start, it was pointed out that this is a critical time for veterans; many have been deployed multiple times and find it a challenge to reestablish work connections. Studies have shown that young veterans have the most difficult time finding jobs, particularly family wage jobs.

The attendees heard first-hand accounts from soldiers who had recently returned from the War on Terror as well as family members describing the transition from being a warrior to being a citizen. Dave Randall, a representative from the Oregon State Police (OSP), talked about why OSP seeks out veterans as employees. He noted their high level of transferable skills, dedication to duty, ability to finish what they start and a host of other desirable attributes.

In break out sessions, workgroups explored job search services currently available to veterans such as OED's specialized veteran's representatives trained to help veterans find jobs. WorkForce Investment Act partners explained their ability to perform assessments of job seeker's abilities, connections to training programs and funding. The apprenticeship programs like Helmets to Hardhats offered paid training and health benefits for qualified veterans.

Exploring gaps in services to veterans showed that much is left to be done. Approximately 3500 Oregon Veterans will be returning from a massive deployment in the summer of 2010. It's estimated that of those, 43% will be unemployed when they return, 18% will be underemployed and that approximately 40% will change careers within the first year of coming home.

Other trials veterans face are lack of recognition of training and experience for credentials or certifications, little knowledge of programs designed to help them find jobs, job transportation funds, employer reticence to hire veterans and family adjustment issues.

By the end of the summit, participants talked about bringing local job service providers, community colleges, local government officials and veteran's groups together in community meetings to plan ways to inform veterans of their benefits, reach out to families of veterans and join with the Oregon National Guard to prepare veteran's career and benefit events.

Oregon Veteran's Employment Summit

Gaps in Services to Veterans

* Flexible/transferable college credits (recognition of military training & experience)

* Certification/credentials recognition for military service/training

* Job transportation funds

* Gap in time to be career ready
  - Things need to be done to get job ready/ need short term job to meet needs
  - ORNG members who are waiting for Education/med benefits need job to fill the gap

* Assistance to families
  - Adjustments to family/work when vets return (counseling)
  - Rental & utility assistance

* Go to the vet with resource information

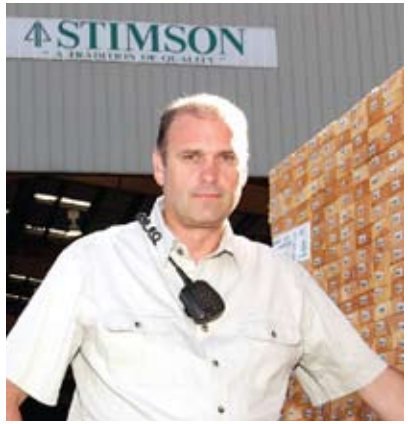
* Resume/interview skills-also learning about transferable skills

Workforce solutions for your business needs

WorkSource Oregon provides access to trained workers whose skills and talents are aligned with the needs of your business and industry.

Veterans are highly trained and motivated job candidates to fill your needs

Why hire a veteran?



"They've already gone through that structured training program and it really makes it easier for them to come into our workforce with those skills and discipline. They've got some good education; usually a very good work ethic and they're usually a very good fit here."

Paul Yackley
Production Superintendent
Stimson Lumber

Visit
www.WorkingInOregon.org
for locations & veterans' representatives

Contact us...

Valuable web site resources for businesses

www.hirevetsfirst.gov - Great resource for businesses including skills translator and business success stories.

www.esgr.org - The Employer Support of the Guard and Reserve (ESGR). Web site contains information about business responsibilities regarding the job rights of returning troops.

WORKSOURCE OREGON

WorkSource Oregon is an equal opportunity program/employer. The following services are available free of cost upon request: Auxiliary aids or services and alternate formats to individuals with disabilities and language assistance to individuals with limited English proficiency. To request these services contact your local WorkSource Oregon Center for assistance.

WorkSource Oregón es un programa/empleador que respeta la igualdad de oportunidades. Disponemos de los siguientes servicios a pedido y sin costo: Servicios o ayudas auxiliares, y formatos alternos para personas con discapacidades y asistencia de idiomas para personas con conocimiento limitado del inglés. Para solicitar dichos servicios, contáctese con el Centro WorkSource Oregon más cercano a su área.

State of Oregon • WorkSource Oregon
www.WorkSourceOregon.org
ESPUB207 (0806)

Hire Veterans

One good job deserves another...

WORKSOURCE OREGON

www.WorkSourceOregon.org

Veterans - a valuable resource

We understand that businesses face unique workforce needs. Veteran job candidates provide several advantages for your business. Use that advantage - hire an experienced veteran, they are prepared for work.

Military service requires passing stringent screening

- Criminal and drug background checks
- Education requirements
- Physical fitness standards

Veterans get the attributes & skills that businesses value

- Leadership
- Professionalism
- Responsibility
- Technical and trade training
- Ability to handle stress
- First-class image
- Timeliness
- Global perspective

Veterans possess "soft skills" businesses desire

- Team work
- Pride in completing a task
- Proven ability to learn
- Positive attitude

Bring the veteran advantage to your work place! ***Experience*** **- that's why they call them veterans.**

WORKSOURCE OREGON

www.WorkSourceOregon.org

WorkSource Oregon Helps Veterans

When Carrie decided to go back to work full time after being self-employed in Web design, she contacted her veterans' representative for assistance.

Her veterans' representative introduced her to iMatchSkills, an award-winning online job matching tool that matches a person's skills with job listings that require those skills.

Between her veterans' representative and iMatchSkills, it wasn't long before Carrie was matched to several openings and was interviewing for chamber director.

"The representatives were quite helpful. They were friendly and knowledgeable in what they did."

Carrie Young, Director
Cornelius Chamber of Commerce

Visit
www.WorkingInOregon.org
For Locations &
Veterans' Representatives

WorkSource Oregon is an equal opportunity program/employer. The following services are available free of cost upon request: Auxiliary aids or services and alternate formats to individuals with disabilities and language assistance to individuals with limited English proficiency. To request these services contact your local WorkSource Oregon Center for assistance.

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State of Oregon • WorkSource Oregon
www.WorkSourceOregon.org
ES PUB 293 (0106)

Veterans' Employment Services

Its All Right Here...

www.WorkSourceOregon.org

Veterans' Resources...

Representatives Are...

available to assist veterans and others eligible for veterans' services at WorkSource Oregon Centers throughout the state.

Local Veterans...

Employment Representatives (LVER) and Disabled Veterans Outreach Program Specialists (DVOP) are located in most offices and specialize in working with veterans and their families.

If you served in the United States Military, you may be eligible for veterans' services, referrals to employment and training opportunities, and information about other available resources.

Veterans Helping Veterans...

We understand your employment needs - from learning to translate military jargon into business language - to getting your military experience recognized by businesses.

Veterans' Representatives help with:

Employment

- Résumé & application assistance
- Vocational guidance
- Referrals to jobs
- Information on federal, state & local government employment opportunities
- Career exploration tools
- Tax credit information
- Job search workshops

Training

- Information on educational and training programs
- Referral to training & retraining programs, including VA Vocational Rehabilitation

Other services

- Information on health issues & where to file disability claims
- Connections to medical facilities assisting veterans
- Referral to local veterans organizations

Website Resources

- **www.WorkingInOregon.org**
  Veterans' representatives nearest you, job listings, iMatchSkills, information about unemployment insurance, job fairs and child care.
- **www.WorkSourceOregon.org**
  Find WorkSource centers and partners in your community. Connect with job opportunities, training and education resources, and local service providers.
- **www.QualityInfo.org**
  Use career exploration tools and economic information to help with career planning.
- **www.odva.state.or.us**
  Connect with benefit counselors, look into home loans and more.
- **www.hirevetsfirst.gov**
  A great resource for veterans that includes 10 reasons to hire a vet, skills translator and résumé writer.
- **www.helmetstohardhats.org**
  Trades apprenticeship information.
- **www.mil.state.or.us**
  Resource links for Oregon National Guard members and their families.

WORKSOURCE™ OREGON

Hire Oregon Veterans Project (HOV)

⌖ $750,000 US Dept of Labor Veterans Workforce Investment Program (VWIP) grant obtained through competitive process

⌖ Life of the grant is one year, July 1, 2006 through June 30, 2007 with possible extensions up to three years (additional two years) **We have been extended through June 2008 and should see another extension through June 2009.**

⌖ WorkSource Oregon and Labor's Community Service Agency (LCSA) are subcontractors to Community Solutions for Clackamas County (CSCC) the grantee

⌖ Purpose of the grant is to assist veterans especially transitioning and combat veterans to obtain employment / employment related training / support services

⌖ Scope of grant is statewide

⌖ Grant Provisions:

- Build on past successful VWIP marketing grant administered by CSCC to make veterans aware of services available to them (1-800 number/ billboards/billing inserts)
- Use regional meetings to strengthen relationships and increase cooperation between WorkSource Oregon DVOP/LVER staff and One-Stop partners to ensure maximum resource integration
- Promote hiring of veterans to employers, unions and apprenticeship committees
- DVOP/LVERs will provide enrollment, assessment, referral, case management, and follow up services to veterans
- Funds are available through the grant to veterans for work-related support service needs, (e.g., tools, work boots) or short term, work-related training
  388 vets @ $700/vet for training ($271,600)
  120 vets @ $200/vet for support services ($24,000)

⌖ Eligibility Criteria:
VWIP Program participants must be veterans who served at least <u>one day in the active military, naval or air service</u>, and who were discharged or released from such service under conditions other than dishonorable. Participants must also be at least one of the following:

- Veterans with service-connected disabilities
- Veterans who served on active duty in the armed forces during a war or in a campaign or expedition for which a campaign badge has been authorized
- Veterans who have significant barriers to employment
- Recently separated veterans (within 48 months of release or discharge)

⌖ Goals of the grant:

485 veterans enrolled	388 entering job related training (80%)
340 entering employment (70%)	272 retaining jobs for 90 days (56%)

Local Veteran's Employment Representative (LVER)

Advocate for employment and training opportunities with business and industry, and community-based organizations.

Plan and participate in **job fairs** to promote services to veterans.

Work with **unions, apprenticeship programs, and business community** to promote employment and training opportunities for veterans.

Promote **credentialing and training** opportunities for veterans with training providers and credentialing bodies.

Contact with employers to develop employment and training opportunities.

Develop employer contact plans for the service delivery point, to include identified federal contractors.

Coordinate with employer relations representatives in the service delivery point (SDP) to facilitate and promote opportunities for veterans seeking jobs.

Provide and facilitate employment and training services to meet the needs of newly separated and other veterans in the workforce development system and especially address the needs of transitioning military personnel through facilitation of **Transition Assistance Program (TAP) workshops**.

Ensure that veterans are provided labor exchange services needed to meet their employment and training needs.

Train other staff and service delivery system partners to enhance their knowledge of veterans' employment and training issues.

Promote veterans in the workforce development systems that have highly marketable skills and experience.

Disabled Veterans Outreach Program (DVOP)

Facilitation of **intensive services** to veterans with special employment and training needs.

a. Conduct assessment
b. Develop and document a plan of action
c. Provide career guidance
d. Coordinate supportive service(s)
e. Provide job development contact(s)
f. Refer to job(s)
g. Refer to training

Conduct **outreach** to locate **veterans** for intensive services & market services to clients in programs such as:

VR&E	Civic and service organizations
HVRP	Partners through WIA
Homeless shelters	State Vocational Rehabilitation Agencies
VA hospitals and Vet Centers	Other Service Providers

Provide and facilitate a full range of employment and training services to veterans, with the primary focus of meeting the needs of those who are unable to obtain employment through core services.

WorkSource Oregon Employment Department Contacts

LVER LIST — **Local Veteran Employment Representative**

City	First Name	Last Name	Position	E-Mail @state.or.us	Phone	Ext	Fax Number
Albany	Jim	Munger	LVER	James.A.MUNGER	541-967-2171	240	541-967-2137
Astoria	Patrick	Preston	LVER	Patrick.C.PRESTON	503-325-4821	227	503-325-2918
Bend	Kandice	Newton	LVER	Kandice.I.NEWTON	541-388-6455		541-388-6453
Eugene/Roseburg	Rob	Bassett	LVER	Robert.J.BASSETT	541-686-7684		541-686-7954
Grants Pass	Dave	Smith	LVER	David.SMITH	541-244-3250		541-474-3195
Hermiston	Bob	Dedlow	LVER	Robert.L.DEDLOW	541-564-5688		541-567-2306
Hillsboro	Jeff	Edwards	LVER	Robert.J.EDWARDS	503-681-0252		503-693-0623
La Grande/Enterprise/Baker City	Brian	Papineau	LVER	Brian.C.PAPINEAU	541-963-7111	25	541-963-5515
North Bend	Keith	Powers	LVER	Keith.G.POWERS	541-751-8518		541-756-3900
Ontario	Miguel	Arredondo	LVER	Miguel.ARREDONDO	541-889-5394		541-889-8437
The Dalles	Allan	Morrison	LVER	Allan.R.MORRISON	541-296-5435	232	541-296-5590
Tualatin	John	Concepcion	LVER	John.T.CONCEPCION	503-612-4238		503-612-4250

DVOP LIST — **Disabled Veteran Outreach Program**

City	First Name	Last Name	Position	E-Mail @state.or.us	Phone	Ext	Fax Number
Albany	Cliff	Springstead	DVOP	Cliff.M.SPRINGSTEAD	541-967-2171	238	541-967-2137
Bend	Roy	Morris	DVOP	Roy.G.MORRIS	541-388-6079		541-388-6453
Eugene	David	Heavirland	DVOP	David.M.HEAVIRLAND	541-686-7753		541-686-7954
Eugene	Robert	Ryker	DVOP	Robert.R.RYKER	541-686-7601	7322	541-686-7954
Gresham	Curtis	Chapman	DVOP	Curtis.L.CHAPMAN	503-669-7112	264	503-666-2230
Hillsboro	Kurt	Carlsen	DVOP	Kurt.J.CARLSEN	503-681-0211		503-693-0623
Klamath Falls	Orlando	Williams	DVOP	Orlando.WILLIAMS	541-883-5630	234	541-883-5540
McMinnville	Dennis	Carmody	DVOP	Dennis.M.CARMODY	503-434-7578		503-434-5408
Medford	Russ	McBride	DVOP	Russ.R.MCBRIDE	541-776-6060	260	541-776-6093
Newport	John	Farrar	DVOP	John.G.FARRAR	541-265-8891	333	541-265-5975
North Bend	Frank	Carpenter	DVOP	Frank.E.CARPENTER	541-751-8510		541-756-3900
Oregon City	Tony	Walton	DVOP	Tony.S. WALTON	971-673-6452		971-673-6405
Oregon City	B.G. 'Buddy'	Reed	DVOP	Barkley.G.REED	971-673-6457		971-673-6405
Portland North	Stan	Stanley	DVOP	Stan.T.STANLEY	503-280-6041		503-280-6015
Portland North	Rene'	Garcia	DVOP	Rene.A.GARCIA	503-280-6061		503-280-6015
Roseburg	Tom	Rapant	DVOP	Thomas.W.RAPANT	541-464-2357		541-440-3498
Salem	Dennis	Durfee	DVOP	Dennis.M.DURFEE*	503-378-4832		503-378-6480
Salem	Kevin	Crapser	DVOP	Dracey.K.CRAPSER	503-378-4917		503-378-6480
St Helens	Phil	Butcher	DVOP	Leonard.P.BUTCHER	503-397-4995	225	503-397-7154
Tualatin	John	Desilets	DVOP	John.F. DESILETS	503-612-4237		503-612-4250

Program Coordinator- Jim Booker 503-947-1845 (Salem) James.H.Booker@state.or.us

Updated 1-2-08

For office addresses and directions go to www.employment.oregon.gov and click on "Office Locations"

Valuable on-line resources for veterans

http://www.employment.oregon.gov/
Featuring job listings, iMatchSkills job matching system, Unemployment Insurance information and job fairs

http://www.qualityinfo.org
Career exploration tools, great place to find out the prevailing wage for various jobs, job availability, outlook for future employment and a lot more

http:/ww.hirevetsfirst.org
A great resource for veterans that includes 10 reasons to hire a vet, skills translator and resume writer

http:/ww.helmetstohardhats.org
Trades apprenticeship information

http://www.orng-vet.org/ or toll free number (1-888-688-2264)
Oregon National Guard Reintegration Team- central point of contact to the agencies that provide benefits and support for soldiers and their dependents

http:/ww.odva.state.or.us
Connect with benefits counselors, look into home loans and more

http:/ww.mil.state.or.us
Resource links for Oregon National Guard members and their families

http://www.oregonchildcare.org/

Oregon Child Care	Phone:	503-375-2644
Resource and Referral Network	Toll Free:	800-342-6712
805 Liberty Street NE, Suite 2	Fax:	503-399-9858
Salem, Oregon 97301		

http:/www.WorkSourceOregon.org
Find WorkSource centers and partners in your community. Connect with job opportunities, training and education resources, and local service providers.

HireVetsFirst
American Excellence at Work.

One Good Job Deserves Another

10 Reasons to Hire a Veteran!!!

1. Leadership
2. Professional
3. Responsible
4. Trained & skilled
5. Physically conditioned
6. On time
7. Can-do attitude
8. Teamwork under pressure
9. First-Class image
10. Global perspective

WORKSOURCE OREGON

Online Search Help

iMatchSkills
Connecting Employers & Job Seekers
WorkingInOregon.org

WorkSource Oregon
Job & Training Resources
WorkSourceOregon.org

OLMIS
Quality Information for Informed Choices
QualityInfo.org

Hire Vets First
Great Resource for Businesses
HireVetsFirst.gov

Helmets to Hardhats
Trades Apprenticeship Information
HelmetsToHardHats.org

WORKSOURCE OREGON

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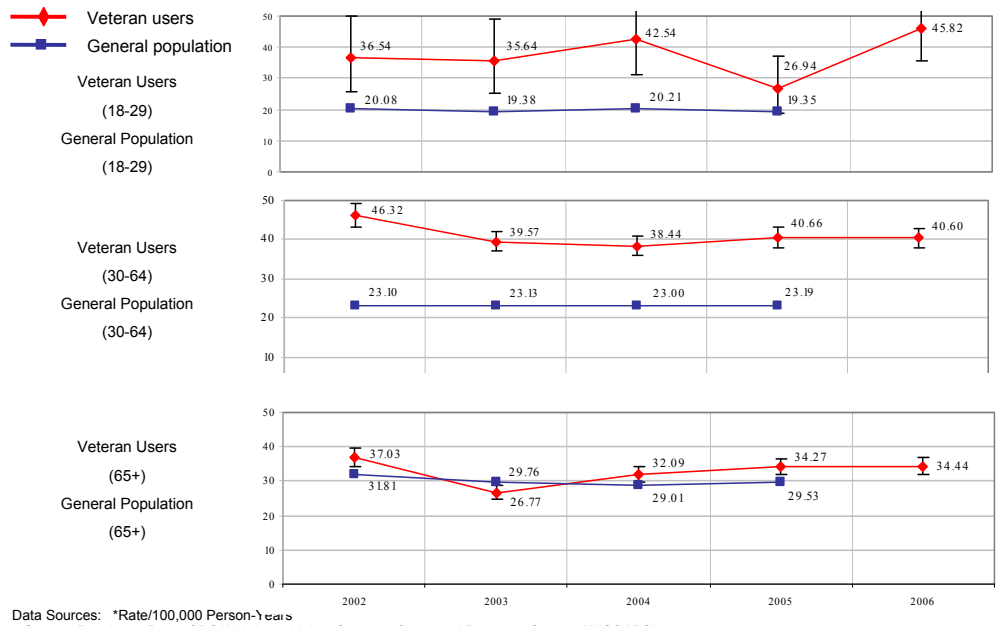
Summary Suicide Rates* 2002-2006
General Adult Population** vs. VA Unique Users: MALES



Data Sources: *Rate/100,000 Person-Years
**General Population Rates CDC Web-based Injury Statistics Query and Reporting System (WISQARS)
Data for 2006 will not be available until November 2008
VA Healthcare Data from VA National Patient Care Data Base
Suicide Data from National Center for Health Statistics National Death Index
8/23/08

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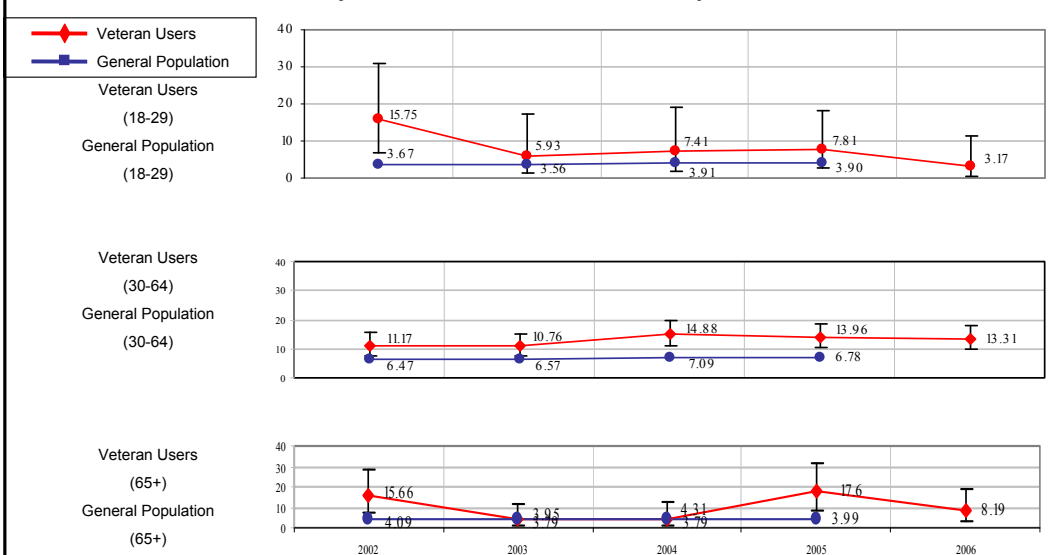
Summary Suicide Rates* 2002-2006
General Adult Population** vs. VA Unique Users: FEMALES



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8/23/08

Order Code RL34471

CRS Report for Congress

Suicide Prevention Among Veterans

May 5, 2008

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Ramya Sundararaman, Sidath Viranga Panangala,
and Sarah A. Lister
Domestic Social Policy Division

Congressional Research Service

Prepared for Members and Committees of Congress

Suicide Prevention Among Veterans

Summary

Numerous news stories in the popular print and electronic media have documented suicides among servicemembers and veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). In the United States, there are more than 30,000 suicides annually. Suicides among veterans are included in this number, but it is not known in what proportion. There is no nationwide system for surveillance of suicide specifically among veterans. Recent data show that about 20% of suicide deaths nationwide could be among veterans. It is not known what proportion of these deaths are among OIF/OEF veterans.

Veterans have a number of risk factors that increase their chance of attempting suicide. These risk factors include combat exposure, post-traumatic stress disorder (PTSD) and other mental health problems, traumatic brain injury (TBI), poor social support structures, and access to lethal means.

Several bills addressing suicide in veterans have been introduced in the 110th Congress. On November 5, 2007, the Joshua Omvig Veterans Suicide Prevention Act (P.L. 110-110) was signed into law, requiring the Department of Veterans Affairs (VA) to establish a comprehensive program for suicide prevention among veterans. More recently, the Veterans Suicide Study Act (S. 2899) was introduced. This bill would require the VA to conduct a study, and report to Congress, regarding suicides among veterans since 1997.

The VA has carried out a number of suicide prevention initiatives, including establishing a national suicide prevention hotline for veterans, conducting awareness events at VA medical centers, and screening and assessing veterans for suicide risk.

This report discusses data sources and systems that can provide information about suicides in the general population and among veterans, and known risk and protective factors associated with suicide in each group. It also discusses suicide prevention efforts by the VA. It does not discuss Department of Defense (DOD) activities, or VA's treatment of risk factors for suicide, such as depression, PTSD, and substance abuse.

This report will be updated when legislative activity warrants.

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L

Suicide Prevention Among Veterans

Introduction

Considerable public attention has been drawn toward the mental health care needs of veterans, especially those returning from combat in Iraq and Afghanistan. Numerous news stories in the popular print and electronic media have documented suicides among servicemembers and veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).[1] Some veterans advocacy groups have filed a class-action lawsuit claiming that the Department of Veterans Affairs (VA) is not providing adequate and timely access to mental health care, and that this has led to an "epidemic of suicides."[2]

However, most often the data cited in these press reports do not differentiate between suicides among veterans and active duty servicemembers.[3] It is important to make this distinction, because two separate health care systems — at the VA and the Department of Defense (DOD), respectively — are responsible for providing mental health care to these two distinct populations. This report explains the difficulties in determining the incidence of suicide among veterans, summarizes what is known about suicides in the general population and among veterans, and discusses known risk and protective factors associated with suicide in each group. It also discusses recent congressional action to address suicide among veterans, and suicide prevention efforts by the VA. The report does not discuss DOD activities, or VA's treatment of risk factors for suicide, such as depression, post-traumatic stress disorder (PTSD), and substance abuse.

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[1] Ken Fuson and Jennifer Jacobs, "Iowans Lauded for Anti-suicide Efforts," *The Des Moines Register,* January 26, 2008; Dana Priest, "Soldier Suicides at Record Level," *Washington Post,* January 31, 2008, Page A01; "Soldier, After Bipolar Treatment and Suicide Attempts, Sent Back to War Zone," *Editor & Publisher*, February 11, 2008; "Suicide Epidemic Among Veterans — A CBS News Investigation Uncovers a Suicide Rate for Veterans Twice That of Other Americans," aired November 13, 2007. OEF, which began in October 2001, conducts combat operations in Afghanistan and other locations. OIF, which began in March 2003, conducts combat operations in Iraq and other locations.

[2] *Veterans for Common Sense and Veterans United for Truth, Inc., v. James B. Peake, Secretary of Veterans Affairs, et al*., Plaintiffs Trial Brief, Case No. C-07-3758-SC, filed April 17, 2008.

[3] Within the context of the VA, a veteran is defined as a "person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable." [38 U.S.C. § 101(2); 38 C.F.R. § 3.1(d)]. The VA largely bases its determination of veteran status upon military department service records.

Data and Data Systems for Tracking Suicide

Suicide is the act of intentionally ending one's life, attempted suicide is an effort that does not have a fatal outcome, and suicidal ideation is thinking about or wanting to end one's life. Because completed (versus attempted) suicide results in death, national statistics on suicide come from death certificate data.[4] These data are collected by state and territorial health officials, under their authority, and are voluntarily reported to the Centers for Disease Control and Prevention's (CDC's) National Vital Statistics System. The CDC analyzes the data and publishes information on numbers and rates of death, and important trends, in the United States.[5] The CDC also publishes a U.S. standard death certificate, which states and territories can modify. Most U.S. deaths are not investigated by government officials. Possible suicides may be investigated, however, pursuant to state and territorial authorities. To the extent that a death is recognized as a suicide, the standard death certificate provides the means to report suicide as the manner of death, but it has limited options for noting other information that may be relevant to the suicide.

In 2003, CDC launched the National Violent Death Reporting System (NVDRS), an active surveillance system that provides detailed information about the circumstances of violent deaths, including suicide.[6] The NVDRS augments death certificate data by linking it to death investigation reports filed by coroners, medical examiners, and law enforcement officials. These added layers of information allow the NVDRS to identify suicide risk factors, such as depression; to gather additional information, such as toxicology results; and to more reliably capture information that could have been, but was not, completed on the standard death certificate. At this time, the NVDRS is not in operation nationwide, but only in 17 states, and NVDRS data might not be generalizable to the entire U.S. population. Also, because protocols for death investigation vary from one state to the next, NVDRS data might not be comparable between those states in which it is in operation. CDC's goal is to expand the system to all 50 states, all U.S. territories, and the District of Columbia, and to continue efforts to standardize data collection and analysis across states.

At this time, there is no nationwide system for surveillance (i.e., tracking) of suicide among all veterans. As with all suicides in civilian jurisdiction, suicides among veterans may be investigated, and the death certificates completed, by state and territorial authorities. Unless a veteran's suicide occurs in a VA facility, opportunities for the VA to become aware of the incident may be limited. Three

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[4] In reference to fatal suicides, the public health community prefers to use the term "completed," rather than "committed" or "successful," to recognize the frequent association of suicide with mental illness, and reduce the accompanying stigma.

[5] For more information, see Centers for Disease Control and Prevention (CDC), Mortality Data from the National Vital Statistics System, at [http://www.cdc.gov/nchs/deaths.htm], visited May 2, 2008.

[6] See CDC, National Violent Death Reporting System, at [http://www.cdc.gov/ncipc/profiles/nvdrs/default.htm].

approaches are being used to track the incidence of suicide among veterans, though each of them has serious shortcomings.

First, CDC's standard death certificate allows officials to note if a decedent *has ever served*[7] in the U.S. Armed Forces. However, the fact that a decedent is a veteran is not always known when the certificate is completed. Although suicides among veterans are a part of total national suicide statistics, it is not known what proportion of that total is made up of veterans.

Second, VA data may be linked to CDC's vital statistics data through the National Death Index (NDI). This CDC data system allows authorized researchers to link national death data to other data systems, identifying the fact that an individual had died of suicide, and that a death certificate has been filed.[8] This would allow the VA to identify suicide deaths among its enrollees. (Subsequent research steps are cumbersome. For example, researchers typically must contact state officials to access the actual death certificates.) The NDI is not an ongoing data linkage that would constitute surveillance for suicide. It can be used, however, to support special studies by linking specific data sets. For example, researchers from the VA and the University of Michigan conducted a study in which they linked data from VA's National Registry for Depression (NARDEP) to the NDI, allowing VA to match its patient registry to certified suicide deaths even when the decedent's veteran status had not been noted on the death certificate.[9] However, because only about one-third of veterans receive their health care from the VA, using VA health systems data for linkage would not capture the complete experience of suicide among veterans.

Third, the NVDRS resolves many of the problems discussed above. Through ongoing active surveillance, NVDRS substantially improves the likelihood that a suicide victim's veteran status will be captured, and it provides additional useful information about suicide incidents. But NVDRS is in operation in only 17 states. Though CDC intends it to become a nationwide system, expansion would depend on appropriations. Congress first provided funding for NVDRS in FY2002 and has expressed support for the program in annual appropriations report language. The program has not received a specified appropriation in recent years, but rather is funded through CDC's budget for intentional injury prevention and control.

Suicide in the U.S. General Population

There are *risk factors* that increase the likelihood that someone will attempt suicide, and *protective factors* that decrease that likelihood. This section provides

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[7] This definition captures current and former U.S. military servicemembers.

[8] See CDC, National Death Index, at [http://www.cdc.gov/nchs/ndi.htm].

[9] Zivin et al., "Suicide Mortality among Individuals Receiving Treatment for Depression in the Veterans Affairs Health System: Associations with Patient and Treatment Setting Characteristics," *American Journal of Public Health*, Vol. 97, No. 12, pp. 2193-8, December 2007, hereafter referred to as Zivin et al., study of depression and suicide in veterans.

some context for suicide among veterans by discussing the incidence, and risk and protective factors, for suicide in the U.S. general population.[10]

Incidence of Suicide

Suicide is a serious public health problem in the United States. According to CDC, there were more than 32,000 suicide deaths in the United States in 2004, making it the 11th leading cause of death that year. On average, there are four suicides among males for each one among females. Use of firearms is the most common method of suicide among males, while poisoning is the most common method among females. Suicide is the second leading cause of death among 25-34 year olds, and the third leading cause of death among 15-24 year olds. Although suicide is a leading cause of death in younger adults, the *rate* of suicide (number of suicides within the age group per 100,000 resident population in the age group) is actually highest in individuals aged 45 or older. **Table 1** presents suicide rates across age groups in the United States for 2004, as published by CDC. It is important to note that except in the youngest age group, these rates may, and probably do, include suicides among veterans, though in proportions that are not known.

Table 1. U.S. Death Rates for Suicide, by Age, 2004

Age Group	5-14 years	15-24 years	25-44 years	45-64 years	65 years and over	All age groups[a]
Suicide rate	0.7	10.3	13.9	15.4	14.3	10.9

Source: CDC, death rates for suicide, according to sex, race, Hispanic origin, and age: selected years, 1950-2004, "Health, United States, 2007," Table 46, at [http://www.cdc.gov/nchs/data/hus/hus07.pdf].

Notes: CDC does not calculate rates based on small numbers of suicides among those younger than five years of age, as such rates are not statistically reliable. In the source above, CDC also published rates for sub-intervals of the age intervals presented here (e.g., for those aged 25-34 years and 35-44 years).

a. This rate is age-adjusted, calculated using the year 2000 standard population.

There are no official national statistics on attempted suicide (i.e., attempts that were not fatal), but it is generally estimated that there are 25 attempts for each death by suicide. Also, it is reported that there are three suicide attempts among females for every one among males.

[10] Unless otherwise noted, information in this section is drawn from CDC: "Suicide, Facts at a Glance," Summer 2007, and "Understanding Suicide, Fact Sheet," 2006, at [http://www.cdc.gov/ncipc/dvp/suicide/]; and "Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2005," *MMWR,* vol. 57(SS03), April 11, 2008, hereafter referred to as NVDRS 2005 report, at [http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5703a1.htm].

Risk and Protective Factors

No single cause or factor leads to suicide. It is a "final common outcome with multiple potential antecedents, precipitants, and underlying causes."[11] A number of factors are known to increase or decrease the likelihood that an individual will attempt suicide. Factors that increase this likelihood are called *risk factors*. Risk factors exist at multiple levels, involving individual, family, community, and societal factors. Conversely, factors that decrease a person's inclination to attempt suicide are called *protective factors*, which also exist at multiple levels. It is important to note that none of these factors in isolation is known to cause or prevent suicide.

The single best predictor of an increased risk of suicide is a history of a prior suicide attempt. Other risk factors for suicide in the general population include certain mental illnesses such as depression, alcohol and substance abuse, history of trauma or abuse, family history of suicide, job or financial stress, the stigma associated with seeking mental health care, barriers to health care access, and easy access to lethal means. Protective factors include strong family or community connections; accessible and effective clinical care; skills in problem solving, conflict resolution, and nonviolent handling of disputes; and cultural and religious beliefs that discourage suicide.[12]

Suicide Among Veterans

In the absence of national surveillance for suicide among veterans, information is limited to the findings of special epidemiological studies and surveys. These vary considerably in their design and in the sub-population of veterans studied, and they often yield conflicting results.

It is tempting to make comparisons between these studies, and with information about suicide in the general population. Such comparisons are often made, but they are not necessarily valid. Among other things, data about suicides in the general population includes suicides among veterans. Information about suicide in groups that exclude veterans is scant, as is information about the extent to which data for veterans may skew the data for the general population, if at all. An additional problem in interpreting the findings of these special studies is that they are often conducted on populations of veterans who are receiving treatment for suicide risk factors. On the one hand, this makes it difficult to determine whether study findings reflect the effects of risk factors, or the effects of interventions. On the other hand, it indicates that efforts to develop systematic surveillance of suicide among veterans may, with careful attention to design, also provide the means to evaluate the

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[11] Testimony of Michael Shepherd, M.D, Office of Healthcare Inspections, Office of Inspector General, Department of Veterans Affairs, in U.S. Congress, House Committee on Veterans' Affairs, hearing on *Stopping Suicides: Mental Health Challenges Within the Department of Veterans Affairs,* December 12, 2007.

[12] Suicide Prevention Resource Center, "Risk and Protective Factors for Suicide," at [http://www.sprc.org/library/srisk.pdf], visited April 30, 2008.

effectiveness of prevention and treatment programs. This section discusses the findings of some key studies of suicide among veterans.

Incidence of Suicide

The true incidence of suicide among veterans is not known. This section discusses information from two recent published studies that yield a partial picture of the burden of suicide in this group.

In 2005, the NVDRS identified 1,821 suicides among former or current military personnel, comprising 20% of all suicides, in the 16 states in which the system was operational that year.[13] CDC's published findings about these 1,821 decedents include the following:

- 1,765 (96.9%) were male.
- 1,415 (77.7%) were 45 years of age or older.
- The most common method used was firearms (67.9%), followed by poisoning (12.7%), and hanging/strangulation/suffocation (11.5%).
- 47.2% were married, 25.0% were divorced, 13.0% were widowed, and 14.0% were never married.[14]

Researchers from the VA and the University of Michigan conducted a cohort study of 807,694 veterans who were diagnosed with depression in the VA health system, and registered in the VA's National Registry for Depression (NARDEP), between 1999 and 2004.[15] During the study period, 1,683 (0.21%) of the veterans in this high-risk group committed suicide. The researchers calculated a rate of 88.25 suicides per 100,000 person-years in this group, seven to eight times higher than the rate in the general population for the same time period. They noted that this rate was similar, though, to a more relevant comparison, namely, to suicides among those in the general population who were depressed.[16] They also found the rate among the group of veterans studied to be highest among those who were younger than 45 years of age, in contrast with the age trend in the general population.

In December 2007, VA testified that it had identified 144 known suicides among OIF/OEF veterans from the time the conflicts began through the end of 2005,

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[13] NVDRS 2005 report. The definition "current and former military personnel" is likely to include both current military personnel and veterans, but the publication does not provide information about each group separately, or about whether such separate information is available.

[14] The remaining small number of decedents were "married but separated," "single, not otherwise specified," or their marital status was not known. These findings were not cross-tabulated by age.

[15] Zivin et al., study of depression and suicide in veterans. The authors used CDC's National Death Index to link NARDEP registrants with death certificate data, in order to identify registrants who had died, and determine that they died of suicide, during the study period.

[16] The authors cited only one study on which to base this comparison, though, which likely reflects the limited availability of studies in groups that are meaningful for comparison. It is not clear whether the comparison group included or excluded veterans.

and that this number translated into a rate that is not statistically different from the rate for age, sex, and race matched individuals from the general population. These data have not been published.[17]

Risk and Protective Factors

While there have been a number of studies to identify risk and protective factors for suicide in the general population, few studies have looked at factors specific to veterans. In the general population, suicide risk factors include male gender; older age; diminished psycho-social support (e.g., homelessness or unmarried status); availability and knowledge of firearms; and the co-existence of medical and psychiatric conditions. This profile describes a large portion of the veteran patient population, making suicide risk management particularly challenging in the VA health care system.[18] A study that screened 703 patients from a general medical outpatient clinic at a VA hospital found that 7.3% of the patients had suicidal ideation.[19] Younger and white patients were found to be at increased risk. The risk was higher in patients with self-described fair or poor mental health, a history of mental health treatment, and fair or poor perceived physical health. When major depression was controlled for, anxiety and substance abuse disorders continued to show an association with suicidal ideation.

CDC's NVDRS data identified the following associated circumstances among a group of 1,622 former or current military personnel who died by suicide in 2005:[20]

- Although almost half of them (47.2%) were depressed at the time of death, only about a fourth (26.7%) were receiving mental health treatment.
- 17.2% had an alcohol problem, and 7.7% had a problem with other substances.
- 24.5% had a problem with an intimate partner.
- 38.4% had a physical health problem.
- 28.0% had experienced an acute crisis during the prior two weeks.
- 33.9% had left a suicide note, 13.3% had made a previous suicide attempt, and 29.0% had disclosed their intent to commit suicide with enough time for someone to have intervened.

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[17] Testimony of Ira Katz, M.D., Ph.D., Deputy Chief Patient Care Services Officer, Office of Mental Health, Veterans Health Administration, Department of Veterans Affairs in U.S. Congress, House Committee on Veterans' Affairs, *Stopping Suicides: Mental Health Challenges Within the U.S. Department of Veterans Affairs,* hearings, 110th Cong., 1st sess., December 12, 2007.

[18] Lambert et al., "Suicide Risk Factors among Veterans: Risk Management in the Changing Culture of the Department of Veterans Affairs," *Journal of Mental Health Administration*, Vol. 24, No. 3, pp. 350-8, Summer 1997.

[19] Lish et al., "Suicide Screening in a Primary Care Setting at a Veterans Affairs Medical Center," *Psychosomatics*, Vol. 37, No. 5, pp. 413-24, 1996.

[20] NVDRS 2005 report. This group is a subset of the 1,821 former or current military personnel whose suicides were recorded in NVDRS in 2005, for whom these additional types of information were collected.

The VA/University of Michigan study of suicide among veterans with depression found that having a service-connected disability was associated with a lower risk of suicide in this group.[21] The authors suggest that greater access to VA health facilities and regular compensation payments may explain the protective effect.

The Effects of PTSD, TBI, and Depression on Suicide Risk

This section describes three suicide risk factors that are common among veterans: Post-traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and depression. PTSD and TBI are common consequences of war, with distinct symptoms, treatment modalities, and long-term effects. PTSD has been recognized in various forms throughout military history. It is an anxiety disorder, with symptoms of varying severity, that can occur following experiences, such as military combat, in which grave physical injury occurred or was threatened. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. TBI occurs when a sudden physical trauma causes damage to the brain. Improvised explosive devices (IEDs), which have been used extensively in the current conflict in Iraq, can cause TBI, sometimes in the absence of obvious external signs of injury. Symptoms of TBI can be mild, moderate, or severe, depending on the extent of the brain injury. When symptoms of TBI or PTSD are mild, they may go undiagnosed, or be confused with conditions with similar symptoms, such as other mental illnesses, including depression, or substance use disorders. Either PTSD or TBI may co-occur with depression or substance abuse. Finally, some veterans have both a TBI and PTSD.

In April 2008, the RAND Corporation published a study of mental health problems in servicemembers and veterans.[22] From their review of the literature, the authors found that in the general population, depression, PTSD, and TBI are each independent risk factors for suicide. More limited information from studies of servicemembers or veterans generally shows the same effect of these three risk factors in specific groups that were studied. This information also typically shows trends comparable to those in the general population with respect to other risk factors for suicide, though the demonstrated effects of interactions of these factors with depression, PTSD and TBI may differ. For example, studies have found that while males are at greater risk of death from suicide than are females, the effects that depression, PTSD and TBI have on increasing this risk is greater in females. Among the general population, substance abuse, prior nonfatal suicide attempts, severity of PTSD symptoms, and certain types of TBI are more predictive for suicide, and may signal areas of greater suicide risk among military and veterans populations as well. Researchers also found that combat exposure increases the risk of suicide, as well as the likelihood of PTSD, which itself also increases the risk of suicide.

The VA/University of Michigan study of suicide among veterans with depression found that PTSD was associated with a lower risk of suicide in this

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[21] Zivin et al., study of depression and suicide in veterans.

[22] Tanelian and Jaycox, "Invisible Wounds of War," RAND, 2008, at [http://rand.org/pubs/monographs/2008/RAND_MG720.1.pdf], visited April 28, 2008.

group.[23] The authors suggest that this unexpected finding may reflect the effect of treatment for PTSD, rather than a protective effect of PTSD itself.

Congressional Action

In the 109th Congress, two measures (H.R. 5771 and S. 3808) were introduced regarding the prevention of suicide among veterans. However, these bills did not see further legislative action.

In the 110th Congress, the Joshua Omvig Veterans Suicide Prevention Act (H.R. 327) was introduced in the House, and a companion version (S. 479) was introduced in the Senate.[24] The House passed H.R. 327 on March 21, 2007, and the Senate passed the House measure with an amendment on September 27. The bill was signed into law (P.L. 110-110) on November 5, 2007.[25] The act, among other things, requires the VA to establish a comprehensive program for suicide prevention among veterans. In carrying out this comprehensive program, the VA must designate a suicide prevention counselor at each VA medical facility. Each counselor is required to work with local emergency rooms, police departments, mental health organizations, and veterans service organizations to engage in outreach to veterans. The act also requires the VA to provide for research on best practices for suicide prevention among veterans, and requires the VA Secretary to provide for outreach and education for veterans and their families, with special emphasis on providing information to veterans of OIF and OEF. The act requires VA to provide for the availability of 24-hour mental health care for veterans and to establish a 24-hour hotline for veterans to call if needed.

Also in the 110th Congress, the National Defense Authorization Act for Fiscal Year 2008 (P.L. 110-181) requires the Secretaries of DOD and VA to develop a comprehensive care and transition policy for servicemembers who are recovering from serious injuries or illnesses related to their military service, and to specifically address the risk of suicide among these individuals in developing the required policy.[26]

More recently, the Veterans Suicide Study Act (S. 2899) was introduced. This measure would require the VA to study and report to Congress regarding suicides that have occurred among veterans since 1997. In carrying out this study, the VA Secretary would have to coordinate with the Secretary of Defense, Veterans Service Organizations, the CDC, and state public health offices and veterans agencies.

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[23] Zivin et al., study of depression and suicide in veterans.

[24] The Joshua Omvig Veterans Suicide Prevention Act is named for a veteran who completed suicide on December 22, 2005.

[25] Codified at 38 U.S.C.§ 1720F. For a detailed legislative history of P.L. 110-110, see H.Rept. 110-55 and S.Rept. 110-132.

[26] See CRS Report RL34371, *"Wounded Warrior" and Veterans Provisions in the FY2008 National Defense Authorization Act*, by Sarah A. Lister, Sidath Viranga Panangala, and Christine Scott.

VA's Suicide Prevention Efforts[27]

In response to legislation and congressional oversight, the VA has initiated several suicide prevention activities. Following is a summary of major activities.

Mental Health Strategic Plan

In 2004, the VA developed the Mental Health Strategic Plan (MHSP), which aimed to present a new approach to mental health care, to focus on recovery rather than pathology, and to integrate mental health care into overall health care for veteran patients. This five-year action plan, with more than 200 initiatives, includes timetables and responsible offices identified for each action item. A number of these action items are specifically aimed at the prevention of suicide. In 2006, following a request by the House Committee on Veterans Affairs, the VA's Inspector General (IG) undertook an assessment of VA's progress in implementing the MHSP initiatives for suicide prevention, and provided recommendations.[28] The IG's findings revealed that MHSP initiatives pertaining to 24-hour crisis availability, outreach, referral, and development of methods for tracking veterans at risk have been implemented in multiple facilities, but not yet systemwide. Initiatives focused on the development of methods for screening, assessment of veterans at risk, emerging best practice treatment interventions, education of VA health providers, and an electronic suicide prevention database have been piloted or are in the process of being piloted at selected facilities.

Mental Health Research

VA's Mental Illness Research, Education and Clinical Center (MIRECC) at Denver, Colorado, and the Center of Excellence in Mental Health and PTSD at Canandaigua, New York, have been specifically focusing on research related to suicide prevention. According to the VA, ongoing studies at these centers are studying suicide risk factors, validation of suicide ideation screening instruments, quality of mental health care and its relationship to suicide prevention, and risk factors for suicide as it relates to depression.

Suicide Awareness

In April 2007, VA held its first Suicide Prevention Awareness Day at all VA medical centers (VAMCs). The program included recognizing risk factors for suicide, and proper protocols for responding to crisis situations. VA held its second Suicide Prevention Awareness Day in September 2007. The program consisted of required training for all staff on general principles of suicide prevention, and the use of the national VA Suicide Prevention Hotline (see below).

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[27] Drawn from the Department of Veterans Affairs, Report to Congress, *P.L. 110-110, Comprehensive Program for Suicide Prevention Among Veterans*, February 2008.

[28] Department of Veterans Affairs, Office of Inspector General, "Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention," Report No. 06-03706-126, 2007.

VA has also appointed Suicide Prevention Coordinators who are located at each VA medical center. They were appointed in response to P.L. 110-110, which required VA to appoint suicide prevention counselors in each VA medical facility. The primary function of these coordinators is to support the identification of patients at high risk for suicide, and to ensure that their monitoring and care are intensified. Furthermore, they are involved in training and education, both within the VA and in the community. All the coordinators are licensed mental health professionals.

Screening

A screening program aims to identify individuals who have mental or emotional problems that increase their risk for suicide.[29] VA has implemented a policy to screen all OEF/OIF veterans for depression, PTSD, and alcohol abuse upon their initial visit to VA medical centers or clinics. Furthermore, screening for depression and alcohol abuse is required on an annual basis for all veterans, and screening for PTSD is required annually for the first five years after enrollment, and every five years thereafter. Veterans who screen positive for one of these conditions are required to receive a follow-up clinical evaluation that considers both the condition(s) related to the positive screen, and the risk of suicide. When this process confirms the presence of a mental disorder or suicide risk, veterans are offered mental health treatment. When there is a referral or request for mental health services, veterans must receive an initial evaluation within 24 hours. If this evaluation identifies an urgent need, treatment is to be provided immediately. Otherwise, veterans must receive a full diagnostic and treatment planning evaluation and the initiation of care within two weeks.

In addition, the DOD administers a post-deployment health reassessment (PDHRA) 90-180 days after a servicememember's return from deployment, to identify health concerns, with an emphasis placed on screening for mental health conditions that may have emerged since returning home. Information gathered during this assessment helps DOD identify servicemembers who require referrals for further evaluation.[30] The Government Accountability Office (GAO) has stated that DOD shares information gathered through the PDHRA with the VA. According to GAO, "VA officials obtain PDHRA information about servicemembers referred to VA and individual servicemembers' [PDHRA] when they access VA health care. Each month, VA receives a report that provides monthly and cumulative totals of servicemembers referred, including servicemembers referred to VA facilities."[31] However, it is unclear at this time if VA uses this information to specifically screen those who may be potentially at risk of suicide.

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[29] For more information on screening tools and their effectiveness, see CRS Report RS22647, *Screening for Youth Suicide Prevention*, by Ramya Sundararaman.

[30] The PDHRA (DD Form 2900) includes questions about feeling down, depressed, or hopeless, the occurrence of nightmares, relationship issues with family and friends, and increased alcohol use.

[31] U.S. Government Accountability Office (GAO), *DOD's Post-Deployment Health Reassessment,* GAO-08-181R, January 25, 2008, p.7.

Suicide Prevention Hotline

The VA has also partnered with the Lifeline Program, a grantee of the Substance Abuse and Mental Health Services Administration (SAMHSA), of the Department of Health and Human Services (HHS), to develop a VA suicide prevention hotline. Those who call 1-800-273-TALK are asked to press "1" if they are a veteran, or are calling about a veteran.[32] When they do so, they are connected directly to VA's hotline call center, where they speak to a VA mental health professional with real-time access to the veteran's medical records. The responders at the VA suicide prevention hotline have received American Association of Suicidology (AAS) credentialing and certification.

In emergencies, the hotline contacts local emergency resources such as police or ambulance services to ensure an immediate response. In other cases, after providing support and counseling, the hotline transfers care to the suicide prevention coordinator at the nearest VAMC for follow-up care.

From October 7 to November 10, 2007, 1,636 veterans and 311 family members or friends called the VA suicide prevention hotline. These calls led to 363 referrals to suicide prevention coordinators and 93 rescues involving emergency services.[33]

Funding for Suicide Prevention

According to VA estimates, in FY2008, spending for the suicide prevention program will include $970,000 to establish the suicide prevention hotline; $1.97 million for the Center of Excellence in Canandaigua, New York; $2.20 million for the Mental Illness Research, Education and Clinical Center in Denver, Colorado; $90,000 for the Serious Mental Illness Research, Education and Clinical Center for monitoring of suicide rates and risk factors; and $14.32 million for Suicide Prevention Coordinators.[34]

Conclusion

There has been considerable recent interest in the burden of suicide among veterans, in particular those who have recently returned from military service in Operation Iraqi Freedom and Operation Enduring Freedom. This interest has thrown a spotlight on the fact that there is not, at this time, a system of surveillance for suicide among veterans.

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[32] VA is using the national suicide prevention hotline to provide this service to veterans.

[33] Testimony of Ira Katz, M.D., Ph.D., Deputy Chief Patient Care Services Officer, Office of Mental Health, Veterans Health Administration, Department of Veterans Affairs in U.S. Congress, House Committee on Veterans' Affairs, *Stopping Suicides: Mental Health Challenges Within the U.S. Department of Veterans Affairs,* hearings, 110th Cong., 1st sess., December 12, 2007.

[34] Department of Veterans Affairs, Report to Congress, *P.L. 110-110, Comprehensive Program for Suicide Prevention Among Veterans*, p. 7, February 2008.

Despite recent interest in comparing suicide rates between veterans and the general population, this may not be the most useful comparison. In numerous ways that affect their suicide risk, veterans are not like the general population. Also, the VA has an interest in decreasing the burden of suicide among veterans, whether this burden exceeds that of the general population or not. What may be more meaningful, and more important to achieve, is the establishment of data systems that support a more robust and reliable understanding of suicide among veterans. The ideal systems would describe a clear baseline, and provide a means to track changes going forward — with respect to such things as risk and protective factors, and the effects of treatment — in order to know which interventions work, and where to target them.

Order Code RL33110

CRS Report for Congress

The Cost of Iraq, Afghanistan, and Other Global War on Terror Operations Since 9/11

Updated October 15, 2008

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Prepared for Members and Committees of Congress

The Cost of Iraq, Afghanistan, and Other Global War on Terror Operations Since 9/11

Summary

With enactment of the FY2008 Supplemental and FY2009 Bridge Fund(H.R. 2642/P.L. 110-252) on June 30, 2008, Congress has approved a total of about $864 billion for military operations, base security, reconstruction, foreign aid, embassy costs, and veterans' health care for the three operations initiated since the 9/11 attacks: Operation Enduring Freedom (OEF) Afghanistan and other counter terror operations; Operation Noble Eagle (ONE), providing enhanced security at military bases; and Operation Iraqi Freedom (OIF).

This $864 billion total covers all war-related appropriations from FY2001 through part of FY2009 in supplementals, regular appropriations, and continuing resolutions. Of that total, CRS estimates that Iraq will receive about $657 billion (76%), OEF about $173 billion (20%), and enhanced base security about $28 billion (3%), with about $5 billion that CRS cannot allocate (1%). About 94% of the funds are for DOD, 6% for foreign aid programs and embassy operations, and less than 1% for medical care for veterans. As of July 2008, DOD's monthly obligations for contracts and pay averaged about $12.3 billion, including $9.9 billion for Iraq, and $2.4 billion for Afghanistan.

The recently enacted FY2008 Supplemental (H.R. 2642/P.L. 110-252) includes a total of about $160 billion for war costs for the Department of Defense (DOD) for the rest of FY2008 and part of FY2009. Funds are expected to last until June or July 2009 well into a new Administration. The Administration did not submit a request to cover all of FY2009.

While Congress provided a total of $188 billion for war costs in FY2008 — $17 billion more than the prior year — this total was a cut of about $14 billion to the Administration's request, including both reductions in DOD's investment accounts and substitutions of almost $6 billion in non-war funding. CRS figures exclude non-war funding.

Congress also cut funding for foreign aid and diplomatic operations for Iraq and Afghanistan by $1.4 billion, providing a total of $4.5 billion. For FY2009, Congress provided $67 billion, close to the request. Earlier, to tide DOD over until passage of the supplemental, the House and Senate appropriations committees approved part of a DOD request to transfer funds from its regular accounts.

In an August 2008 update, the Congressional Budget Office projected that additional war costs for the next ten years from FY2009 through FY2018 could range from $440 billion, if troop levels fell to 30,000 by 2010 to $865 billion, if troop levels fell to 75,000 by about 2013. Under these CBO projections, funding for Iraq, Afghanistan and the GWOT could total about $1.3 trillion or about $1.7 trillion for FY2001-FY2018. This report will be updated as warranted.

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The Cost of Iraq, Afghanistan, and Other Global War on Terror Operations Since 9/11

Introduction

Since the terrorist attacks of September 11, 2001, the United States has initiated three military operations:

- Operation Enduring Freedom (OEF) covering Afghanistan and other Global War on Terror (GWOT) operations ranging from the Philippines to Djibouti that began immediately after the 9/11 attacks and continues;
- Operation Noble Eagle (ONE) providing enhanced security for U.S. military bases and other homeland security that was launched in response to the attacks and continues at a modest level; and
- Operation Iraqi Freedom (OIF) that began in the fall of 2002 with the buildup of troops for the March 2003 invasion of Iraq and continues with counter-insurgency and stability operations.

In the seventh year of operations since the 9/11 attacks, the cost of war is a major concern including the total amount appropriated, the amount for each operation, average monthly spending rates, and the scope and duration of future costs. Information on costs is useful to Congress to assess Department of Defense (DOD) war costs in FY2008, conduct oversight of past war costs, and consider future alternatives for Iraq ranging from maintaining pre-surge levels after July 2008 to future withdrawal options. This report analyzes war funding for the Defense Department and tracks funding for USAID and VA Medical funding.

For congressional action on the FY2008 Supplemental, see CRS Report RL34451, *Second FY2008 Supplemental Appropriations for Military Operations, International Affairs, and Other Purposes* by Stephen Daggett, Susan B. Epstein, Curt Tarnoff, Pat To*well, Catherine Dale and Shannon S. Loane*.

Total War Funding As of the FY2009 Bridge Fund

In the FY2008 Supplemental (H.R. 2642/P.L.110-252), Congress funded DOD's war costs not only for the rest of FY2008 but also for the first part of FY2009 in order to give a new Administration breathing room to set its war policies. As of enactment of H.R. 2642, the FY2008 Supplemental, the cumulative total for funds appropriated since the 9/11 attacks to DOD, State/USAID and VA for medical costs for the wars in Iraq, Afghanistan and enhanced security total $864 billion. This total includes:

- $657 billion for Iraq;
- $173 billion for Afghanistan;
- $28 billion for enhanced security; and
- $5 billion unallocated (see **Tables 2, 3, and 4**).

Of this total, 76% if for Iraq, 20% for Afghanistan, 3% for enhanced security and 1% unallocated. Almost all of the funding for Operation Enduring Freedom (OEF) is for Afghanistan.

Some 94% of this funding goes to the Department of Defense to cover *incremental* war-related costs, that is, costs that are in addition to normal peacetime activities. These costs include funds to deploy troops and their equipment to Iraq and Afghanistan, to conduct military operations, to provide in-country support at bases, to provide special pay for deployed personnel, and to repair, replace, and upgrade war-worn equipment. DOD's baseline or regular budget covers the costs of normal pay for all military personnel, training activities, running and building facilities on U.S. installations, buying new military equipment, and conducting research to enhance future military capabilities.

FY2009 Bridge Fund Finances War Costs Through June 2009

When the Administration submitted its original request in January 2008, the Defense Department stated that its intent was for the bridge fund to last until after a new Administration was in-place.[1] With the $66 billion provided for FY2009 in the bridge fund included with the latest supplemental, Congress ensured that war funding would last through June or July 2009 (check) or until after a new Administration was in place.[2]

Based on FY2008 spending rates for Army operations, the service with the largest war funding demands, and by temporarily tapping both the FY2009 bridge and tapping baseline funds, the Army could finance war costs until July 2009 assuming that troop levels remain at the post-surge level of 15 brigade combat teams in Iraq. This is a conservative estimate since troop levels in FY2009 could be lower than in FY2008 when 20 brigades were in place for the first part of the year for the "surge" and were then gradually withdrawn in the latter part of the fiscal year.[3]

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[1] DOD, "New Briefing with Press Secretary Morrell from the Pentagon," January 29, 2008, p. 5.

[2] CRS estimate based on funding in P.L.110-252, and average Army obligations in FY2008 (check).

[3] DOD's request includes $31.2 billion for baseline OMA and $35.6 billion for funds for war or a total of $66.8 billion. Assuming monthly obligations of $6.9 billion, those funds would last almost ten months.

War Cost Issues in the 110th Congress

This report is designed to answer frequently asked questions as well as to address some of the major war cost issues that arose in the 110th Congress and are likely to confront the next Congress as well.

Some of the most commonly asked questions center on total war-related costs.

- How much has Congress appropriated in total and for each of the three missions since the 9/11 attacks — Operation Iraqi Freedom (Iraq), Operation Enduring Freedom (Afghanistan and other Global War on Terror operations), and Operation Noble Eagle (enhanced security for defense bases) for defense, foreign operations, and related VA medical care?

- How and why have average monthly DOD obligations changed over time for each mission?

- How long the Army can last with currently available funding?

- How could war cost requests be made more transparent and what are the problems with current war cost reporting.

Current war cost issues that have been addressed in the past and are likely to confront the new Congress include the following.

- What are the bounds of future war costs under various scenarios assuming more or less gradual draw downs in the number of troops over the next several years?

- How large and how urgent are reconstitution and reset costs for repair and replacement of war-worn equipment and what is appropriately considered to be emergency war-related procurement as opposed to DOD's ongoing modernization efforts;

- How to judge and respond to readiness problems that stem from war operations;

- What are the pros and cons of continued reliance on emergency supplementals to fund DOD war costs?

- What mechanisms can Congress use to increase Iraqi burden-sharing of war-related costs to rebuild their security forces?

- What types of congressional funding restrictions are available to affect policy options for Iraq.

This report begins by providing CRS estimates of the amount appropriated for each of the three missions to date, average obligations per month, and other measures of

costs. It's followed by a discussion of some of the major budgetary war issues facing the Defense Department.

For information about State Department and USAID programs, see CRS Report RL34023, *State, Foreign Operations, and Related Programs: FY2008 Appropriations*, by Connie Veillette and Susan Epstein; CRS Report RL31833, *Iraq: Reconstruction Assistance*, by Curt Tarnoff; and CRS Report RL30588, *Afghanistan: Post War Governance and U.S. Policy*, by Kenneth Katzman; CRS Report RL34276, *FY2008 Emergency Supplemental Appropriations for International Affairs*, by Connie Veillette, Susan Epstein, Rhoda Margesson, and Curt Tarnoff.

War Cost Estimates Through Enactment of the FY2008/FY2009 Bridge

CRS has estimated the allocation of all DOD budget authority (BA) by the three operations — Iraq, Afghanistan, and enhanced security — because DOD has not done so. Although DOD has reported the total amount appropriated for the Global War on Terror (GWOT), DOD does not allocate all of these funds.

Although CRS and CBO estimates of total war funding to date are close, there continue to discrepancies with DOD, which appear to reflect different interpretations of which funding is war-related. As of passage of the FY2008 Supplemental (including partial FY2009 funding), CRS and CBO estimates of total funding appropriated to date for DOD, State/USAID and VA Medical are similar — $864 billion for CRS and $858 billion for CBO. The CBO total of $809 billion and the CRS total of $815 billion for DOD are higher than DOD's total of $802 billion.[4] CBO and CRS totals may be larger because they include funds transferred from DOD baseline appropriations and some funds that DOD does not count as GWOT-related.[5]

For consistency, CRS also excludes certain funds that do not appear to be war-related (e.g. funds to cover higher fuel costs in DOD's regular programs), includes

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[4] See Box 1-1, CBO, *The Budget and Economic Outlook: An Update*, September 2008, p. 13. For DOD, see Office of the Secretary of Defense, Comptroller, "Cost of War Update as of July 31, 2008," p. 6; to compare the estimates, CRS added $66 billion for the FY2009 bridge, which DOD does not include.

[5] For DOD total, see DOD, *FY2008 Global War on Terror Amendment*, October 2007, Figure 1, p.1, October 2007; for CBO total, see CBO, *The Budget and Economic Outlook: An Update,*Box 1-1, p. 13, September 2008; for CRS total, see Table A-1 in this report. DOD justification material for its FY2007 and FY2008 war requests shows that budget authority for war fell $2 billion short in FY2001 and $4 billion short in FY2004 — a gap presumably met by transferring funds from its regular appropriations. CRS added $2 billion to its estimates to reflect these funds. Specifically, CRS calculations of DOD funding include some $5 billion appropriated for GWOT in FY2003 in P.L. 107-48, about $10 billion in transfers from DOD's baseline appropriations that were transferred to meet war needs, as well as intelligence and other funding not tracked by DOD (see **Table B1** and section, "Problems in War Cost Estimates and Reporting").

funds transferred from regular accounts to meet war needs, and includes funds previously considered war related but no longer requested in supplementals (enhanced security). DOD also considers some congressional additions, such as C-17 transport aircraft, as not-war related.[6] CRS war cost estimates also exclude funding in supplementals for other emergency programs such as additional food aid, military and economic assistance to Pakistan and foreign assistance activities in several African countries.

In its FY2007 and FY2008 requests, DOD allocated enacted and requested budget authority (BA) between Iraq, Afghanistan and enhanced security, but failed to do so in its FY2008 and FY2009 bridge requests.[7] In a monthly report, DOD also reports annual and cumulative obligations incurred for each operation, which reflects when personnel are paid, contracts are signed, or orders placed.[8] This reporting system, however, exclude some $56 billion of DOD funding for programs and activities that DOD does not track.[9] Obligations also do not include funds that have been requested or appropriated but have not yet been obligated.

As of July 31, 2008, DOD reported that $608.5 billion has been obligated for the Global War on Terror (GWOT) including

- $473.7 billion for Iraq,

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[6] For example, CRS estimates DOD's FY2008 request as $101.3 billion rather than $102.5 billion because CRS excludes as non-war costs funds for baseline fuel and repairs of Walter Reed. DOD's total FY2008 request is $189.3 billion; CRS excludes from DOD's request for $742 million for higher fuel prices in its baseline program and $416million to accelerate the closure of Walter Reed and replacement by new hospital facilities; see DOD, *FY2008 Global War on Terror Amendment*, February 2007, p. 53. For example, DOD excludes Congressional adds for C-17 aircraft in FY2007 as non-war related.

[7] In its FY2007 and FY2008 war requests, DOD does not allocate $6 billion to $9 billion for intelligence, fuel for its baseline program, and other programs to either OIF or OEF; CRS allocates most of these amounts since they are requested as war funds; see Table 1a. in DOD, *FY2007 Emergency Supplemental Request for the Global war on Terror*, February 2007; [http://www.dod.mil/comptroller/defbudget/fy2008/fy2007_supplemental/FY2007_Emergency_Supplemental_Request_for_the_GWOT.pdf]; hereinafter, *FY2007 Supplemental*, and in DOD, *FY2008 Global War on Terror Request*, February 2007, p. 74; [http://www.dod.mil/comptroller/defbudget/fy2008/fy2007_supplemental/FY2008_Global_War_On_Terror_Request.pdf] hereinafter, DOD, *FY2008 GWOT Request;* DOD, MRAP amendment, July 31, 2007; [http://www.defenselink.mil/comptroller/defbudget/fy2008/fy2007_amendment/FY2008_Global_War_On_Terror_Request/FY_2007_MRAP_Budget_Amendment-_DoD_portion.pdf]; hereinafter, DOD, *MRAP Amendment*; and DOD, *FY2008 Global War on Terror Amendment*, October 2007; hereinafter, DOD, *October Amendment;* [http://www.defenselink.mil/comptroller/defbudget/fy2008/Supplemental/FY2008_October_Global_War_On_Terror_Amendment.pdf].

[8] Compiled by the Defense Finance Accounting Service (DFAS) each month, these reports are entitled "Supplemental and Cost of War Execution Reports," and show different types of costs as well as totals by Operation Enduring Freedom (Afghanistan), Operation Iraqi Freedom, and Operation Noble Eagle (enhanced security).

[9] DOD, "Global War on terror: Appropriated vs. Obligated Funds, FY 2001 - FY2008," October 2008.

- $106.9 billion for Operation Enduring Freedom, and
- $27.9 billion for Operation Noble Eagle (enhanced security).[10]

In this report, CRS estimates the allocation of all funds appropriated to DOD for war costs (excluding non-war items in supplementals) rather than only those obligated thus far, relying primarily on DOD's reporting of obligations. Such estimates give Congress a better sense of the current status of funding available for each operation, and allow comparisons between fiscal years. CRS uses previous spending trends as a guide to estimate the allocation of funds still to be spent or unreported. CRS has also compiled the funds allocated to Iraq and Afghanistan for foreign and diplomatic operations and for VA medical costs for OIF/OEF veterans (see **Tables 1**, **2**, and **3**).

Table 1. Estimated War Funding by Operation: FY2001-FY2009 Bridge

(CRS estimates in billions of dollars of budget authority)

Operation	FY01 and FY02	FY03[a]	FY04[b]	FY05[b]	FY06	FY07	FY08[c]	FY09 Bridge[d]	Enacted Cum.: FY01- FY09 Brdge as of H.R. 2642, P.L.110-252, 6-30-08[cd]
Iraq	0.0	53.0	75.9	85.5	101.7	133.6	153.5	54.1	**657.3**
OEF	20.8	14.7	14.5	20.0	19.0	36.9	34.0	13.1	**172.9**
Enhanced Security	13.0	8.0	3.7	2.1	0.8	.5	.2	0	**28.3**
Unallocated	0.0	5.5	0.0	0.0	0.0	0	0	0	**5.5**
Total	**33.8**	**81.1**	**94.1**	**107.6**	**121.5**	**171.0**	**187.7**	**67.2**	**864.0**
Annual Change	NA	140%	16%	14%	14%	41%	10%	NA	NA
Change Since FY03	**NA**	**NA**	**16%**	**33%**	**50%**	**111%**	**131%**	**NA**	**NA**

Sources and Notes: NA = not applicable. Totals may not add due to rounding. For a further breakdown of agency spending by operation, see **Table 3.** Revised CRS estimates reflect Defense Finance Accounting Service, *Cost of War Execution Reports* through September 2007 by operation in DOD, *FY2007 Emergency Supplemental Request for the Global War on Terror*, February 2007, p. 93 and other data; [http://www.dod.mil/comptroller/defbudget/fy2008/fy2007_supplemental/FY2007_Emergency_Supplemental_Request] for theGWOT.pdf]; and DOD, *FY2008 Global War on Terror Request*, February 2007; [http://www.dod.mil/comptroller/defbudget/fy2008/fy2007_supplemental/FY2008_Global_War_On_Terror_Request.pdf]; DOD, *FY2008 Global War on Terror Amendment,* October 2007; [http://www.defenselink.mil/comptroller/defbudget/fy2008/Supplemental/FY2008_October_Global_War_On_Terror_Amendment.pdf]; appropriations reports, public laws and DOD transfers.

a. Includes $5.5 billion of $7.1 billion appropriated in DOD's FY2003 Appropriations Act (P.L. 107-48) for the global war on terror that CRS cannot allocate and DOD cannot track.

b. Of the $25 billion provided in Title IX of the FY2005 DOD appropriations bill, CRS included $2 billion in FY2004 when it was obligated and the remaining $23 billion in FY2005. Because Congress made the funds available in FY2004, CBO and OMB score all $25 billion in FY2004.

c. Includes $16.8 billion appropriated for Mine Resistant Ambush Protected (MRAP) vehicles requested by DOD for war needs in FY2008 provided in the first FY2008 Continuing Resolution (H.J.Res 52/P.L. 110-92) and the FY2008 DOD Appropriations (H.R. 3222/P.L. 110-116), $70 billion in Division L, FY2008 Consolidated Appropriations Act (P.L. 110-161), and $92.2 billion in FY2008 Supp (H.R. 2642/P.L. 110-252). In FY2008, CRS includes funds for enhanced security in DOD's regular budget, and excludes as non-war related funds to cover higher fuel prices in DOD's regular program, base closure funding, and childcare centers, hospitals, medical

[10] DOD, "Cost of War Car Card Through July 31, 2008," September 2008.

facility and Army barracks renovation funds for facilities in the United States for a more consistent definition of war costs. VA Medical estimates reflect VA FY2008 budget materials, and CRS estimate that based on OIF/OEF share of total VA patients, the Congressional add of $3.6 billion for VA Medical Services in Division I, FY2008 Consolidated Appropriations Act includes 4.5% for war-related needs. Amounts for foreign and diplomatic operations reflect State Department reported figures through FY2007 and estimate for FY2008 based on Joint Explanatory Statement for Division J, FY2008 Consolidated Appropriations Act in Congressional Record, Dec. 18, 2007 and appropriations committee tables; figures may be adjusted later by the State Department; excludes VA Medical funding for OIF and OEF in FY2009 baseline request; State/USAID funds may change with new agency allocations.

d. In the enacted FY2008 Supplemental, CRS excludes DOD's request to cover higher fuel prices in its regular programs, and a request to accelerate the replacement of Walter Reed; CRS also includes an estimate for enhanced security ($530 million) based on FY2007 and funded in DOD's baseline in FY2007 in order for totals to be consistent with previous years. CRS also excludes FY2008 baseline requests that were not enacted in the FY2008 Consolidated Appropriations (P.L. 110-161).

Funding for Each Operation. According to CRS estimates, Congress has appropriated about $864 billion in budget authority (BA) from FY2001 through the recently passed FY2008 Supplemental for DOD, the State Department and for medical costs paid by the Department of Veterans' Affairs (P.L. 110-252). CRS estimates that this total includes about

- $657 billion for Iraq (76%),
- $173 billion almost all for Afghanistan with a small amount for other counter terrorism operations (20%),
- $28 billion for enhanced security (4%), and
- $5 billion that CRS cannot allocate (see **Table 1**).

Funding for Each Agency. Of the $859 billion enacted thus far, about $809 billion, the lion's share or over 90% goes to the Department of Defense. DOD regulations require that the services request *incremental* war costs, in other words, costs that are in addition to regular military salaries, training and support activities, and weapons procurement, RDT&E or military construction (see **Table 3**).

Table 2. Estimated War Funding by Agency: FY2001- FY2009 Bridge

(CRS estimates in billions of dollars of budget authority)

Agency	FY01 & FY02	FY03	FY04	FY05	FY06	FY07	FY08[ab]	FY2009 Bridge[c]	Cum.: FY01-FY09 Bridge Enacted as of H.R. 1642/P.L.110-252, 6-30-08[b]
DOD	33.0	77.4	72.4	102.6	116.8	165.0	181.2	65.9	**814.5**
State/USAID	0.8	3.7	21.7	4.8	4.3	5.0	5.1	1.2	**46.6**
VA Medical	0.0	0.0	0.0	0.2	0.4	1.0	1.3	0	**2.9**
Total	**33.8**	**81.1**	**94.1**	**107.6**	**121.5**	**171.0**	**187.7**	**67.2**	**864.0**

Sources: Public laws, congressional appropriations reports, and CRS estimates; see **Table 3**.

a. For FY2008, includes $16.8 billion for MRAP vehicles appropriated in first FY2008 Continuing Resolution (H.J.Res. 52/P.L. 110-92) and the FY2008 DOD Appropriations Act (H.R. 3222/P.L. 110-116), $70 billion in Division L of the FY2008 Consolidated Appropriations Act (H.R. 2764/P.L. 110-161), and $92.2 billion in FY2008 Supplemental (H.R. 2642/P.L. 110-252).

b. Includes funds appropriated for FY2008 in the First Continuing Resolution (P.L. 110-5), the FY2008 DOD Appropriations Act (P.L. 110-92), the FY2008 Consolidated Appropriations (P.L. 110-61), and the FY2008 Supplemental (P.L. 110-252); excludes funds for FY2009 in P.L. 110-252 and $2.9 billion in FY2009 baseline funding, funds for enhanced security in DOD's regular budget; Excludes as non-war related $5.7 billion in DOD funds to cover higher fuel prices for its regular program, base closure funding, renovations to DOD health care facilities, childcare centers and Army barracks renovations in the United States.

c. Includes funds appropriated for FY2009 in H.R. 2642/P.L. 110-252.

For military personnel, incremental costs cover hostile fire or other combat-related special pays and the cost of activating reservists and paying them on a full-time basis. For operations and maintenance, war costs cover the cost of transporting troops and equipment to the war zone, conducting war operations, and supporting deployed troops, as well as repairing and replacing equipment worn out by war operations.

As of the FY2008 Supplemental (P.L. 110-252), which includes some but not all of the funding for FY2009 war costs, State and USAID have together received about $46.8 billion for reconstruction, embassy operations and construction, and various foreign aid programs for Iraq and Afghanistan. The full amount for FY2009 has not been requested. The Veterans Administration has received about $2.9 billion

for medical care for veterans of these operations including funds above their request.[11]

Trends in War Funding

The total cost for all three operations — Iraq, Afghanistan, and other GWOT and enhanced security — has risen steeply since the 9/11 attacks primarily because of higher DOD spending in Iraq. Annual war appropriations more than doubled from about $34 billion in FY2001/FY2002 to about $80 billion for the preparation and invasion of Iraq in FY2003 (see **Table 3**).

By FY2007, annual appropriations for both wars doubled again to $171 billion. With enactment of the full year's war funding in the FY2008 Supplemental (H.R. 2642/O.L.110-252), annual war funding for both operations totaled $188 billion. This FY2008 level is double the funding in FY2004, which could be considered the first year of stability operations.

Table 3 provides a breakdown of war-related funds for each operation and each agency by fiscal year. DOD's funding covers not only operational costs but also replacing and upgrading military equipment, converting units to new modular configuration, training Afghan and Iraqi security forces, providing support to allies and enhanced security at DOD bases. Such investment funding has grown steeply in recent years (see **Table 4**). Foreign and diplomatic operations cover the cost of reconstruction, building and operating embassies in Iraq and Afghanistan and various foreign aid programs.

Over 90% of DOD's funds were provided as emergency funds in supplemental or additional appropriations; the remainder were provided in regular defense bills or in transfers from regular appropriations. Emergency funding is exempt from ceilings applying to discretionary spending in Congress's annual budget resolutions. Some Members have argued that continuing to fund ongoing operations in supplementals reduces congressional oversight. Generally, much of foreign and diplomatic funding has been funded in regular rather than emergency appropriations.

[11] Foreign operations activities are managed by both the State Department and USAID, which handles most U.S. development assistance programs.

Table 3. Budget Authority for Iraq, Afghanistan, and Other Global War on Terror (GWOT) Operations: FY2001-FY2009 Bridge

(CRS estimates in billions of budget authority)

By Operation and Funding Source	FY01 & FY02[a]	FY03	FY04	FY05	FY06	FY07	FY08[b]	FY09 Bridge[c]	Enacted Cum: FY01-FY09 Bridge as of H.R. 2642/P.L. 110-252, 6-30-08[c]
OPERATION IRAQI FREEDOM (OIF)[d]									
Department of Defense	0	50.0	56.4	83.4	98.1	129.6	149.7	53.4	**620.6**
Foreign Aid and Diplomatic Ops[e]	0	3.0	19.5	2.0	3.2	3.2	2.8	0.6	**34.2**
VA medical[f]	0	0	0	0.2	0.4	0.9	1.0	0.0	**2.5**
Total: Iraq	**0.0**	**53.0**	**75.9**	**85.5**	**101.7**	**133.6**	**153.5**	**54.1**	**657.3**
OPERATION ENDURING FREEDOM (OEF)/Afghanistan and GWOT									
Department of Defense	20.0	14.0	12.4	17.2	17.9	34.9	31.4	12.5	**160.1**
Foreign Aid and Diplomatic Ops[e]	0.8	0.7	2.2	2.8	1.1	1.9	2.4	0.6	**12.4**
VA Medical[f]	0	0	0	0	0.0	0.1	0.3	0.0	**0.4**
Total: OEF	**20.8**	**14.7**	**14.5**	**20.0**	**19.0**	**36.9**	**32.8**	**13.1**	**172.9**
ENHANCED SECURITY (Operation Noble Eagle)									
Department of Defense	13.0	8.0	3.7	2.1	0.8	0.5	0.2	0.0	28.3
Total: Enhanced Security[g]	**13.0**	**8.0**	**3.7**	**2.1**	**0.8**	**0.5**	0.2	0.0	**28.3**
DOD Unallocated	**0.0**	**5.5**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**5.5**
ALL MISSIONS									
Department of Defense	33.0	77.4	72.4	102.6	116.8	165.0	**181.2**	**65.9**	**814.5**
Foreign Aid and Diplomatic Operations[e]	0.8	3.7	21.7	4.8	4.3	5.0	**5.1**	**1.4**	**46.6**
VA Medical[f]	0	0	0	0.2	0.4	1.0	**1.3**	**0.0**	**2.9**
Total: All Missions	**33.8**	**81.1**	**94.1**	**107.6**	**121.5**	**171.0**	**187.7**	**67.2**	**864.0**

Sources and Notes: Because DOD has not provided a breakdown by operation for all appropriations received, CRS estimates unobligated budget authority using past trends as shown in DOD's Defense Finance Accounting Service (DFAS) reports, *Supplemental & Cost of War Execution Reports* and other budget justification materials including DOD, *FY2007 Supp*, February 2007, Table 1a.; [http://www.dod.mil/comptroller/defbudget/fy2008/fy2007_supplemental/FY2007_Emergency_Supplemental_Request_for_the_GWOT.pdf]; DOD, FY2008 Supplemental Requests, February, July, and October 2007. CRS budget authority (BA) totals are higher than DOD figures because CRS includes all funding provided in supplementals, bridge funds or baseline appropriations

for Iraq and the Global war on Terror as well as transfers from DOD's baseline funds for GWOT requirements, and enhanced security. CRS also splits the $25 billion provided in the FY2005 Title IX bridge between the $1.8 billion obligated in FY2004 and the remainder available for FY2005; all those funds are scored as FY2004 because they were available upon enactment in August 2005. Figures include funds provided in P.L. 107-38, the first emergency supplemental after 9/11, and funds allocated in P.L. 107-117. Numbers may not add due to rounding.

a. CRS combined funds for FY2001 and FY2002 because most were obligated in FY2002 after the 9/11 attacks at the end of FY2001. In FY2008, CRS includes funds for enhanced security in DOD's regular budget, and excludes as non-war related DOD request for funds to cover higher fuel prices for its regular program and accelerate the replacement of Walter Reed for a more consistent definition of war costs.
b. Includes funds provided in the First Continuing Resolution (H.J.Res 52/P.L. 110-92), FY2008 DOD Appropriations Act (H.R. 3222/P.L. 110-116), the FY2008 Consolidated Appropriations Act (H.R. 2764/P.L. 110-161), and the FY2008 Supplemental (H.R. 2642/P.L. 110-252).
c. Reflects H.R. 2642 as enacted on June 30, 2008 excluding funding not related to Iraq and Afghanistan; excludes $1.4 billion in the regular FY2009 State/USAID request for Iraq and Afghanistan.
d. DOD's new estimate in FY2007 for Iraq shows BA from FY2003 as $48 billion, $2 billion higher than reported by DFAS without identifying a source for these funds.
e. Foreign operations figures include monies for reconstruction, development and humanitarian aid, embassy operations, counter narcotics, initial training of the Afghan and Iraqi army, foreign military sales credits, and Economic Support Funds. For FY2007, figures reflect State Department figures; for FY2008, figures reflect Joint Explanatory Statement for Division J, FY2008 Consolidated Appropriations Act (P.L. 110-161) in December 17, 2007 Congressional Record; FY2008 Supplemental funding may be revised by State Department at a later date.
f. Medical estimates reflect figures in VA's FY2008 budget justifications, and CRS estimate of OIF/OEF shares of $3.6 billion added by Congress to VA Medical in FY2008 Consolidated Appropriations Act (P.L. 110-161).
g. Known as Operation Noble Eagle, these funds provide higher security at DOD bases, support combat air patrol, and rebuilt the Pentagon.

Estimates for Iraq and Afghanistan and Other Operations

How much has Congress provided for each of the three operations launched since the 9/11 attacks — Iraq, Afghanistan and other GWOT, and enhanced security? Relying primarily on DOD data, congressional reports and other methods, CRS estimated the distribution of war-related funds appropriated for defense, foreign operations, and VA medical costs from the 9/11 attacks through the FY2008 supplemental request (see **Table 3**). With enactment of the FY2008 Supplemental Appropriations Act on June 30, 3008 (H.R.2642/P.L. 110-252), CRS estimates that war-related appropriations enacted to date total about $859 billion allocated as follows

- $657billion for Iraq (or 76%);
- $173billion for Afghanistan (or 20%);
- $28 billion for enhanced security (4%); and
- $5 billion unallocated (1%) (see **Table 3**).

For FY2008, this includes $16.8 billion for MRAP vehicles provided to DOD in four acts — the FY2008 Continuing Resolution (H.J.Res.2/P.L. 110-92), the FY2008 DOD Appropriations bill (H.R. 3222/P.L. 110-116), Division L of the FY2008 Consolidated Appropriations Act (H.R. 2764/P.L. 110-61), and funds in the recently enacted FY2008 Supplemental (H.R. 2642/P.L. 110-252). (For additional information about congressional action in FY2008, see **Appendix A**.)

Since the FY2003 invasion, DOD's war costs have been dominated by Iraq. Costs for OEF have risen dramatically since FY2006 as troop levels and the intensity of conflict have grown. The cost of enhanced security in the United States has fallen off from the earlier years which included initial responses to the 9/11 attacks. Foreign and diplomatic operations costs peaked in FY2004 with the $20 billion appropriated for Iraq and Afghan reconstruction and since then run about $4 billion to $5 billion a year.

Although some of the factors behind the rapid increase in DOD funding are known — the growing intensity of operations, additional force protection gear and equipment, substantial upgrades of equipment, converting units to modular configurations, and new funding to train and equip Iraqi security forces — these elements do not appear to be enough to explain the size of and continuation of increases. Although DOD included more extensive justification of its FY2007 and FY2008 supplemental requests, it still provides little explanation of how changes in force levels affect funding levels.

The FY2007 DOD Emergency Request and the FY2008 Global War on Terror (GWOT) request provide more justification material than previously. The FY2009 budget initially included a $70 billion placeholder figure for war costs that was superceded by an amendment in the spring of 2009 and more detailed justification though much of it was posted after congressional consideration was largely complete. This justification material did not estimate how long the funds requested would last or allocate funds between Iraq and Afghanistan.[12] The Administration includes no war funding beyond FY2009 in its budget.

CBO Projections of Future Costs. Based on two illustrative scenarios assuming a more and a less gradual drawdown in deployed troop levels, CBO updated its projections for the cost of all three operations for the next ten years from 2009 - 2018 in September 2008. CBO projects that over the next ten years war costs for DOD, State, and VA could total

- $440 billion if troop levels fell to 30,000 by 2010; or
- $865 billion if troop levels fell to 75,000 by 2013.[13]

This CBO estimate does not split funding for Iraq and Afghanistan. If these CBO projections are added to funding already appropriated, the cost of Iraq, Afghanistan, and enhanced security could reach from $1.3 trillion to $1.7 trillion by 2018 if troops fell to 30,000 or 75,000 respectively.

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[12] Department of Defense, *Fiscal Year 2009 Global War on Terror Bridge Request*, May 2008 (posted on defenselink in late summer); [http://www.defenselink.mil/comptroller/defbudget/fy2009/Supplemental/FY2009_Global_War_On_Terror_Bridge_Request.pdf]; U.S. Department of Defense, *Fiscal Year 2009 Global War on Terror Bridge Request,* May 2008; [http://www.defenselink.mil/comptroller/defbudget/fy2009/Supplemental/FY2009_Global_War_On_Terror_Bridge_Request.pdf] [http://www.defenselink.mil/comptroller/defbudget/fy2009/supplemental/FY2009_Global_War_On_Terror.pdf].

[13] See footnotes in Table 1-8 in CBO, *The Budget and Economic Outlook: An Update*, September 2008; [http://www.cbo.gov/doc.cfm?index=9706].

Under CBO's "low alternate path" where troop levels fall to 30,000 troops by FY2010, additional funding would total about $440 billion in the next ten years between FY2009 and FY2018. In this projection, costs would fall from $186 billion in FY2008 for 210,000 deployed troops to:

- $147 billion for 170,000 troops in FY2009;
- $85 billion for 75,000 troops in FY2009;
- $41 billion for 30,000 troops in FY2010;
- $34 billion for 30,000 troops in FY2011;
- $34 billion for 30,000 troops in FY2012; and
- about $33 billion for 30,000 troops a year from FY2013 to FY2018.

For CBO's "high alternate path," funding would total about $865 billion over the next ten years with deployed troops reaching a steady-state level of 75,000 by FY2013. Starting from the same level in FY2008 of $186 billion for 210,000 deployed troops, CBO's year-by-year projections for costs and deployed troops levels are:

- $151 billion for 180,000 troops in FY2009;
- $137 billion for 170,000 troops in FY2010;
- $118 billion for 135,000 troops in FY2011;
- $94 billion for 100,000 troops in FY2012;
- $73 billion for 75,000 troops in FY2013; and
- $72 billion for 75,000 troops each year from FY2013 to FY2018.[14]

Some observers would suggest that these two scenarios bound the most likely alternatives in the next ten years while others might argue that maintaining current levels or withdrawing entirely could also be options. These CBO projections assume that troops withdrawn return to the United States. Yet another option would be for some number of troops to remain deployed in neighboring countries like Kuwait. These options do not reflect specific assumptions about whether withdrawals occur in Iraq or in Afghanistan.

CBO considers these to be rough projections rather than formal estimates in part because future costs are difficult to estimate given the problems with current information from DOD on costs incurred to date, the lack of outlays or actual expenditures for war because war and baseline funds are mixed in the same accounts. Nor is information available on many of the key factors that determine costs such as personnel levels each year or the pace of operations.[15]

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[14] CBO, "Additional Information on the Alternate Paths, 2009-2018," and Table 1-8 in CBO, *Budget and Economic Outlook, September Update*, September 2008; [http://www.cbo.gov/doc.cfm?index=9706].

[15] CRS adjusted the CBO estimates by subtracting $70 billion for the additional funding assumed by CBO for FY2007; see Letter to Chair, Senate Budget Committee, Kent Conrad, "Summarizing and projecting funding for Iraq and GWOT under two scenarios," February 7, 2007, Table 1 and p. 2 - p. 3; [http://www.cbo.gov/ftpdocs/77xx/doc7793/02-07-CostOfWar.pdf]. See also, CBO, Statement of Robert A. Sunshine, Assistant Director, before the House Budget Committee, "Issues in Budgeting for Operations in Iraq and the (continued...)

In the more rapid CBO projection above, costs fall somewhat more slowly than troops levels in the first three years — with a cumulative cost decrease of 78% and an 86% drop in troop levels — perhaps because the cost to repair and replace war-worn equipment offsets some of the savings from the withdrawal itself. In the slower withdrawal projection, costs fall close to proportionately to troop levels in each year — for example by about a third by the third year — which may reflect both more gradual savings as troops leave and equipment is sent home for repair.

Both the FY2009 Consolidated Security, Disaster Assistance, and Continuing Appropriations Act (H.R. 2638/P.L. 110-239) and the FY2009 National Defense Authorization Act (S3001/NDAA), passed at the end of the session, recognize the need for better information on troop levels. The FY2009 NDAA requires that DOD identify separately troop levels and funding in Iraq and in Afghanistan in its budget requests while the appropriations act requires monthly reporting on current troop levels and related funding as well as those in the next three months.[16] To estimate future costs, however, better information on past troop levels and other factors driving costs would be useful; currently that information is inconsistent and spotty (see discussion on war cost reporting).

Both CBO scenarios assume a gradual drawdown in forces over the next ten years. The Administration has not provided any long-term estimates of costs despite a statutory reporting requirement that the President submit a cost estimate for FY2006-FY2011 that was enacted in 2004.[17]

Past Trends and Future DOD Costs in Iraq. *How has funding for Iraq changed over time and what is the outlook for the future?* CRS estimates that Iraq funding totals about $524 billion including the FY2008 Consolidated Appropriations Act (see **Appendix A**) primarily DOD funding. That funding for Iraq has risen sharply from initial funding to deploy troops starting in the fall of 2002 (presumably drawn from DOD's regular appropriations since supplemental funds were not available) to $53 billion in the invasion year of 2003, about $134 billion for FY2007 and $154 billion enacted for FY2008.

Projections of Future Iraq Costs. Since FY2004, the first year of stability operations, the DOD total for Iraq has doubled (see **Table 3**).[18] The enacted total for

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[15] (...continued)
War on Terrorism," January 18, 2007.

[16] Sec. 1502, *S. 3001* as passed by both houses and signed by the president; no public law number assigned yet; and "Boots-on-the-Ground and Cost of War Reporting," in Joint Explanatory Statement for H.R. 2638 in *Congressional Record,* September 24, 2008, P. H9438, which may be submitted in a classified form.

[17] Sec. 9012 required that the president submit an estimate for FY2006-FY2011 unless he submitted a written certification that national security reasons made that impossible; the Administration did not submit a waiver but then-OMB Director, Joshua B. Bolten sent a letter on May 13, 2005 to Speaker of the House J. Dennis Hastert saying that an estimate was not possible because there were too many uncertainties.

[18] CRS estimates the allocation of about $9 billion in funding requested in the FY2007 (continued...)

Iraq in FY2008 is some $154 billion, or about 10% more than the previous year. Much of the large increases in recent year is due to higher procurement funding, that, in turn, reflects an expansive definition of reset — funds to restore units to pre-war condition — to cover only the repair and replacement of equipment damaged in war or that is not worth fixing but also to upgrade and buy new equipment to meet future needs for the "long war on terror (discussed further in section on reset and reconstitution).[19]

Another Withdrawal Option. In response to a request in 2006, CBO estimated the cost of two alternative scenarios for Iraq for FY2007-FY2016 if all troop levels were to be removed by the end of 2009 or if the number of deployed troops fell to 40,000 by 2010. Adjusting CBO's estimates for passage of the FY2007 Supplemental, a withdrawal by FY2009 could cost an additional $147 billion while a reduction to 40,000 troops by 2010 could cost an additional $318 billion.[20]

Maintaining a Long-Term Presence. CBO has also estimated that the annual cost of maintaining about 55,000 troops in Iraq over the long-term — referred to as the Korea option — in Iraq would be about $10 billion in a non-combat scenario and $25 billion with combat operations.[21] CBO's projections of costs assumes only minimal procurement costs for replacing or upgrading war-worn equipment unlike DOD's recent and current war requests.

Past Trends and Future DOD Costs in Afghanistan. *How has funding for Afghanistan and other Global War on Terror Operations changed over time and what does the future hold?* As of enactment of the FY2008 Supplemental, Afghanistan has received about $173 billion in appropriations for DOD, foreign and diplomatic operations, and VA medical. In recent years, funding for Afghanistan was about $20 billion annually but jumped by 75% to about $37 billion in FY2007, then falls to $34 billion in FY2008 when more funding is included for operations and less for training Afghan security forces.[22]

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[18] (...continued)
Supplemental for classified programs and for baseline fuel that DOD does not include for either OIF or OEF. CRS also excludes some DOD funding not related to war, as e.g. funds for baseline fuel cost increases.

[19] See CRS, Testimony of Amy Belasco to House Budget Committee, "the Growing Cost of the Iraq War," October 24, 2007.

[20] CBO, Letter to Congressman John M. Spratt, Jr., "Estimated funding for two specified scenarios for Iraq over the period 2007-2016," July 13, 2006, Table 1; [http://www.cbo.gov/ftpdocs/73xx/doc7393/07-13-IraqCost_Letter.pdf]. CRS adjusted CBO's estimate by subtracting the amount assumed for FY2007.

[21] CBO, Letter to Congressman Spratt on Long-Term Presence in Iraq, 9-20-07 [http://www.cbo.gov/ftpdocs/86xx/doc8641/09-20-ConradLTpresenceinIraq.pdf].

[22] DOD, *FY2008 Global War on Terror Amendment,* Table 2, Funding by Functional Category, October 2007, p. 57; training of Afghan Security Forces falls from $7.4 billion in FY2007 to $1.5 billion in FY2008, see P.L. 110-252.

Cost increases reflect higher troop levels, training of Afghan forces, and a share of upgrading and replacing equipment and converting Army and Marine Corps units to a new modular configuration. The $17 billion growth in the FY2007 supplemental reflects a $5.5 billion more to equip and train Afghan security forces above the previous year as well as $510 million for 7,200 more troops, as well as other unidentified factors. The $34 billion in FY2008 includes only $1.5 billion to train Afghan forces and presumably some increase for the continued growth in troop levels. The reasons for jump in costs are not clear.

Past Trends and Future Costs in Enhanced Security. *How has the cost of Operation Noble Eagle or enhanced security for DOD bases changed since 9/11?* Funding for enhanced base security and other responses to the initial attacks fell from the $12 billion available in the first year after the attacks to $8 billion in 2003. These decreases reflect the end of one-time costs like Pentagon reconstruction ($1.3 billion), the completion of security upgrades, the scaling back of combat air patrol (about $1.3 billion for around-the-clock coverage), and a cut in the number of reservists guarding bases.[23] In FY2004, the cost of enhanced security more than halved again, dropping to $3.7 billion.

Beginning in FY2005, DOD funded this operation in its baseline budget rather than in supplementals and costs fell to under $1 billion in FY2006 and $500 million in FY2007, and about $200 million for FY2008 as well (see **Table 3**). The services are now requesting funds for some base security in the United States that they consider war costs in the FY2007 and FY2008 Supplemental, which could overlap with the enhanced security mission.

DOD Spending Thus Far

Average monthly obligations are frequently used as a way to measure the rate of ongoing war spending. As of the end of July 2008, DOD estimated that the cumulative total of war-related obligations were $608.5 billion.[24] Obligations capture the amount of budget authority for military and civilian pay and for contracts signed by the government or orders placed within DOD for parts, repairs, and purchase of weapons systems and supplies.

Based on DOD data, CRS estimates that average monthly obligations for the first 10 months of FY2008 were running about $12.3 billion including $9.9 billion for Iraq, $2.4 billion for Afghanistan, and $12 million for enhanced security. Compared to FY2007, this monthly average for FY2008 is about $400 million lower for Iraq and $400 million higher for Afghanistan, and about the same altogether (see

[23] DOD's new estimate for ONE is $8 billion rather than the $6.5 billion shown in an earlier DOD briefing. For more information, see CRS Report RL31187, *Combating Terrorism: 2001 Congressional Debate on Emergency Supplemental Allocations*, and CRS Report RL31829, *Supplemental Appropriations FY2003: Iraq Conflict, Afghanistan, Global War on Terrorism, and Homeland Security*, both by Amy Belasco and Larry Nowels.

[24] DOD, "Cost of War Through July 2008."

Table 4). These figures differ somewhat from those reported by DOD because CRS estimates some expenses not captured by DOD reports.[25]

Although these figures capture DOD's contractual obligations for pay, goods, and services, they do not give a complete picture because they do not capture all appropriated funds or all funds obligated. DOD acknowledges that these figures do not capture classified activities or about $19 billion that DOD does not consider "GWOT related."[26] According to DOD, funds which DOD does not consider to be war-related — such as for Congressional adds for equipment for the National Guard and Reserve, force protection, and more C-17 aircraft — will not be captured in Defense Finance Accounting Service (DFAS) reports because the services will treat these as part of DOD's regular programs.[27]

Table 4. DOD's Obligations by Operation: FY2001-FY2008

(in billions of dollars)

Mission and Type of Spending	Average Monthly Obligations						DOD Reported Cum. Obs from FY01-July 30, 2008[a]
	FY03[a]	FY04[a]	FY05[a]	FY06[a]	FY07[a]	FY08 to Date[a]	
Operation Iraqi Freedom							
Operations[b]	4.2	4.3	4.7	5.9	7.1	7.3	**NA**
Investment[c]	0.2	0.6	1.8	1.3	3.2	2.6	**NA**
Total	**4.4**	**4.8**	**6.5**	**7.2**	**10.3**	**9.9**	**473.7**
Afghanistan and the Global War on Terror[d]							
Operations[b]	1.1	0.9	0.9	1.2	1.9	2.3	**NA**
Investment[c]	0.2	0.1	0.2	0.2	0.1	0.1	**NA**
Total	**1.3**	**1.0**	**1.1**	**1.4**	**2.0**	**2.4**	**106.9**
Enhanced Security and Other[e]							
Operations[b]	0.5	0.3	0.2	0.1	0.0	0.0	**NA**
Investment[c]	0.0	0.0	0.0	0.0	0.0	0.0	**NA**
Total	**0.5**	**0.3**	**0.2**	**0.1**	**0.0**	**0.0**	**27.9**
All Missions							
Operations[b]	5.8	5.5	5.8	7.2	9.1	9.6	**NA**
Investment[c]	0.4	0.7	2.0	1.5	3.2	2.7	**NA**
Total	**6.2**	**6.2**	**7.7**	**8.7**	**12.3**	**12.3**	**608.5**

Sources and Notes: NA = Not available. Numbers may not add due to rounding. Monthly estimates reflect Defense Finance Accounting Service (DFAS) reported

[25] DOD, "Cost of War Card through July 2008" shows average overall obligations of $11.6 billion.

[26] DOD, "Cost of War Update as of July 31, 2008."

[27] Communication with DOD Comptroller staff, October 2007 and Table 1a in DOD, *FY2008 Global War on Terror Amendment*, October 2007, for total for non-DOD intelligence and non-GWOT; [http://www.defenselink.mil/comptroller/defbudget/fy2008/Supplemental/FY2008_October_Global_War_On_Terror_Amendment.pdf].

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obligations through September 2007; see DOD, *Supplemental & Cost of War Execution Reports*; cumulative obligations from DOD, "Cost of War Through April 2008," 6-19-08.

a. Figures for FY2003-July 2008 reflect CRS calculations based on DFAS reports with estimated adjustments for funds excluded by DFAS such as intelligence and Congressional additions. DOD figures in last column do not include these adjustments.
b. Includes funds appropriated for military personnel, operation and maintenance, working capital, and defense health.
c. Includes funds appropriated for procurement, RDT&E, and military construction.
d. Operation Enduring Freedom funds Afghanistan and other global war on terror (GWOT) activities.
e. 'Enhanced Security and Other' includes additional security at defense bases, combat air patrol around U.S. cities, and reconstruction of the Pentagon after the 9/11 attacks.

Although obligations go up and down from month-to-month, cumulative averages in FY2008 have been fairly stable. **Table 4** shows DOD-reported figures and CRS estimates of average monthly obligations after adjusting DOD accounting reports to add classified and other unreported war-related activities through July 2008.[28] These estimates show adjusted FY2008 obligations running $12.3 billion per month on average including:

- $9.9 billion for Iraq;
- $2.4 billion for Afghanistan; and
- $12 million for enhanced security.

Average obligations are a good indicator of ongoing operational costs because these funds must be obligated — put in contract — within the first year. For investment costs, however, average monthly obligations lag appropriated budget authority since only some funds are obligated in the first year because of the time for the planning and negotiation of contracts.

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Obligations figures do not reflect outlays — or payments made when goods and services are delivered — which would be a better measure of spending rates and actual costs. DOD does not track outlays for its war costs because war-related appropriations are co-mingled with regular or baseline funds in the same accounts making it difficult to segregate the two. If DOD had separate accounts for war and peace costs, outlays could be tracked, which would capture the amount spent and give a better sense of actual spending rates.

Changes in Average Monthly Obligations. Largely on the basis of DOD accounting reports, average monthly obligations grew from $6.2 billion in FY2004 to $12.3 billion in FY2008, a doubling in four years for Iraq and Afghanistan together.

More Procurement Increases Iraq Spending. In the case of Iraq, much of the increase reflects a five-fold increase in investment obligations, primarily procurement, as the services have begun to spend substantial amounts on reset — the

[28] Averages correct for monthly fluctuations which may reflect when individual contracts are signed. Operational costs include working capital funds, defense health, and counterdrug monies and investment costs include procurement, RDT&E and military construction.

procurement of new weapons systems and equipment not simply to replace war losses (a small share of the total) but more often to upgrade and replace "stressed" equipment and enhance force protection.

Some observers have questioned whether all of DOD's war-related procurement reflects the stresses of war. For example, a recent CBO study found that more than 40% of the Army's spending for reset — the repair and replacement of war-worn equipment — was not for replacing lost equipment or repairing equipment sent home. Instead, Army funds were spent to upgrade systems to increase capability, to buy equipment to eliminate longstanding shortfalls in inventory, to convert new units to a modular configuration, and to replace equipment stored overseas for contingencies.[29] DOD has suggested that procurement obligations slowed in FY2008 as DOD awaited passage of the FY2008 supplemental.[30]

Operating Costs Rise in Afghanistan. In the case of Afghanistan, spending rates are growing for operations because of rising troop levels, increasing hostilities, and more spending to upgrade Afghan Security forces. In response, DOD deployed additional Army and Marine Corps forces in FY2008, an additional brigade will be sent in February 2009, and commanders in-country are calling for several additional brigades but a decision has not yet been made.

As of July 2008, obligations are running about $12 billion a month with Iraq at $9.9 billion and Afghanistan at $2.4 billion.[31] The monthly average for enhanced security (Operation Noble Eagle) has fallen substantially from $520 million per month in FY2003 to $12 million in FY2008 as one-time costs ended and costs have been incorporated in day-to-day base operations.

Total Obligations to Date. Overall, DOD reports that as of its July 2008, $608.5 been obligated since FY2001:

- $473.7 billion or 78% is for Iraq;
- $106.9 billion or 18% is for Afghanistan and other GWOT; and
- $27.9 billion or 5% is for enhanced security (see **Table 4**).

These shares have been fairly stable over time. This does not include obligations for intelligence or other expenses that are included in CRS estimates but not captured by DOD's DFAS reports.

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[29] CBO, *Replacing and Repairing Equipment Used In Iraq and Afghanistan: The Army's Reset Program* by Frances M. Lussier, September 2007, p. ix, pp. 35-37; available at [http://www.cbo.gov/showdoc.cfm?index=8629&sequcence=0&from=7].

[30] Office of Undersecretary Comptroller, "Cost of War Update as of July 31, 2008," p. 3.

[31] CRS estimates would be somewhat higher.

Recent and Future War Cost Issues

The following sections discuss several war cost issues that have arisen and are likely to be faced by Congress including:

- How long the Army can operate before passage of the FY2009 supplemental;
- What are the cost implications of further troop withdrawals beyond the five combat brigades that were sent in last spring's "surge," to Iraq and of sending additional troops to Afghanistan;
- What is the total likely cost of training and equipping Iraqi and Afghan security forces who are replacing U.S. forces and how might those costs be shared with Iraqis and other coalition forces?
- What is the cumulative and likely future cost of reset — the repair and replacement of war-worn equipment — including whether part or all of future reset requests should be considered emergency war expenses or be assessed as part of DOD's regular budget?
- How to judge and respond to readiness problems that stem from war operations;
- What are the pros and cons of continued reliance on emergency supplementals to fund DOD war costs?
- What mechanisms can Congress use to increase Iraqi burden-sharing of war-related costs to rebuild their security forces?
- How to use congressional funding mechanisms to affect policy options for Iraq; and
- What are the problems in war cost reporting.

Cost Implications of Troop Withdrawals and Basing Decisions

As of November 2008, Department of Defense has announced that it will withdraw one brigade from Iraq after the withdrawal of the "surge" forces of five combat brigades that were sent to Iraq last spring. The Administration has also announced plans to send an additional brigade to Afghanistan. Additional decisions about withdrawals from Iraq or additional forces to be sent to Afghanistan are likely to await the new Administration.

The FY2008 war budget request was predicated on maintaining 15 combat brigades in Iraq once the five additional brigades are withdrawn by June 2008.[32] The FY2007 Supplemental included about $4 billion to $5 billion to fund the increase troops in Iraq by five combat brigades or about 30,000 personnel to establish security in Baghdad and Anbar province as well as to heighten naval presence in the Gulf by deploying an additional carrier and extending one Marine Expeditionary Group "as a gesture of support to our friends and allies in the area who were becoming very worried about Iran's aggressiveness" according to Secretary of Defense Gates.[33]

There has been limited discussion thus far of the cost implications of additional troop withdrawals. How war funding could fall if additional troops are withdrawn will depend on the pace of withdrawals and how many bases DOD maintains well as whether and how many additional troops are sent to Afghanistan. Moreover, the cost of the troops added in 2007is not necessarily a guide to the effect on costs of further withdrawals because little if any additional infrastructure was required for their support.[34]

At the same time, the increase in troops was only in effect for part of the year, so costs would have to be pro rated. For example, average overall troop strength for Iraq and Afghanistan was only 4% higher in FY2007 compared to FY2006 even though troop levels at the end of the year were 10% higher when the "surge" was fully implemented compared to the beginning of the year.[35]

An important factor in estimating the effects of further troop withdrawals are the Administration's plans for basing in Iraq — whether DOD plans to consolidate or disperse U.S. personnel if troop levels decline. Congress has included provisions in both the National Defense Authorization Act and DOD appropriations acts for the past two years that prohibit permanent basing in Iraq. Both President Bush and the Iraqis have said there will be no permanent bases although the "the 'size and shape' of any long-term U.S. presence basing arrangements with the Iraq government," is

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[32] DOD's October amendment to its FY2008 supplemental includes an additional $6.5 billion to continue the surge, with a return to pre-surge levels by May or June of 2008.

[33] DOD reduced its initial estimate of the cost of the additional troops. The estimate also included the cost of increasing naval presence as well. House Armed Services Committee, transcript of hearing on "Fiscal 2008 Budget: Defense Department," February 7, 2007, p. 45. DOD revised its request in March 2007 to include support troops after CBO estimated that additional funds would be needed; see CBO, Cost Estimate for Troop Increase Proposed by the president, 2-1-07 [http://www.cbo.gov/ftpdocs/77xx/doc7778/TroopIncrease.pdf]. DOD, FY2007 Supplemental, p. 83; [http://www.dod.mil/comptroller/defbudget/fy2008/fy2007_supplemental/FY2007_Emergency_Supplemental_Request_for_the_GWOT.pdf].

[34] DOD disagreed with the CBO estimate of the cost of the additional troops for this reason; CBO, Cost Estimate for Troop Increase Proposed by the president, 2-1-07 [http://www.cbo.gov/ftpdocs/77xx/doc7778/TroopIncrease.pdf]. DOD, FY2007 Supplemental, p. 83; [http://www.dod.mil/comptroller/defbudget/fy2008/fy2007_supplemental/FY2007_Emergency_Supplemental_Request_for_the_GWOT.pdf]

[35] CRS calculations based on Defense Manpower Data Run, *DRS 17253, Average Number of Members by Month, 0901-1107*, received January 11, 2008.

part of ongoing discussions about extending the basis for U.S. presence before the end of December when the U.N. mandate expires.[36]

Funding to Train and Equip Iraqi and Afghan Security Forces

U.S. commanders have argued for some time that the pace of withdrawal of U.S. forces depends on both conditions on the ground, i.e. the number and types of attacks by various insurgent groups — and the size, readiness and capabilities of Afghan and Iraqi security Forces. As of passage of the FY2008 Supplemental/FY2009 Bridge (H.R. 2642/P.L. 110-252) this summer, funding to train and equip these forces totals $39 billion including $15.6 billion for Afghanistan and $23.2 billion for Iraq. Since FY2004, annual funding to train Afghan forces has grown rapidly reaching a highpoint of $7.4 billion in FY2007 and then falling off to $2.8 billion in FY2008. Funding for Iraqi forces has fluctuated between $3 billion and $5 billion in those years, falling in FY2008 as well (see **Table 5**).[37]

Table 5. Afghan and Iraq Security Forces Funding: FY2004-FY2009 Bridge

(in billions of dollars)

Account	FY04	FY05	FY06	FY07	FY08[a]	FY09 Bridge[a]	Total Enacted[a]
Afghan Security Forces Fund[b]	[.348][a]	1.285	1.908	7.406	2.750	2.000	15.647
Iraq Security Forces Fund[b]	[5.000][a]	5.700	3.007	5.542	3.000	1.000	23.249
Total	**[5.339]**	**6.985**	**4.915**	**12.948**	**5.750**	**3.000**	**38.946**

Sources and Notes:

a. Includes all appropriations through FY2008 Supplemental/FY2009 bridge (H.R. 2642/P.L. 110-252), including funds provided to the President in FY2004 shown in square brackets.

b. Figures in [ ] brackets are funds to train Iraqi security forces that were appropriated to the President and transferred to the Coalition Provisional Authority, and implemented by the Army. Iraq total includes enacted funds from all U.S. sources. Afghanistan total does not include about $1 billion to $2 billion that Afghan security forces received in FY2004 and FY2005 through State Department or foreign military sales financing according to GAO-05-575, *Afghanistan Security: Efforts to Establish Army and Police Have Made Progress, but Future Plans Need to Be Better Defined*, June 2005, p. 9. Figures reflect CRS calculations from public laws and conference reports.

Despite Congressional concerns about the readiness of Afghan and Iraqi security forces, and the effectiveness of training efforts thus far, Congress provided full

[36] See CRS Report RL3339, *Iraq: Post-Saddam Governance and Security* by Kenneth Katzman, p. 14ff.; also, testimony by CRS analyst, Kenneth Katzman, before the Subcommittee on the Middle East and South Asia, House Foreign Affairs Committee, January 23, 2008; [http://foreignaffairs.house.gov/hearing_notice.asp?id=936].

[37] Total includes $5 billion appropriated to the State Department for Iraq training in FY2004. Afghanistan has also received funding for its training from State Department accounts.

funding of DOD's request through the FY2008 presumably because of the high stakes involved. This year, however, Congress has voiced additional concerns about about U.S. funding of the rebuilding of Iraqi security forces at a time when Iraqi government revenues have been rising rapidly with the swell in oil prices.

In the FY2009 bridge fund, Congress halved the ISFF request and cut the ASFF request from $3.67 billion to $2.0 billion. With DOD's recent announcement of proposals to double the size of the Afghan security forces in the next four years at a cost of about $20 billion, congressional concerns may start to include Afghanistan as well. Secretary of Defense Gates has discussed cost-sharing with NATO partners but without success thus far.[38]

The House Budget Committee's September 2008 hearing on war costs and the Iraqi budget surplus included many calls for more "burdensharing" by Iraq in the rebuilding of its security forces. The hearing was held in response to a recent GAO report report that estimated that the Iraqis could accumulate a surplus of from $67 billion to $79 billion by 2008 depending on oil prices and production, though those amounts could be reduced with the August passage of an Iraqi supplemental.[39]

Iraq's ability to pay for the expansion and improvement of its security forces depends on several factors ranging from the effects of attacks on the pipelines and corruption on production to reaching consensus within the country on managing and distributing oil revenues.[40] During the hearing, members raised concerns about the Iraqi government's recent spending rate of below 30% for investment projects.[41] About 70% of all U.S. funds to train and equip Iraqi forces have been obligated — or contracted for — though the amount spent has not been reported.[42]

This push to require Iraq to share the burden of rebuilding its security forces is also evident in new restrictions recently enacted that prohibit or place restrictions on U.S. funding of "infrastructure" projects in Iraq, including those to rebuild security forces. The FY2008 Supplemental (P.L. 110-252) requires cost-sharing of all infrastructure projects above $750,000 while the FY2009 National Defense Authorization Act (S. 3001) prohibits U.S. funding of any facilities projects for Iraqi forces other than U.S. military construction projects or small-scale reconstruction funding in the Commanders Emergency Response Program.[43]

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[38] "U.S. Urges Allis to Fund Afghan Army Growth," September 19, 2008.

[39] GAO-08-1144T,Statement of Joseph A. Christoff before the House Budget Committee, "Stabilizing and Rebuilding Iraq: Iraqi Revenues, Expenditures, and Surplus," p. 3, September 16, 2008.

[40] CRS Statement of Christopher M. Blanchard, CRS, "Iraqis Budget Surplus," before the House Budget Committee, September 16, 2008.

[41] House Budget Committee, Transcript of hearing, Iraqi's Budget Surplus," September 16, 2008, p. 4, and *passim*.

[42] CRS calculations based on Defense Finance Accounting System monthly reports, "Supplemental & Cost of War Reports."

[43] See Explanatory Statement for H.R. 2642 in Congressional Record, May 19, 2008, p.
(continued...)

To monitor Iraqi progress, the FY2008 Supplementals also require continuation of DOD reports on the readiness, operations, and transfer of responsibility to Iraqi units as well as an estimate from OMB of the total cost to train both Iraqi and Afghan security forces every 90 days.[44]

Reset and Reconstitution

Another major unsettled war cost issue that may arise during consideration of the FY2008 Supplemental this spring and the FY2009 bridge fund once it is presented to Congress is the amount of funds needed to "reset" or restore the services' equipment to pre-war levels. In its FY2008, DOD requested $46 billion for reconstitution, primarily procurement funds. In the FY2008 , Congress funded only a small portion of that request.[45] The largest single reason for the increase is war costs between FY2004 and FY2007 is the amount requested and received by DOD for reset. Although repair and replacement costs might be expected to grow over time as operations wear down equipment, it appears that much of the growth reflects a broadening of the definition of what is required.[46]

DOD Changes Definition of War Costs. For the past ten years, DOD financial regulations have defined the cost of contingencies to include only incremental costs directly related to operations. Until October 2006, that guidance was largely used by the services to prepare their estimates for Iraq and GWOT. The guidance required that the service show assumptions about troop levels, operational tempo, and reconstitution and limits requests to incremental costs — "that would not have been incurred had the contingency operation not been supported." Investment requests are also to be incremental and included "only if the expenditures were necessary to support a contingency operation."[47] (Little of this information was provided to Congress in DOD's requests.)

In the July 19, 2006 guidance to the services for developing the FY2007 Supplemental and FY2008 war cost requests, these strictures were reiterated. That guidance also prohibited including Army modularity "because it is already programmed in FY2007 and the outyears," and warned that the services would have to demonstrate that investment items were "directly associated with GWOT

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[43] (...continued)
S4337; and Sec. 1508 in S. 3001, the FY2009 National Defense Authorization Act.

[44] Sec. 9205, *P.L. 110-252*.

[45] Division L.

[46] CRS, Statement of Amy Belasco before the House Budget Committee, "The Growing Cost of the Iraq War," October 24, 2007 [http://budget.house.gov/hearings/2007/10.24Belasco_testimony.pdf].

[47] DOD, *Financial Management Regulations*, Chapter 12, Sec. 23, "Contingency Operations," p. 23-11ff, 23-21, 23-25, 23-27; [http://www.dod.mil/comptroller/fmr/12/12_23.pdf].

operations," rather than to offset "normal recurring replacement of equipment."[48] In addition, the services would have to show that reset plans could be executable in FY2007, likely to mean within the last several months of the fiscal year based on experience in FY2006.

On October 25, 2006, Deputy Secretary of Defense Gordon England issued new guidance for requesting war funds to the services, requiring them to submit new requests within two weeks that reflect the "longer war on terror" rather than strictly the requirements for war operations in Iraq, Afghanistan and other counter-terror operations.[49] Such a substantial change would be expected to reflect guidance from the Secretary of Defense, the Office of Management and Budget and the President. This new definition appeared to open the way for including a far broader range of requirements particularly since the needs of the "longer war" are relatively undefined.

In its review of the FY2007 Supplemental, the appropriators rejected certain procurement and depot maintenance requests as either unexecutable or not clearly an emergency. (See CRS Report RL33900, *FY2007 Supplemental Appropriations for Defense, Foreign Affairs, and Other Purposes*, by Stephen Daggett et al.) Since the long war on terror is now part of DOD's key missions according to the national strategy, it could be argued that these types of expenses should be included in DOD's regular budget where they would compete with other defense needs.

Procurement Funding in FY2007 and FY2008. War-justified procurement requests have increased substantially in recent years from $20.4 billion in FY2006 to $39.7 billion in FY2007 and $64.0 billion in FY2008. Although some of this increase may reflect additional force protection and replacement of "stressed" equipment, much may be in response to Mr. England's new guidance to fund requirements for the "longer war" rather than DOD's traditional definition of war costs as strictly related to immediate war needs.

For example, the Navy initially requested $450 million for six EA-18G aircraft, a new electronic warfare version of the F-18, and the Air Force $389 million for two Joint Strike Fighters, an aircraft just entering production; such new aircraft would not be delivered for about three years and so could not be used meet immediate war needs. Other new aircraft in DOD's supplemental request include CV-22 Ospreys and C-130J aircraft. In its March amendment to the FY2007 Supplemental, the Administration withdrew several of these requests, possibly in anticipation that Congress would cut these aircraft.

Front Loading Reset Funding. The FY2007 Supplemental included an additional $14 billion for reset — the replacement of war-worn equipment. DOD's request appears to front load (or fund in advance) DOD's reset requirements, a fact

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[48] Under Secretary of Defense, Memorandum for Secretaries of the Military Departments, "Fiscal Year (FY) 2008-2013 Program and Budget Review," July 19, 2006, p. 34-49, specifically p. 36, 39, 41.

[49] Deputy Secretary of Defense Gordon England, Memorandum for Secretaries of the Military Departments, "Ground Rules and Process for FY'07 Spring Supplemental," October 25, 2006.

acknowledged by then-OMB Director Robert Portman in recent testimony.[50] According to DOD figures, Army and Marine Corps reset requirements were fully met in the enacted FY2007 fund when Congress provided $23.7 billion for Army and Marine Corps reset costs, the amount that the services said was needed.[51]

As substantial amounts of equipment are being sent back to the United States for repair, the Army and Marine Corps would be expected to be able to check previous estimates of the effect of current operations on wear and tear of equipment. As of enactment of the FY2007 Supplemental, DOD has received about $64 billion for reset, which is defined as the "process of bringing a unit back to full readiness once it has been rotated out of a combat operation," by repairing and replacing equipment and resting and retraining troops.[52] The services are to repair equipment if economical or replace it if replacement costs almost as much as repair.

The FY2007 Supplemental and the FY2008 war request both appear to include an extra year of Army and Marine Corps reset requirements. According to statements by Army Chief of Staff, General Peter J. Schoomaker and other military spokesman, Army reset is estimated to be $12 billion to $13 billion a year as long as the conflict lasts at the current level and "for a minimum of two to three years beyond"[53] According to Marine Corps Commandant, General Michael Hagee, their requirements are about $5 billion a year for a total of about $17 billion for the two services most heavily affected.[54]

DOD estimated that reconstitution would total $37.5 billion in FY2007 and $46 billion in FY2008, which was largely supported by Congress in FY2007.[55] The front

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[50] Testimony of OMB Director Robert Portman before the House Budget Committee, *Hearing on the FY2008 DOD Budget*, February 6, 2007, p. 41 of transcript.

[51] See table inserted by Senator Stevens in *Congressional Record*, August 2, 2006, p. S8571 showing $23.7 billion for reset, including $14 billion in procurement; total funded also provided $4.9 billion for unfunded FY2006 requirement; see also DOD's *Report to Congress, Long-Term Equipment Repair Costs*, September 2006.

[52] See CRS Report RL33900, *FY2007 Supplemental Appropriations for Defense, Foreign Affairs, and Other Purposes*, by Stephen Daggett et al; for definition, see Office of the Secretary of Defense, Report to Congress, *Ground Force Equipment Repair, Replacement, and Recapitalization Requirements Resulting from Sustained Combat Operations*, April 2005, p. 8; see also GAO-06-604T, *Defense Logistics: Preliminary Observations on Equipment Reset Challenges and Issues for the Army and Marine Corps*, p. 3.

[53] Statement of Peter J. Schoomaker, Chief of Staff, Department of the Army, before the House Armed Services Committee, "Reset Strategies for Ground Equipment and Rotor Craft," June 27, 2006, p.2; see also testimony of Brigadier General Charles Anderson, U.S. Army, House Armed Services Subcommittee on Readiness and Subcommittee on Air and Land Forces Hold, transcript, "Joint Hearing on Costs and Problems of Maintaining Military Equipment in Iraq," January 31, 2007, p. 6.

[54] Testimony of General Michael Hagee, Marine Corps Commandant before the House Armed Services Committee, "Army and Marine Corps Reset Strategies for Ground Equipment and Rotor Craft," June 27, 2006, p. 41.

[55] DOD, *FY2008 Global War on Terror Request*, February 2007, Table 3; (continued...)

loading of requirements may be an attempt by the services to avoid being in the position of requesting reset funds after U.S. troops have started to withdraw. While Congress endorsed most of the repair piece of reconstitution (funded in O&M) in the $70 billion FY2008 fund, only $6 billion of procurement monies related to reconstitution was included.[56]

Carryover of DOD War Investment Funding. DOD's latest procurement request for reconstitution could be considered less urgent because DOD had a $45 billion carryover of war-justified investment funds — i.e., funds provided in previous years' acts but not yet obligated or placed on contract — as of the beginning of FY2008.[57] Because investment funding is available for two to three (RDT&E for two years, procurement and military construction for three years), some of the funds may be obligated beyond the first year as contracts are written and processed.

Most of these funds are procurement monies, suggesting that unobligated war-related procurement funds still available to be spent are about half of the $81 billion in procurement funds provided to DOD in FY2007 for its regular appropriations.[58]

Accuracy and Expansion of Reconstitution Requests. Although it is clear that reset requirements reflect the stress on equipment from operations, the accuracy of services estimates has not been determined. Recently, GAO testified that until FY2007, the Army, with the largest reset requirement, could not track reset or ensure that funds appropriated for reset were in fact spent for that purpose, making it more difficult to assess the accuracy of DOD's requests.[59] In addition, presumably much of the equipment that is being repaired now because of the effect of war operations, was originally slated for repair or replacement at a later date, and so is being repaired or replaced sooner than anticipated. That could mean DOD's baseline budget could be reduced to offset war funding already provided.

Reset requirements may also be uncertain because the number of troops and intensity of operations may change. Service estimates of requirements have changed over the past couple of years. In a September 2006 report to Congress, for example, annual reset requirements in FY2008 were estimated to be $13 billion for the Army

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[55] (...continued)
[http://www.dod.mil/comptroller/defbudget/fy2008/fy2007_supplemental/FY2008_Global_War_On_Terror_Request.pdf] hereinafter, DOD, *FY2008 GWOT Request.*

[56] Congress also provided $16.8 billion to buy and support MRAPS, a force protection request not related to reconstitution; see December 18, 2007 Congressional Record, p. S15858 for procurement items funded in the FY2008 included in Division L of the FY2008 Consolidated Appropriations Act.

[57] CRS, Statement of Amy Belasco before the House Budget Committee, "The Rising Cost of the Iraq War," October 24, 2007; [http://budget.house.gov/hearings/2007/10.24Belasco_testimony.pdf].

[58] See Table 2 in CRS Report RL33999, *Defense: FY2008 Authorization and Appropriations*, by Pat Towell, Stephen Daggett, and Amy Belasco.

[59] GAO-07-439T, Testimony of William Solis before the Subcommittee on Readiness and Air and Land Forces, House Armed Services Committee, January 31, 2007, p. 2 and 3.

and about $1 billion for the Marine Corps.[60] Several months earlier in the spring of 2006, the Army estimated that reset requirements would decrease from $13 billion a year to $10.5 billion a year for the next two years and then decline to $2 billion a year if troops were withdrawn over a two-year period.[61] A year earlier, in March 2005, CBO estimated that annual repair and replacement costs would run about $8 billion a year based on the current pace of operations and service data.[62] In a report last fall, CBO estimated that 40% of the Army's war requests were not directly for reset needs.[63]

DOD's definition of reset now includes not only replacing battle losses (typically about 10% of the total), equipment repair (about half) but also recapitalization that typically upgrades current equipment, and repair and replacement of prepositioned equipment stored overseas that has been tapped to meet war needs. The Army has been planning to recapitalize equipment and modernize prepositioned equipment stocks to match the new modular designs as part of its ongoing modernization. For this reason, it's not clear whether these expenses are actually incremental wartime requirements.

Modularity as an Emergency Expense. The distinction between war-related and regular funding has also ben made murky by DOD requests to treat conversion of Army and Marine Corps units to new standard configurations — known as modularity and restructuring — as a war requirement. In a report last year, for example, the Army acknowledged that "since modularity requirements mirror the equipment requirements the Army already procures for its units, the ability to precisely track modularity funds is lost."[64]

At DOD's request, Congress agreed to provide $5 billion in the FY2005 and in FY2006 supplementals for converting units with the understanding that DOD would move these funds back to its regular budget in later years. The FY2007 supplemental again included $3.6 billion to convert two Army brigade teams and create an additional Marine Corps regimental combat team highlighting the issue of whether funds that are part of DOD's regular requirements are being shifted to emergency funding. The FY2008 war request also includes $1.6 billion to accelerate the creation of more modular brigades plus additional funds for equipping them.[65]

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[60] Office of the Secretary of Defense, Report to the Congress, "Long-Term Equipment Repair Costs," September 2006, p. 24 and p. 25.

[61] Army Briefing, "Army Equipment Reset Update," May 18, 2006, p. 8.

[62] CBO Testimony by Douglas Holtz-Eakin, Director, "The Potential Costs Resulting from Increased Usage of Military Equipment in Ongoing Operations," before the Subcommittee on Readiness, House Armed Services Committee April 6, 2005, p. 2.

[63] CBO, *Replacing and Repairing Equipment Used In Iraq and Afghanistan: The Army's Reset Program* by Frances M. Lussier, September 2007; [http://www.cbo.gov/showdoc.cfm?index=8629&sequcence=0&from=7], p. ix.

[64] Secretary of the Army, "Sec. 323 report required by the FY2007 National Defense Authorization Act, P.L. 109-364," February 14, 2007, p. 4.

[65] DOD, *FY2008 Global War on Terror Amendment*, October 2007, [http://www.defenselink
(continued...)

DOD argued that these costs should be considered war-related because having more modular units makes it easier to rotate units to the war zone and hence would extend the time between deployments giving soldiers more time at home, or "dwell time" and hence improving readiness. This conclusion has been questioned in studies by CBO and the RAND. Both studies found that modularity would only marginally improve rotation schedules. CBO estimated that the Army's modularity initiative would only make available an additional 6,000 to 7,000 troops.[66] DOD does not estimate the effect of either its previous or new funding for modularity on the amount of time soldiers have at home between deployments.

Congress included the funds in the FY2005 and FY2006 with some reluctance (effectively giving the Army more room in its regular budget for two years) based on an understanding with DOD that this funding would return to the regular budget after FY2006 and that $25 billion was set aside for the Army in future years to cover these costs.[67] Congress appears to have approved these costs in FY2007 as well.

Growing the Force as a War Cost. Previously, Congress has provided funding to cover "overstrength" or the cost of recruiting and retaining additional personnel above the Army's pre-war end strength of 482,000 and the Marine Corps end strength of 175,000. DOD has argued that these increases were required to reduce the stress on forces and that the increases would be temporary. In January 2007, the President announced plans to permanently increase the size of the Army and Marine Corps by 92,000 over the next six years including the almost 30,000 additional personnel already on board.

The FY2007 supplemental included a total of $4.9 billion to cover the military personnel cost of additional troops plus $1.7 billion for equipment and infrastructure for the forces to be added in FY2007. DOD promises that funding to equip future increases in the force will be funded in the regular budget starting in FY2009.

In a reversal of its previous position, DOD argued that the Army and Marine Corps need to be permanently expanded by 92,000 by 2012. The President's proposal marks a major change and appears to assume that the United States needs to be able to deploy substantial numbers of troops on a permanent basis. CBO estimates that adding two divisions to the Army — roughly equivalent to the President's proposal

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[65] (...continued)
.mil/comptroller/defbudget/fy2008/Supplemental/FY2008_October_Global_War_On_Terror_Amendment.pdf], p. 48 and 49.

[66] The RAND study argued that the types of units created were not those most needed. RAND, *Stretched Thin: Army Forces for Sustained Operations*, 7-15-05; [http://www.rand.org/pubs/monographs/2005/RAND_MG362.pdf]. CBO, *An Analysis of the Military's Ability to Sustain an Occupation in Iraq: an Update*, October 5, 2005; [http://www.cbo.gov/ftpdocs/66xx/doc6682/10-05-05-IraqLetter.pdf].

[67] Program Budget Decision 753, "Other Secretary of Defense Decisions," December 23, 2004, p. 1.

— would require an additional $108 billion between FY2008 and FY2017, a major investment.[68]

Questions About War-Related Procurement Issues. To evaluate DOD's war-related reconstitution and procurement requests, Congress may want to consider

- whether reset requirements are sufficiently firm to justify front loading and what assumptions about force levels and the pace of operations underlie those requests;
- whether upgrading equipment and replacing prepositioned equipment is actually a war expense rather than a part of ongoing modernization initiatives;
- how war funding of repair and replacement of equipment could affect maintenance and procurement needs funded in DOD's regular budget;
- whether upgrades requested reflect requirements to equip deployed or deploying forces — war-related — or the entire force; and
- whether DOD estimates of war requirements for force protection reflect war-related requirements for deploying forces or modernization of the entire force.

To some extent, these war-related requirements for recapitalization, modularity, force protection, and upgrades overlap each other and the baseline budget since all involve the purchase of new equipment to improve capability. Since DOD is constantly modernizing, some of the funding for these requirements may have been assumed in estimates for the later years of DOD's baseline budget. DOD appears to have shifted some of its baseline requirements to war requests.

Shifting funding from the regular budget to emergency funding is attractive because DOD's emergency spending has not been subject to budget caps, allowing the services to substitute other less urgent requirements in their baseline budgets. On the other hand, DOD consistently faces budget pressure from unanticipated increases in the cost of its new weapon systems.

The FY2007 Supplemental also includes a more than doubling of the amounts for force protection, and substantial increases in funding Iraq and Afghan Security Forces as well as over $1 billion for military construction funding in FY2007. See CRS Report RL33900, *FY2007 Supplemental Appropriations fo Defense, Foreign Affairs, and Other Purposes*, by Stephen Daggett et al for additional information on these and other war issues.

Potential Readiness Issues

For some time, service representatives and Members of Congress have raised concerns about current readiness levels, particularly the Army's ability to respond to

[68] CBO, *Budget Options*, February 2007, p. 9-10 [http://www.cbo.gov/ftpdocs/78xx/doc7821/02-23-BudgetOptions.pdf].

the full range of potential war scenarios with trained personnel and fully operational equipment, a concern recently reiterated to Congress by General Pace, Chair of the Joint Chiefs of Staff.[69] According to reports, current Army readiness rates have declined to the lowest levels since the end of the Vietnam war with roughly half of all Army units, both active and reserve, at the lowest readiness ratings for currently available units.[70]

Because DOD's standard ratings (known as C-ratings) assess readiness relative to the full range of standard wartime scenarios, however, they do not necessarily reflect whether units are ready to deploy to Iraq and Afghanistan to conduct counterinsurgency operations. For example when asked about his readiness concerns during a hearing of the House Armed Services Committee, General Schoomaker, Chief of Staff of the Army stated that "I have no concerns about how we are equipping, training and manning the forces that are going across the berm into harm's way. But I do have continued concerns about the *strategic depth* of the Army and its readiness," referring to other potential missions of the Army [italics added].[71]

General Schoomaker's testimony may reflect an alternate DOD readiness system that assesses units about to deploy to carry out missions that are not their traditional ones. In this circumstance, the services use an alternate readiness reporting system known as "Percent Effective" or PCTEF. Unlike standard ratings, which largely reflect specific quantitative criteria, percent effectiveness ratings reflect a "subjective assessment of the unit's ability to execute its currently assigned 'nontraditional' mission."[72] Unit commanders are to judge whether the unit has:

- the required resources and is trained to carry out all missions (a rating of 1);
- most of its missions (a rating of 2);
- many but not all of its missions (a rating of 3); or
- requires additional resources to carry out its assigned missions (a rating of 4).[73]

According to reports, the Army is facing shortages of certain equipment and personnel for state-side units who are currently either training up so as to deploy at a later date or are part of the strategic reserve who could be called upon should other contingencies arise elsewhere. Such shortages could affect a unit's ability to train and be fully prepared for its various missions. At the same time, some training limitations that are captured in a unit's standard readiness ratings — for example, for large-scale combat operations — may not affect a unit's ability to conduct counter-insurgency

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[69] Washingtonpost.com, "General Pace: Military Capability Eroding," February 27, 2007.

[70] U.S. House of Representatives, Committee on Appropriations — Democratic Staff, "United States Army Military Readiness," September 13, 2006, pp. 2-4.

[71] Transcript of hearing before House Armed Services Committee, "Hearing on Iraq Policy Issues: Implications of the President's Policy for Readiness, the Total Force and Strategic Risk," January 23, 2007, p. 10.

[72] Joint Chiefs of Staff, "Chairman of the Joint Chiefs of Staff Manual 3150.02A," p. J-4.

[73] Ibid.

operations in Iraq or Afghanistan. In testimony in January 2007, however, then-Army Chief of Staff, General Peter Schoomaker acknowledged that for deploying units, "there is important equipment that is only available in Kuwait that they must train on before they cross the berm," that is training conducted shortly before final deployment in-country.[74]

Another readiness concern is the fact that some active duty members are redeploying with less than a year at home to rest and retrain raising concerns that members may choose not to reenlist which could create problems in meeting recruitment and retention goals. Although there were some shortfalls in FY2005, the Army was only 1% short of meeting its FY2006 goal of recruiting 186,000 personnel for its active-duty and reserve forces, and retention continues to exceed goals.[75]

While some units redeploy within a year, many of the individuals that make up those units are no longer in that unit because of new assignments. A better measure may be the fact that of the 1.5 million individuals who have deployed for Iraq of OEF, about 30% have had more than one deployment.[76]

Reserve units have also been frequently cited as short of equipment because some equipment has been left behind in Iraq and replacement equipment has not been delivered. Problems with reserve readiness are longstanding because until the Afghan and Iraq operations, reservists were seldom deployed for contingencies and thus were traditionally given less equipment and fewer personnel.[77] Recent DOD requests include substantial funding for new equipment for the reserves.

While some readiness concerns, like those of the reserves, are longstanding, it is not clear how long other readiness problems have persisted or how long they will continue. This debate about readiness has sharpened with the President's decision to increase troop levels in Iraq and Afghanistan by about 35,000 and congressional consideration of withdrawal options. At issue may be how long readiness problems are expected to persist and whether problems reflect lack of resources or management problems such as an inability to identify ongoing reset and hence ensure that equipment that is needed most urgently is fixed or replaced first.

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[74] Transcript of hearing before House Armed Services Committee, "Hearing on Iraq Policy Issues: Implications of the President's Policy for Readiness, the Total Force and Strategic Risk," January 23, 2007, p. 10.

[75] See Tables 1, 3, and 5 in CRS Report RL32965, *Recruiting and Retention: An Overview of FY2005 and FY2006 Results for Active and Reserve Component Enlisted Personnel*, by Lawrence Kapp and Charles A. Henning.

[76] Defense Manpower Data Center, "Contingency Tracking System Deployment File for Operations Enduring Freedom & Iraqi Freedom," as of December 31, 2006.

[77] GAO-5-660, *Reserve Forces: An Integrated;* GAO-06-1109T*, Reserve Forces: Army National Guard and Army Reserve Readiness for 21st Century Challenges, September 21, 2006.*

Congressional Options to Affect Military Operations

As interest in alternate policies for Iraq has grown, Congress may turn to the Vietnam and other experience to look for ways to affect military operations and troop levels in Iraq. In the past, Congress has considered both funding and non-funding options. Most observers would maintain that restrictions tied to appropriations have been more effective. (For an analysis of the legal issues in restricting military operations, see CRS Report RL33837, *Congressional Authority to Limit U.S. Military Operations in Iraq*, by Jennifer K. Elsea, Michael John Garcia, and Thomas J. Nicola. For examples of past enacted and proposed restrictions, see CRS Report RL33803, *Congressional Restrictions on U.S. Military Operations in Vietnam, Cambodia, Laos, Somalia, and Kosovo: Funding and Non-Funding Approaches*, by Amy Belasco, Hannah Fischer, Lynn Cunningham, and Larry Niksch. For recent proposals to restrict military operations, see CRS Report RL33900, *FY2007 Supplemental Appropriations for Defense, Foreign Affairs, and Other Purposes*, by Stephen Daggett et al.)

Restrictive funding options generally prohibit the obligation or expenditure of current or previously appropriated funds. Obligations occur when the government pays military or civilian personnel, or the services sign contracts or place orders to buy goods or services. Expenditures, or outlays, take place when payment is provided.

Past attempts or provisions to restrict funding have followed several patterns including those that

- cut off funding for particular types of military activities but permit funding for other activities (e.g., prohibiting funds for combat activities but permitting funds to withdraw troops);
- cut off funds as of a certain date in a specific country;
- cut off funds "at the earliest practical date," which essentially gives the president leeway to set the date;
- cut off funds if certain conditions are met (such as a new authorization) or certain events take place (such as the release of U.S. prisoners of war).

Other non-funding approaches to restrict military operations have

- required that troops be withdrawn by a specified date in the future or at the "earliest practical date;"
- withdrawn funds unless there was a declaration of war or a specific congressional authorization of the war activities; or
- repealed previous congressional resolutions authorizing military activities.

One or both houses may also state a "sense of the Congress," or non-binding resolution that does not need to be signed by the President that U.S. military operations should be wound down or ended or forces withdrawn.

While only a handful of provisions have been enacted, congressional consideration of these various limiting provisions placed pressure on the Administration and thus influenced the course of events. For example, the well-known Cooper-Church provision that prohibited the introduction of U.S. ground troops into Cambodia was enacted in early 1971 after U.S. forces had invaded and then been withdrawn from Cambodia; that provision was intended to prevent the reintroduction of troops.[78]

Although President Nixon did not reintroduce U.S. troops, the United States continued to bomb Cambodia for the next three years. Later in 1973, Congress passed two provisions that prohibited the obligation or expenditures of "any funds in this or any previous law on or after August 15, 1973" for combat "in or over or from off the shores of North Vietnam, South Vietnam, Laos or Cambodia."[79] The final version reflected negotiations between the Administration and Congress about when the prohibition would go into effect with August 15, 1973 set in the enacted version and bombing did stop on that day.

Several well-known proposals that were not enacted — two McGovern-Hatfield amendments and an earlier Cooper-Church amendment — were also part of this Vietnam Era jockeying between the Administration and Congress. One McGovern-Hatfield amendment prohibited expenditure of previously appropriated funds after a specified date "in or over Indochina" except for the purpose of withdrawing troops or protecting our Indochinese allies while another also prohibiting spending funds to support more than a specified number of troops unless the president notified the Congress of the need for a 60 day extension. The earlier Cooper-Church amendment prohibited the expenditure of any funds after July 1, 1970 to retain troops in Cambodia "unless specifically authorized by law hereafter."[80]

Generally, Congress continued to provide funds for U.S. troops in Vietnam at the requested levels as the Nixon Administration reduced troop levels. Overall, funding restrictions have generally proven more effective than the War Powers Act, which has been challenged by the executive branch on constitutional grounds.[81]

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[78] See discussion and language of the Cooper-Church amendment (Sec.7, P.L. 91-652) in CRS Report RL33803, *Congressional Restrictions on U.S. Military Operations in Vietnam, Cambodia, Laos, Somalia, and Kosovo: Funding and Non-Funding Approaches*, by Amy Belasco, Hannah Fischer, Lynn Cunningham, and Larry Niksch.

[79] One provision was included in both P.L. 93-52, the Continuing Appropriations Act of 1974 and the Second Supplemental Appropriations Act of 1973, P.L. 93-50, both enacted July 1, 1973; see CRS Report RL33803, *Congressional Restrictions on U.S. Military Operations in Vietnam, Cambodia, Laos, Somalia, and Kosovo: Funding and Non-Funding Approaches*.

[80] See H.R. 17123, H.R. 6531, and H.R. 15628 in Table 1 and Appendix of CRS Report RL33803, *Congressional Restrictions on U.S. Military Operations in Vietnam, Cambodia, Laos, Somalia, and Kosovo: Funding and Non-Funding Approaches*.

[81] CRS Report RS20775, *Congressional Use of Funding Cutoffs Since 1970 Involving U.S. Military Forces and Overseas Deployments*, by Richard F. Grimmett.

Problems in War Cost Estimates and Reporting

GAO, CBO and CRS have all testified to Congress about the limited transparency in DOD' war cost estimating and reporting.[82] While DOD has provided considerably more justification material for its war cost requests beginning with the FY2007 Supplemental, many questions remain difficult to answer — such as the effect of changes in troop levels on costs — and there continue to be unexplained discrepancies in DOD's war cost reports.

How might Congress get better, accurate information on war costs? To provide Congress a better basis for oversight, DOD could:

- provide estimates of the allocations of all budget authority provided for OIF and OEF, and compare those to outlays to date;
- provide past, current and future estimates of average troop strength — both deployed and total — for each operation and other key cost drivers such as operating tempo;
- set up separate appropriation accounts for war funding to create visibility on outlays and increase accuracy;
- compare all budget authority appropriated for war with obligations for each operation to identify trends and reporting inconsistencies;
- explain the rationale and assumptions underlying estimates of reset requirements to repair and replace equipment that is worn out or lost in combat, and track amounts actually spent;
- estimate and explain how recapitalization and upgrade requirements are related to war needs rather than ongoing modernization;
- show how funding provided in supplemental appropriations may reduce DOD's baseline requests by funding maintenance or procurement earlier than anticipated;
- estimate future costs under various scenarios.

In its Section 9010 report, DOD provides Congress with fairly detailed quarterly reporting on various metrics for success in Iraq — ranging from average daily hours of electrical power by province to average weekly attacks on civilians, Iraq Security Forces and coalition forces — but measures of U.S. military costs are not required. Detailed reporting of different military costs and troop levels could be included as a metric for assessing operations Iraq, Afghanistan and other counter terror operations.[83] Particularly if the global war on terror is indeed "the long war" of indefinite duration, better cost reporting could aid congressional oversight and assessment of emergency funding requests.

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[82] See testimony to House Budget Committee, October 24, 2007, July 31, 2007, and testimony to Subcommittee on National Security, Emerging Threats and International Affairs, House Government Reform, July 18, 2006.

[83] H.Rept. 109-72, p. 97; DOD, Section 9010 Report to Congress, "Measuring Stability and Security in Iraq" [http://www.defenselink.mil/pubs/iraq_measures.html].

Difficulties in Explaining DOD's War Costs

What makes war costs change? Changes in war costs would be expected to vary with troops levels, war-related benefits, the intensity of operations, and levels of basing and support. The extent of competition in contracts and the price of oil would also be expected to affect the prices of goods and services purchased by DOD.

A list of the primary war cost drivers would be expected to include:

- the number of troops deployed or anticipated to deploy;
- changes in the pace of operations or optempo;
- changes in the amount of equipment and number of personnel to be transported to the theater of operations;
- whether support is designed to be temporary or longer-term;
- force protection needs;
- how quickly equipment breaks down and how quickly it is to be replaced or upgraded; and
- military basing plans that underlie construction requests.

Troop levels would be expected to be the basic underlying factor that determines the cost of military activities and support ranging from the number of miles driven by trucks (which, in turn, affects how quickly trucks break down), purchases of body armor (varying with the threat), or meals served and housing provided. Troop levels, however, have risen far less than costs.

Little of the $93 billion DOD increase between FY2004 and FY2007 appears to reflect changes in the number of deployed personnel, which has grown by only 15% (see **Table 2**). Rather the increase is attributable to several factors:

- certain unanticipated requirements for force protection gear and equipment;
- the cost of training and equipping Afghan and Iraqi security forcesx; and
- even more, a broadened definition of th types of programs that DOD considers part of war reconstitution or reset — funds to repair and replace war-worn equipment.[84]

Changes in Troop Strength. In testimony and supplemental requests, DOD typically cites the number of "boots on the ground" at a particular time to illustrate military personnel levels. For example, DOD figures show that there were about 139,000 troops in Iraq and 19,000 in Afghanistan or about 158,000 as of October 1, 2006.[85] Similar figures are cited by DOD witnesses in hearings.

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[84] See CRS, Statement of Amy Belasco before the House Budget Committee, Hearing on "The Rising Cost of the Iraq War," October 24, 2007; [http://budget.house.gov/hearings /2007/10.24Belasco_testimony.pdf] Stat.

[85] DOD, Information Paper, "Congressional Research Service Request for Boots on the Ground (BOG) Statistics for Iraq and Afghanistan, January 1, 2007," 1-2-07.

This figure, however, does not include all troops in the region deployed for OIF or OEF operations or capture the annual average as troops rotate in and out of the theater during the year. Nor does it capture activated reservists in the United States who are training, backfilling for deployed troops, or supporting DOD's enhanced security (ONE) mission. For these reasons, "boots on the ground" figures understate the number of military personnel dedicated to these operations.

For example, in FY2006, average troop strength was some 297,000 for operations in Iraq, Afghanistan and other counter-terror operations or almost twice as high as "boots on the ground" figures (see **Table 5**). In its new supplemental request, DOD cites about 320,000 for its troop strength in FY2007, acknowledging the higher troop levels for the first time.[86] The reported average for the year was 303,000 (see **Table 5**).

In FY2004, the first year of occupation, DOD figures show average troop strength for all three missions of 304,000. In its FY2007 Supplemental request, DOD projected a total of about 319,000 troops, a 5% increase since FY2004. Costs would more than double from $72 billion in FY2004 to $165 billion for FY2007 (see **Table 2**). Reported troop strength for FY2007 was 303,000 (see **Table 5**).

Some would argue that the average number of *deployed* troops dedicated to Iraq and GWOT operations would be provide a better metric to explain war costs because those are the troops carrying out ongoing operations. Under this reasoning, reservists in the United States — whether training up or backfilling — are considered the support tail for deployed troops.

Between FY2004 and FY2006, average deployed troop strength increased from about 216,000 to 247,000 or by about 14% whereas funding levels increased by 60% (see **Table 5**). DOD's "surge" or "plus-up" for FY2007 of about 30,000 troops increased average troop strength by only 10,000 or about 4% over FY2006 (taking into accounts dips earlier in the year and the fact that additional troops would be in place for only part of the year). That brought troop strength for FY2007 to about 256,000 or about 19% above FY2004. At the same time, DOD's enacted funding for FY2007 is more than double the amount in FY2004. Changes in troop strength do not explain such increases. Defense Manpower Data Center does not show average troop strength data by operation.

[86] DOD, *FY2007 Emergency Supp,* p. 16. [http://dod.mil/comptroller/defbudget/fy2008/fy2007_supplemental/FY2007_Emergency_Supplemental_Request_for_the_GWOT.pdf].

Table 6. Average Troop Strength for Iraq, Afghanistan, and Other Counter-Terror Operations, FY2001-FY2007

(in thousands)

Average Deployed by Service	FY01	FY02	FY03	FY04	FY05	FY06	FY07
	51	**77**	**220**	**216**	**245**	**247**	**256**
Army	8	17	110	143	156	156	156
Navy	29	30	42	25	29	32	40
Marine Corps	0	4	32	25	35	32	32
Air Force	14	26	35	24	25	27	27
Activated Reserves State-side[a]	**NA[b]**	**51**	**92**	**87**	**66**	**50**	**46**
All OIF/OEF/ONE Military Personnel	**50**	**129**	**312**	**304**	**312**	**297**	**303**

Source: CRS calculations from Defense Manpower Data Center, *DRS17253 Report*, Average Number of Members By Month, 0901-1107, January 2008.

Note: Average strength computed by the Defense Manpower Data Center by totaling the number of days deployed for each service member in a year and then dividing that figure by the 365 days in the year. Numbers may not add due to rounding.

a. Activated reservists in the United States are training up for deployments, backfilling the positions of deployed active-duty personnel, or providing enhanced security at U.S. installations.
b. Not available.

Military personnel funding has hovered between $16 billion and $20 billion a year (see **Table 6**). About half of war-related military personnel cost is for the full-time pay and benefits to the 150,000 reservists to110,000 reservists who have been activated each year since FY2004, with the number falling in recent years.[87]

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[87] Average annual strength for activated reservists from Defense Manpower Data Center, "Average Member Days Deployed by Service Component and Month/Year, 9/01 to 11/06."

Table 7. DOD's War Enacted Budget Authority by Title: FY2004-FY2009 Bridge

(in billions of dollars)

Title	FY04	FY05	FY06	FY07	FY08	FY09 Brdge
Military Personnel	17.8	19.7	16.7	18.8	19.1	1.2
Operation & Maintenance	42.0	47.9	60.0	75.0	78.3	51.9
Defense Health	0.7	1.0	1.2	3.0	2.0	1.1
Other Defense Programs[a]	0.1	0.2	0.2	0.4	0.3	0.2
Procurement	7.2	18.0	22.9	45.4	44.8	4.4
Research, Dev., Tstg. & Eval.	0.4	0.6	0.8	1.5	1.6	0.4
Working Capital Funds[b]	1.6	3.0	3.0	1.1	1.9	0.0
Military Construction	0.5	1.2	0.2	1.7	2.7	0.0
Subtotal: Regular Titles	**70.3**	**91.7**	**105.1**	**146.9**	**150.4**	**59.2**
Special Funds and Caps						
Iraqi Freedom Fund (IFF)	2.0	3.8	3.3	0.4	3.8	0.0
Afghan Sec. Forces Training Fd.[c]	0.0	1.3	1.9	7.4	2.8	2.0
Iraq Security Forces Training Fd[c]	[5.0]	5.7	3.0	5.5	3.0	1.0
Joint Improvised Explosive Device (IED) Defeat Fd[d]	0.0	0.0	3.3	4.4	4.3	2.0
Strategic Reserve Readiness Fd.[d]	0.0	0.0	0.0	1.6	0.0	0.0
Coalition Support Cap[e]	[1.2]	[1.2]	[.9]	[1.1]	[.8]	[.2]
Lift and sustain Cap[f]	[0]	[0]	[.4]	[.3]	[0]	[0]
Global lift and sustain Cap[e]	[0]	[0]	[0]	[0]	[0]	[0]
Global train and equip Cap[e]	[0]	[0]	[.1]	[0]	[.2]	[NA]
Cmdrs' Emerg.Response Cap[e]	[.2]	[.8]	[.9]	[1.0]	[1.8].	[1.3]
Mine Resistant Ambush Protected Transfer Account	0.0	0.0	0.0	0.0	16.8	1.7
Special Transfer Authority Cap[f]	[3.0]	[3.0]	[4.5]	[3.5]	[6.5]	[4.0]
Subtotal: Special Funds	**2.0**	**10.7**	**11.5**	**19.3**	**30.6**	**6.7**
Dept. of Defense Total	**72.3**	**102.4**	**116.7**	**166.2**	**181.1**	**65.9**
Coast Guard Transfer	0.0	[.2]	[.1]	[.2]	[.2]	[0]
Intell. Comm. Mgt Fund	0.0	0.3	0.2	0.1	0.0	0.0
Def. Nuclear Nonproliferation	0.0	0.0	0.0	0.1	0.0	0.0
Salaries & Expenses, FBI	0.0	0.0	0.0	0.1	0.0	0.0
Subtotal: Defense-Related[g]	**0.0**	**0.3**	**0.2**	**0.3**	**0.0**	**0.0**
National Defense Total	**72.3**	**102.6**	**116.8**	**166.5**	**181.1**	**65.9**

Sources: CRS calculations based on H.Rept. 110-60, S.Rept. 110-37, H.Rept. 110-107, H.R. 1591 and H.R. 2206 as passed by both houses, and "additional explanatory materials" in the *Congressional Record*, May 24, 2007, p. H.8506ff. Submitted by Congressman Obey, Chair of the House Appropriations Committee.

Notes: Numbers may not add due to rounding. This table separates funds with special purposes such as the Afghan Security Forces Fund from the regular titles to better identify trends. For FY2007, request reflects amended FY2007 supplemental submission of March 9, 2007; see OMB, *Appendix: FY2008 Budget*, "Other Materials: FY2007 Supplemental and FY2008," February 5, 2007 for original request, p. 1143ff; [http://www.whitehouse.gov/omb/budget/fy2008/pdf/appendix/sup.pdf]. For amended request, see OMB, "Estimate No. 3," [http://www.whitehouse.gov/omb/budget/amendments /amendment_3_9_07.pdf]. Includes transfers from baseline accounts to war to meet unanticipated needs through FY2005.

a. "Other Defense Programs" includes counter drug and Office of Inspector General funds.
b. Working capital funds finance additional inventory for support items such as spare parts.
c. Training Iraqi security forces was initially funded in the State Department [shown in brackets] but is now funded in DOD. The Afghan Army also received some State Department funds.
d. The Joint IED Defeat Fund finances responses to IED attacks through transfers to procurement, RDT&E, and operation and maintenance programs. Initially, Congress appropriated $1.4 billion for IED Defeat to the Iraq Freedom Fund and then appropriated $1.9 billion to a separate new account, the Joint IED Defeat Fund. The $3.3 billion total for FY2006 includes both amounts.
e. Congress sets caps on different types of coalition support — reimbursements to allies conducting operations or logistical support for OIF and OEF, and lift, support, training and equipping of allies conducting other counter-terror operations. Congress also sets a cap on CERP, a program which permits military commanders to fund small-scale reconstruction projects in Iraq and Afghanistan.
f. Congress sets the amount of transfer authority in each bill. The table includes amounts provided for both bridge and supplemental funds. Includes $10.4 billion for Iraq Freedom Fund in FY2003 (deducting specified floors) plus $2 billion in transfer authority.
g. Defense-related programs are included in the national defense budget function.

Funds for war-related military personnel also include special war-related pay and benefits (e.g., hostile fire or imminent danger pay or survivors benefits) and "overstrength" or the additional active-duty personnel who have been recruited and retained to meet wartime needs above DOD's pre-war strengths — 482,000 for the Army and 172,000 for the Marine Corps. "Overstrength" has been considered a war cost because DOD initially argued that the increases would be temporary but in the FY2007 Supplemental, the Defense Department requested that these increases be part of a permanent expansion of the Army and Marine Corps, an issue still to be resolved.

Since FY2004, DOD has reduced its reliance on reservists with the number activated falling from 151,000 in FY2004 to 113,000 in FY2006. Despite this 25% decrease, DFAS cost reports show a more modest 8% decrease in cost from $8.8 billion to $8.1 billion. It is not clear why cost figures are inconsistent with average troop levels but GAO has found various inconsistencies in DOD reporting of military personnel costs.[88]

Reliance on Reservists Falls. Between FY2004 and FY2006, DOD reduced its reliance on reservists as their share of total personnel dedicated to war missions declined from 30% to 24% (see **Figure 1**). This change reflects the fact that some reservists have bumped up against a DOD-imposed policy set after the 9/11 attacks that limited their total deployment time to 24 months. Since reserve deployments were typically for 18 months — including time to train up — reservists were often available for only one deployment.

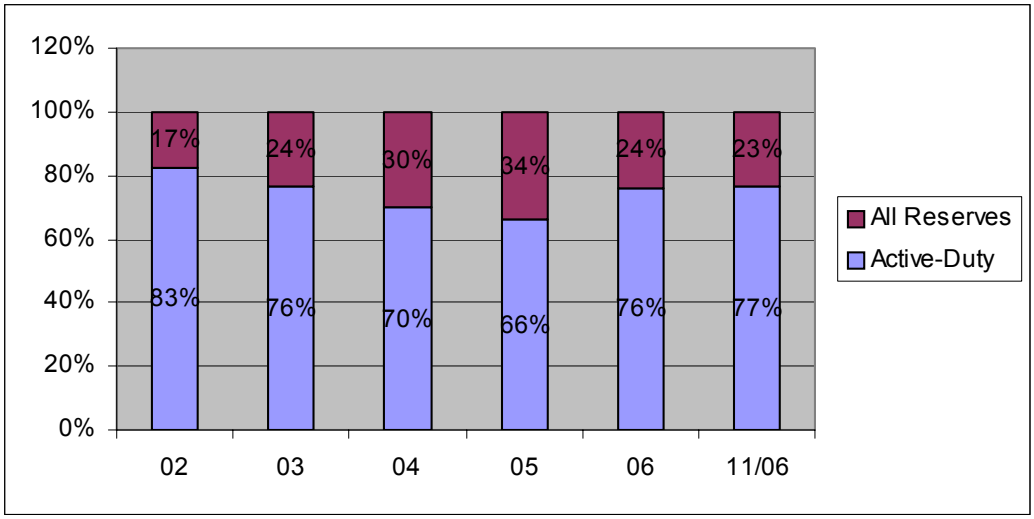
Secretary Gates recently changed this policy, setting call-ups for 12 rather than 18 months. The services could also exclude train up and demobilization time and make exceptions if necessary. The policy change also emphasizes activating units

[88] GAO, *FY2004 Costs for Global War on Terrorism Will Exceed Supplemental*, July 2004 [http://www.gao.gov/new.items/d04915.pdf].

rather than individuals to improve morale and readiness.[89] This policy change is likely to make reservists available for two tours if necessary.

Changes in Military Personnel Costs. As DOD reduces its reliance on activated reservists, war-related military personnel costs would be expected to fall because the incremental cost of active-duty personnel — special pays — is less than paying full-time salaries to reservists. Budget authority for military personnel dips in FY2006 but rises again in FY2007 (see **Table 6**). At the same time, military personnel costs increase as DOD "overstrength" or the number of personnel over the Army and Marine Corps pre-war levels — grows. Yet DFAS reports show a decline in funding for overstrength from $2.0 billion in FY2005 to $1 billion in FY2006, possibly a reporting error.[90] Although the Administration announced in January 2007 that these increases would be permanent in order to sustain higher deployments for the Global War on Terror, DOD requested the funds in the FY2007 supplemental as an unanticipated emergency expense.

Figure 1. Active-Duty and Reserve Shares of OIF/OEF Average Annual Troop Levels, FY2003-Early FY2007



Notes and Sources: Includes all activated reservists whether deployed, preparing to deploy or serving in the United States. Data from Defense Manpower Data Center, Contingency Tracking System, "Average Member Days Deployed by Service Component and Month/Year," November 2006. The Contingency Tracking System covers military personnel serving in Operation Iraqi Freedom, Operation Enduring Freedom, and Operation Noble Eagle.

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[89] David S. C. Chu, Under Secretary of Defense for Personnel and Readiness, "Mobilization/Demobilization Personnel and Pay Policy for Reserve Component Members Ordered to Active Duty in Response to the World Trade Center and Pentagon Attacks," September 20, 2001; and Robert M. Gates, Secretary of Defense, "Utilization of the Total Force," January 19, 2007.

[90] DFAS, *Supplemental and Cost of War Execution Reports*, September 2005 and September 2006, "DoD Totals."

Changes in Operating Costs. Even if troop strength remains the same, operational costs could grow if operating tempo intensifies, repair costs increase, or support costs grow. These factors appear to explain some but not all of the $17 billion increase in operating costs from $43 billion in FY2004 to $60 billion in FY2006 (see **Table 7**). Based on DOD reporting of obligations, this increase reflects

- more body armor and other protective gear for troops (purchased with O&M funds), growth of $1 billion to $2 billion;
- the jump in oil prices and the rise in intensity of operations, growth of about $4 billion;
- the coming due of maintenance bills as equipment wears out, growth of $4 billion; and
- a $2 billion increase in command, communications, control, computers and intelligence support.[91]

With the exception of force protection gear where congressional interest has been high, DOD has provided little explanation for these changes.

With enactment of the FY2007 Supplemental, operating costs jump from $60 billion in FY2006 to $75 billion in FY2007 or by 25%. This increase reflects the Administration's surge in troop levels and naval presence (about $5 billion), higher repair costs ($3 billion), more force protection gear (about $1 billion), a doubling in transportation costs for unspecified reasons ($2 billion), increased LOGCAP contractor support ($300 million), and higher operating tempo.[92] These factors account for some but not all of the increase though the rationales for the changes are often not clear. The total of $78 billion in FY2008 is similar to FY2007 with the surge in effect for part of that year as well.

Changes in Investment Costs. Since FY2004, the rise in investment costs has been dramatic — about a sixfold increase from $7.2 billion in FY2004 to $45 billion in FY2007 and in FY2008. Procurement almost doubles between FY2006 and FY2007. Investment costs include procurement, RDT&E and military construction. As a share of DOD war appropriations, investment monies grew from about 10% in FY2004 to about 20% in FY2006 and about 29% in FY2007 and FY2008. Since FY2003, DOD has received about $142 billion in war-related procurement funds — equal to about 1 and 1/2 year's worth of peacetime procurement budgets (see **Table 6**).[93]

Again, some of the reasons for this upsurge in war-related investment costs are known:

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[91] DFAS, *Supplemental and Cost of War Execution Reports*, September 2005 and September 2006, "DoD Totals."

[92] Department of the Army, *Global War on Terrorism (GWOT)/Regional War on Terrorism (RWOT), FY2007 Supplemental Budget Estimate,* Volume 1, February 2007; [http://www.asafm.army.mil/budget/fybm/fy08-09/sup/fy07/oma-v1.pdf].

[93] DOD received $80.9 billion for procurement in FY2006; see H.Rept. 109-676, p. 135.

- a push by both DOD and Congress to provide more force protection equipment and increase situational awareness (e.g., uparmored High Mobility Multipurpose Wheeled Vehicles (HMMWVs), radios, sensors);
- a decision to fund equipment for newly configured Army and Marine Corps units, known as modularity or restructuring;
- the growing bill to rebuild or replace damaged equipment, a process known as reset or reconstitution;
- extensive upgrading of equipment; and
- the building of more extensive infrastructure to support troops and equipment in and around Iraq and Afghanistan.

These reasons do not fully explain the scope of increases thus far or sort out whether the new requests are war-related emergencies rather than being part of ongoing modernization or transformation programs. DOD has provided little rationale or explanation for its requirements or changes in requirements for replacing war-worn equipment or extensive upgrades.

In some cases, requirements do not appear to be strictly related to war needs. For example, Congress included funds for C-17 aircraft in order to keep the production line open though its relationship to current war needs is tenuous. Congress also agreed to fund the cost of equipping newly configured Army and Marine Corps units — a pre-war initiative known as modularity or restructuring initiative — in the FY2005 and FY2006 supplemental (see section on reset below and CRS Report RL33900 on FY2007 Supplemental).

Typically, war funds do not include RDT&E or military construction because both activities take considerable time, and hence do not appear to meet an emergency criterion. In this respect, the Iraq and GWOT conflicts are breaking new ground. DOD is now receiving war funding for RDT&E in both specific programs and in the Joint IED Defeat Fund, a new account where DOD transfers funds after enactment with prior reporting to Congress.

In the FY2007 Supplemental, DOD is receiving an additional $1.7 billion for military construction, almost doubling the previous peak in FY2005. Funding for military construction has been controversial for two reasons — concerns among some Members that construction indicates an intent to set up permanent bases in Iraq and construction funding in the United States that is part of proposed plans to increase the size of the force, and not clearly an emergency. Although DOD has not ruled out retaining bases in Iraq, current guidelines limit the use of concrete structures and emphasize building relocatable units and the FY2007 Supplemental continues a prohibition on spending funds to set up permanent bases in Iraq. In FY2008, DOD receives an additional $2.7 billion for war-related military construction.

Special Funds and the Flexibility Issue. Since the 9/11 attacks, Congress has relied on a variety of special accounts that give DOD additional flexibility to respond to the uncertainty of wartime needs. Congress has also been more willing to approve higher levels of transfer authority which allow DOD to move funds into different accounts after enactment. The funding in these new accounts generally does not reflect troop levels or immediate operational needs.

Table 6 shows the funding provided in these flexible accounts including

- Afghan and Iraq Security Forces Funds for training and equipping police and security forces;
- the Joint Improvised Explosive Device (IED) Defeat Fund for providing funds to be transferred to procurement, RDT&E, or operation and maintenance to develop and field solutions to the IED threat;
- the Iraq Freedom Fund set up to cover war operations cost in the first year of the invasion and occupation (IFF);
- the Natural Resources Risk Remediation Fund set up to cover expected damage to Iraqi oil fields; and
- the Defense Emergency Response Fund (DERF).

Typically, Congress has given DOD latitude in how to use these funds and required after-the-fact quarterly reporting.

The Afghan and Iraq Security Forces Funds provide lump sums which DOD could then allocate between equipment and training needs. Similarly the Joint IED Defeat Fund allows DOD to decide where funds are needed to meet this threat. Although the new accounts are designated to meet particular goals, they are similar to funding flexibility given to DOD after the 9/11 attacks.

In the first two years after the 9/11 attacks, Congress gave DOD substantial leeway to move funds after enactment to meet war needs by appropriating funds to special accounts. Initially, DOD received $17 billion in its Defense Emergency Response Fund (DERF), spending those funds in broadly defined allocations such as "increased situational awareness," and "increased worldwide posture."[94] In the FY2002 Supplemental, Congress appropriated $13 billion for war costs including $11.9 billion in the DERF, transformed into a transfer account, with guidelines set in the conference report.[95]

In the FY2003 Supplemental, Congress appropriated a total of $77.4 billion in war funding, including $15.6 billion in a new Iraq Freedom Fund (IFF) where DOD could transfer funds after enactment and then report to Congress.[96] Since FY2004, Congress has appropriated most war funds to specific accounts but has given DOD larger amounts of transfer authority where DOD can move funds after enactment with the consent of the four congressional defense committees (see **Table 6**) as well as setting up new transfer accounts for specific purposes such as training Iraqi security forces.

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[94] Congress appropriated $20 billion in the government-wide Emergency Response Fund which could be spent by the President at his discretion (P.L. 107-38). DOD also received another $3.5 billion in the DERF but had to follow allocations that were set in the FY2002 DOD Conference report (H.Rept. 107-350, p. 423).

[95] H.Rept. 107-593, p. 17 and 128.

[96] Congress rescinded $3.5 billion of the $15.6 billion originally appropriated to the IFF and included ceilings for certain purposes, such as intelligence, within the total.

Congress has also set caps or ceilings on funding within O&M accounts for specific purposes rather than set program limits. These include funding for

- various types of coalition support which pays U.S. allies for their logistical support in counter-terror operations related to OIF and OEF or other counter-terror operations; and
- Commanders Emergency Response Program (CERP) for small reconstruction projects selected and run by individual commanders;

The issue for Congress is the amount of flexibility to give DOD to meet needs which it cannot define when appropriations are provided.

Average Cost Per Deployed Troop and Future Costs

To give another window into trends and how changes in troop levels may affect costs, CRS estimated the average annual cost for each deployed troop — showing operational and investment costs separately. Because only some costs (e.g., for meals, body armor, operating tempo, and ammunition) are likely to vary in proportion with troop levels, the average cost per troop cannot be used to directly estimate the cost of alternate troop levels (see **Table 8**).

Table 8. Average Annual Cost Per Deployed Troop: FY2003-FY2006

Average Troop Strength & Obligations	FY03	FY04	FY05	FY06	Change Since FY2003
Number of deployed troops[a]	225,800	219,600	258,800	269,300	19%
Average annual obligations (in 000s of $)	$320,000	$340,000	$350,000	$390,000	22%
Operational costs[b]	$300,000	$300,000	$270,000	$325,000	8%
Investment costs[c]	$20,000	$40,000	$80,000	$65,000	225%

Notes and Sources: Numbers rounded. CRS calculations based on average deployed troop strength from the Defense Manpower Data Center (DMDC) and costs from Defense Finance Accounting Service, *Supplemental & Cost of War Execution Reports*, FY2003-FY2006 with CRS estimates of unreported expenses. DMDC troop strength does not separate Iraq and OEF.

a. Does not include additional activated reservists who are training up for deployments, backfilling for active-duty personnel or providing additional security at bases. DMDC figures do not separate military personnel in OIF and OEF.
b. Includes military personnel and operation and maintenance costs.
c. Includes procurement, RDT&E, and military construction costs.

Some costs would rise or fall immediately as troops are withdrawn (e.g., meals served, fuel consumed, spare parts replaced), whereas other costs would change more slowly (e.g., utilities costs, building maintenance, equipment wear and tear). Still other costs would temporarily increase, such as transportation costs to ship personnel and equipment back to the United States. Over time, however, support costs would begin to change in proportion with personnel levels if higher troop levels persist or if troops are withdrawn.

Since FY2003, the estimated average cost per deployed troop has risen from about $320,000 to $390,000 per deployed troop.[97] While that increase reflects primarily more spending for procurement — for replacement and upgrading of equipment — operational costs have also grown (see **Table 8**).

Estimates of Future Costs. CBO has again projected the future cost of the Global War on Terror under two alternative scenarios — both Iraq and OEF — in its most recent 2008-2018 budget outlook. Under the faster drawdown scenario, troop levels would decline from about 205,000 to 30,000 troops by FY2010. Concurrently, costs would decline from $193 billion in FY2008 (the Administration's request) to about $33 billion in FY2011 with:

- $118 billion in FY2008;
- $50 billion n FY2010;
- $33 billion in FY2011;
- $33 to $35 billion each year from FY2012 through FY2018.

Under the more gradual drawdown scenario, troop levels would decline from 205,000 to 75,000 troops by FY2013. Costs would decline to about $77 billion once the steady state was reached with:

- $161 billion in FY2009;
- $147 billion in FY2010;
- $128 billion in FY2011;
- $101 billion in FY2012;
- $79 billion in FY2013; and
- about $77 billion a year for FY2014 through FY2018.[98]

CBO did not estimate a more rapid withdrawal of troops.

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[97] CRS revised these costs because of better data on average deployed troop levels received recently from the Defense Manpower Data Center. Because this data does not segregate military personnel by OIF and OEF, CRS includes only one figure for both.

[98] See Table 1-5 in CBO, *The Budget and Economic Outlook" Fiscal Years 2008-2018*, January 2008; [http://www.cbo.gov/ftpdoc.cfm?index=8917].

Appendix A. Congressional Action on FY2008 and FY2009 War Funding

On June 30, 2008, the President signed the FY2008 Supplemental and FY2009 Bridge Fund (H.R. 2642, P.L. 110-252) that was passed by the Senate on June 26, 2008 and by the House a week earlier. Referred to as the FY2008 Supplemental, the act provides a total of about $160 billion including $92 billion to cover the rest of FY2008 (in addition to the $90 billion already appropriated) plus a $67 billion bridge fund that is expected to cover war costs until July 2009 well into a new Administration. The bulk of the funding is for DOD war operations, troop support, and modernization.

Congress reduced the Administration's request by about $13.7 billion, with some $12.6 billion taken from the DOD request, including an across-the-board cut of $3.8 billion of DOD's investment and working capital fund accounts and a substitution of $5.7 billion of funding not related to war such as the cost of higher fuel costs and base closure costs for DOD's baseline budget as well as hospitals, childcare centers and modernization of DOD facilities in the United States.[99] These reductions may indicate growing congressional scepticism about the validity of DOD requests as well as congressional decisions to fund additional C-17 and C-130 aircraft not requested by the Administration.

Table A1. Chronology of FY2008 War and FY2009 War Requests

(in billions of $)

Agency	FY2008 Req. As of Feb. 07	FY2008: July 07 MRAP Amdt.[a]	FY2008: Oct. 07 Amdt.	Total FY2008 Req.[b]	FY2008 Supp. Req.	FY2009 Baseline War Req. As of Feb. 08	FY2009 Bridge, May 2, 2008 Req.
DOD	141.0	5.3	42.3	188.7	101.3	0.2	66.0
State/USAID	5.0	0.0	1.1	3.4	3.4	1.4	2.5
VA Medical	0.8	0.0	0.0	0.8	0.0	1.3	0.0
Total	**146.8**	**5.3**	**43.4**	**192.8**	**104.7**	**2.9**	**68.5**

Sources: CRS calculations based on Administration request and relevant acts and bills, except where otherwise noted. Totals may not add due to rounding.

a. MRAP = Mine Resistant Ambush Program (MRAP) vehicles.

[99] The Administration's October 2007 amended request included about $1.2 billion in non-war costs. CRS calculations based on H.R. 2642 as requested by the Administration and passed by the House on June 19, 2008, and the Senate on June 26, 2008. DOD's Title IX funding was passed by the House on May 22, 2008 and by the Senate on June 19, 2008. Both houses also passed Military Construction/VA/State/USAID funding plus the across-the-board cut to DOD investment and working capital fund accounts on June 19, 2008 by the House and on June 26, 2008 by the Senate. For statutory language, see *P.L. 110-252*; for explanatory statements, see *Congressional Record*, May 19, 2008, p. S4318ff, Amendment #2, for DOD funding and *Congressional Record*, June 26, 2008, p. S6239ff for Military Construction, VA, and State/USAID funding.

b. CRS includes an estimated $530 million for enhanced security based on FY2007 obligations, $504 million for health care increases for Wounded, Ill and Injured soldiers as war-related, and excludes $762 million to cover higher fuel costs in DOD's regular program and $416 million to accelerate the conversion of Walter Reed Army Medical Hospital, and non-emergency State/USAID requests; DOD considers the last three 'Other Emergency' requests. CRS calculations based on OMB and DOD budget submissions.

Taking into account all war funds appropriated, Congress provided a total of $182 billion for FY2008 — some $11 billion more than in FY2007, continuing the annual increases albeit at a slower rate. The Administration requested funds from Congress in three installments — an original FY2008 request in February 2008, an amendment for Mine Resistant Ambush Program (MRAP) vehicles on July 31, 2008, and a second amendment to cover additional costs submitted on October 22, 2008 (see **Table B1**).

Like last year, the newly enacted P.L.110-252 also provides funds to cover part of FY2009 war costs expected to last until June or July of 2009, well into the next administration by relying on both supplemental and regular appropriations.[100] Congress passed a Continuing Resolution to fund the Administration's FY2009 baseline requests for all agencies except for DOD, VA, and the Department of Homeland Security (see **Table A1**).

P.L. 110-252 includes an additional $92 billion for FY2008 for DOD, State/USAID and VA as well as $67.4 billion in bridge funds for FY2009 (see **Table A2**). Combined with regular DOD funding, these monies would cover war costs until about June or July 2009 or well into a new administration. The Administration did not submit a request for war funding for the entire fiscal year despite a congressional requirement to do so, presumably because of uncertainty about future troop levels in Iraq.

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[100] The FY2008 Consolidated Appropriations Act included $70 billion for FY2008 war funding to cover the first part of the fiscal year. The amended FY2009 request provides a breakdown by account and some details compared to the "placeholder" request submitted with the FY2009 budget. The House Appropriations Committee said that the DOD request arrived too late in the process to be considered.

Table A2. Enacted FY2008 and FY2009 War Funding

(in billions of dollars)

Agency	First Continuing Resolution, P.L. 110-5, 9-29-07	FY2008 DOD Approp. P.L. 110-92, 11-13-07[a]	Division L, FY2008 Consolidated Approp. P.L. 110-61, 12-26-07	FY2008 Total Enacted as of 6-15-08	FY2008 Supp. in H.R. 2642/P.L. 110-252, 6-30-08[a]	FY2009 Bridge in H.R. 2642/ P.L.110-252, 6-30-08[a]	Total FY2008/ FY2009 Fdg in H.R. 2642/ P.L.110-252, 6-30-08[a]
DOD	5.2	12.2	70.0	87.4	88.7	65.9	154.7
State/ USAID	0.0	0.0	2.1	2.1	3.1	1.4	4.5
VA Medical	0.0	0.0	0.9	0.9	0.4	0.0	0.4
Total	**5.2**	**12.2**	**73.0**	**90.3**	**92.2**	**67.4**	**159.6**

Sources: CRS calculations based on public laws cited above and explanatory statements in *Congressional Record*, May 19, 2008 and June 26, 2008.

a. CRS excludes $5.7 billion in P.L. 11-252 as non-war costs including $2.5 billion for higher fuel costs for DOD's regular program, $1.3 billion in BRAC costs, and $1.9 billion to renovate or build new facilities on bases in the United States ($500 million for facilities modernization, $172 million for childcare centers, $200 million for Army barracks renovations, $818 million for hospitals, and $293 million for medical facility renovations).

The final version of the FY2008 Supplemental represents a compromise between congressional and Administration positions including an expansion of education benefits for veterans and extended unemployment insurance originally opposed by the Administration, and lower amounts for domestic funding endorsed by the Senate, plus new disaster funding for flooding in the Midwest.[101]

Earlier versions of H.R. 2642, the FY2008 Supplemental and the FY2009 bridge fund were passed before the Memorial Day recess, partly in response to warnings from the Administration that the current funding would run out by June 15, 2008 unless DOD took additional actions.[102] A recently approved funding transfer extended DOD war financing until early July 2008 (see below). To avoid threatened vetoes by the president, the final version included funding for Iraq and Afghanistan

[101] OMB, "Statement of Administration Policy, H.R. 2642, Supplemental Appropriations Act," June 19, 2008; available at [http://www.whitehouse.gov/omb/legislative/sap/110-2/saphr2642-h2.pdf]. Senate Appropriations Committee, Press Release, "Statement of Senator Robert C. Byrd (D-W.Va.) Chairman, Senate Appropriations Committee n Supplemental Funding for Investments in America, June 26, 2008"; [http://appropriations.senate.gov/pressroom.cfm]; House Appropriations Committee, Press Release, "Emergency Supplemental Funding for Iraq, Afghanistan Veterans, workers, and Midwest Disasters," June 19, 2008; [http://appropriations.house.gov/pdf /EmergencySupplemental6-19-08.pdf].

[102] *Congress Daily*, "Reid Pushes Back Supplemental Timing," 5-14-08; *Inside the Navy,* "Nussle: War Funds Needed Before June To Avoid Furlough Warnings," 4-21-08.

for DOD, reduced funding for domestic emergencies, modified new GI benefits developed by Congress, and dropped policy provisions on Iraq.

Estimates of FY2008 and FY2009 Funding for Iraq and Afghanistan. CRS estimates that the enacted version of the FY2008 Supplemental includes a total of about $160 billion in war costs including about $128 billion for Iraq and $32 billion for Afghanistan for all agencies.

For FY2008, CRS estimates that H.R. 2642/P.L. 110-252 includes an additional $92.2 for war funding for Iraq and Afghanistan for all agencies. This includes:

- $73.7 billion additional for Iraq bringing the FY2008 total to about $149.2 billion, or about $16 billion above FY2007;
- $18.5 billion additional for Afghanistan bringing the FY2008 total to about $33 billion, or $4.1 billion below FY2007.

For FY2009, CRS estimates the FY2008 Supplemental includes a total $67.4 for war funding for Iraq and Afghanistan for all agencies, including:

- $54.3 billion for Iraq or about $900 million more than the request; and
- $13.1 billion for Afghanistan, or about $2 billion below the request.

CRS estimated the allocation of FY2009 funding between the two operations using DOD data for the prior year because DOD did not provide that information for its FY2009 bridge request.[103] Nor did DOD request funding for the full year or provide detailed justification materials as is required by the 2007 National Defense Authorization Act (P.L. 109-364).[104]

FY2008 Supplemental and FY2009 Bridge Funding by Agency. As in the past, most of the war funding enacted in the FY2008 Supplemental goes to the Department of Defense for operations, troop support, and modernization of equipment. The $160 billion total in P.L. 110-252 includes

- $88.7 billion in FY2008 and $65.9 billion in FY2009 for DOD;
- $3.1 billion in FY2008 and $1.4 billion in FY2009 for State's foreign and diplomatic operations; and

[103] CRS requested this information two months ago and is awaiting a reply.

[104] OMB, Letter to the President, May 1, 2008, accompanying *Estimate #2 — FY 2009 Emergency Budget Amendments: Operation Iraqi Freedom, Operation Enduring Freedom, and Selected Other International Activities,* 5/2/08, p. 2; [http://www.whitehouse.gov/omb/budget/amendments/amendment_5_2_08.pdf]. The CRS calculation relies on DOD allocations between OIF and OEF by account for FY2008 because DOD did not provide any allocation for FY2009, and allocations for international affairs based on the explanatory statement for the Senate-passed version of H.R. 2642 in the *Congressional Record,* May 19, 2008 (see p. S. 4709ff).

- a $400 million congressional add for VA medical in FY2008 to accelerate construction of an additional poly trauma center.[105]

These estimates exclude $1.4 billion requested in the regular FY2009 budget of $1.4 billion for foreign and diplomatic operations and $1.3 billion in Department of Veterans Affairs funding for medical services for Iraq and Afghanistan that are being considered separately during the regular appropriations process.

Congressional Changes to DOD Requests. In March 2008, DOD submitted an informal request to the congressional defense committees to reallocate $9.9 billion within the pending FY2008 Supplemental request; no official request is planned. The draft DOD reallocation would free up funds primarily from $2.5 billion in unanticipated savings in Army operating costs because of reliance on more lightly equipped units and $6.6 billion cuts in Army procurement reflecting execution or lower requirements.

These funds would be used to fund higher fuel prices in DOD's base program (+$3.3 billion), unanticipated base closure costs, other Army and Marine Corps war-related procurement ($4 billion), higher National Guard recruiting costs, an increase for the Commanders Emergency Response Program (a $500 million increase from $1.2 billion to $1.7 billion) and other adjustments. Congress adopted most of the savings proposed by DOD and some but not all of the additional requests (e.g. funding fuel and some urgent procurement).

The war request assumed that by July 2008, DOD gradually withdraws the five additional brigades deployed last spring and summer and returns to the 15 brigade level that pre-date last spring's "surge." On April 8, 2008, General Petraeus, the commanding general in Iraq, testified that he is recommending that a 45-day period of "consolidation and evaluation" after the completion the withdrawal of the five brigades that were deployed last year for the "surge" in July to be followed by a "process of assessment to examine the conditions on the ground and, over time, determine when we can make recommendations for further reductions."[106] The last of the five combat brigades is expected to be withdrawn by the end of July and it not clear whether DOD will recommend any additional withdrawals in 2008.[107]

Both houses shifted the mix of funding in FY2008, providing less for procurement and Research, Development, Test & Evaluation (RDT&E), and more for Military Construction including $1.3 billion to cover DOD's request for BRAC monies to implement base closures that were dropped in DOD's regular bill, a non-war cost.

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[105] CRS calculations based on H.R. 2642 as passed by the Senate on 5-22-08 relying on bill language and the explanatory statement in the *Congressional Record*, May 19, 2008, p. S4709ff.

[106] Testimony of General David Petraeus before the Senate Armed Services Committee, April 8, 2008.

[107] DOD, "Transcript of Press Conference with Geoffrey Morrell," 5-21-08; [http://www.defenselink.mil/transcripts/transcript.aspx?transcriptid=4232].

For FY2009, appropriators shifted funds into operations accounts while reducing funds for Iraqi Security Forces in response to congressional pressure for the Iraqis to shoulder more of the cost of rebuilding their security forces, and cutting other accounts where the needs were uncertain. The new bill includes a prohibition on paying salaries of Iraqi security forces.

Based on a comparison of the request with the enacted version, the chief changes to the request were to:

- reduce the Army procurement request by $9 billion (a 25% cut) and the Navy by $1.6 billion (an 8% cut) through both an across-the-board cut and reductions to Other Procurement which has received large infusions of funds in recent years;
- add procurement funds for additional C-17 transport aircraft, in part to meet the needs of a larger Army and U.S. Marine Corps as well as keep the production line open, and add funds for C-130 aircraft and MQ-9 Reaper unmanned aircraft;
- halve DOD's request for Research, Development, Test & Evaluation to $1.7 billion; and
- provide additional funds for Military Construction including non-war funding for base closures, hospitals, and childcare centers; and
- use savings in Operations and Maintenance (O&M) to fund higher fuel costs.

For FY2009, Congress recommended close to the Administration's $66 billion request but:

- shifted an additional $6 billion into operating accounts;
- decreased FY2009 funding for the Afghan Security Forces by $1.7 billion and for the Iraq Security Forces Fund by $1 billion as well as prohibit DOD from paying Iraqi salary costs in order to get them to shoulder more of their own rebuilding costs, a strong congressional concern; and
- trimmed funds requested for Mine Resistant Ambush Program (MRAP) vehicles and the Joint Improvised Explosive Device Fund by about $1 billion each, both of which are transfer accounts which have received substantial funding and where requirements are uncertain.

H.R. 2642, as proposed by the House and Senate appropriators, also includes funding levels for diplomatic operations and foreign assistance that differ from the Administration's request and would affect war cost estimates.

Appendix B. DOD Tools to Extend Financing War Cost

Urgency in Passing the FY2008 Supplemental. On June 4, 2008 while awaiting further congressional action on the supplemental, the House and Senate appropriations committees approved part of DOD's request to transfer additional funds to the Army to cover military personnel and operating costs until passage of the supplemental. Without transfers of funds, DOD had raised alarms that the Army would otherwise run out of funds to pay troops by mid-June 2008 and to fund operating expenses soon thereafter, and would need to furlough employees.

The FY2008 Supplemental was passed by both houses by June 26, 2008 and signed by the President on June 30, 2008. To ensure that military pay and operations were funded until then, the Defense appropriations subcommittees approved all of DOD's request to temporarily "loan" $5.7 billion in military personnel funds from the other services to the Army, and $1.6 billion of DOD's $4 billion request to transfer funds to the Army's operations and maintenance funds.[108]

In a memorandum of June 9, 2008, Deputy Secretary England issued guidance and required the services to describe activities that would be shut down, estimate the number of furloughs should funding not be received, and identify activities essential to national security that would continue should supplemental funding not be received, repeating some of the actions announced in December 2007 during the last stand-off over the FY2008 Fund.[109]

The reprogramming approved carried DOD until early July 2008. If necessary, DOD could have requested the congressional defense committees to approve transfer of an additional $7.8 billion that would enable the Army to last until early August 2008, or another five weeks. These funds could be available from excess cash in its DOD's working capital fund and transfer authority provided in the FY2008 DOD Appropriations Act (P.L. 110-116) and the FY2008 bridge fund (P.L. 110-161) that is still available.[110]

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[108] *Congress Daily*, "Senate Panel OKs Only Part of Pentagon's Transfer Request," June 11, 2008; Department of Defense, Press Release, "DoD Submits Reprogramming Action to Cover the Absence of Supplemental Funding," 5-28-08.DOD, FY08-18PA, "Army Military Personnel Requirements, and DOD, FY08-19PA, "Army Operational Requirements," May 27, 2008; *Congress Daily*, "Senate Panel OKs Only Part of Pentagon's Transfer Request, June 11, 2008.

[109] Inside Defense, "England Outlines Guidance to Military brass in Anticipation of Furlough Notices," June 12, 2008; DOD, DoD News Briefing with Geoff Morrell," from the Pentagon, Arlington, Va; available at [http://www.defenselink.mil/transcripts/transcript.aspx?transcriptid=4224]; Secretary of Defense Robert M. Gates, Memorandum for the Secretary of the Army, Navy and Under Secretary of Defense (Comptroller), "Contingency Budget planning," November 16, 2007.

[110] This CRS estimate assumes that DOD still has available $6.2 billion of transfer authority for FY2008 that was provided in P.L. 110-116 and P.L. 110-161 as well as $1.6 billion in excess cash reserves from working capital funds based on a GAO estimate. CRS calculations (continued...)

If no additional funds are transferred, DOD has sufficient transfer authority to move operating funds "loaned" by the Air Force and Navy to the Army back to the original accounts. In the past, Congress has exempted similar transfers, allowing DOD to return funds as well as recoup its transfer authority and use it for other purposes.

With enactment the FY2008 DOD Appropriations Act (P.L. 110-116) and the FY2008 Consolidated Appropriations Act (P.L. 110-116), DOD has relied on both its regular funding and the $86 billion already appropriated for war costs, which has provided some cushion before passage of the remaining war request. In the last couple of months, DOD has been financing its war costs by using funds for its regular activities that are slated to be used at the end of the year, a practice known as cash flowing. (Unless Congress restricts the use of these funds, DOD, for example, can pay for fixing a truck in either Iraq or Kansas using operations and maintenance funds appropriations provided in either its regular or supplemental appropriations; the funds are mixed in the same account.)[111]

At issue has been the extent to which Congress will approve and DOD is willing to exploit available tools to transfer funds from other accounts to meet Army needs should the supplemental not be passed as planned and when funds run out, a now familiar dilemma. (See **Table B1** for a list of tools available to DOD.)

Last year, while awaiting passage of the FY2008 fund, DOD adopted a similar approach, but assumed that civilian workers needed to be notified of potential furloughs two months in advance which would have required sending notices out just before the December holidays. This time, DOD has not yet notified civilians of potential furloughs; according to current regulations, a minimum of 15 days notification of short furloughs is required unless there is a sudden emergency.[112]

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[110] (...continued)
of Army needs are based on obligations to date in the March 2008 Standard Form 133, a projection of third quarter obligations, prior approval and internal transfers to date, revised O&M, Army war requirements this year (see above), and a weekly obligation rate of $1.5 billion for the remainder of the year.

[111] This practice of mixing war and baseline appropriations in the same accounts increases flexibility for both the Administration and Congress but reduces visibility on war costs because war and baseline funds are co-mingled in the same accounts. Exceptions are separate accounts to fund the training of Iraq and Afghan security forces, and the Iraq Freedom Fund transfer account as well as the Iraq Relief and Reconstruction set up by Congress.

[112] *Washington Post*, Federal Diary, "Pentagon Prepares for Layoffs in Budget Standoff," December 12, 2007. For non-emergency furloughs of less than 30 days, DOD civilians must receive a minimum of 15 days advance notification unless the action is due to "unforeseen circumstances," including "sudden emergencies requiring immediate curtailment of activities;" see Code of Federal Regulations, Sec. 9901.609. CRS analysts Jon Shimabukuro, Thomas Nicola, and Barbara Schwemle provided assistance with this issue. See 5 Code of Federal Regulations, Sec. 9901.714.Based on this concern, DOD announced that the Secretary of Defense had directed the Army and Marine Corps to initiate planning to "reduce operations at all Army bases by mid-February and all Marine installations by (continued...)

Although DOD prefers to use its transfer authority to make programmatic adjustments later in the year, financing war costs is consistent with the standard criteria for transferring funds — the need to meet higher priority needs — and would be less disruptive than furloughing civilians or planning to close down operations, as DOD has proposed. DOD could also temporarily free up monies by delaying the signing of contracts for non-essential base support or depot maintenance contracts where there is currently a large backlog (see **Table B1** for a listing of tools available).[113]

Based on an analysis of past obligations, current funding and DOD authorities, CRS estimates that DOD could continue to finance war costs for an additional one to two months by using currently available tools such as transfer authority to provide additional resources to the Army until passage of the supplemental.

Similar arguments about the disruption and harmfulness of delays in providing war funds have been made in previous years. DOD contended that if Congress did not pass the FY2007 supplemental in the spring of 2007, the Army would run out of funds for its wartime and peacetime operations, and face serious readiness problems and disruption in Army operations. To cope with the delay, the Army adopted a series of restrictions to slow non-war-related activities to conserve funding that would not affect readiness, projecting that $3.6 billion could temporarily be saved and used to fund war needs.

Since FY2005, Congress has provided DOD with bridge funds to cover the gap in funding of war costs before passage of a supplemental, providing $25 billion in FY2005 (P.L. 108-287), $50 billion in FY2006 (P.L. 109-148), $70 billion in FY2007 (P.L. 109-289), and $86 billion in FY2008 (see **Table A1**).[114] With these bridge funds, the debate has shifted to the spring of each year as those funds run low.

In the case of both the FY2007 and FY2008 supplementals, DOD appears to have taken advantage of some but not all the tools at its disposal to extend these time

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[112] (...continued)
mid-March 2008," and to "begin notifying roughly 200,000 civilians and contractors that we can no longer afford their services and that absent additional funding, they will be furloughed, or temporarily laid off, within a matter of weeks...just before Christmas;" Deputy Secretary of Defense Gordon England notified the defense committees News Briefing, Transcript, "Defense Department Holds Regular News Briefing, November 20, 2007 [http://www.defenselink.mil/transcripts/transcript.aspx?transcriptid=4091]. See Vice Chair, Army, General Richard A. Cody, "Contingency Budget Planning," November 26, 2007 for instructions. Notification requirement is in 10 U.S.C. 1597 (e) and is cited in Deputy Secretary of Defense Gordon England, "Letter to Senator Carl Levin, Chair, Senate Armed Services Committee," December 7, 2007.

[113] *Congressional Quarterly*, "Charges of 'Starving the Troops' Color Debate Over War Supplemental Bill," May 9, 2008.

[114] Army Budget Office, "OMA FY07 Spending Projections," February 5, 2007. The FY2006 Supplemental was enacted in mid-June 2006, while the Army claimed that the supplemental needed to be enacted by the end of April 2007 to avoid disruptions to Army operation and maintenance activities, including childcare centers.

lines and provide additional funding to the Army. Based on DOD data, CRS and the Army estimated that the Army had sufficient funds to last through June 2007 before passage of the FY2007 Supplemental.[115]

The supplemental was enacted on May 25, 2007.[116] In the case of the FY2008 war request, DOD argued in November 2007 that passage was needed by December 2007 to avoid furloughs of civilian personnel in February 2008. At that time, CRS estimated that the Army could last until late March by using available transfer authority, excess cash and delaying placing depot orders. In December 2007, Congress included $70 billion for war funds in the FY2008 Consolidated Appropriations Act (H.R. 2764/P.L. 110-161). With those funds, DOD estimates that the Army can last until early July 2008.

Time Line for the FY2008 Supplemental. CRS checked DOD estimates that the Army could operate until early July 2008 with the $70 billion bridge fund in the FY2008 Consolidated Appropriations Act by analyzing Army obligations in FY2007 taking into account DOD's current plans to withdraw this spring the five additional combat brigades sent to Iraq and Afghanistan in last year's "surge." Although CRS estimates also suggest that the Army's current funding will be exhausted by mid-June for Military Personnel and early July, 2008 for O&M. DOD could extend that time line by one to two months or until early August 2008 if necessary by using available authority to transfer additional funds to the Army or by temporarily slowing spending.

With the current bridge fund, the Army has $62.5 billion available in regular and emergency appropriations to cover its total costs — both wartime and regular — for Army Operations and Maintenance. Although Army obligations for Operation and Maintenance (O&M) dipped and spiked from month to month in FY2007, CRS estimated that monthly obligations will be lower in the first quarter of FY2008 ($5.9 billion actual) as the Army benefits from high obligations or supply orders placed at the end of FY2007, and in the third quarter ($6.2 billion) as the additional troops sent to Iraq last spring are withdrawn. Conversely, obligations are likely to be higher in the quarter of FY2008 ($7.0 billion) as the Army reorders and at the end of the year as the Army places its orders to repair equipment returning home with the planned withdrawal of the five brigades sent last year ($6.5 billion).[117]

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[115] For additional information about the FY2007 Supplemental, see CRS Report RL33900, *FY2007 Supplemental Appropriations for Defense, Foreign Affairs, and Other Purposes*, by Stephen Daggett et. al. Department of Defense Press Release, "President Bush's FY2008 Defense Submission," February 5, 2007.

[116] Army Briefing, April 2007. See the section titled, "Financing Army Operations Until Passage of the Supplemental," in CRS Report RL33900, for more details.

[117] CRS's cross-check of DOD estimates assumes total Operation and Maintenance, (O&M) Army budget authority from both baseline and emergency funds of $62.5 billion with monthly obligations for Army Operation and Maintenance by quarter as follows: $5.9 billion in 1st quarter based on actuals; estimate of $7.0 billion in 2nd quarter, estimate of $6.2 billion in 3rd quarter; and estimate of $6.5 billion in fourth quarter based on experience in FY2007 and plans to reverse the "surge."

In the case of military personnel, the Army has some $32.3 billion to fund its regular and wartime military personnel costs, which DOD estimates will last until about late June 2008. In addition, Congress has given DOD authority to transfer funds among military personnel accounts (Sec. 8005, P.L. 110-116), which allows DOD to extend the financing of the Army's military personnel war costs by "loaning" funds from the other services without tapping its General Transfer Authority. Military personnel war costs are likely to drop in the second half of the year as the five additional brigades sent to Iraq for the surge are withdrawn.

Tools to Extend How Long the Army Can Last. **Table B1** outlines tools that are currently available to DOD that could extend financing of Army military personnel and Operations and Maintenance should passage of the FY2008 Supplemental be delayed and outlines precedents and potential consequences of using these tools. Although these tools are routinely used by DOD to meet unanticipated needs, tapping these authority for war needs would reduce DOD's flexibility to finance other unanticipated higher priority needs.

The most readily available tool for DOD to extend financing of war costs is to transfer funds into Army military personnel and O&M accounts from other accounts. In FY2008, DOD has available two sources of transfer authority that total $7.7 billion which permits DOD to respond to unanticipated higher priority needs by moving funds between accounts. This total includes:

- $3.7 billion in general transfer authority where funds can be moved
- from DOD's baseline program to war needs; and
- $4.0 billion within the $70 billion in emergency supplemental appropriations which could be moved between wartime needs, e.g. from procurement to operations;
- $2.1 billion in excess cash in the working capital funds.

Other available tools that DOD could use to extend funding, such as using excess working capital fund cash (often done in the past), deferring placing depot maintenance orders or slowing baseline operations, would need to be implemented before funds run out to be effective.

Slowing spending as the Army did last spring could temporarily save $3.6 billion but would have to be implemented soon. DOD has argued that slowdowns or "belt-tightening," achieved mostly by delaying contracts to upgrade facilities and deferring orders of non-essential supplies by relying on current inventories at bases, would not be worthwhile in light of the amount of time gained vs. the potential disruption to Army operations. Last spring, while the slowdown was in effect, the Army's regular O&M obligations slowed considerably without evidence of harmful effects, perhaps partly because obligations were higher in the early part of the year.

Deferring placing depot maintenance orders would not necessarily delay equipment repairs because the Army's has a 7½ months backlog of work awaiting repairs at depots. A deferral all new FY2008 depot maintenance contracts for four months would reduce the backlog to about three months, similar to backlogs in previous years. In addition, the Army could use this hiatus to evaluate which orders should be placed first in line to meet the needs of troops preparing to deploy. Both

GAO and CBO have criticized the Army for its lack of priority setting for repairing items in depot maintenance that are needed by troops preparing to deploy.

Another longstanding authority that has been used in emergency situations is to invoke the Feed and Forage Act, an emergency authority that allows DOD to contract for emergency operational needs without having the necessary appropriations. Although DOD has mentioned this civil war era authority that permits the department to sign contracts to provide support for troops even if appropriations are not available, and it has been used periodically, the authority has been criticized for eroding congressional authority, particularly the War Powers Act. If implemented at the maximum level used in the past, it would finance one month of Army needs. At the same time, DOD might have to convince contractors to accept delayed payment, which could raise prices.

Table B1. Ways To Extend How Long Army Can Operate Without FY2008 Supplemental Appropriations

Option	Potential Additional Funds/Reduction in Obligation of FY2008 Funding in billions of $	Potential Number of Weeks or Days Financed at Obligation Rate Assumed by Army	Date Funding Might Run Out if Options Are Cumulative and Fully Implemented Precedents/ Notes	Precedents/Notes	Potential Consequences
Currently Available Tools					
Cash flow using FY2008 DOD Appropriations	$27.4 billion for Army O&M and $31.5 billion in Army Military Personnel in FY2008 DOD Appropriations Act earlier in the year	38 to 40 weeks	3rd week of June for Military Personnel and early July for O&M	"Cash flowing" — i.e., moving funds from the end of the year to the beginning has been common in recent years.	Services have long complained that "cash flowing" such large amounts is disruptive.
Use general transfer authority provided in FY2008 DOD Appropriations Act (Sec. 8005, P.L. 110-116)	$3.7 billion	2 -3 weeks	Until 2nd or 3rd week in July 2008	General Transfer Authority was used in FY2007 was later restored by Congress. Requires approval of congressional defense committees.	Would exhaust $3.7 billion in General Transfer Authority which DOD would prefer to have available for other unanticipated needs unless and until Congress were to restore it.
Use special DOD transfer authority in FY2008 Consolidated Appropriations (Sec. 603, P.L. 110-161)	$4.0 billion	2 -3 weeks	End of 1st wk of August 2008	Special Transfer Authority is intended and has been used to respond to unanticipated wartime needs, such as purchase of uparmored HMMWVs or MRAPs	DOD would not be able to use this authority for other unanticipated war needs.

Option	Potential Additional Funds/Reduction in Obligation of FY2008 Funding in billions of $	Potential Number of Weeks or Days Financed at Obligation Rate Assumed by Army	Date Funding Might Run Out if Options Are Cumulative and Fully Implemented Precedents/ Notes	Precedents/Notes	Potential Consequences
Use all remaining excess cash balances in working capital funds	$2.1 billion as of the beginning of the fiscal year	1-2 weeks	2nd week of August 2008	Cash balances are a common source of funding for O&M accounts; requires approval of congressional defense committees	Would probably require action before funds run out.
Slow obligations of baseline O&M funds as the Army did in FY2007	$3.6 billion	2 weeks	3rd week of August 2008	In April, DOD achieved savings from delaying contracts and other belt-tightening measures. Monthly obligations often fluctuate.	Proposed measures appeared likely to become increasingly disruptive to Army operations over time. Effects uncertain.
Invoke Feed and Forage Act, 41 U.S.C. 11	To be determined (TBD)	4 weeks?	TBD	This emergency authority to contract without having appropriations in hand has been invoked 11 times since 1962 for as much as $7.4 billion. Requires appropriations once payment is due.	Requires contractors to accept potential delays in payment for goods or services, which could mean higher prices.

Option	Potential Additional Funds/Reduction in Obligation of FY2008 Funding in billions of $	Potential Number of Weeks or Days Financed at Obligation Rate Assumed by Army	Date Funding Might Run Out if Options Are Cumulative and Fully Implemented Precedents/ Notes	Precedents/Notes	Potential Consequences
Transfer responsibility for LOGCAP, Other Base Support, Civilian Subsistence and Linguists from Army to another services.	Illustrative $5 billion to $10 billion	3 to 6 weeks	TBD	Secretary of Defense has the authority to assign responsibility for management and funding of war-related support to any service, and to transfer civilian personnel managing those services.	No precedents. Could be analogous to lead roles of individual services in specific missions; e.g. Air Force role in space-based intelligence; uncertain whether there would be implementation problems. Could erode congressional controls on use of funds unless Congress endorses transfers.

Sources and Notes: CRS calculations based on Army, Justification of FY2008 GWOT Operation and Maintenance Request, October amendment, 2007; H. Report 110-434, Conference report on FY2008 DOD Appropriations Act, November 6, 2007; Department of Defense, Supplemental & Cost of War Execution Reports, monthly for FY2007; H.R. 2764, December 17, 2007; see Division L, "Emergency Supplemental Appropriations for Operation Enduring Freedom and for Other Purposes," FY2008 Consolidated, H.R. 2764, as amended/P.L. 110-161; [http://www.rules.house.gov/110/text/omni/amnd2/110_hr2764amnd2.pdf].

New Tools. A new tool that would require some planning and early implementation, for which there is not a precedent but where the authority is currently available, would be to transfer funding and management responsibility for certain war-related support functions from the Army — such as $6.2 billion in wartime logistical support for all the services (LOGCAP), other base support ($3 billion), a $1.1 billion contract for linguists, and $675 million in subsistence costs for DOD civilians and contractor personnel[118] — to the Air Force and Navy. This could finance an additional month or two of Army operations and would reduce funding for Air Force and Navy by about two months. Assessing whether such a change is worth considering now and for future years could also depend on the likelihood that providing war funds continues to be a contentious issue.

Under statute, the Secretary of Defense has the authority to transfer support functions for deployed forces to any service. Title X, Section 165 provides that "the Secretary of Defense may assign the responsibility (or any part of the responsibility) for the administration and support of forces assigned to the combatant commands to other components of the Department of Defense..."[119] The Secretary also has authority to detail civilian personnel from one service to another as part of his general responsibility for managing the department so Army personnel currently managing these contracts could be detailed to another service to ensure continuity.[120]

If the Secretary were to transfer responsibility for these types of activities, the Army could be relieved of $5 billion to $10 billion of funding responsibility for wartime support activities. While this would extend the time the Army or Marine Corps could operate without a supplemental, it would reduce the funding for Air Force and Navy operations by about two months. War costs of the Air Force and Navy are much smaller than those of the Army.[121] Congress might be concerned by this action because it could undermine congressional limitations on funds and the integrity of the account structure.

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[118] Department of the Army, *Fiscal Year (FY) 2008 Supplemental Budget Estimate, Operation and Maintenance, Army, Justification Book — Amendment*, October 2007, p. 13 and p. 22; [http://www.asafm.army.mil/budget/fybm/fy08-09/sup/fy08/oma-v1.pdf].

[119] Sec. 165, Title X.

[120] See Title 5, Section 3341 and Title 10, Sec. 113 (d).

[121] For example, Navy O&M war-related obligations totaled $6.5 billion in FY2007 compared to $33.1 billion for its FY2008 baseline O&M.

Appendix C. War Appropriations by Act and by Agency

Table C1. Defense Department, Foreign Operations Funding, and VA Medical Funding for Iraq, Afghanistan and Other Global War on Terror Activities, FY2001-FY2009

(in billions of dollars of budget authority)[a]

Name of Law	Public Law No.	Date Enacted	DOD Funds	Foreign Aid Embassy	VA Medical	Total cost
FY2001 Emerg. Supp. Approp. Act for Recovery from and Response to Terrorist Attacks on the United States	P.L. 107-38	9/18/01	14.0	0.3	0.0	14.3
FY2002 Dept. Of Defense and Emergency Terrorism Response Act	P.L. 107-117	1/10/02	3.4	0.0	0.0	3.4
FY2002 Emergency Supplemental	P.L. 107-206	8/2/02	13.8	0.4	0.0	14.1
FY2002 Regular Foreign Operations	P.L. 107-115	1/10-02	0.0	0.2	0.0	0.2
FY2003 Consolidated Approps	P.L. 108-7	2/20/03	10.0	0.4	0.0	10.4
FY2003 Emergency Supplemental	P.L. 108-11	4/16/03	62.6	3.4	0.0	66.0
FY2003 DOD Appropriations[b]	P.L. 107-48	10/23/02	7.1	0.0	0.0	7.1
FY2004 DOD Appropriations Act[b]	P.L. 108-87	9/30/03	-3.5	0.0	0.0	-3.5
FY2004 Emergency Supplemental	P.L. 108-106	11/6/03	64.9	21.2	0.0	86.1
FY2004 Foreign Operations Approps.	P.L. 108-199	1/23/04	0.0	0.5	0.0	0.5
FY2005 DOD Appropriations Act, Titles IX and X[c]	P.L. 108-287	8/5/04	25.0	0.7	0.0	25.7
FY2005 Supplemental Approps[d]	P.L. 109-13	5/11/05	75.9	3.1	0.0	79.0
FY2005 Consolidated Appropriations	P.L. 108-447	12/8/04	0.0	1.0	0.0	1.0
FY2005 DOD Appropriations Act[e]	P.L. 108-287	8/5/04	2.1	0.0	0.0	2.1
FY2006 DOD Approps Act, Title IX[c]	P.L. 109-148	12/30/05	50.0	0.0	0.0	50.0
FY2006 DOD Appropriations Act[e]	P.L. 109-148	12/30/05	0.8	0.0	0.0	0.8
FY2006 Foreign Operations Approps.	P.L. 109-102	11/14/05	0.0	1.0	0.0	1.0
FY2006 Science, State, & Rel. Agencies Appropriations Act[d]	P.L. 109-108	11/22/05	0.0	0.1	0.0	0.1
FY2006 Interior & Rel. Ag. Approp.[f]	P.L. 109-54	8/2/05	0.0	0.0	0.2	0.2
FY2006 Military Quality of Life & Veterans Affairs[f]	P.L. 109-114	11/30/05	0.0	0.0	0.4	0.4
FY2006 Emergency Supplemental	P.L. 109-234	6/14/06	66.0	3.2	0.0	69.2
FY2007 DOD Appropriations Act, Baseline and Title IX[c]	P.L. 109-289	9/29/06	70.5	0.0	0.0	70.5
FY2007 Continuing Resolution[g]	P.L. 110-5	2/15/07	0.0	1.3	0.6	1.8
FY2007 Supplemental	P.L. 110-28	5/25/07	94.5	3.8	0.4	98.7
FY2008 Continuing Resolution	P.L. 110-92	9/29/07	5.2	0.0	0.0	5.2
FY2008 DOD Appropriations Act	P.L. 110-116	11/13/07	12.2	0.0	0.0	12.2
FY2008 Consolidated Approps. Act	P.L. 110-161	12/26/07	70.0	2.1	0.9	73.0
FY2008 Supplemental Approps. Act	P.L.110-252	6/30/08	160.2	3.1	0.4	163.6

Name of Law	Public Law No.	Date Enacted	DOD Funds	Foreign Aid Embassy	VA Medical	Total cost
Subtotal			**804.1**	**46.6**	**2.9**	**864.0**
Unidentified Transfers[h]	unknown	unknown	2.0	0.0	0.0	2.0
FY2003 Transfers	various	NA	1.2	0.0	0.0	1.2
FY2004 Transfers	various	NA	5.7	0.0	0.0	5.7
FY2005 Transfers	various	NA	1.5	0.0	0.0	1.5
Subtotal Transfers[h]			**10.4**	**0.0**	**0.0**	**10.4**
Total Enacted (w/ transfers)	NA	NA	**814.5**	**46.6**	**2.9**	**864.0**

Source: CRS calculations based on public laws, reports, explanatory statements, and DOD documents. Totals may not add due to rounding.

Notes: NA=Not Applicable. Totals may not add due to rounding.

a. Totals reflect budget authority for war-related expenses from appropriations and transfers, and exclude contingent appropriations not approved, rescissions that do not affect war-related funds, and transfers that were later restored in supplemental appropriations.
b. FY2003 Appropriations Act included $7.1 billion in regular FY2003 defense appropriations for GWOT that DOD cannot track; the FY2004 DOD Appropriations Act rescinded $3.5 billion in FY2003 war monies.
c. DOD's regular appropriations bills included a separate Title IX for additional emergency appropriations for war costs in FY2005, FY2006, and FY2007 to " bridge" the gap between the beginning of the fiscal year and passage of a supplemental. Title IX funds in FY2005 do not include a $1.8 billion scoring adjustment that reverses the previous rescission of FY2004 funds because this did not change wartime monies.
d. Excludes funds for Tsunami relief.
e. Reflects funds obligated for enhanced security (Operation Noble Eagle) in FY2005 and FY2006 from DOD's baseline funds as reported by Defense Finance Accounting Service.
f. Includes VA medical funds for Iraq and Afghan veterans in emergency funding in Interior bill and in regular VA appropriations.
g. State Department figures for foreign aid, reconstruction and embassy operations in FY2007 CR and CRS estimates of likely amounts to be provided for Iraq and Afghanistan for VA medical under the FY2007 Continuing Resolution.
h. CRS calculations of transfers from DOD's regular appropriations to war funding based on DOD's 1414 reports on prior approval reprogrammings and other sources. From DOD documents, it appears that DOD transferred about $2.0 billion from its baseline funds to prepare for the Iraq invasion during the summer and fall of 2002 but the source of those funds is not identified.