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Statement of

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Introduction

Chairman Takano, Ranking Member Dr. Roe, and distinguished Committee Members, my name is Sidath Panangala, from the Congressional Research Service (CRS). I am honored to appear before the Committee today. As requested by the Committee my testimony will highlight major milestones pertaining to eligibility laws for Department of Veterans Affairs (VA) health care provided through the Veterans Health Administration (VHA). CRS takes no position on the Commission of Care recommendation[1] or legislative proposals to examine veterans' eligibility for VA health care.

Background

Beginning with the early colonial settlements of America, the nation has provided benefits in varying degrees to those who have worn the uniform and suffered physical disabilities in service to the nation—sacrifices that are inherent to the profession of arms. In 1718, for instance, the colony of Rhode Island enacted legislation that provided benefits not only to every officer, soldier, or sailor who served in the colony's armed services, but also to the wives, children, parents, and other relations who had been dependent upon a slain servicemember. "The physically disabled were to have their wounds carefully tended and healed at the colony's expense, while at the same time an annual pension was provided to him out of the general treasury sufficient for the maintenance of himself and family, or other dependent relatives."[2] These benefits were continued by the Continental Congress, which passed a resolution on August 26, 1776, providing for disabled veterans to receive half of their monthly pay for life or for as long as their disability existed.[3] The earliest federal government benefits for veterans were pension programs, while medical and hospital care were generally provided by states or communities. From the Revolutionary War to the current conflicts, as the nature of the nation's wars have evolved, and as the needs of each generation of veterans who fought those wars have changed, Congress has debated, legislated, and revised benefits and services provided to veterans.

The following parts of my testimony highlight major statutory changes to eligibility criteria used to determine which veterans are eligible for health care provided by the VA. This is not an exhaustive examination of all laws. Additionally, while in the early years eligibility laws pertained mostly to hospital-based inpatient care and domiciliary care,[4] in later years statutory eligibility requirements focused on the health care settings, such as hospital, nursing home, and outpatient care. Lastly, it provides information on current basic and special eligibility requirements for VA health care.

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[1] Section 202 of the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146; 128 Stat. 1773) established a Commission on Care to examine veterans access to VA care and how to organize the Veterans Health Administration, and allocated health care resources, and provide health care to veterans. Recommendation #18 from the Commission's final report among other things was that "[t]he President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use Underutilized [Veterans Health Administration] VHA providers and facilities, providing payment through private insurance." Commission on Care, *Final Report of the Commission on Care*, Washington , DC, June 30, 2016, p. 161.

[2] U.S. Congress, House Committee on Veterans' Affairs, *The Provision of Federal Benefits for Veterans, An Historical Analysis of Major Veterans Legislation, 1862-1954*, committee print, 84th Cong., 1st sess., December 28, 1955, H.Prt. No. 171, p. 2.

[3] Department of Veterans Affairs, *Veterans Benefits Administration: An Organizational History: 1776-1994*, Washington, DC, November 1995, p. 6. Although the Continental Congress passed resolutions promising benefits, it lacked the authority and resources to implement these benefit laws, and left this task to individual states.

[4] Domiciliaries provided medical and other professional care in a residential setting for ambulatory veterans who were disabled by age, disease or injury but who did not require hospitalization. Today, domiciliary programs are integrated with the Mental Health Residential Rehabilitation and Treatment Programs (MH RRTPs). For more information see, https://www.va.gov/homeless/dchv.asp.

Brief History of the VA and the VHA

To provide some context to the discussion on eligibility, it is important to provide a brief history of the VA and VHA. The history of the present-day Department of Veterans Affairs (VA) can be traced back to the passage of P.L. 67-47 in 1921, when Congress established the United States Veterans Bureau. On July 21, 1930, President Hoover issued Executive Order 5398, creating an independent federal agency known as the Veterans Administration by consolidating many separate veterans' programs.[5] On October 25, 1988, President Reagan signed legislation (P.L. 100-527) creating a new federal cabinet-level Department of Veterans Affairs to replace the Veterans Administration, effective March 15, 1989.

The veterans' hospital system was created in 1922 when 57 Public Health Service (PHS) hospitals treating veterans were transferred to the newly established Veterans Bureau.[6] The current day VHA was established in 1946 as the Department of Medicine and Surgery, it was succeeded in 1989 by the Veterans Health Services and Research Administration, and renamed the Veterans Health Administration (VHA) in 1991.

Major Eligibility Changes

Before World War I, federal responsibility for providing health care primarily consisted of the U.S. Naval Home for "disabled and decrepit navy officers, seamen, and marines",[7] and the National Homes for Disabled Volunteer Soldiers.[8] Eligibility was open to "all volunteer officers, soldiers, and seamen who have served during the present war, who have been or who may be totally disabled by wounds received or sickness contracted in the line of their duty."[9] Initially known as "National Asylums for Disabled Soldiers" these facilities provided domiciliary care, including medical care, to disabled veterans of the "Civil War, Indian Wars, Spanish-American War, Mexican War and the discharged members of the regular armed forces."[10] Therefore, it could be stated that, "[t]he only hospital and medical care available for veterans before World War I was that provided as incidental to residence in a soldiers' home."[11] With World War I adding approximately 4.7 million new veterans to the nation's veteran population,[12] Congress turned its attention to programs and services that were required to meet needs of this new generation of veterans.

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[5] In the 1920s three federal agencies, the Veterans Bureau, the Bureau of Pension in the Department of the Interior, and the National Home for Disabled Volunteer Soldiers, administered various benefits for the nation's veterans.

[6] Archived CRS Report 83-99 EPW, *Medical Care Programs of the Veterans Administration, p.2.* Also see, Adkins, Robinson E. *Medical Care for Veterans.* House Committee on Veterans Affairs. Committee Print No. 4, April 17, 1967.

[7] An Act establishing Navy Hospitals, 2 Stat. 650. February 26, 1811.

[8] An Act to incorporate a national military and naval Asylum for the Relief of the totally disabled Officers and Men of the Volunteer Forces of the United States.13 Stat. 509. March. 3, 1865.

[9] 13 Stat. 510, March. 3, 1865.

[10] Archived CRS Report 83-99 EPW, *Medical Care Programs of the Veterans Administration, p.2.* Also see, "VA Domiciliary Care programs celebrate 150th anniversary" https://www.blogs.va.gov/VAntage/17699/va-domiciliary-care-programs-celebrate-150th-anniversary/.

[11] U.S. Congress, House Committee on Veterans' Affairs, *The Provision of Federal Benefits for Veterans, An Historical Analysis of Major Veterans Legislation, 1862-1954*, committee print, 84th Cong., 1st sess., December 28, 1955, H.Prt. No. 171, p. 291.

[12] Department of Veterans Affairs, *America's Wars*, Fact Sheet, November 2019, https://www.va.gov/opa/publications/factsheets/fs_americas_wars.pdf.

Eligibility for VA Health Care from the End of World War I to the Beginning of World War II

On October 6, 1917, Congress enacted legislation (P.L. 65-90) that required the Bureau of Risk Insurance to provide specified health care services to certain veterans.[13] Article III of this amended act, in addition to making provision for compensation, provided that "the United States' shall, furnish to the injured person such reasonable governmental medical, surgical, and hospital services, and such supplies, including artificial limbs, trusses, and similar appliances: as the Director may determine to be useful and reasonably necessary."[14] In implementing these provisions, the Bureau of War Risk Insurance ran into practical difficulties and the Director of the Bureau of War Risk Insurance made several recommendations to Congress to broaden the eligible population of veterans:

> The present war risk insurance act provides that hospitalization, medical care, and treatment, including the furnishing of prosthetic appliances, may be furnished for injuries or diseases contracted in or aggravated by the person's military service. Under this limitation a war-risk patient suffering seriously from tuberculosis, being entitled to and receiving compensation and medical care and treatment, receives a new injury or disease, while separate and apart from the tuberculosis and cannot in itself be traced directly or indirectly to the military service, it is none the less a serious element in the retarding of the patient's progress in the arrest or cure of tuberculosis. It is very difficult, indeed-in fact, it is almost entirely impracticable—for the Government to be treating a war-risk patient for a disability or disease traceable to his service and to ignore other new injuries or diseases which in themselves affect very materially the patient's progress in the recovery from the injury or disease contracted in or aggravated by military service.[15]

In 1924, Congress passed the World War Veterans Act of 1924 (P.L. 68-242). This act, authorized free "hospital, dental, medical, surgical, and convalescent care and treatment and prosthetic appliances for any member of the military or naval forces of the United States, not dishonorably discharged, disabled by reason of any wound or injury received or disease contracted, or by reason of any aggravation of a preexisting injury or disease, specifically noted at examination for entrance into or employment in the active military or naval service while in the active military or naval service of the United States on or after April 6, 1917, and before July 2, 1921." This law also authorized care for veterans (not dishonorably discharged) of any war since 1897, including hospitalization, and related travel expenses regardless of "nature or origin of their disabilities." The act also required that preference for hospitalization was to be given to those veterans who were financially unable to pay for hospitalization and their necessary traveling expenses.

Eligibility for VA Health Care from World War II to 1980s

Prior to 1943, World War II veterans were provided eligibility for hospital care only if they had a compensable service-connected disability.[16] Veterans of previous wars who had no service-connected

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[13] Act to amend an Act entitled "An Act to authorize the establishment of a Bureau of War Risk Insurance in the Treasury Department," 40 Stat.398, October 6, 1917. The Bureau of War Risk Insurance was established in 1914 to insure U.S. ships and the goods they transported.

[14] 40 Stat.406.

[15] Bureau of War Risk Insurance, *Annual Report of the Director of the Bureau of War Risk Insurance, for the Fiscal Year Ended June 30 1920*, Washington, DC, 1920, pp. 105-106.

[16] 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. 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%.

disability could receive hospital care if they stated under oath they could not pay for the service elsewhere, and if beds were available.[17] On March 17, 1943, with the enactment of P.L.78-10, An act to amend Veterans Regulation Numbered 10, "Any person who served in the active military or naval service of the United States on or after December 7, 1941 and before the termination of hostilities in the present war as determined by proclamation of the President or by concurrent resolution of the Congress" were made eligible for hospital care and other medical benefits similar to World War I veterans.[18]

By the late 1960s, eligibility for care could be summarized as follows:[19]

> The Department of Medicine and Surgery is responsible for medical and related benefits: (1) VA outpatient clinics provide, generally, only for those veterans suffering from service-connected disabilities. In certain cases, pre-hospital and post-hospital care is available at VA clinics to veterans suffering from non-service-connected disabilities. Outpatient care is not as "glamorized" in the public imagination as is hospital care, but for the VA it has the practical advantage of keeping beds available for other patients who need them. And for the outpatient veteran, it has the psychological advantage of enabling him to live at home and be gainfully employed, at least part time;
>
> (2) VA hospitals provide care for three classes of veterans:
>
> (a)Those suffering from service-connected disability.
>
> (b)Those who have a service-connected disability, but now need care for some other disablement—provided a bed is available in a VA or other Federal hospital.
>
> (c) Those suffering from a non-service-connected disability and financially unable to defray the cost of hospitalization. Veterans in this third group are hospitalized by the VA if all three of the following conditions are met:
>
> > Hospitalization is deemed necessary;
> >
> > They state under oath that they are financially unable to defray the cost of hospitalization; and
> >
> > Beds are available.
>
> By law VA beds must first be made available to veterans suffering from service-connected disabilities.

On October 22, 1970, the Elderly Veterans' Medical Care Assistance Act (P.L.91-500) was enacted. This act authorized hospital care to veterans age 65 or older for a non-service-connected disability. They no longer needed to state under oath that they were financially unable to defray the cost of hospitalization.

In 1973, Veterans Health Care Expansion Act of 1973 (P.L. 93-82) was considered and enacted. Among other things, the act placed peacetime veterans on the same basis as wartime veterans for hospital care for nonservice-connected conditions. Additionally, veterans who were 80 percent service-connected disabled were eligible for outpatient care for any disability. According to the committee report "the extension of this provision to include all peacetime veterans would benefit those veterans whose service was between World War I and World War II and between World War II and the beginning of the Korean conflict, and who have not attained the age of 65."[20] Lastly, it authorized outpatient medical services to any veteran eligible for VA hospital care, where such services obviated the need for hospital admission.

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[17] Adkins, Robinson E. *Medical Care for Veterans.* House Committee on Veterans Affairs. Committee Print No. 4, April 17, 1967.

[18] Ibid, p. 168.

[19] Ibid, p.7.

[20] U.S. Congress, House Committee on Veterans' Affairs, *Veterans Health Care Expansion Act of 1973*, report to accompany H.R. 90481, 93rd Cong., 1st sess., July 10, 1973, H.Rept. 93-368, p. 30.

In the 1980s eligibility changes focused on (1) enhancing revenue–for example, by imposing fees on some veterans or billing non-federal entities, such as health insurers, for nonservice-connected care furnished to insured veterans, and (2) further refinement of eligibility requirements for outpatient care.

Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) significantly changed hospital care eligibility for veterans and modified nursing home and outpatient care eligibilities. Congress expanded eligibility for hospital care to include all veterans, requiring the VA to provide care for a select group of veterans and to authorize care for the remainder. The law dictated that hospital care would be provided to three groups of veterans with different priority levels for each group. It also changed the basis for determining if a veteran was unable to defray the costs of care requirements from a certification of inability to pay to an income-based "means test" system. Prior to this, there was no standard for evidence established in law, a veteran who did not have a service-connected disability was required to sign a statement that he or she was unable to defray necessary medical expenses to be eligible for hospital or nursing home care. The law *required* hospital care to be provided to any veteran for a service-connected disability and for any disability for a certain category of veterans. This group was commonly referred to as "Category A" veterans:

- A veteran whose discharge or release from active military, naval or air service was for a disability incurred or aggravated in the line of duty.
- A veteran who is in receipt of or would be entitled to receive disability compensation.
- A veteran who has a service-connected disability rated at fifty percent or more.
- Any other veteran who has a service-connected disability.
- A veteran who is a former prisoner of war.
- A veteran exposed to a toxic substance or radiation.
- A veteran of the Spanish-American War, the Mexican border period, or World War I.
- A veteran for nonservice-connected disability, if the veteran is unable to defray the expenses of necessary care.

The act also provided that hospital care *may* be provided for any non-service connected disability to two other categories of veterans, referred to as Categories B and C veterans:

- Veterans whose income level did not exceed $20,000 for a veteran without dependents; and $25,000 for a veteran with one dependent plus $1,000 for each additional dependent.
- Veterans who agree to a copayment equal to the lesser of the cost of furnishing such care or the amount of Medicare deductible plus one-half of such amount for each 90 days of care after the first 90 days of such care during any 365-day period; and only to the extent that resources and facilities are available.

Under these changes, the VA would now be required to provide hospital care to veterans in Category A instead of just being authorized to do so. Veterans in Categories B and C were authorized to receive hospital care but were not guaranteed care.

The Consolidated Omnibus Budget Reconciliation Act of 1985 also amended nursing home care and outpatient care. For nursing home care the act provided that the VA *may* provide nursing home care to all veterans within categories A, B, and C. However, the act did not did not guarantee nursing home care to any veteran but merely authorized it. Eligibility for outpatient care was also expanded to include all veterans with some restrictions. Under P .L. 99-272, outpatient medical services may be provided to any veteran for a service-connected disability incurred or aggravated in the line of duty and for which the

veteran was discharged or released from active duty, and for a nonservice-connected disability of a veteran who has a service-connected disability rated at 50 percent or more. P .L. 99-272 continued to allow outpatient medical services for any disability to any veteran eligible for hospital care if the services were necessary for the preparation for, to obviate the need of, or for after care of hospital care; and to a veteran who is a former prisoner of war. Additionally, the Consolidated Omnibus Budget Reconciliation Act of 1985 established a copayment requirement for Category C veterans.

Veterans Benefits and Services Act of 1988 (P.L. 100-322)

The Veterans Benefits and Services Act of 1988, revised eligibility requirements for outpatient care. One of the major changes made by this act was to require outpatient care for certain veterans rather than merely authorizing it. By this act Congress effectively created a priority system for care. Under the law the VA was required to provide outpatient care to:

- Any veteran for a service-connected disability that was incurred or aggravated in the line of duty and for which the veteran was discharged or released from active duty.
- A veteran, for any disability, who has a service-connected disability rated at fifty percent or more.
- Any veteran for a disability for which the veteran is in receipt of compensation or would be entitled to compensation.
- Veterans who have a service-connected disability rated at thirty or forty percent or whose annual income does not exceed the maximum annual rate of pension that would be applicable if they were eligible for a veteran's pension, in order to obviate the need for, in preparation for and as a follow-up to hospital care.

Furthermore, P.L. 100-322 authorized, but did not require, outpatient care to:

- Any veteran who is a former prisoner of war.
- Any veteran of the Mexican border period or of World War I.
- Any veteran who is receiving increased pension or additional compensation or allowances by reason of being permanently housebound.
- Any veteran who qualifies for hospital care in order to obviate the need for, in preparation for and as a follow-up to hospital care.

Lastly, the Veterans Benefits and Services Act of 1988 amended eligibility for domiciliary care. The VA was authorized to provide domiciliary care to: (1) any veteran whose annual income does not exceed the maximum annual rate of pension that would be applicable to the veteran if they were eligible for pension; or (2) any veteran who the VA Administrator determines has no adequate means of support. Prior to this change only those veterans with a service-connected disability were eligible for domiciliary care if they had no adequate means of support. Those veterans with nonservice-connected disabilities would only qualify if they were unable to defray the cost of care.

Eligibility for VA Health Care 1990s to the Present

By the start of the 1990s, Congress continued to address eligibility issues and made one major change to hospital and nursing home care prior to comprehensively addressing eligibility reform in 1996.

The Omnibus Reconciliation Act of 1990 (P.L. 101-508)

This act amended eligibility requirements for hospital and nursing home care. The law combined "Category B" and "Category C"[21] of eligible veterans to create a new "Category B". Under the new act, veterans seeking hospital and/or nursing home care for nonservice-connected disabilities would be required to make a copayment.[22] Additionally, the act made the following changes to VA health care:

- Established, in the Treasury, on behalf of the Department of Veterans Affairs, a Medical-Care Cost Recoveries Fund (MCCRF) and authorized use of the fund to pay expenses incurred in (a) identifying, billing and collecting amounts due to the United States from third-party payers for the cost, including both direct and indirect costs, of care provided and (b) copayments, as required by law, for the cost of care provided in VA medical facilities.
- Established a copayment of $2.00 for each 30-day supply of medication provided on an outpatient basis for the treatment of a nonservice-connected disability or condition. Veterans who were receiving treatment for a service-connected condition and those veterans who were rated 50% or more service-connected were made exempt from the copayment requirement. Amounts collected were to be deposited in the MCCF. Prior to this veterans who received outpatient care at VA medical centers did not make a copayment for prescription medication.
- Assessed all non-entitled veterans a copayment of $10 per day for inpatient care and a copayment of $5 per day for nursing home care, and extended copayment for outpatient care to all non-entitled veterans.
- **Table 1** shows eligibility for hospital care, outpatient care, nursing home care, and contracted (community) care during the early 1990s prior to the enactment of the Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262).

[21] As previously discussed, in 1986, with passage of P.L. 99-272, Congress established three categories of eligibility for VA health care. The law provided that hospital care shall be provided, free of direct charge, to veterans within Category A. The term "shall" was interpreted by many as meaning "entitled" to hospital care. These Category A veterans were defined to include those with service-connected disabilities, low-income veterans without such disabilities, and certain "exempt" veterans, including (for example) former prisoners of war, those exposed to Agent Orange, recipients of VA pensions, and those eligible for Medicaid. Moreover, P.L. 99-272 provided that Category A veterans may be provided outpatient and nursing home care. The term "may" was interpreted by many as meaning "eligible" for outpatient and nursing home care. Veterans not in Category A were assigned to either Category B or Category C on the basis of current income and net worth; VA could furnish care to these veterans on a resources-available basis. Veterans not eligible for Category B on the basis of either income or net worth were placed in Category C. Veterans in Categories B and C were eligible to receive care but were not entitled to care.

[22] A form of medical cost sharing in health insurance plans that requires an insured person to pay a fixed dollar amount when a medical service is received.

Table 1.VA Health Care Eligibility: Early1990s

(Eligibility Prior to the Veterans' Health Care Eligibility Reform Act of 1996)

	"Category A" Veterans				All Other Veterans[a]
	Service-connected disabilities rated 50% or more disabling	**Service-connected disabilities rated 50% or less disabling**	**Special Treatment Authority[b]**	**Nonservice-connected with incomes below means test threshold**	**Incomes above means test threshold**
VA Hospital Care	Care **SHALL** be provided	Care **SHALL** be provided	Care **SHALL** be provided	Care **SHALL** be provided	Care ***MAY*** be provided
VA Comprehensive Outpatient Care	Care **SHALL** be provided	Care **SHALL** be provided[c]	Care ***MAY*** be provided	Care ***MAY*** be provided	Care ***MAY*** be provided
VA Limited Outpatient Care[d]	Not applicable	Care **SHALL** be provided[e]	Not applicable	Care ***MAY*** be provided[f]	Care ***MAY*** be provided
VA Nursing Home Care	Care ***MAY*** be provided	Care ***MAY*** be provided	Care ***MAY*** be provided	Care ***MAY*** be provided	Care ***MAY*** be provided
Community (contracted) Nursing Home Care[g]	Care ***MAY*** be provided	Care ***MAY*** be provided	Care ***MAY*** be provided	Care ***MAY*** be provided	Care ***MAY*** be provided
Community (contracted) Hospital Care[h]	Care ***MAY*** be provided[c]	Care ***MAY*** be provided[c]	Care ***MAY*** be provided[i]	Care ***MAY*** be provided[i]	Care ***MAY*** be provided[i]
Community ("Fee Basis") Outpatient Care[h]	Care ***MAY*** be provided	Care ***MAY*** be provided[b]	Care ***MAY*** be provided[j,k]	Care ***MAY*** be provided[k]	Care ***MAY*** be provided[k]

Source: Congressional Research Service, based on "Figure 2 VA Health Care:1990 General Eligibility Profile," U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Hospitals and Health Care, *VA Health Care Eligibility Reform*, 102nd Cong., 2nd sess., May 20, 1992 and July 22, 1992 (Washington: GPO, 1993), p. 177.

Notes:

a. Subject to copayments.

b. World War I veterans; former POWs; veterans receiving VA pensions and whose disabilities require aid and attendance or who are housebound; veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki or Agent Orange during Service in the Republic of Vietnam between January 9, 1962, and May 7, 1975.

c. For treatment of service-connected disabilities only.

d. Treatment to "obviate the need" for hospitalization or as a follow-up to an episode of inpatient care.

e. For any veteran with service-connected disabilities rated 30% or 40% disabling.

f. Mandatory treatment for "very low" income veterans (at the time this table was published the threshold was $10,800 or less for a veteran with no dependents).

g. Available for up to six months following discharge from inpatient care, unless the veteran received care for a service-connected disability or requires nursing home care for a service-connected disability.

h. Limited to care authorized by VA if VA or other government facilities cannot provide care, or are geographically inaccessible to the veteran.

i. For veterans who have received VA hospital care, VA nursing home care or VA domiciliary care.

j. For World War I veterans and veterans receiving pensions with aid and attendance or housebound benefits.

k. When treatment is needed as a follow-up to inpatient hospital care.

Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262)

The Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262) created the modern eligibility and enrollment system in use today. The context for reform was driven by three major factors: (1) the complex eligibility rules (see **Table 1**) created numerous challenges in delivering health care to veterans; (2) President Clinton's Administration proposed reforming the national health care system;[23] and (3) a "blue ribbon" commission set-up by then VA Secretary Derwinski in 1990, presented proposals which included recommendations for restructuring the system.

Beginning in the early part of 1992, House and Senate Veterans' Affairs Committees began a series of hearings on reforming the VA health care system and eligibility for VA health care. The then Chairman of the House VA Committee, Representative G.V. (Sonny) Montgomery, stated the following: "Most of us are not really satisfied with the eligibility to get in a VA hospital. The A, B, C categories are not working that well."[24] Additionally, then Ranking Member Bob Stump, stated: "According to the mission commission in their blueprint for the future structure of the Department of Veterans Affairs, [Quote] "The rules of eligibility pose many problems for the delivery of care today and in the future." The Commission proposes major restructuring of the VA's current eligibility requirements."[25] During a hearing in 1993, then Chairman of the House VA Committee, Subcommittee on Hospitals and Health Care, Representative J. Roy Rowland stated:

> As the debate on this national health care progresses, it is critical that we focus on the VA as an integral part of any reforms. It is also necessary that we understand the current state of the VA health care system, both its strengths and its weaknesses. As the country's largest health care system, the VA should provide a model for the health care reformers to consider. However, all of us know the current reality facing many veterans who seek their care from the VA. While most Category A veterans seeking inpatient care are treated on a timely basis, long waiting lines for many outpatient care services have become commonplace. In some areas, VA has been forced to cut back on outpatient services to many veterans who previously received their care from the VA, because VA simply does not have the resources to continue to provide them care.[26]

Furthermore, the General Accounting Office (GAO, now known as the Government Accountability Office) reported:

> The complex eligibility provisions that have developed over many decades are often ill-defined and confusing—which ultimately creates frustration for veterans and VA staff. Veterans are often uncertain about which services they are eligible to receive and what right they have to require VA to provide them. VA physicians are likewise frustrated by requirements that they determine, before treatment can be provided, whether a condition is related to a service-connected disability or whether, if left untreated, the condition would require immediate hospitalization.
>
> Unlike public and private health insurance, VA cannot offer well-defined benefits or guarantee the availability of covered services. Further, because provision of VA care is contingent upon available resources, whether a veteran receives care can depend on where and when the veteran seeks care. To add to veterans' confusion, VA medical centers use different methods to ration care when funds

[23] The Health Security Act (H.R. 3600 [103rd Congress]) was introduced in November 1993.

[24] U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Hospitals and Health Care, *VA Health Care Eligibility Reform*, 102nd Cong., 2nd sess., May 20, 1992 and July 22, 1992 (Washington: GPO, 1993), p. 1.

[25] Ibid. p.76.

[26] U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Hospitals and Health Care, *National Health Care Reform*, 103rd Cong., 1st sess., June 3 and June 4, 1993 (Washington: GPO, 1993), p. 2.

> are not sufficient to meet demand. Because of these problems, veterans may be unable to obtain needed health care services from VA facilities.[27]

In response to these findings and recommendations, during the 104th Congress, eligibility for VA medical services underwent reform with the passage of the Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262). Although the Eligibility Reform Act refers to "eligibility reform" in both its title and legal provisions, in practice, the legislation did not significantly alter the eligibility criteria.[28] However, the act eliminated the distinctions between eligibility for inpatient care and for outpatient care, and did require the VHA to manage the provision of hospital care and medical services through an enrollment system based on prioritization and available resources.[29] As stated in the report language accompanying the act,

> [t]he 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.[30]

Taking these issues into consideration, the Eligibility Reform Act established two broad mutually exclusive categories of eligibility:[31]

1. Veterans who meet one or more of the following criteria:
   a. veterans with service-connected disabilities;[32]
   b. veterans who are former prisoners of war;
   c. veterans exposed to certain toxic substances and environmental hazards, such as Agent Orange;
   d. veterans whose attributable income and net worth are not greater than an established "means test"; or
   e. veterans of World War I.
2. Veterans who do not meet any of the above criteria (i.e., veterans with no service-connected disabilities, who are not former prisoners of war, who were not exposed to certain toxic substances and environmental hazards, or with attributable incomes above an established "means test," and were not veterans of World War I).

Beginning on October 1, 1998, the VA started enrolling eligible veterans in the VA health care system. Unless otherwise exempt, veterans are required to enroll in the VA health care system to receive inpatient

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[27] U.S. General Accounting Office, *VA Health Care: Issues Affecting Eligibility Reform Efforts*, GAO/HEHS-96-160, p. 6. (On July 7, 2004, the GAO's legal name was changed from the General Accounting Office to the Government Accountability Office.)

[28] Although the Veterans' Health Care Eligibility Reform Act of 1996 did not alter basic eligibility for a veteran to receive care, it did place inpatient and outpatient care on the same statutory footing so that the VA can provide needed care in the most medically appropriate setting. (Source: Kenneth W. Kizer et al., "Reinventing VA Health Care, Systematizing Quality Improvement and Quality Innovation," *Medical Care*, vol. 28, no. 6, pp. 1-8.)

[29] 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.

[30] Ibid., p. 6.

[31] 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. 5.

[32] A service-connected disability is a disability that was incurred or aggravated in the line of duty in the U.S. Armed Forces (38 U.S.C. §101(16)). The VA determines whether veterans have service-connected disabilities and assigns ratings from 0% to 100% based on the severity of the disability. Ratings are assigned in increments of 10% (38 C.F.R. §§4.1-4.31).

hospital and outpatient medical care.[33] Since the law's enactment, the enrollment categories have been amended through both statutory and regulatory changes.[34]

Current Basic and Special Eligibility Requirements

Generally, a veteran has to meet *three* basic criteria to be eligible for VA health care.[35] A veteran must (1) meet the statutory definition of a "veteran," meaning an "individual who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable"[36] (see text box for definitions of military discharges); (2) meet the statutory definition of "active duty," meaning full-time duty in the Armed Forces, other than active duty for training;[37] and (3) have served a minimum period of 24 months of continuous active duty.[38]

Descriptions of Military Character of Discharge

- **Honorable discharge** applies when the quality of a servicemember's service generally has met the standards of acceptable conduct and performance of duty for military personnel, or is otherwise so meritorious that any other characterization would be clearly inappropriate
- **General (under honorable) discharge** applies when a servicemember's service has been honest and faithful. Characterization of service as general (under honorable conditions) is warranted when the positive aspects of a servicemember's conduct or performance of duty outweigh negative aspects of the servicemember's conduct or performance of duty as documented in their service record.
- **Other-than-honorable discharge** applies when separation is based on a pattern of behavior that constitutes a significant departure from the conduct expected of servicemembers, or when separation is based on one or more acts or omissions that constitute a significant departure from the conduct expected of servicemembers. Factors that may lead to such a discharge include: the use of force or violence to produce serious bodily injury or death; abuse of a special position of trust; disregard by a superior of customary superior-subordinate relationships; acts or omissions that endanger the security of the United States or the health and welfare of other servicemembers; and deliberate acts or omissions that seriously endanger the health and safety of other persons.
- **Bad-conduct discharge** applies only to enlisted persons and may be adjudged by a general court-martial and by a special court-martial. A bad-conduct discharge is less severe than a dishonorable discharge and is designed as a punishment for bad conduct rather than as a punishment for serious offenses of either a civilian or military nature. It is also appropriate for an accused servicemember who has been repeatedly convicted of minor offenses and whose punitive separation appears to be necessary.
- **Dishonorable discharge** applies only to enlisted persons and warrant officers who are not commissioned and may be adjudged only by a general court-martial. A dishonorable discharge may be adjudged for any offense in which a warrant officer who is not commissioned has been found guilty. It is reserved for those who should be separated under conditions of dishonor, after having been convicted of offenses typically recognized in civil jurisdictions as felonies, or of offenses of a military nature requiring severe punishment.

Source: CRS, adapted from the Department of Defense, *Enlisted Administrative Separations,* DOD Instruction 1332.14, effective April 12, 2019 and the *Manual for Courts-Martial United States* (2019 edition).

In addition to the general eligibility criteria above, from time to time Congress has enacted legislation providing limited eligibility to certain categories of veterans for specific conditions or specific services under special treatment authorities. These specific eligibilities, among others, are discussed below.

[33] 38 C.F.R. §17.36(a).

[34] 38 U.S.C. §1705 and 38 C.F.R. §17.36.

[35] Department of Veterans Affairs, Veterans Health Administration, *Eligibility Determination*, VHA Directive 1601A.02, July 6, 2020.

[36] 38 U.S.C. §101(2).

[37] 38 U.S.C. §101(21).

[38] 38 U.S.C. §5303A or exceptions at 38 U.S.C. §5303A(b)(3).

Eligibility for Veterans Exposed to a Toxic Substance

Vietnam-Era, Herbicide-Exposed Veterans

Prior to the 1981 Veterans' Health Care, Training and Small Business Loan Act (P.L. 97-72), veterans who complained of Agent Orange-related illnesses were generally at the lowest priority for treatment at Department of Veterans Affairs (VA) medical facilities because these conditions were not considered "service-connected."[39] The 1981 act elevated Vietnam veterans' priority status for health care at VA facilities by recognizing a veteran's own report of exposure as sufficient proof to receive medical care unless there was evidence to the contrary. Under the Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262) a veteran does not have to demonstrate a link between a certain health condition and exposure to Agent Orange; instead, medical care is provided unless the VA has determined that the condition did not result from exposure to Agent Orange or the condition has been identified by the National Academy of Sciences as having "limited/suggestive" evidence of *no* association between the occurrence of the disease and exposure to a herbicide.[40] "[T]he determination of whether a Vietnam-era herbicide-exposed veteran's disability may be related to that exposure is strictly a clinical judgment to be made by the responsible physician (acting in accordance with the guidelines issued by the Under Secretary of Health and [conditions identified by the National Academy of Sciences]."[41]

Persian Gulf War Veterans

Similar to Vietnam-era veterans exposed to Agent Orange, in 1993 Congress passed P.L. 103-210, which provides additional authority for the VA to provide health care for veterans of the Persian Gulf War, for medical conditions possibly related to exposure to toxic substances or environmental hazards during active duty service in the Southwest Asia theater of operations during the Gulf War.[42]

In 1998, Congress—responding to growing concern over Persian Gulf War veterans' undiagnosed illnesses—passed the Veterans Programs Enhancement Act of 1998 (P.L. 105-368). The act entitled veterans (including National Guard and Reserve components) who served on active duty in a theater of combat operations during a period of war after the Persian Gulf War to enroll in VA health care during a two-year period following the date of discharge and receive care even if there is insufficient medical evidence to conclude that such illnesses are attributable to such service. In 2007, the National Defense Authorization Act (NDAA), FY2008 (P.L. 110-181), created the current five-year period of enrollment eligibility for veterans who served in a theater of combat operations after November 11, 1998.[43]

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[39] 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. 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%.

[40] "Limited/suggestive" evidence of no association is when several adequate studies, covering the full range of levels of exposure that human beings are known to encounter, are consistent in not showing a positive association between any magnitude of exposure to herbicides and the outcome of disease.

[41] Department of Veterans Affairs, "Third Party Billing for Medical Care Provided Under Special Treatment Authorities," 82 *Federal Register* 55548, November 22, 2017.

[42] U.S. Congress, House Committee on Veterans' Affairs, *Priority VA Health Care for Persian Gulf War Veterans,* report to accompany H.R. 2535, 103rd Cong., July 29, 1993, H.Rept. 103-198.

[43] The Clay Hunt Suicide Prevention for American Veterans Act (P.L. 114-2) authorized an additional one-year period of eligibility to enroll for those veterans who were discharged from active duty after January 1, 2009, and before January 1, 2011, but who did not enroll during the five-year period of post-discharge eligibility. This one-year period began on February 12, 2015, the enactment date of the Clay Hunt Suicide Prevention for American Veterans Act. It ended on February 12, 2016. Expanded eligibility under the act was established in response to concerns that the five-year special eligibility period was not an adequate

For combat veterans who do not enroll with VA during the five-year post-discharge period, eligibility for enrollment and subsequent health care is subject to such factors as a service-connected disability rating, VA pension status, catastrophic disability determination, or financial circumstances.[44]

Eligibility for Veterans Who Served on Active Duty at Camp Lejeune

The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154), as amended by the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235, Division I, Title II, Section 243), established a presumptive service connection for veterans' health care for one or more of 15 diseases and health conditions that may be associated with exposure to trichloroethylene (TCE), tetrachloroethylene (PCE), vinyl chloride, and other contaminants discovered in drinking water supplies at Camp Lejeune, North Carolina. Veterans and their family members who worked or lived at Camp Lejeune for no less than 30 days (consecutive or nonconsecutive) from August 1, 1953, to December 31, 1987, generally are eligible for VA health care services under this law.[45] Eligible veterans and family members can receive free care for any of the 15 covered illnesses or conditions.[46] To be eligible, a veteran or former reservist or member of the National Guard (1) must have been stationed at Camp Lejeune, or traveled to Camp Lejeune as part of his or her professional duties, and (2) must have served on active duty[47] for at least 30 (consecutive or nonconsecutive) days during the period beginning on August 1, 1953, and ending on December 31, 1987.[48]

Under current law, special treatment authorities do not extend, to conditions and disabilities that the VA has determined have resulted from causes other than those described in law or regulations. [49] However, veterans may still be provided treatment but, depending on the facts, the veteran may be subject to copayment requirements in connection with such treatment.[50]

Eligibility for Former Servicemembers with Discharges Characterized as Under Other–Than-Honorable (OTH) Conditions

To be eligible for VA health care, a veteran generally has to meet certain criteria, including a discharge or release from active service under conditions other than dishonorable.[51] A discharge that is characterized by the Department of Defense (DOD) as an honorable discharge or general under honorable conditions,

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amount of time for veterans seeking mental health treatment. U.S. Congress, Senate Committee on Veterans 'Affairs, *Clay Hunt Suicide Prevention for American Veterans Act*, report to accompany H.R. 203, 114th Cong., 1st sess., April 23, 2015, S.Rept. 114-34 (Washington: GPO, 2015), p. 9.

[44] If their financial circumstances place them in Priority Group 8, they will be "grandfathered" into a Priority Group 8a or Priority Group 8c, and their enrollment in VA will be continued, regardless of the date of their original VA application.

[45] 38 U.S.C. §1710(e)(1)(F); 38 U.S.C. §1787; and 38 C.F.R. §17.400.

[46] A covered illness or condition incudes any of the following: esophageal cancer; lung cancer; breast cancer; bladder cancer; kidney cancer; leukemia; multiple myeloma; myelodysplastic syndromes; renal toxicity; hepatic steatosis; female infertility; miscarriage; scleroderma; neurobehavioral effects; and Non-Hodgkin's lymphoma (38 C.F.R. §17.400).

[47] As defined in 38 U.S.C. §101(21).

[48] As originally enacted, P.L. 112-154 specified January 1, 1957, as the beginning date of eligibility. The Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235, Division I, Title II, Section 243), amended P.L. 112-154 to change this date to August 1, 1953, based on more current information suggesting that the contaminated water supplies may have been in use earlier than previously thought.

[49] 38 U.S.C. 1710(a)(2)(F) and (e).

[50] Department of Veterans Affairs, "Third Party Billing for Medical Care Provided Under Special Treatment Authorities," 82 *Federal Register* 55548, November 22, 2017.

[51] 38 U.S.C. §101(2); 38 C.F.R. §3.1(d).

with some exceptions, qualifies veterans for VA health care services.[52] If the discharge is under OTH conditions, administrative discharge, or is a punitive bad conduct discharge (BCD), the VA is required to make a character of discharge (COD) determination on a case-by-case basis to determine eligibility.[53] Generally, when a former servicemember with an OTH or BCD discharge applies for health care services, the VHA forwards the request for an eligibility determination by submitting VA Form 20-0986 to a Veterans Benefits Administration (VBA) Regional Office (RO).[54] COD determinations result in one of three potential outcomes:

1. *Honorable for VA purposes*, meaning that the veteran qualifies for all veterans benefits, including health care benefits, provided that other eligibility criteria (such as minimum active duty service requirements) are met.
2. *Dishonorable for VA purposes, but eligible to receive health care services*, meaning that the veteran is eligible to receive health care only for service-connected or service-aggravated disabilities or conditions.[55]
3. *Dishonorable for VA purposes due to a statutory bar to VA benefits*, meaning that the veteran is not eligible for service-connected disability compensation or health care services. In essence, the VA is barred from providing any benefit or service to the former servicemember.[56]

Special Eligibility Rules for Those Seeking Mental Health Care Services

Section 258 of the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2018 (P.L. 115-141, as amended by P.L. 115-182 and P.L. 115-251) authorized the VA to provide an initial mental health care assessment and subsequent mental or behavioral health care services to certain former servicemembers, including those who served in the Reserve components and who meet each of the following criteria:

- *Conditions of discharge*: the veteran served on active duty and was discharged or released under a condition that is not honorable (but not a dishonorable discharge), or was discharged by court-martial (i.e., those with a dishonorable discharge or a discharge by court-martial would not be eligible for mental health care services from the VA).
- *Duration of service*: the veteran served for a period of more than 100 cumulative days.
- *Conditions of service*: the veteran (1) was deployed in a theater of combat operations, in support of a contingency operation, or in an area at a time during which hostilities occurred, including by controlling an unmanned aerial vehicle (UAV) from a location

[52] This applies unless the separation reason is explained in the DD-214 form (Certificate of Release or Discharge From Active Duty) as a bar to benefits under 38 U.S.C. 5303(a).

[53] Adjudication Procedures Manual M21-1, Part III, Subpart v, Chapter 1, Section B - Statutory Bars to Benefits and Character of Discharge (COD).

[54] Department of Veterans Affairs, Veterans Health Administration, *Eligibility Determination*, VHA Directive 1601A.02, July 6, 2018.

[55] 38 C.F.R. §3.360. If the outcome is dishonorable for VA purposes, but the veteran is eligible for health care services, the VBA RO must prepare a rating decision addressing service connection for treating only specific service-connected disabilities or conditions. A rating decision is "a record purposes document detailing the formal determination made by the RO rating activity regarding one or more issues of benefit entitlement. The rating decision states the decisions made and provides an explanation supporting each decision." (Adjudication Procedures Manual, M21-1, Part III, Subpart iv, Chapter 6, Section C - Completing the Rating Decision Narrative).

[56] Adjudication Procedures Manual, M21-1, Part III, Subpart v, Chapter 7, Section A - Eligibility for Hospital, Nursing Home, Domiciliary, and Medical Care.

other than such theater or area; or (2) was the victim of a physical assault of a sexual nature, a battery of a sexual nature, or sexual harassment.

- *Not currently enrolled* in VA's health care system.[57]

Those veterans with an OTH administrative discharge and who meet the above criteria are not required to enroll in VA's health care system, to meet the minimum active duty service requirements, or to pay any copayments for mental and behavioral health care services included under VA's standard medical benefits package. However, these veterans are not authorized to receive care in the community.[58]

Eligibility Based on Presumption of Mental Illness or Psychosis

Certain veterans, including those with an OTH administrative discharge, may qualify for free care under presumptions of eligibility for psychosis[59] or mental illness other than psychosis to treat those conditions. Former servicemembers who meet either of the two presumptive criteria do not have to meet the minimum active duty service requirements, and they are not required to pay any copayments for the treatment of covered conditions.

Under the presumptive eligibility for psychosis, a former servicemember must have served on active duty during World War II, the Korean conflict, the Vietnam era, or the Persian Gulf War and developed an active psychosis (1) within two years after discharge from active duty and (2) before specific statutory dates associated with the war or conflict in which the servicemember served, as follows:

- World War II: before July 26, 1949.
- Korean conflict: before February 1, 1957.
- Vietnam era: before May 8, 1977.
- Persian Gulf War: before the end of the two-year period beginning on the last day of the Persian Gulf War.[60]

Under the presumptive eligibility for mental illness other than psychosis, a former servicemember must have served on active duty in the Persian Gulf War and developed an active mental illness other than psychosis (1) within two years after discharge and (2) before the end of the two-year period beginning on the last day of the Persian Gulf War.[61]

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[57] 38 U.S.C. §1720I.

[58] Department of Veterans Affairs, Veterans Health Administration, *Eligibility Determination*, VHA Directive 1601A.02, July 6, 2020.

[59] "Psychosis is a range of symptoms that includes experiencing hallucinations and/or delusions. It is seen most commonly in schizophrenia, schizoaffective disorder, and bipolar disorder." Source: Jared Bernard et al., *A Clinician's Guide to Psychosocial and Psychotherapeutic Interventions for Veterans with Psychosis*, VA South Central Mental Illness Research, Education and Clinical Center (SC MIRECC), https://www.mirecc.va.gov/VISN16/docs/psychotherapy-for-psychosis-clinician-brochure.pdf.

[60] 38 U.S.C. §1702 and 38 C.F.R. §17.109. The Persian Gulf War is defined as "the period beginning on August 2, 1990, and ending on the date thereafter prescribed by Presidential proclamation or by law." 38 U.S.C. §101(33). No end date has yet been prescribed. Generally, to qualify for eligibility, a veteran must have been on active military duty service in Southwest Asia during the Gulf War (Operation Desert Shield, Operation Desert Storm, Operation Iraqi Freedom [OIF], and Operation New Dawn [OND], including service in one or more of the following areas: Iraq, Kuwait, Saudi Arabia, the neutral zone (between Iraq and Saudi Arabia), Bahrain, Qatar, the United Arab Emirates, Oman, and the waters of the Persian Gulf, Red Sea, Arabian Sea, and Gulfs of Aden and Oman (Department of Veterans Affairs, Veterans Health Administration, *Gulf War Registry*, VHA Directive 1325, June 1, 2017).

[61] 38 U.S.C. §1702 and 38 C.F.R. §17.109. See previous note.

Eligibility vs. Enrollment

Once a veteran meets the basic eligibility criteria, enrollment in the VA health care system is not guaranteed. The Veterans' Health Care Eligibility Reform Act of 1996 provided clear intent that the provision of health care to veterans depends on available resources. The committee report accompanying it states that the provision of hospital care and medical 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."[62] Therefore, Congress built in mechanisms to limit enrollment in the event that VA resources and facilities were insufficient to meet the demand for care.

On January 17, 2003, the then Secretary of Veterans Affairs announced that the VA would suspend enrolling veterans without service-connected disabilities or other special eligibility criteria and with incomes above the Geographic Means Test [GMT].[63] Those who had enrolled in the VA health care system prior to January 17, 2003, were not affected by this suspension.[64] At that time VA claimed that, despite its funding increases, it cannot provide all enrolled veterans with timely access to medical services because of the tremendous increase in the number of veterans seeking care from VA.

Subsequently, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (P.L. 110-329) which was enacted on September 30, 2008, amended this enrollment suspension. The accompanying report language stated that funding "has been provided ... to support increased enrollment for Priority Group 8 veterans whose income exceeds the current veterans means test and geographic means test income thresholds by 10% or less."[65] The act provided $375 million for FY2009 to fund increased enrollment. On January 21, 2009, the VA issued regulations indicating its plans to enroll new veterans who met the expanded means-test thresholds.[66] The VA began enrolling new veterans on June 15, 2009.[67] Since then, the VA has amended the Priority Group 8 income threshold annually.

Conclusion

Since the 1920s, VA's role and its mission to provide health care to the nation's veterans have changed significantly. Congress has enlarged the scope of the VA's health care mission and has enacted legislation requiring the establishment of new programs and services. Through numerous laws, Congress has also extended to additional categories of veterans' eligibility for the many levels of care the VA now provides. What started out as a hospital and domiciliary care system to care for injuries or diseases incurred or

[62] 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. 5.

[63] Veterans with no service-connected conditions or other eligibility factors may only qualify based on their gross household income (income of the veteran, spouse, and dependent children) and deductible expenses income for the previous calendar year. If a veteran's household income is *above* the VA National Means Test (NMT) and the geographical income limits established by the U.S. Department of Housing and Urban Development (HUD) for the fiscal year that ended on September 30 of the previous calendar year (known as the Geographic Means Test [GMT]), based on the area that the veteran resides, then the veteran is not eligible to enroll.

[64] 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.

[65] P.L. 110-329, U.S. Congress, House Committee on Appropriations, *Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009*, committee print, 110th Cong., 2nd sess. (Washington: GPO, 2008), p. 750.

[66] Department of Veterans Affairs, "Expansion of Enrollment in the VA Health Care System," 74 *Federal Register* 3535-3540, January 21, 2009.

[67] Department of Veterans Affairs, "Expansion of Enrollment in the VA Health Care System," 74 *Federal Register* 22832-22835, May 15, 2009.

aggravated by the person's wartime military service, has evolved into a comprehensive health care system, not only providing primary, specialized medical care, and nursing home care—both within and outside its facilities—but also conducting medical research, educating health care professionals, and serving as a back-up to the nation's health care system during national emergencies and disasters. While Congress has changed eligibility for care—sometimes narrowly and sometimes more broadly—in response to veterans needs and changing nature of war, it has also had to grapple with the central policy question pertaining to VA health care: which veterans should be eligible for care and under what circumstances while striking a balance between budgetary constraints "and a grateful nation'[s] attempts to repay its indebtedness to those who serve[d] in the military."[68]

[68] *A 21st Century System for Evaluating Veterans for Disability Benefits*, ed. Michael Mc Geary et al. (Washington DC: The National Academies Press, 2007), p. 23.