ABSTRACT

AN EVALUATION OF THE CURRENT STATE OF VETERANS AFFAIRS AND VETERANS' PERCEPTIONS OF THEIR FEDERAL BENEFITS

The Department of Veterans Affairs (VA) operates with a multi-billion-dollar annual budget in service of the millions of veterans alive in the United States. The benefits provided by the Department include a multitude of services that impact various aspects of veterans' lives post-service. Because of the magnitude of the budget allocated and the effects these have on the lives of veterans, it is necessary that this system is efficient and effective. The current study surveyed 87 veterans from a large, public university in the American West. Results indicate that education benefits, health benefits, and disability compensation are the most important. Furthermore, health benefits and disability compensation are the most in need for improvement, as evidenced by dissatisfaction ratings and the ranking by participants of benefits needing revision. Demographic differences presented across all variables and veterans' perspectives about society at large were associated with benefits-related responses. The results indicate the need to reform the disability rating schedule, make health benefits more efficient, and require a mandatory transition course to increase veterans' knowledge and understanding of their benefits.

Shelby Anne Elia

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AN EVALUATION OF THE CURRENT STATE OF VETERANS AFFAIRS AND VETERANS' PERCEPTIONS OF THEIR FEDERAL BENEFITS

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Shelby Anne Elia

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We, the undersigned, certify that the thesis of the following student meets the required standards of scholarship, format, and style of the university and the student's graduate degree program for the awarding of the master's degree.

Shelby Anne Elia
Thesis Author

Kurt Cline (Chair) Political Science

Lisa Bryant Political Science

Bernadette Muscat Social Sciences

For the University Graduate Committee:

Dean, Division of Graduate Studies

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TABLE OF CONTENTS

Page

LIST OF TABLES vii
LIST OF FIGURES viii
CHAPTER 1: INTRODUCTION AND HISTORICAL PERSPECTIVE 1
Historical Background of Veterans Benefits 2
CHAPTER 2: CURRENT BENEFITS AND RESEARCH 23
Current Benefits for Veterans 23
Review of Current Surveys and Research 45
Research Design 62
CHAPTER 3: METHODS AND RESULTS 68
Survey 68
Results 73
CHAPTER 4: SUMMARY AND CONCLUSION 105
Discussion of Findings 105
Implications 110
Limitations and Future Research 115
REFERENCES 119
APPENDICES 125
APPENDIX A: VETERANS' SURVEY 126
APPENDIX B: FREQUENCY REPORT 134

LIST OF TABLES

Page

Table 1 *Percent of Benefits Subcategory Use by Respondent Race* 75

Table 2 *Number of Respondents Ranking Specified Benefit as the Most Important by Respondent Race* 78

Table 3 *Number of Respondents Ranking Specified Benefit as in Greatest Need for Improvement by Respondent Race* 81

Table 4 *Respondents Satisfaction with Specified Benefit Subcategory* 84

LIST OF FIGURES

Page

Figure 1. A comparison of respondents' rating of the military's job of educating them on their benefits and personal knowledge of their benefits 92

Figure 2. A comparison of respondents' satisfaction with the U.S. Government and satisfaction with the U.S. Military 99

CHAPTER 1: INTRODUCTION AND HISTORICAL PERSPECTIVE

> "Our debt to the heroic men and valiant women in the service of our country can never be repaid. They have earned our undying gratitude. America will never forget their sacrifices."
> -President Harry S Truman addressing Congress on April 16th, 1945 (Donovan, 1977)

According to the U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics (2016a), as of 2017, the United States has documentation of 20 million living veterans. Although Gulf War veterans make up the largest cohort (7.3 million), the majority of veterans are from an older generation and a previous conflict. America's surviving veterans are of diverse age groups with differing medical issues, distinct combat environments, and varied levels of need for governmental support. Aside from the needs of veterans still living, the U.S. Department of Veterans Affairs (n.d.a.) reports that 1.1 million American lives have been lost in service since the Revolutionary War. These service members who give the ultimate sacrifice often leave behind families and dependents who inherit their rights to benefits.

The Department of Veterans Affairs (VA), with an operating budget of $173.69 billion, provided benefits to nearly 10 million veterans in 2016 (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2018). This vast and diverse population of veterans and dependents continue to rely on the work of the VA to receive healthcare, pension checks, retirement, life insurance, educational benefits, disability compensation, home loans, and transition assistance. With an executive-level department of this size,

operating a vast amount of services in addition to the largest integrated health care system in the United States, the VA has developed a history of administering reactionary policy, handed down to them, in a manner not conducive to providing the best service possible for our nation's most courageous men and women (Ortiz, 2012).

As a result of this historic trend of passing reactionary legislation, the administrative state has been ill equipped to meet the needs of veterans. The unnecessary complexity that results from this policy process impairs the ability of veterans to gain knowledge and understanding of the benefits that exist and the eligibility requirements in place for individual benefits. Because of this, veterans may have limited access to these benefits systems. The current study seeks to provide an evaluation of the current system through the lens of veterans' firsthand experiences. An assessment of veterans' use of their benefits, knowledge of the system, and satisfaction with the process provide a gauge for the government's present ability to administer benefits to veterans. The results of this study will identify the areas of strength and weakness in the current system in order to inform improvement efforts.

Historical Background of Veterans Benefits

Benefits for veterans in the United States' Armed Forces have changed significantly throughout the history of the country. In addition to matching the needs of the veterans at the time, benefits policy must also meet the political environment of the time (Ortiz, 2012). An evolution of benefits can be seen beginning in the late 18th century in response to the Revolutionary War. For nearly 230 years, the United States has structured and restructured its system of providing benefits to departing servicemembers and veterans (Ortiz, 2012).

Through this evolution, benefits have been expanded and constricted, created and dismantled, fought for and died for by its members. Currently, the Department of Veterans Affairs provides the most diverse, comprehensive system of benefits and entitlements to a singular population that this country has ever seen (Campbell, 2004).

The relative purpose of these benefits has evolved alongside the policy. When the pension system was expanded following the closure of the Civil War, it was not intended simply as a welfare state, but rather "an unabashed system of national public care… for the deserving core of a special generation" (Skocpol, 1992, p. 151). A special kind of morality was awarded to servicemembers, and the benefits for them arose out of a moral desire to fulfill a debt for their sacrifices. This is not to say that this special morality has not been extended to modern generations of veterans. Rather, the purposes of veterans benefits following the cease of the Selective Service draft in 1973 were twofold. In addition to providing care to those who have earned this aid, veterans benefits serve as a recruitment mechanism for the U.S. Military (Ortiz, 2012). A consideration of these purposes is necessary to fully understand the changes made to the benefits system through time.

The evolution of benefits for veterans has, unfortunately, often been reactionary and haphazard. The legislation passed for the purpose of providing benefits to veterans is frequently done in response to social or economic concerns (Lisio, 1994; Ortiz, 2012; Resch, 1982; Skocpol, 1992). In an effort to provide benefits as quickly as possible, policy has been pushed hurriedly through the legislative process without purposeful, systematic reflection of the policy's ability to provide wholesome benefits. The legislative process has also often ignored the implications of the policies on the administrative state. When erratic policies are

passed, administrators struggle in their ability to manage the bureaucracies in place to provide these services to veterans (Kinder, 2012; Skocpol, 1992).

Post-Revolution through World War I

The ratification of the United States' Constitution in 1789 marked the beginning of the responsibility of the federal government to financially and administratively dispense veterans benefits. This year also saw the inaugural piece of legislation which first addressed pension payments in the United States. According to this law (1 Stat. 95), veterans were granted the ability to qualify for half pay for life in the event that their service resulted in the loss of a limb or another debilitating injury (U.S. Department of Veterans Affairs, n.d.a.). At this time, the Bureau of Pensions administered these payments under the direction of the Secretary of War. With just a few thousand veterans receiving benefits, the 1818 Service Pension Law was passed to ensure payments were issued on the basis of need and to the benefit of needy veterans (U.S. Department of Veterans Affairs, n.d.a.). This was to ensure that payments were received in a timely fashion. As a result of this legislation, pension payments payouts increased tenfold by 1820 (Resch, 1982).

The nature of the American Civil War of the 1860s contributed to the rapid expansion of pensions available to veterans and their dependents. Given the nature of the conflict, this American war included the entire citizenry as it was being fought on domestic soil and produced a direct, physical impact on the polity. The Civil War was also the most catastrophic war in United States' history (Finn, 2014). By 1865, nearly 2 servicemembers for every 100 in the population were killed (Skocpol, 1992). The volume of surviving veterans and dependents of those mortally wounded set the groundwork for a massive expansion of the federal

pension system. These individuals desperately needed the assistance of the government, as so the pension system was set in place as quickly as possible. The political patronage and lack of a bureaucratic state at this time left the system largely unchecked (Skocpol, 1992).

By the end of the Civil War in 1865, the population of United States veterans (not including Confederate soldiers) rose to over 2 million.[1] Two important pieces of veterans' legislation passed in the midst of the Civil War. Veterans were given priority ranking to purchase land at a discounted rate through the Homestead Act of 1862. The General Pension Act of 1862 upgraded benefits on the basis of rank and disability and extended compensation to the dependent widows or orphans of veterans (U.S. Department of Veterans Affairs, n.d.a.). Because the degree of disability was often left to the subjective interpretation of the regional doctors, corruption was introduced into the system (Skocpol, 1992, p. 107). This Act also provided compensation in the event a communicable disease was contracted during service, such as tuberculosis. The Consolidation Act of 1873 changed, yet again, the way benefits were distributed by largely removing the service rank component from the equation which was previously introduced in 1862 (U.S. Department of Veterans Affairs, n.d.a.). A change of this magnitude, made just eleven years after the original legislation, began the legacy of confusion that now plagues the benefits system.

It is important to recognize the political context in which this pension system was rapidly expanded following the 1870s. Especially influential was the lobbying group, the Grand Army of the Republic, who fought for better pensions

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[1] Confederate soldiers were not allowed to receive federal benefits until 1958. Until then, states in the south provided Confederate soldiers small pension payments (Skocpol, 1992).

(Skocpol, 1992). This social pressure by Union veterans was one piece of the puzzle that coalesced to bring higher pension payments. The Republican Party, which was in power at the time, also had motive to secure these better benefits. The protective tariffs in place during the 1870s created an enormous federal surplus but served to benefit the businesses in the North who had control over the Republican Party (Skocpol, 1992). As opposed to limiting the tariffs (as requested by the Democratic Party), the Republicans chose instead to 'spend' the money through veterans benefits. This also generated Republican voters through satisfied veterans in the Midwest (Skocpol, 1992). This scheme worked up until 1915, when 95% of living veterans had already signed up for benefits (Skocpol, 1992). This politicization of the benefits system worked as a disservice to the veterans that relied on it. Because veterans benefits were contingent on a federal surplus, it was impossible to know what benefits would remain readily available in the future.

With this rapid increase in applications for veterans benefits in the 1870s, bureaucratic inadequacies became largely apparent. The U.S. Pension Bureau was simply understaffed and unprepared for the influx of applicants (Skocpol, 1992). The sheer size of the workload for these bureaucrats made way for the possibility of fraudulent applications and falsified disabilities. The nature of the application system also invited deception. In order to determine the disability ranking of veteran applications, doctors within a veteran's own locale were tasked with providing reports (Skocpol, 1992). Because of the lack of supervision by the U.S. Pension Bureau, family doctors could produce medical reports without being subject to scrutiny. The first attempt to remedy this issue through the "Sixty Surgeon Pension Bill" was shot down by Congress who instead chose small, incremental changes (Skocpol, 1992, p. 119).

Referring now to another type of benefit provided to veterans, the U.S. Soldier's Home (USSH) was established in 1853 to begin caring for veterans following the Mexican War (Byerly, 2012). Shortly thereafter in 1866, the National Home for Disabled Volunteer Soldiers (NHDVS) was established to provide domiciliary and medical care for Civil War veterans (Byerly, 2012). The third component of this system to provide room and care for veterans included state-sponsored homes for veterans funded by the USSH Board of Managers (Byerly, 2012). These facilities became of crucial importance with the spread of tuberculosis amongst soldiers (U.S. Department of Veterans Affairs, n.d.a.). Although science had progressed such that doctors realized the mechanism by which the disease spread, there was still no cure at this time. In 1900, tuberculosis was responsible for killing the most Americans annually, and so the risk of contamination was already great. In an effort to protect patients being treated for other illnesses, veterans with tuberculosis were confined to one medical facility, Fort Bayard (Byerly, 2012).

Fort Bayard was not without its own problems. Because the concerns over tuberculosis prompted a rapid expansion of medical facilities to treat these health issues, policies were not yet in place to dictate how health benefits and pension payments would be made compatible (Byerly, 2012). At Fort Bayard, administrators were uncertain of which veterans qualified for health benefits. The complex benefits system allowed veterans to exit and reenter the system for health-related needs all the while receiving pension payments. Although the cost of the medical treatment was supposed to be dependent on a veteran's ability to pay vis-à-vis his pension, the right of a veteran to keep this information confidential often interfered with the facility's ability to process claims fairly (Byerly, 2012). This issue was further complicated by the fact that these houses

often served as sanctuaries for veterans who had returned to die. The incurability of the disease at this time often meant that men would return after a hiatus from the confines of the hospital, just to be finally laid to rest by the military (Byerly, 2012). The ability of the government to track these ever-changing situations and update their records was limited in the early 1900s, being that it was an era without the luxury of modern technology. The work load placed on the administration also limited the amount of time that was dedicated to record-keeping.

The first major piece of legislation for veterans in the 20th Century was the War Risk Insurance Act of 1914 (Stevens, 2012). Although the original Act covered only military property (e.g., ships and cargo), the War Risk Insurance Act Amendments in 1917 directly protected servicemembers through the provision of life insurance (Stevens, 2012). This legislation was important for its rehabilitative additions for veterans returning from World War I, as it provided readjustment and vocational training for veterans with permanent disabilities (U.S. Department of Veterans Affairs, n.d.a.). These benefits were extended through the Vocational Rehabilitation Act of 1918, which established the Federal Board for Vocational Education. Under this act, any honorably discharged disabled veteran was eligible to receive occupational training in order to assimilate successfully back into civilian society (Kinder, 2012).

The Creation of the Veterans Bureau through World War II

As World War I came to a close in 1918, domestic medical facilities were struggling to handle the influx of newly-admitted disabled veterans. In an attempt to streamline the system, Congress decided to delegate the responsibility of most hospitals to the Public Health Service (Stevens, 2012). The chaos and continued

bureaucratic inadequacies that followed left many veterans unable to receive services and trapped within the systemic red tape (Stevens, 2012). In an effort to decrease the inter-agency division, the Veterans Bureau was established in 1921. This bureau was a consolidation of veterans' services provided by the Bureau of War Risk Insurance, the Federal Board of Vocational Education, and the Public Health Service (U.S. Department of Veterans Affairs, n.d.a.). Although the hospitals run by the Public Health Service were included, the National Homes for Disabled Volunteer Soldiers and the Bureau of Pensions remained separate from the Veterans Bureau. Even though the Bureau did begin to consolidate the agencies providing veterans benefits, the multitude of agencies by which a veteran might have obtained benefits created delays and confusion.

The first 2 years of the Bureau's existence were ripe with controversy. Issues arose with the misallocation of funds provided by the federal government to construct new hospital buildings (Stevens, 2012). The Director of the Veterans Bureau, Col. Charles R. Forbes, was relieved from his duty because of the inefficiency and political corruption (Stevens, 2012). With the appointment of a new director, Gen. Frank T. Hines, in 1923 the Veterans Bureau began its refurbishment process (Stevens, 2012). Hines sought to restructure the Bureau in order to ensure veterans were receiving efficient and effective benefit services (Stevens, 2012). This restructuring of the Veterans Bureau included establishing six separate, overhead categories of services, in which all of the Bureau's functions fit (U.S. Department of Veterans Affairs, n.d.a.). The remainder of the 1920s ran smoothly in regard to veterans benefits.

In 1930, President Hoover signed an executive order which officially established the Veterans Administration (Lisio, 1994). This new administration was a consolidation of the Veterans Bureau, the Bureau of Pensions, and the

National Homes for Disabled Volunteer Soldiers (Lisio, 1994). The Veterans Administration was now responsible for the services of the aforementioned bureaus including medical care, pension payments, disability compensation, and bonus certificates (U.S. Department of Veterans Affairs, n.d.a.). Having been a worthy director of the Veterans Bureau, Gen. Frank T. Hines was appointed as the first administrator of this newest agency (Lisio, 1994). Although this consolidation provided veterans with some clarity of the avenues by which to obtain services, legislation in the 1930s delimited the benefits that were available.

The controversy surrounding veterans benefits in the 1930s were incited by the convergence of two separate events. The first of these was the World War Adjustment Compensation Act of 1924 (Lisio, 1994). This piece of legislation was passed by Congress in an effort to help veterans financially after their return from the Great War. The Act awarded bonuses to veterans on both the basis of their length of service during World War I and whether that service was on domestic or foreign soil. Veterans were awarded about $1 per day of service, and those who amassed up to $50 received their payments immediately (Lisio, 1994). However, any veteran who earned more than the $50 maximum was given an adjusted service certificate by the Bureau, which would not be payable until 20 years after the date of issuance (Lisio, 1994). The federal budget did not have the capacity to make these payments. Veterans who thought they would finally be receiving financial relief, 6 years after the end of the War, were unable to claim their bonuses.

The compounding event which catapulted this legislation into such national controversy was the economic recession in the late 1920s, which culminated into the Great Depression (Lisio, 1994). Because World War I servicemembers received low wages while actively involved in the global conflict, the economic

slump hit them particularly hard (Lisio, 1994). Many veterans were struggling to provide for their families or simply stay alive. When the Great Depression reached its pinnacle, veterans saw no other choice than to ask for an expedited payout regarding the 1924 Act. In March of 1932, veterans began to assemble and march across the country towards the U.S. Capitol (Lisio, 1994). As they traveled, more unemployed veterans amassed with the group (Lisio, 1994).

This group of tens of thousands of destitute veterans became known as the "Bonus Expeditionary Forces." Because of the circumstances surrounding their march, the veterans set up camp during their journey in areas with poor living conditions and a lack of sanitation facilities, the combination of which invited the spread of disease (Lisio, 1994). Although the federal government set up an emergency hospital for the veterans in Virginia, this is not to say that the legislature was beginning to budge. After rioting and escalating violence through the summer of 1932, the veterans were ultimately removed from the area by federal troops (Lisio, 1994). It was not until 1936 that Congress gave their authorization to begin immediately paying the bonuses that these veterans so desperately fought for (Lisio, 1994). As a result, veterans spent nearly a decade struggling to survive without the economic means to do so. The message put forth by this march was part of a larger societal issue in which the United States struggled knowing how best to help servicemembers transition back into society.

The Board of Veterans Appeals was established in the midst of the Bonus March in 1933. This administrative body worked through cases of benefits decisions in which veterans felt they were given improper or inadequate services (Brown, 2014). The Secretary of Veterans Administration appointed members to the Board, who were then approved by the President of the United States. Although this may seem like a promising countermeasure to the misuse of

bureaucratic discretion in benefits' decisions, the Board of Veterans Appeals operated within the Veterans Administration. The Board was without judicial oversight until the creation of the U.S. Court of Appeals for Veterans Claims in 1988 (Mall, 2013).

At the cusp of another world war, Congress passed the Selective Training and Service Act of 1940. This was the nation's first peacetime draft, and it was requested by President Roosevelt because of growing pressure from Allied countries overseas (Finn, 2014). The legislation did award certain rights to servicemembers for their transition back into society once the conflict ended. Veterans were given reemployment rights for the jobs they left when joining the military (U.S. Department of Veterans Affairs, n.d.a.). There was an important update to the insurance program for modern day soldiers in 1940. The new program served to ensure that World War II veterans would not be protected under the same veil as World War I veterans, who were receiving small premiums (U.S. Department of Veterans Affairs, n.d.a.).

The End of World War II through Vietnam War

During World War II, legislation was passed to provide assimilation assistance to veterans of the war. The first act, the Disabled Veterans' Rehabilitation Act of 1943, provided job training for veterans and ultimately helped over 600,000 regain employment post-discharge (Jennings, 2012; U.S. Department of Veterans Affairs, n.d.a.). Arguably the most influential piece of social welfare legislation to its date was the Servicemen's Readjustment Act of 1944. This legislation is famously known as the "G.I. Bills of Rights." In an effort to avoid the missteps regarding the treatment of veterans which occurred after the Great War, this legislation sought to provide an all-encompassing approach to

post-war reintegration for some 12 million service members returning home (Young, 2012). Although the passing of the legislation generated a congressional battle concerning a nationwide welfare state, the Act ultimately had three main provisions (Young, 2012).

The first of these were education benefits. Servicemembers returning home from World War II were provided either 4 years of training or 4 years of education and a monthly allowance (U.S. Department of Veterans Affairs, n.d.a.). Much to the disdain of the states' rights activists, the authority to govern these educational rights to veterans remained within the federal government (Young, 2012). Unemployment compensation, on a temporary basis, was also given to veterans as they acclimated back into civilian life. These payments were not to exceed $20 a week and veterans were entitled to a maximum of 52 weeks of unemployment payment (Young, 2012). The final provision of the G.I. Bill of Rights was federally guaranteed loans. Veterans were eligible to receive up to $2,000 in loans at an interest rate of 4% (Young, 2012). This legislation served to ensure a relatively smooth transition for veterans while simultaneously boosting the United States post-war economy.

One last major piece of legislation was enacted during World War II. The Veterans' Preference Act of 1944 required that any organization operating with federal money give preference in hiring to veterans (U.S. Department of Veterans Affairs, n.d.a.). This law also required that employers give preference to their employees who served in the military in cases of reduction in force (Brown, 2014). In the case a government agency chooses not to hire a veteran, they must prepare in writing an explanation as to why they are justified in making that hiring decision (U.S. Department of Veterans Affairs, n.d.a.).

Even with these safeguards in place, the United States struggled with the influx of veterans requiring medical care once the demobilization of forces had begun. In 1946 the new administrator to Veterans Administration, General Omar N. Bradley, stated that the VA had the capacity to care for 82,241 individuals with an estimated addition of around 14,000 beds (U.S. Department of Veterans Affairs, n.d.a.). Nearly 100,000 hospital beds may seem like a lot, but an estimated 670,846 servicemembers sustained non-fatal injuries during World War II (Jennings, 2012). This massive flood of veterans with disabilities overwhelmed the VA system, which was too small to handle the needs of so many individuals. In order to provide the necessary aid to these men and women, the Army and the Navy provided care within their own facilities usually reserved for active servicemembers (Jennings, 2012). Bradley also authorized the expansion of the staff operating the VA who handled veterans' claims (U.S. Department of Veterans Affairs, n.d.a.). Nonetheless, many veterans were put on waiting lists to be admitted into hospitals in order to receive medical care. Yet again, the Veterans Administration failed to act proactively so that enough medical care facilities would be available to veterans before they ever returned to domestic soil.

The Veterans Readjustment Assistance Act of 1952, also known as the Korean G.I. Bill, marked a step backward in providing support for veterans returning home. There were several reasons that this legislation proved less generous than the original G.I. Bill. The first of these was the uncovering of abuses and bureaucratic inefficiencies in the first bill that led to the loss of taxpayer money (Pash, 2012). Lawmakers were aware of the fact that this G.I. Bill could stand as the template for future post-war legislation, and as a result tended to consider the needs of veterans post-service in a more constrained fashion (Pash, 2012). Congressmembers were also mindful of the general public's feelings

toward the war effort as “popular support for the war dipped as low as 35%” (Pash, 2012). Consideration was given to this fact throughout the legislative process. As a result, the Korean G.I. Bill allowed for only 26 weeks of unemployment compensation and 36 months of lumpsum payments for training or education (Pash, 2012).

The Veterans Administration experienced yet another influx of veterans as the Korean War ended in 1953. Although there were not nearly as many active servicemembers in this conflict compared to World War II, the administration still struggled to care for these veterans alongside the aging World War II veterans (U.S. Department of Veterans Affairs, n.d.a.). This resulted in yet another reorganization of the body responsible for veterans’ services into three departments: the Department of Medicine and Surgery, the Department of Veterans Benefits, and the Department of Insurance. These new administrations were responsible for medical, financial, and insurance benefits, respectively (U.S. Department of Veterans Affairs, n.d.a.).

This rapid expansion in the number of veterans needing medical attention extended into the years of the Vietnam War. As with the Korean War, the advancements in technology, namely airlift improvements, increased the amount of servicemembers who would return home after sustaining critical injuries (U.S. Department of Veterans Affairs, n.d.a.). Throughout the eleven years of the Vietnam War, the United States lost an estimated 58,261 men and women (Finn, 2014, p. 282). The number of servicemembers who did not die as a result of their injuries was nearly three times that amount; approximately 153,303 were wounded (U.S. Department of Veterans Affairs, n.d.a.). The U.S. Department of Veterans Affairs (n.d.a.) noted several unique considerations for Vietnam-era veterans

including: culture shock from arriving on American soil just days after being in armed combat, the anti-war climate at home, and a coinciding recession.

In preparation for the Vietnam servicemembers' return, Congress passed the Veterans' Readjustment Benefits Act of 1966. Better known as the Vietnam G.I. Bill, this legislation restored more of the generosity in educational allowances commensurate of the original 1944 G.I. Bill (Boulton, 2012). Veterans were allotted 1 month of educational allowances per month served in the war effort (U.S. Department of Veterans Affairs, n.d.a.). The allowances increased to $340 a month with legislation in 1974 (Boulton, 2012). The Vietnam G.I. Bill did receive criticism. Because of the Bill's main advocate, Ralph Yarborough, benefits were extended to both peacetime and wartime veterans (Boulton, 2012). This component of the policy greatly increased the number of veterans covered, and it has been argued that as a result, wartime veterans did not receive the quality or quantity of benefits they needed to be able to face the economic struggles spawned from their disabilities (Boulton, 2012). In an attempt to provide benefits for everyone, this legislation failed to adequately consider the subset of veterans who were conceivably more deserving of these benefits.

The Veterans Administration chose to extend exiting-servicemembers' knowledge of their benefits through Operation Outreach in 1968 (Veterans Administration, 1968). In order to do so, the VA established 21 United States Veterans Assistance Centers in major cities across the country. These assistance centers helped servicemembers transition into society as veterans, obtain their educational benefits, or find gainful employment (Veterans Administration, 1968). This outreach program was even expanded to include assistance centers at foreign military bases. The rationale behind this expansion was to begin educating soldiers before they had even stepped foot again on American soil (U.S. Department of

Veterans Affairs, n.d.a.). Operation Outreach marked the first efforts to increase veterans' knowledge of the benefits available to them.

Post-Vietnam War through Modern Veterans Affairs

Similar to the special action plan for the spread of tuberculosis in post-Civil War treatment facilities, the VA had to be vigilant in their handling of Agent Orange exposure in Vietnam veterans. This herbicide was used in massive quantities by the United States in South Vietnam to eliminate the forest foliage used by the North Vietnam Army for coverage and blitz attacks (Institute of Medicine, 2014). Because of these chemicals, Vietnam veterans began experiencing exposure-related illnesses (Institute of Medicine, 2014; U.S. Department of Veterans Affairs, n.d.a.). Although the VA began offering treatment specific to Agent Orange exposure in 1978, it was not until 1994 that any of the medical issues stemming from this herbicide were fully covered and recognized by the government (Institute of Medicine, 2014). Agent Orange has been linked to cancers (for example, leukemia, sarcoma, lymphoma, and other cancers), heart disease, diabetes, neuropathy, and nervous system disorders which have required significant action by Veterans Administration by way of medical benefits (Brown, 2014). Benefits were also extended to children of Vietnam veterans who suffer from exposure-related spina bifida. These conditions further expanded the population of veterans and dependents who were eligible for health benefits.

Because of the mounting expenditures of the VA following the aging of World War II veterans and the return of servicemembers from Vietnam, several eligibility changes were made. The Veterans' and Survivors' Pension Improvement Act of 1978 mandated an evaluation of a veteran's spouse's income

before determining pension payments (U.S. Department of Veterans Affairs, n.d.a.). This allowed for a more accurate understanding of a veteran's financial need. This consideration was later extended to healthcare eligibility in 1986 to ensure only financially dependent, disabled veterans were receiving healthcare at no cost. The Veterans Healthcare Amendments Act of 1979 served to establish unique Vet Centers to respond to the psychological needs of veterans in an environment separate from medical facilities for physical ailments (U.S. Department of Veterans Affairs, n.d.a.). This legislation also restored the ability of the VA to extend fee-basis medical treatment after VA facilities had met their capacity of patient intake (Veterans Administration, 1979). These policy responses following the end of the Vietnam War provide evidence of the constant changes in eligibility requirements and the continuous expansion and contraction of veterans benefits.

Part of the contraction of veterans benefits following the Vietnam War can be attributed to the general public's negative opinions on the war effort. By 1971, 72% of the public believed the United States had made a mistake by entering the war with Vietnam (Lunch & Sperlich, 1979). Lunch and Sperlich (1979) claimed that an executive "is likely to encounter policy-making limits imposed by Congress in response to popular pressures" (p. 44). Public sentiment likely drove some of the contractionary efforts by Congress in the decade following the Vietnam War. The effects of the public's view on the war effort also extended into policies directly affecting the military.

The Selective Service ceased draft orders following the close of the Vietnam War. The reestablishment of volunteer armed forces in the United States required that the Veterans Administration begin recruitment efforts. In an effort to recruit more servicemembers, Congress passed the Veterans' Educational

Assistance Act of 1984, known as the Montgomery G.I. Bill (U.S. Department of Veterans Affairs, n.d.a.). This legislation ensured 36 months of educational assistance payments to veterans, assuming they had met the minimum requirements. Servicemembers were required to pay $100 per month during their first year of service and must have either served 3 years in active duty or 2 years in active duty in combination with four years in the reserves (Brown, 2014).

By the late 1980s, the Veterans Administration was responsible for caring for millions of veterans. In fact, one third of the population of the United States was eligible to receive veterans benefits as either dependents or survivors (U.S. Department of Veterans Affairs, n.d.a.). Because of this administrative responsibility, President Reagan signed legislation elevating the VA to Cabinet-level status in 1988. The Department of Veterans Affairs was officially recognized the following year in 1989. This new department included three divisions: the Veterans Health Administration, the Veterans Benefits Administration, and the National Cemetery System (U.S. Department of Veterans Affairs, n.d.a.).

The Persian Gulf War, which began in 1990, brought with it a new wave of veterans for the Department to consider. In response to their needs, Congress passed the Persian Gulf Conflict Supplemental Authorization and Personnel Benefits Act in 1991. This legislation served to elevate the Persian conflict to a wartime status in order to provide the full sweep of benefits to these servicemembers (U.S. Department of Veterans Affairs, n.d.a.). According to the U.S. Department of Veterans Affairs (n.d.a.), this Act increased the monthly payments for educational benefits, doubled the death benefit provided to families of fallen servicemembers, and also doubled the group life insurance to $100,000. The Veterans Health Administration also provided special medical and disability benefits to Gulf War veterans with undiagnosed illnesses related to their service

after studies in 1993 demonstrated the possibility of chemical exposure (Brown, 2014).

In order to bring the VA health care system into the 21st century, a Capital Asset Realignment for Enhanced Services (CARES) planning process started in 2002 (Draft National Capital Asset Realignment for Enhanced Services (CARES) Plan: Notice, 2003). The CARES study suggested several changes to the system to enhance quality of care, efficiency of services, and maximization of resources. This study looked not only at the current needs of veterans, but also how to best prepare the healthcare system for the needs of veterans in the future (Draft National Capital Asset Realignment for Enhanced Services (CARES) Plan: Notice, 2003). After forecasting probable future needs, the CARES plan recommended that new hospitals, community clinics, and specialty centers be built in regions that the study determined would be geographically relevant (U.S. Department of Veterans Affairs, n.d.a.). There was a notable insistence towards placing facilities in the appropriate location for the service needs directly impacting specific communities. This plan served to improve the ability of veterans to access the health benefits they needed.

To extend educational benefits to veterans who served in active duty after the September 11th terrorist attacks, Congress passed the Post-9/11 Veterans' Educational Assistance Act of 2008 (Dortch, 2017). This legislation, known as the Post-9/11 G.I. Bill, provides tuition, a housing allowance, and a supply stipend to eligible veterans. In order to qualify for 100% coverage, veterans must have served 36 cumulative months on active duty (Brown, 2014). If veterans were honorably discharged after having served for 3 years, they received benefits for 36 months, which would fully cover four, 9-month school years (Brown, 2014). Veterans who served 90 aggregate days on active duty after September 11, 2001

received the smallest amount of this benefit, where 40% of the maximum amount payable would be authorized (Brown, 2014).

In 2014, scandal broke out in the Department of Veterans Affairs within the Veterans Health Administration when allegations arose about fabricated wait time reports. There were reports of VA health system employees hiding patient forms for individuals they had been unable to provide services to. Although the allegations arose out of Phoenix, Arizona, the Office of Inspector General soon uncovered a systemic problem (Molina, 2018). In order to satisfy the VA's policy of a 14-day maximum wait time for veterans seeking health care, employees at various VA medical facilities were falsifying scheduling reports. The Secretary of Veterans Affairs, Eric Shinseki, resigned once the revelations surfaced and noted that the lack of integrity amongst hospital administrators needed to be addressed (Molina, 2018). By the end of 2015, the Joint Commission acknowledged improvements made within the Veterans Health Administration regarding wait times and leadership (Gordon, 2017). Nevertheless, the *Pending Appointments Data* provided by the U.S. Department of Veterans Affairs (2018) indicates there is still progress to be made.

As made evident by this historical review, the system of veterans benefits has been evolving since the Revolutionary War (Ortiz, 2012). Knowlton Durham, writing in 1932, noted that veterans benefits and "public policy should be worked out on a basis of reason. But it has never been done" (Durham, 1932, p. 18). Because the policies passed by the legislature regarding these benefits have often been in reaction to external events, the laws that follow can be haphazard, confusing, and disorganized. When these types of policies are delivered to the administrative state, they struggle making sense of the eligibility criteria for benefits and keeping up with the quantity of veterans needing services. Ultimately,

this process damages veterans' ability to access the benefits they are entitled to receive. Once it becomes apparent that veterans' access to their benefits has been hampered, efforts to reform the system must follow. Hopefully, the advice given by Durham in the 1930s will soon be followed.

CHAPTER 2: CURRENT BENEFITS AND RESEARCH

According to the most recent data from fiscal year 2016, the Department of Veterans Affairs' expenditures total more than $170 billion annually. These expenditures cover the cost for the 9.6 million veterans reported to have used at least one of their federal benefits in 2016, which represents 43% of the total number of veterans living in the United States (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2016a). The most widely used service provided to veterans is healthcare. Approximately 6 million veterans use healthcare per year at an annual cost of $63 billion to the Department of Veterans Affairs (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2017a). The largest annual cost to the VA comes by way of disability compensation and pension payments. Four and a half million veterans receive a total of $84 billion in compensatory payments each year (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2016a, 2017a). In addition to these three, federal benefits include vocational and employment benefits, educational and G.I. Bill benefits, VA home loan guaranties, and life insurance.

Current Benefits for Veterans

The benefits currently available to veterans are complex. Part of this complexity can be attributed to the extensiveness and diversity of the benefits themselves. These benefits are also confusing, however, because of the policy process by which they were created (Ortiz, 2012). The confusion that stems from the highly specific eligibility rules is a hindrance to veterans' ability to access their benefits. It is important to have an understanding of these various rules and the

multitude of policies to be able to fully appreciate this hindrance. As such, the seven overarching benefits categories are to be discussed in detail.[2]

Health Care Benefits

According to the U.S Department of Veterans Affairs (2014), veterans discharged from the military under conditions other than dishonorable may qualify for VA health care benefits after 24 months of continuous service in active duty. Veterans must fill out an online application to begin the enrollment process. Once the VA determines that an individual is eligible to receive benefits, he/she may begin receiving treatment at any facility within the VA integrated health care network. It is important to note that the ability of the VA health care system to accept new applicants changes annually. This is partially the result of a yearly change in population as older, health care enrolled, veterans are laid to rest. The number of new enrollees in the system also depends on the amount of money allocated to the VA each year by Congress (Brown, 2014). In 2012, 6.3 of the 22.3 million living veterans (28.3%) received health care (U.S. Department of Veterans Affairs, 2013). In contrast, the Department reported providing health benefits to 6 million of the 20.4 million living veterans (29.4%) in fiscal year 2016 (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2017b). Because of this fluidity of resources, the VA assigns each veteran to a priority group based on factors such as service-connected disability ratings, combat exposure, and income.

[2] The discussion of benefits from pages 24-45 is based on information from the U.S. Department of Veterans Affairs 2014 *Federal Benefits for Veterans, Dependents, and Survivors* handbook and 2018 information from the U.S. Department of Veterans Affairs website (accessible at https://benefits.va.gov/benefits/)

Service-connected disability ratings are determined by the VA after a veteran has supplied the requisite paperwork and their medical records. According to the U.S. Department of Veterans Affairs (2014), the rating is a combination of the severity of their condition(s) and the impact that their disability has on their earning potential. The VA does not provide information to veterans such that they could reasonably predict their service-connected disability rating by looking at a table or an infographic. Rather, veterans depend on their physicians to provide correct information to the Department for their claim. Unless an individual understands medical jargon or works on disability ratings claims regularly, they would be unable to determine their own disability rating. Currently, veterans wait an average of 123 days for their claims to process and for the VA to tell *them* how disabled they are (Mall, 2013). This leaves veterans largely in the dark and unable to receive all of their health benefits for those 4 months.

The U.S. Department of Veterans Affairs (2014) outlines the eight priority groups for VA health care. Veterans who have a 50% or greater service-connected disability rating or are unemployable due to their service-connected conditions make up priority group one. The second priority group is composed of veterans with service-connected disabilities rated 30 or 40%. Prisoners of war, Purple Heart Medal awardees, and Medal of Honor awardees make up part of priority group 3. Also included in priority group 3 are veterans with 10 or 20% disability rankings and veterans discharged for a disability incurred or aggravated during service. Priority group 4 veterans are those receiving increased compensation because they are housebound and in need of regular aid, or veterans determined to be catastrophically disabled. The fifth priority group is made up of both veterans with a 0% noncompensable service-connected disability whose annual income does not exceed the financial threshold and veterans who receive VA pension payments.

Veterans with 0% compensable service-connected disabilities fall under priority group 6. Also within this sixth group are veterans exposed to radiation, Vietnam veterans, Gulf veterans who served before 1998, and veterans who served after 2003 for 5 years post discharge. The seventh priority group contains veterans whose income falls below the designated threshold and who agree to copayment. Finally, priority group 8 consists of veterans whose income exceeds the threshold and who agree to copayment. Veterans who meet the criteria of several priority groups will be placed within the group that gives them the best benefit.

Veterans, if enrolled in the VA health care system, will receive treatment for service-connected injuries or disabilities at no cost to them. Once enrolled in the system, veterans who were rated as 50% or more disabled or are seeking care for a service-related condition have priority access to appointments and scheduling of procedures. In order to ensure the efficacious treatment of veterans, in conjunction with primary care, the VA has taken care to respond specifically to conditions that may be unique to military service. The U.S. Department of Veterans Affairs (2014) describes how special consideration has been given to military sexual trauma, such that counseling and treatment programs have been instated which work towards healing and health for victims. Targeted care and treatment facilities are also in place for veterans who sustained spinal cord injuries in active duty. The VA has 24 medical facilities with specialized centers for these spinal injuries, five of which are long-term care centers. In addition to the above considerations, the VA is actively working to manage the care of returning combat veterans by providing screening at the time of discharge to be proactive in the care of these veterans. The VA has also set up special health registries to track the needs of veterans exposed to Agent Orange, depleted uranium, and ionizing radiation who maintain presumptive conditions as such.

For the care of conditions or injuries not related to service, members of priority groups 7 and 8 are subject to co-payments. According to the U.S. Department of Veterans Affairs (n.d.b.), veterans from priority group 7 are responsible for paying $236.80 for 90 days of inpatient care, while their counterparts in priority group 8 have a co-payment of $1,184 for 90 days of treatment. Veterans from these priority groups, who either fail to complete an annual financial assessment or have an income that exceeds the established threshold, are also subjected to co-payments for outpatient services. Primary care visits require a copayment of $15 per visit, while specialty care visits require a $50 copayment. There are several VA health services that are exempt for copayments and include registry examinations, military sexual trauma treatment, care for PTSD, cancer screenings, immunizations, etc. Regarding medication, priority groups 7 and 8 are required to pay $9 for each 30-day supply. The only copayment priority groups 2 through 6 are required to pay is for medication at a rate of $8 for each 30-day supply.

There are a wide variety of resources available to veterans through the VA regarding mental health. The first of these is readjustment counseling services. Veterans are eligible for these services if they served in active duty in any combat theater. Counseling can be provided in either an individual or a group setting and serves to help veterans make a smooth transition from military to civilian life. According to the U.S. Department of Veterans Affairs (2014), these services are provided at one of 300 Vet Centers situated in all 50 states and can include psycho-social treatment for PTSD. These community-based facilities also provide bereavement counseling to any immediate family members of a servicemember who died while on active duty. Vet Centers also host Combat Call Centers, which

are confidential call centers where veterans and their families can speak freely about their experience and struggles with readjusting.

The U.S. Department of Veterans Affairs (2014) explains how extended mental health care treatment is also available to veterans eligible for VA medical care. In order to match the differing medical needs of various veterans, these services can be found in primary care clinics, specialty mental health centers, inpatient mental health facilities, and rehabilitation programs. In addition to general mental health care, specialized treatment for PTSD, military sexual trauma, substance abuse, and suicide prevention is available. VA medical doctors may also prescribe psychiatric medication in the treatment of mental disorders. A 24-hour veterans' crisis line is also available to serve the immediate needs of veterans in a crisis situation. Specialized programs such as Coaching Into Care and The PTSD Coach provide information to veterans and their families about available treatment and resources for mental health concerns. Residential treatment facilities for mental health are also available to veterans with more intensive needs.

Dental care provided by the VA acts as its own entity, such that eligibility rules that apply for all other health care are different from dental care eligibility. The U.S. Department of Veterans Affairs (2014) eligibility rules are as follows. Veterans with a service-connected dental disability, who are a former prisoner of war, or who have a 100% disability rating are eligible to receive any needed dental health care. Veterans who are homeless or who applied for dental care within 180 days of discharge are eligible for a one-time course of dental treatment. Veterans with dental problems aggravating and/or caused by their service-connected disability are eligible for dental care to treat the condition deemed by a VA practitioner to be impairing their health. Veterans who are currently registered to a

vocational program or who are scheduled for impatient care may receive dental care to treat conditions that complicate their overriding medical needs.

As outlined by the U.S. Department of Veterans Affairs (2014), veterans who are eligible to receive VA health care are also given access to vocational assistance, which includes assessment, guidance, and counseling to prepare for employment. Compensated work therapy programs are available for both transitional and supported employment. Transitional work programs operate at VA medical facilities and local businesses and give veterans the opportunity for temporary employment under clinical supervision. Supported employment is designed to act as a recovery mechanism for veterans with severe mental illness through employment opportunities in conjunction with clinical support. Sheltered workshops are also in operation to evaluate veterans in a simulated work environment and provide guidance for outside employment. Lastly, incentive therapy provides work experience for veterans at a VA medical center who are experiencing severe mental illness or physical disabilities and are not seeking outside employment.

Nursing home care is available to veterans through the VA health care system. The three programs that host this care include Community Living Centers, State Veterans' Homes, and the community nursing homes program (U.S. Department of Veterans Affairs, 2014). The first of these programs, the community living centers, are owned and operated by the VA and provide short-term and long-term care. State Veterans' Homes are the property of the states who are also responsible for operation. States have the ability to apply for construction grants from the VA and are then awarded a portion of the per diem costs to provide nursing care to veterans. Community nursing homes work on contract with the VA to provide additional care to veterans. These facilities allow veterans

to receive care while remaining near to family. Veterans are eligible for any of these three programs if they are free from acute illness, demonstrate significant functional deficiencies, and are approved to receive care by a VA health care provider.

The VA recognizes the contributions made by veteran family caregivers and provides resources to improve care. According to the U.S. Department of Veterans Affairs (2014), veteran caregivers are able to request skilled in-home health aides and adult day health care. Respite care is also available to caregivers in order to offer them relief from their caregiving position temporarily by providing medical treatment for the veteran through other means. Caregivers also have access to training and education both at the point of discharge and in the event that unique medical considerations require specialized training. The VA also provides support services, either in-person or on the telephone, by way of counseling, recreation, or spiritual care.

Disability Compensation

Veterans with service-connected disabilities are awarded compensation payments each month depending on their disability rating as determined by the VA. This benefit, which is paid directly to veterans, is tax-free. A veteran may have either sustained an injury in active duty or had a pre-existing condition aggravated while in service to be considered disabled. In order to be eligible for disability compensation, a veteran must have been discharged under conditions other than dishonorable. According to the U.S. Department of Veterans Affairs (n.d.b.) benefits administration website, a veteran with a 10% disability rating is awarded $136.24 per month, while a 100% disabled veteran with no dependent receives $2,973.86 per month in 2018. Veterans with a 30% or larger disability

rating are awarded additional compensation for spouses and dependent children and parents. In addition to this overarching disability compensation benefit, there are other special compensation programs.

The. U.S. Department of Veterans Affairs (2014) provides guidelines for Concurrent Retirement and Disability Pay, which is offered to allow certain veteran populations to receive both their military retirement pay and their disability compensation benefits. This program allows receipt of both payments by veterans with a disability rating of at least 50%. Previously, the Department of Veterans Affairs required veterans receiving both disability and retirement entitlements to waive their right to their retirement pay in the amount of their tax-free disability compensation. Under the Concurrent Retirement and Disability Pay program, veterans receive the full amount of both their taxable military retirement pay and tax-free disability compensation.

Veterans who are receiving both military retirement pay and disability compensation but have a service-connected disability ranking of less than 50% are rendered ineligible for concurrent pay. To offset this loss, Combat-Related Special Compensation may provide additional payments (U.S. Department of Veterans Affairs, 2014). Veterans may be eligible to receive this special compensation to eliminate the offset generated by the retirement pay waiver. They may be entitled to compensation that raises their total monthly income up to the maximum amount they would under the Concurrent Retirement and Disability Pay program. To be eligible, veterans must have a service-connected, combat-related disability as decided by their respected military branch. A combat-related disability may include an injury incurred as a result of armed conflict, training that simulates war, hazardous duty, or an instrumentality of war.

According to the U.S. Department of Veterans Affairs (2014), Special Monthly Compensation payments are also available to veterans who lost or lost the use of organs or extremities due to military service. This may include amputation of the hand or foot, loss of sight, deafness, inability to communicate, or loss of a reproductive organ. The extra disability compensation is intended to help cover the aid and attendance of another person for the disabled veteran. Special consideration and increased monthly payments will be given to veterans who incurred more than one of the abovementioned injuries. For example, a veteran who lost anatomical use of one hand and one foot would receive a monthly payment of $3,987.67. A veteran who lost anatomical use of both hands and both feet would receive $4,371.03 per month (U.S. Department of Veterans Affairs, n.d.b.).

Pursuant to 38 U.S. Code, section 2101, veterans with severe service-connected disabilities may also be eligible for specialty housing grants in order to buy a new adapted home or adapt an existing home to meet their medical needs (Limitations on Assistance Furnished, 2012). A Specially Adapted Housing grant is eligible for veterans with a total and permanent service-connected disability as the result of the loss of two limbs, blindness, severe burns, or the loss of one lower limb from service after September 11, 2001. According to the U.S. Department of Veterans Affairs (n.d.b.) benefits administration website, Specially Adapted Housing grants are available to disabled veterans in an amount not exceeding $81,080. Grant amounts are set each year as a result of the cost-of-construction index increase for the previous fiscal year (Limitations on Assistance Furnished, 2012). A Special Home Adaption grant is also available for veterans with certain service-connected disabilities. To be eligible for the Special Home Adaption grant veterans must have incurred blindness with 5/200 visual acuity, have lost or lost

the use of both hands, have severe burn injuries, or have severe respiratory injuries. According to the U.S. Department of Veterans Affairs (n.d.b.), the maximum amount available through this grant is $16,217.

The Temporary Residence Adaption grant can be made available to veterans who qualified for either the Specially Adapted Housing or Special Home Adaption grant. As per the U.S. Department of Veterans Affairs (2014), this grant is used specifically to cover the costs of adapting a veteran's family member's home to meet their disability needs. Veterans receiving the $81,080 grant would be eligible to use $35,593 to adapt a family member's home (U.S. Department of Veterans Affairs, n.d.b.). Veterans in receipt of the $16,217 grant would be eligible to use $6,355 for adaption purposes. While the Specially Adapted Housing and Special Home Adaption grants can be used a maximum or three times, the Temporary Residence Adaption grant may only be used once.

In addition to construction grants, veterans with disabilities may also qualify for allowances toward an automobile or clothing. An automobile allowance is one-time payment provided to veterans with disabilities stemming from either the loss of a hand or foot or blindness. This vehicle allowance helps disabled veterans acquire an automobile suitable to assist them in and out for reasons of transportation. According to the U.S. Department of Veterans Affairs (n.d.b.), the VA may award a maximum of $20,577.28 in grant money for these purposes. The VA issues the grant directly to the seller of the automobile and veterans are limited to one automobile grant in their lifetime. Clothing allowances are available to veterans in a maximum amount of $753 per year to compensate for adaptive equipment or a skin condition that permanently damages clothing.

Vocational Rehabilitation and Employment Benefits

Veterans (and servicemembers) have access to resources to help them gain employment and transition back into civilian society. These vocational benefits differ from those previously mentioned in that these services can be provided outside of Veterans Health Administration facilities. According to the U.S. Department of Veterans Affairs (2014), to be eligible, veterans must be other than dishonorably discharged and have either a 20% disability rating and an employment handicap or a 10% disability rating and a severe employment handicap. To determine the severity, if any, of the employment handicap, veterans can meet with a Vocational Rehabilitation Counselor. Once this counselor has determined the entitlement, they work side-by-side with the veteran to determine the appropriate form of action. The counselor will determine the veteran's skills, interests, how their disability will affect their employment, and will help with goal development. Depending on the specialized needs of the veteran, the counselor will assign the individual to one of five service tracks as described by the U.S. Department of Veterans Affairs (2014). The VA will pay for the cost of training and the monthly subsistence deemed necessary.

The U.S. Department of Veterans Affairs (2014) explains that the first track is in place to assist a veteran to obtain reemployment with a previous employer after separating from the service. Rapid access to employment is the second path within the vocational rehabilitation and employment system. This track serves individuals who aim to secure employment immediately following discharge or who have the necessary skills to find gainful employment. The next path helps veterans become self-employed in the event that their disability or life circumstance requires flexible scheduling or accommodations in the work place. The fourth track assists veterans who require specialized training in order to be

employable through long-term services. Finally, veterans may follow the fifth path towards independent living. This service helps veterans unable to work who require rehabilitation to live independently.

Veterans who qualify for vocational rehabilitation and employment services by meeting the aforementioned eligibility requirements have 12 years to use these benefits, per the U.S. Department of Veterans Affairs (2014) guidelines. The time limit of 12 years begins either at the date of separation or at first notification of a compensable service-connected disability, whichever happens last. Once initiated, these services are provided to veterans on a part-time of full-time basis for a maximum of 48 months. Those veterans who were determined by the Vocational Rehabilitation Counselor to need independent living services may receive a maximum of 30 months of care. The monthly subsistence allowance can be provided to veterans whose path requires education or training and is based on the ZIP code of the training or education program. The monthly allowances are adapted each year to reflect the consumer price index increase. As of 2017, the Department of Veterans Affairs provided regular subsistence allowances ranging from $147.06 per month to $855.28 (U.S. Department of Veterans Affairs, n.d.b.). These amounts are based upon the type of training and rate of attendance. Actual subsistence allowances are usually greater than the regular rates.

VA Pensions

Wartime veterans may be eligible to receive pension payments to elevate their annual income to a maximum rate predetermined each year by Congress. The U.S. Department of Veterans Affairs (2014) explains that veterans qualify for pensions if they have limited annual income and are either age 65 or older, or if they are permanently and totally disabled by means other than their own

misconduct. Veterans must have served for 90 days in active service, where at least some of their service was during a wartime. A veteran's discharge from the military must have been under other than dishonorable conditions. Medal of Honor recipients are automatically awarded a pension benefit. According to the U.S. Department of Veterans Affairs (n.d.b.) benefits administration website, these veterans received $1,329.58 per month in 2017. Housebound veterans are also eligible for more than the general pension maximum and this pension is determined by the presence of aid and attendance in everyday living.

The VA provides new maximum pension rates each year. In 2017, according to the U.S. Department of Veterans Affairs (n.d.b.), a veteran without a dependent received the smallest maximum at $13,166. A veteran with one dependent was capped at $17,241. A housebound veteran with one dependent was eligible for up to $20,166 in 2017. A veteran with aid and attendance benefits and one dependent had a maximum rate of $26,036. The VA also takes into consideration that two veterans may be married to one another and sets maximum rates for that scenario. Two veterans who are married to each other have a maximum rate range of $17,241 through $34,837 annually depending on the housebound or aid and attendance benefits of either individual. Two veterans who are married and have no extra benefit considerations would be capped at the lesser of the two extremes. Married veterans who both require aid and attendance benefits would have a maximum annual pension rate at the highest end of the spectrum. According to the U.S. Department of Veterans Affairs (n.d.b.), veterans receive, in addition to the preset maximum, $2,250 for each child.

Education and Training (G.I. Bill) Benefits

Veterans are eligible to receive educational and training benefits through the VA. The Post-9/11 G.I. Bill provides for veterans the opportunity to pursue a college degree or training program to better themselves. The U.S. Department of Veterans Affairs (2014) explains that the VA requires that veterans must have served at least 90 days in active duty and have been honorably discharged to receive a percentage of assistance in funding. This shortest service requirement results in 40% of the maximum benefit. Veterans who served more than 6 months but less than 36 months of active duty will be eligible for between 50 and 90% of the maximum benefit. In order to be eligible for the full 100% benefit, veterans must have either served at least 36 months or 30 continuous days before being discharged for a service-connected disability.

Veterans will receive a portion of funding equivalent to their allotted percentage based on service for three education-related costs. The first of these is tuition and fees. For the 2016-2017 school year, the U.S. Department of Veterans Affairs (n.d.b.) benefits administration website reported covering in-state tuition and fees and up to $22,805.34 per academic year at a private institution. A monthly housing allowance is also provided to veterans using their Post-9/11 G.I. Bill benefits. The maximum monthly housing payment is the same as the basic allowance for a military E-5 with dependents in the same ZIP code as the institution or program. According to the U.S. Department of Veterans Affairs (2014), veterans may also receive a maximum of $1,000 per academic year for books and supplies. The tuition payments are made directly to the school by the VA, while the monthly housing allowance and supply stipend are paid directly to the veteran.

Veterans may also be eligible to receive educational and training benefits under the Montgomery G.I. Bill. This legislation provides these benefits to veterans who first served in active duty after June of 1985 (U.S. Department of Veterans Affairs, 2014). To qualify, veterans must have received a fully honorable discharge and have served for either three continuous years or 2 years of active duty and 4 years in the reserves. Veterans must have paid the voluntary $100 per month for their first 12 months of service to be eligible for Montgomery G.I. Bill benefits. Once deemed eligible, veterans receive 36 months of educational benefits for college, training programs, testing, and licensing. Unlike the Post-9/11 G.I. Bill, the Montgomery G.I. Bill provides a monthly lumpsum payment directly to veterans based on the type of training and the time commitment. According to the U.S. Department of Veterans Affairs (n.d.b.), a full-time veteran in institutional training will receive a monthly payment of $1,928. A full-time veteran participating in an apprenticeship or on-the-job training will receive $1,446 monthly for the first 6 months, $1,060.40 for the second 6 months, and $647.80 monthly for the remainder of training.

Veterans who entered active duty before June of 1985 and after December of 1976 may be eligible to participate in the Veterans' Educational Assistance Program if they made a financial contribution into the program before April of 1987 (U.S. Department of Veterans Affairs, 2014). The maximum allowed contribution to the program is $2,700. Veterans must not have received a dishonorable discharge to be eligible and have 10 years from the date of departure from active duty to utilize the benefits. The Department of Defense will contribute $2 for every $1 contributed by the servicemember. Veterans will receive a maximum amount of $300 per month for full-time training in college, vocational, or technical schools.

According to the U.S. Department of Veterans Affairs (2014), the VA also collaborates with institutions to defray costs through the Yellow Ribbon G.I. Education Enhancement Program. This partnership allows Post-9/11 G.I. Bill veterans to attend universities where the costs exceed the maximum amount set by the VA. Within the Yellow Ribbon Program, the VA will match the percentage of tuition that the university waives to reduce the out-of-pocket expenses on the part of the veteran. Only veterans who are eligible to receive 100% of the maximum benefit under the Post-9/11 G.I. Bill may utilize the Yellow Ribbon Program.

The U.S. Department of Veterans Affairs (n.d.b.), explains how the Department of Defense may allow a transfer of entitlement of educational benefits to dependent children or a spouse. There are stipulations to be eligible for this transfer. The individual with benefits that they wish to transfer must be actively serving in the armed forces at the time of transfer. A servicemember must have either served 6 years before the transfer of benefits and agree to 4 additional years of service or have at least 10 years of prior service. Servicemembers are allowed to choose the number of months to transfer. If a servicemember has not utilized any of the G.I. Bill benefits, they may choose to transfer all 36 months of benefits to their dependent. Otherwise, the servicemember can transfer any remaining months of benefits. Because these stipulations limit the ability of servicemembers to transfer benefits, some dependents of veterans are unable to receive their educational benefits.

Home Loan Guaranty

The VA provides home loan guaranties to eligible veterans (and servicemembers) to help them qualify for a loan for the purpose of purchasing a primary residence. According to the U.S. Department of Veterans Affairs (2014),

the loan guaranty, issued by the VA, serves to protect lenders in the event a borrower defaults on payments. Veterans are required to satisfy certain requirements before they are eligible to apply for a loan with a VA-backed guaranty. Veterans must have a sufficient credit rating, determined by the lender, and adequate income to repay the loan. They must also provide evidence of a valid Certificate of Eligibility from the VA and provide a written statement that they agree to live within the home purchased.

As per the U.S. Department of Veterans Affairs (2014), a veteran must have met service requirements in order to receive the Certificate of Eligibility from the VA. For World War II, Korean War, and Vietnam War veterans, they must have served 90 days of active duty. Veterans in service during any of the post-war periods must have at least 181 days of continuous service in active duty to be eligible for the home loan guaranty. Gulf War Veterans, or those who have served in active duty since August of 1990, must have 24 months of continuous service or have fulfilled the time period for which they were called to active service (at least 90 days). For any peacetime or wartime veteran, discharge from the service must have been under other than dishonorable conditions. Veterans may be exempted from these service requirements if they were discharged early due to a service-connected disability.

Veterans who meet the eligibility requirements may apply for a loan of any amount, but the VA will only guarantee the loan up to a certain amount. The guaranty amount is up to 25% of the county loan limit established annually by the Federal Housing Finance Agency (U.S. Department of Veterans Affairs, 2014). For veterans who are applying for a home loan without an addition down payment, this means their loan amount can be up to the county loan limit, given that lenders require 25% of the loan to be covered upfront. The U.S. Department of Veterans

Affairs allows a basic entitlement to a VA home loan guaranty in the amount of $36,000. This basic entitlement would allow a veteran to purchase a home worth $144,000. Most veterans using their VA home loan guaranty benefits are eligible for an additional $70,025 in entitlement. According to the U.S. Department of Veterans Affairs (n.d.b.) benefits administration website, this basic and bonus entitlement together would ensure an entitlement of $106,025 for a home loan up to four times this value. As such, many veterans are eligible to purchase a home costing $424,100. In some high cost areas, this amount may be increased to match the cost of living.

The VA home loan guaranty program allows veterans to purchase a home without an upfront down payment. There are still, however, certain other fees that a veteran is required to pay. To finance a VA home loan, borrowers must provide closing costs to include recording fees, insurance premiums, and prepaid taxes (U.S. Department of Veterans Affairs, 2014). This is the only out of pocket cost which veterans are required to upfront. The VA also charges a funding fee to recover the costs associated with guaranteeing loans which go into default. The VA funding fee is a percentage of the home loan and is dependent of the type of service. For a first-time user of the VA home loan guaranty program serving in active duty, the funding fee is 2.15% of the loan amount. For a first-time user of this program who is positioned in the reserves, the funding fee is equal to 2.4%. Veterans who provide a down payment towards the loan will be required to pay a funding fee equal to a smaller percentage of their loan amount. This funding fee may be rolled over into the loan and paid as part of a monthly payment.

VA Life Insurance

While still serving in the armed forces, servicemembers are automatically enrolled in Servicemembers' Group Life Insurance. This insurance program applies to both active duty personnel and reserves members who participate in 12 trainings per year. According to the U.S. Department of Veterans Affairs (2014), the maximum coverage amount under this policy is $400,000. Servicemembers pay a premium equal to 7% of their coverage amount per month. This equates to $28 per month for a fully-covered member. Servicemembers are also automatically enrolled in the Traumatic Injury Protection program. The U.S. Department of Veterans Affairs (2014) describes how this policy adds a premium amount of $1 per month in exchange for an additional benefit between $25,000 and $100,000 depending on the traumatic injury. To be eligible to receive payment from Servicemembers Group Life Insurance Traumatic Injury Protection, servicemembers must have sustained a scheduled loss[3] as a result of traumatic injury within 2 years of the injury.

The Servicemembers' Group Life Insurance coverage can be converted into renewable term Veterans' Group Life Insurance at the time of discharge. Per the U.S. Department of Veterans Affairs (2014), members are required to apply within 1 year and 120 days from discharge. Veterans who apply within the first 120-day period are exempt from producing evidence of good health. This coverage, too, has a maximum amount of $400,000. Veterans' Group Life Insurance premiums are determined from the amount of insurance and the age of the veteran. A fully insured, veteran who is 30 years old would pay $40 per month in premium, while a fully insured, 75-year-old veteran would pay $1,840 per month in premium (U.S.

[3] A scheduled loss is the loss of a body part or body function as the result of an injury. Preset insurance amounts are determined by the VA for specific injuries.

Department of Veterans Affairs, n.d.b.). Veterans are also able to convert their VA life insurance into an accepted commercial life insurance policy at any time.

Veterans with service-connected disabilities are entitled to apply for additional coverage through Service-Disabled Veterans Insurance. The coverage provided from this policy cannot exceed $10,000. To be eligible, veterans must have been released under other than dishonorable conditions, have a service-connected disability, be in otherwise good health, and have applied within 2 years of receiving disability notice. Certain disabled veterans may be eligible for more coverage under the Veterans Benefits Act of 2010. According the U.S. Department of Veterans Affairs (2014), this extra insurance is provided for veterans rated as totally disabled and increases the maximum coverage amount by $30,000. Although premiums can be waived for the $10,000 coverage, they cannot be waived for the additional $30,000 coverage.

According to the U.S. Department of Veterans Affairs (2014), the VA also offers Veterans' Mortgage Life Insurance. If eligible, veterans may receive up to $200,000 in coverage which is payable directly to the mortgage holder in the event of the veteran's death. Veterans' Mortgage Life Insurance is only available to veterans who are severely disabled. To qualify, veterans must have been approved for a Specially Adapted Housing Grant (discussed above), have a mortgage on a home, and have applied before age 70. This mortgage insurance is a decreasing term insurance, such that the amount payable to the mortgage holder is equal to the amount that is still owed by the veteran at the time of their death. Regardless of the mortgage loan remaining, veterans pay a fixed premium throughout the life of the policy.

Miscellaneous Benefits

The U.S. Department of Veterans Affairs provides assistance for servicemembers preparing to transition back into civilian society. Through the Transition Assistance Program, departing servicemembers can develop skills useful for job searches, resume building, and finances. According to the U.S. Department of Veterans Affairs (2014), these transition classes are generally three days long and provide valuable information to veterans regarding their myriad of benefits. It is recommended that departing servicemembers enroll and complete this course at a military installation at least 90 days before separation. The Federal Recovery Coordination program is a more specialized transition program that is available for disabled veterans. Run jointly by the Department of Defense and the VA, this system is in place to coordinate benefits and services at the local, state, and national level. Federal Recovery Coordinators are in place to help departed servicemembers through their recovery, rehabilitation, and reintegration.

The U.S. Department of Veterans Affairs (2014) describes that burial and memorial benefits are available to veterans who had served on active duty and had been discharged under other than dishonorable conditions. Reservists who were eligible for retirement are also eligible. Certain spouses and dependent children of servicemembers or veterans may also be eligible for burial benefits. Included in the burial benefits is the gravesite, grave-liner, headstone, and perpetual care of the cemetery. Deceased servicemembers buried in private cemeteries are eligible for some benefits including a headstone and even a burial or plot allowance in certain conditions. Upon request, services may include military funeral honors. These honors include the playing of “Taps,” the folding of a burial flag, and the presence of at least two uniformed members of the service.

A veteran dissatisfied with their benefits may appeal the decision to the Board of Veterans' Appeals. According to the U.S. Department of Veterans Affairs (n.d.b.), Cheryl L. Mason is currently the Chairman of the Board. The Board reviews and decides cases of appeal on behalf of the Secretary of Veterans Affairs. Cases are heard by the Board in Washington, D.C., but claimants may choose to present their case via videoconference if they are unable to present in person. If, after hearing the decision made by the in-house Board of Veterans' Appeals, the claimant is still dissatisfied they may choose to appeal to the U.S. Court of Appeals for Veterans Claims. The U.S. Court of Appeals for Veterans Claims provides judicial oversight for the Department of Veterans Affairs. In rare cases, an appeal may even be made to the Supreme Court of the United States.

There is a diverse array of complex benefits currently available to veterans.[4] The eligibility rules and time restraints differ by benefit making the process of obtaining benefits confusing. This is not to say that the VA should limit the amount of benefits to make the system easier to understand, but rather there needs to be a larger effort to ensure all veterans have a working knowledge of their benefits. The system must begin to appreciate that the burden does not lie on veterans entirely to find a way to access benefits.

Review of Current Surveys and Research

By September 2018, the Department of Veterans Affairs predicts having 17,699,763 male veterans on record. Half of these male veterans (50.2%) will be

[4] Again, more information of the benefits discussed in pages 24-45 can be found in the U.S. Department of Veterans Affairs 2014 *Federal Benefits for Veterans, Dependents, and Survivors* handbook and information from the U.S. Department of Veterans Affairs website (accessible at https://benefits.va.gov/benefits/)

65 years of age or older with the largest cohort having served in the Vietnam War (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2016b). Also by September, the Department estimates there to be 1,902,553 female veterans. Only one-fifth of female veterans (18.1%) will be 65 years of age of older. Female veterans are much younger on average, with 52.0% being between ages 35 and 60. This is likely due to increased military opportunities for women in recent decades. The largest cohort of female veterans served during Post-9/11 era. The median age of male veterans is 65, while the median age of women veterans is 50 (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2018).

As of 2016, 78.9% of male veterans and 65.6% of female veterans were Caucasian (White) (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2018). The second largest racial/ethnic group of veterans in 2016 was African American; 10.6% of males and 19.5% of females fell into this category (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2018). Overall, female veterans are more racially and ethnically diverse than their male counterparts. This racial disparity can be partly attributed to the median age of male veterans. In fact, the *Profile of Veterans: 2016* study by the U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics (2018) demonstrated that although World War II veterans were 94.5% White, the Post-9/11 veterans are 66.4% White. The largest percentage increase of a veterans' racial group since World War II has been African American.

Utilization of Benefits

The use of VA health care and receipt of disability compensation or pension payments accounted for 76% of all VA benefits use in 2016 (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2017b). As of 2017, the Department of Veterans Affairs was providing disability compensation and pension payments to 4,522,804 veterans (23%) in the amount of $84 billion (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2017a, 2017c). Of disabled veterans, approximately 600,000 (13.3%) were listed with a 100% disability ranking (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2017c). Nearly half (45.6%) of veterans receiving disability compensation were 65 years or older. Of the disabled veterans, 69.6% were both enrolled in and using VA health care in 2016 (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2017b). The combination of disability compensation and VA health care use increases with the rate of disability. Only 43.0% of veterans with a service-connected disability rating of 0% utilized both benefits. In contrast, 90.0% of veterans with a 100% disability rating used both disability compensation and VA health care benefits (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2017b). In 2015, the Department of Veterans Affairs reported providing 6 million veterans with healthcare benefits (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2016a). These healthcare recipients equated to a $63 billion expenditure for the VA in 2016 (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2017a). This corresponds with 36.5% of the Department's annual budget.

In 2016, approximately 800,000 veterans (4.1%) utilized either or both education and vocational rehabilitation programs (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2017a). These benefits amounted to an expenditure of nearly $14 billion of the Department's $173 billion budget (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2017a). 2.6 million veterans (13.3%) used VA home loan guaranties, which cost the Department of Veteran Affairs $1 billion in 2016 (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2017a; 2017b). A total of 1.1 million veterans (5.6%) utilized VA life insurance programs in 2016 (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2017b). The Department of Veterans Affairs spent $1.6 billion making insurance and indemnity payments in 2016 (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2017a). General operating expenses accounted for $7.9 billion and construction costs were $1.7 billion in 2016 (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2017a). These expenses equated to 5.5% of the Department's total budget.

National Survey of Veterans. As required by U.S. Code 38, section 527, the Secretary of the Department of Veterans Affairs must "measure and evaluate on a continuing basis the effect of all programs authorized under this title" (Evaluation and Data Collection, 2006). As such, the Secretary published findings from the sixth national veterans benefits survey in 2010. In addition to informing future benefits systems, the survey sought to analyze beneficiary awareness of the major programs. This national survey generated a sample of 8,710 veterans. The results

of this analysis can be used to ascertain the patterns of benefits utilization and veterans' knowledge of these benefits.

The *National Survey of Veterans* from 2010 demonstrated that 41.0% of veterans understood the general benefits provided to them either "Some" or "A lot" (U.S. Department of Veterans Affairs & Westat, 2010, p. 48). Veterans were also asked to rate their understanding of health care, burial, education and training, life insurance, and home loan guaranty benefits. The percentage of veterans reporting a strong understanding of a benefit subgroup was largest within the education and training benefits subgroup (37.7%) and was smallest within veterans life insurance benefits (20.0%) (U.S. Department of Veterans Affairs & Westat, 2010). The most positive response came when the majority of veterans (68.2%) indicated they were aware that the VA had a home loan guaranty program (U.S. Department of Veterans Affairs & Westat, 2010). The *National Survey of Veterans* also contained questions related to the Transition Assistance Program for the purpose of discovering awareness. Of all the veteran respondents, 12.8% reported attending this voluntary program, while Post-9/11 veterans in particular reported 57.6% attendance (U.S. Department of Veterans Affairs & Westat, 2010). It is important to note that of those veterans who attended, 85.1% found that the benefits briefing portion was beneficial (U.S. Department of Veterans Affairs & Westat, 2010).

Survey questions included an opportunity for veterans to report which benefits they have utilized and, if relevant, allowed them to select a reason indicating why they did not. Just over one quarter of veterans indicated they had been enrolled in VA health care (26.8%) or had ever used VA health care benefits (28.4%) at some point in time (U.S. Department of Veterans Affairs & Westat, 2010). Of the remaining group of veterans who had never used these benefits,

42.3% were not aware of VA health care benefits and 26.4% indicated they did not know how to apply (U.S. Department of Veterans Affairs & Westat, 2010). Regarding disability compensation, just over one fifth, or 21.3% of veterans reported they had ever applied for VA disability compensation benefits. The majority of veterans reported that they had not applied for these benefits and, of those, 17.1% stated they were not aware of the service-connected disability program (U.S. Department of Veterans Affairs & Westat, 2010). Another 14.2% of veterans in this subgroup indicated that they did not know how to apply (U.S. Department of Veterans Affairs & Westat, 2010). Of the veterans that did report application for disability compensation, 14.8% also had used vocational rehabilitation services for the VA (U.S. Department of Veterans Affairs & Westat, 2010). Nearly one third of veterans (32.3%) who had applied for disability compensation but who had not used vocational rehabilitation services reported that they did not know how to apply for these services (U.S. Department of Veterans Affairs & Westat, 2010). The trends present throughout the analysis of the *National Survey of Veterans* from 2010 indicate that the absence of veterans' knowledge of their benefits has resulted in a large portion of the veteran population not utilizing the benefits they have earned through their service.

A sizeable portion of veterans surveyed (36.9%) indicated that they had used VA education or training benefits (U.S. Department of Veterans Affairs & Westat, 2010). The majority of veterans who used these benefits (86.4%) reported usage, which began after active duty. Of those who did not utilize VA education of training benefits, 36.6% were not aware of these benefits and 19.4% did not know how to apply (U.S. Department of Veterans Affairs & Westat, 2010). More than half of veterans (55.2%) reported that they had ever obtained a home loan and of those, 66.7% had utilized the VA home loan guaranty program (U.S. Department

of Veterans Affairs & Westat, 2010). In the case of the veterans who have had a home loan but have not used the VA home loan guaranty program, 33.6% indicated they were not aware of this benefit. Less than 10% of veterans (8.3%) reported that they were covered by VA life insurance, due in part to the fact that the majority of veterans (66.3%) have life insurance from another source (U.S. Department of Veterans Affairs & Westat, 2010). Of those not covered by VA life insurance, 65.8% were unaware of the benefit and 27.4% did not know how to apply. Finally, 13.4% of veterans surveyed indicated that they planned to be buried in a VA cemetery (U.S. Department of Veterans Affairs & Westat, 2010). Within the group of veterans not planning to be buried in a VA cemetery, 27.5% reported they did plan to have a VA provided headstone. Some of the veterans not planning to use these services (29.1%) indicated they did not know the eligibility criteria (U.S. Department of Veterans Affairs & Westat, 2010). Again, it becomes apparent that many veterans are not receiving benefits because they are unaware they exist or because they are unaware of how to access them.

The *National Survey of Veterans* from 2010 also noted differences in benefits utilization and understanding amongst demographic subgroups. As deduced from analyses from multiple responses, there is an overall tendency of younger veterans accessing the internet more often and being more willing to use the internet to access benefit information. Post-9/11 veterans also reported higher rates of information seeking regarding benefits in the past year (74.2%) compared to the World War II subgroup of veterans (35.6%) (U.S. Department of Veterans Affairs & Westat, 2010). A smaller proportion of World War II veterans reported a strong understanding of the benefits available (44.6%) than the Post-9/11 veterans (60.5%) (U.S. Department of Veterans Affairs & Westat, 2010).

Differences across gender and racial/ethnic groups appeared in an analysis of disability compensation and VA health care. Overall, 27.7% of veterans with a disability rating reported a 70% or higher disability (U.S. Department of Veterans Affairs & Westat, 2010). However, female (39.2%) and African-American veterans (30.9%) both reported higher percentages of disability ratings of 70% or higher. Gender differences in reporting were also present regarding the need of aid and attendance. Whereas nearly 20% of older women (19.5%) reported needing the aid and attendance of another, only 10% of older men (10.4%) needed this extra care (U.S. Department of Veterans Affairs & Westat, 2010). Certain ethnic groups also required more of this particular benefit. Although the overall rate of aid and attendance of another was 7.3% of the veteran population, 11.5% of African Americans and 20.3% of American Indian/Alaska Natives reported use of the aid and attendance of another (U.S. Department of Veterans Affairs & Westat, 2010). Fewer African American veterans (76.7%) and American Indian/Alaska Native veterans (79.5%) had health insurance coverage compared to the average rate of 90% (U.S. Department of Veterans Affairs & Westat, 2010). These findings are important because they indicate a greater need for health care on the part of minority veterans.

Demographic differences in utilization were also present in non-health related benefits. More Vietnam (47.5%) and Post-9/11 veterans (43.0%) reported use of their VA education of training benefits compared to the average rate of 36.9% (U.S. Department of Veterans Affairs & Westat, 2010). Veterans of World War II reported the highest use of VA life insurance (23.9%) in comparison to the less than one tenth (8.3%) of all veterans reported use. In contrast younger, Post-9/11 veterans (73.0%), Hispanic veterans (78.1%), and African-American veterans (80.1%) reported higher utilization rates of VA home loan guaranties when

compared to the average rate of 66.7% (U.S. Department of Veterans Affairs & Westat, 2010). Finally, differences existed in burial preferences. More Hispanic veterans (25.6%) and Asian/Pacific Islander veterans (22.0%) reported plans of being buried in a VA cemetery than the average veteran (13.4%) (U.S. Department of Veterans Affairs & Westat, 2010). Post-9/11 veterans (40.4%) and African-American veterans (35.4%) reported the most interest in utilizing a VA headstone compared to the average rate of 27.5% of veterans.

Based on these demographic differences, a few rudimentary conclusions can be made. First off, younger veterans are both more regularly seeking information about benefits and report higher rates of understanding of their benefits. Regarding health-rated concerns, minority veterans (female and non-White) generally carry a higher service-connected disability rating, are in need of more aid and attendance of another, and are more likely to be without health insurance. World War II veterans, perhaps because of age-related concerns, reported the highest enrollment in VA life insurance. Finally, Veterans who are younger and belong to a minority ethnic group are both more likely to have used a VA home loan and more likely to have plans for either burial in a VA cemetery or garnishment of a VA headstone. These demographic differences matter because it is important to ensure that all groups of veterans are receiving the benefits *they* need, not just the services the majority is requesting.

Utility of Benefits

The *National Survey of Veterans* from 2010 included a handful of questions for respondents related to the utility of their federal benefits. However, because the study objectives included obtaining, “information VA may use in planning and allocating resources for programs and services,” questions were geared more

toward utilization than they were utility (U.S. Department of Veterans Affairs & Westat, 2010, p. viii). The evaluative component of this wave of the *National Survey of Veterans* was aimed toward benefits awareness, pursuant to P.L. 108-454, Section 805. Nevertheless, the components of the survey which addressed the efficacy of benefits may be used to set a basic foundation of the usefulness of these programs through the perspective of the veteran.

Regarding VA health care benefits, of the quarter of veterans who reported having used this benefit, 67.6% indicated they had either received services at the VA or had VA paid services in the last 6 months (U.S. Department of Veterans Affairs & Westat, 2010). It can be concluded then that nearly one fifth of veteran respondents (19.2%) rely on this federal benefit for regular health care needs. Respondents also indicated reliance on disability compensation payments in day-to-day life. Of the 14.3% of veterans who reported receipt of monthly disability compensation, 77.7% indicated that receiving these monthly payments was very important in helping them meet financial needs (U.S. Department of Veterans Affairs & Westat, 2010). As such, one tenth of veteran respondents (11.1%) have a sustained need for monthly assistance through this benefit. Of the veterans receiving both disability compensation and vocational rehabilitation services (14.8%), 60.6% reported that these programs were very important in helping meet employment goals (U.S. Department of Veterans Affairs & Westat, 2010). Based on these results, it can be concluded that nearly one tenth of veterans (9.0%) relied on vocational rehabilitation services to gain employment.

Educational and training benefits provided to veterans also proved to be well utilized. Over one third of veterans indicated use of this benefit (36.9 %) and of these veterans, 66.6% indicated they had completed the training or received the degree for which they were striving (U.S. Department of Veterans Affairs &

Westat, 2010). In addition, 73.2% of the veterans using educational and training benefits reported that these benefits were very important in achieving educational goals or preparing for better employment. Veterans' responses also expressed the utility of the VA home loan guaranty. Of the 36.8% of veterans who reported having used this program, 46.0% noted the lack of a down payment as instrumental (U.S. Department of Veterans Affairs & Westat, 2010). Of the 13.4% of veteran respondents planning to be buried in a VA cemetery, half of them (50.4%) indicated as a reason their connection to the military and past service (U.S. Department of Veterans Affairs & Westat, 2010). This reasoning gives credence to the idea that for many veterans, their service in the armed forces is an important era of their life and is a part of their identity.

External research. Although academic research regarding veterans' perceptions of their federally afforded benefits is in its infancy, there is a growing body of literature of this topic from various disciplines. Given the diverse, multifaceted nature of the extensive government programs for past servicemembers, it makes sense that the research of this topic has been promulgated from varying disciplines. Journals of military medicine, sociology, psychology, law, and labor relations have published research related to the benefits currently provided to veterans.

Fried, Helmer, Halperin, Passannante, and Holland (2015) reviewed a handful of cases, dating back to 1983, in which variations of health care use between veterans denied or awarded VA disability compensation were analyzed. Their review of the literature suggested that statistically significant differences exist between the two groups. Fried et al. (2015) reported that those denied disability compensation have lower PTSD severity scores, although some evidence

suggests they have poorer physical functioning (or comparable physical functioning) than their awarded counterparts. Fried et al. (2015) also determined that veterans denied disability compensation utilized less VA health care services and reported lower quality of life. In addition, those denied disability compensation had poorer social functioning. The results of the research by Fried et al. (2015) indicated that the award of disability compensation for veterans serves as a crucial component of future health and quality of life.

Researchers have also been interested in patient satisfaction as it relates to veterans' use of VA health care. Wright, Craig, Campbell, Shaefer, and Humble (2006) looked specifically at differences in satisfaction among male and female veterans. Overall, the component of outpatient care that received the lowest satisfaction rating for both males and females was pharmacy pickup experience (64% satisfaction and 59%, respectively). The highest satisfaction rating for outpatient care was for courtesy, in which both males and females reported 95% satisfaction. Regarding inpatient care, the component with the lowest satisfaction was the same for males and females. Emotional support in inpatient care received a 63% satisfaction for males and a 61% satisfaction for females. Again, courtesy was rated the highest in inpatient care such that 88% of males and 86% of females were satisfied. With respect to gender differences, Wright et al. (2006) found significant differences during bivariate analyses such that females reported lower satisfaction with health care. The findings were, however, made smaller after adjusting for various covariates. Wright et al. (2006) were able to demonstrate that patient satisfaction was greater amongst male veterans and greater for outpatient care.

Hundt, Robinson, Arney, Stanley, and Cully (2015) investigated the utility of peer support groups in the treatment of posttraumatic stress disorder (PTSD)

and military sexual trauma (MST). Qualitative interviews were conducted with veterans receiving care for PTSD and all participants indicated endorsement for peer support programs, even though a handful of those interviewed felt they would not personally participate for reasons related to social anxiety. Veterans indicated that possible benefits of these peer support groups included mutual understanding, purpose and meaning, normalization of symptoms, and as a link to professional treatment. Hundt et al. (2015) found unanimous support for separate peer groups dedicated to PTSD and MST. The research also indicated that although Vietnam veterans were in favor of groups, which included veterans of all eras, veterans of more recent conflicts preferred support groups that included only veterans of their era. This research is important to consider when evaluating possible reform efforts in the area of mental health.

Sanford Mall authored an article in 2013 evaluating the disability claims process from the position of a VA-accredited attorney. Mall (2013) discovered that in fiscal year 2012 the VA handled over one million veteran claims of disability and suffered a backlog of half-a-million claims. VA regional offices with particularly slow processing times included those in California and Texas. Mall (2013) also found that the VA admitted mistakes on 14% of all claims cases, far from their goal of maintaining 98% accuracy. Another component of Mall's (2013) analysis involved an evaluation of the current disability rating schedule. As of 2016, the VA should have completely revised its antiquated rating schedule, created in 1945. In the *2016 Report to the Secretary of Veterans Affairs* the VA Advisory Committee on Disability Compensation reported that although they had significantly reduced processing times from 348 days to 123 days, the VA had yet to complete the updated disability claims schedule and set a new deadline for September 2018 (U.S. Department of Veterans Affairs, 2016). Mall's (2013)

research brings to light the inefficiency in the current process of obtaining disability compensation.

Edens, Kasprow, Tsai, and Rosenheck (2011) sought to evaluate the relationships of substance abuse, VA service-connected disability rating, and homelessness amongst veterans. Their analysis indicated that middle-aged, male, African-American, low income veterans were overrepresented in the homeless group. Edens et al. (2011) also discovered that the single greatest predictor of veteran homelessness was illicit drug use, followed by other addiction disorders, and finally severe mental health disorders. VA service-connected disability ratings of over 50% were found to be protective factors against homelessness. This is perhaps the result of having the financial means to maintain housing, and due to the fact that veterans with higher disability ratings receive priority within the health care system. Eden et al.'s (2011) research gives credence to the possible utility of increasing the availability of substance use programs to combat veteran homelessness.

Researchers have also been interested in the utility of educational benefits in supporting veterans in civilian society to determine if the economic burden of educational benefits has resulted in positive changes for veterans. Smith-Osborne (2009) evaluated the mediation effects of the GI Bill and other related benefits on educational attainment for veterans with disabilities. The results of Smith-Osborne's (2009) analysis indicated that non-labor income and informational social support (and not the G.I. Bill benefits) mediated the effects of disability on educational attainment. At the time of writing, the Post-9/11 G.I. Bill, with substantially greater benefits, had not yet been enacted.[5] This research, which

[5] The Post-9/11 G.I. Bill provided a greater monthly allowance for veterans, paid for veterans' tuition, and provided a book stipend.

points to the validity of including monthly housing allowances to ensure that veterans can maximize their educational benefits, reinforces the policy decisions made in respect to the Post-9/11 G.I. Bill. Smith-Osborne (2009) also suggested strengthening opportunities for veterans to engage in social networks.

Angrist (1993) also conducted a study related to the Montgomery G.I. Bill and earlier educational benefits for Vietnam veterans. This research aimed to ascertain the effects of educational benefits on earning potential. Angrist (1993) described how 77% of veterans who had utilized these benefits had attended college or graduate programs (as opposed to other training). Those who attended college had an average of 1.4 more years of schooling compared to their counterparts, which resulted in annual earnings 6% greater than those who did not utilize their educational benefits for college or graduate programs. Because the United States shifted to an All-Volunteer Force in 1973, the utility of these educational benefits can be considered a recruitment incentive for possible servicemembers. Angrist (1993) concluded by stating that the return value of this 6% earnings increase more than compensates for the upfront educational costs over the veteran's 30-year working life. The research by Angrist (1993) and Smith-Osborne (2009) support the validity of including educational benefits for veterans post-service.

Research done by Sayer et al. (2011) sought to determine risk factors associated with post-deployment reintegration difficulties amongst veterans utilizing VA health care. Their research indicated that veteran reintegration difficulties were associated with worse overall mental health, demonstrating the importance of understanding risk factors for reintegration difficulties to direct intervention programs. Nonwhite and unemployed veterans had higher ratings of community reintegration difficulty. Sayer et al. (2011) also found that

reintegration difficulty scores were higher for veterans who screened positive for PTSD and drug/alcohol problems. The results of this research indicate a need to prioritize reintegration program efforts towards nonwhite, unemployed veterans and those with PTSD or drug/alcohol problems. Recall, too, that Edens et al. (2011) demonstrated that illicit drug use is also a predictor of veteran homelessness.

Bagnell et al. (2013) researched the differences in veteran wellness by demographic variables, including military branch and combat exposure. Both of these particular variables were significantly associated with post-deployment wellness. The researchers found that being exposed to combat was related to worse wellness ratings after service. In addition, Air Force, Navy, and Coast Guard members reported better wellness than did Army servicemembers. Bagnell et al. (2013) also reported a greater degree of wellness issues with Hispanic, female, and less educated servicemembers. It is important to be cognizant of these findings when addressing veterans' post-service and to consider what changes can be made to address the wellness gap with combat-exposed, Army, or minority veterans. These veterans may also prove to be more dependent on (or report higher utilization of) certain benefits.

Parker (2012) conducted research to ascertain the differences between combat and non-combat veterans, if any. It has been well established that, "war-related trauma affects many aspects of veterans' post-service lives, usually for the worse" (Parker, 2012, p. 281). The stress that this trauma causes may induce social disengagement on the part of the veteran. To evaluate this more specifically, Parker (2012) aimed to determine if combat exposure influenced a veteran's allegiance to their country. The conclusions of this research indicate that combat veterans, who have sustained psychological injuries, are more likely to withdraw

from the political system. Parker (2012) also reported that the hyperarousal present in posttraumatic stress disorder sufferers impairs their cognitive abilities. Parker's (2012) study indicates a need to provide extra assistance to veterans with war-related trauma because their cognitive deficits may impair their ability to access benefits.

The work completed by Teigen (2012) analyzes whether veterans differ in their political attitudes from non-veterans. The results indicate that veterans hold similar views to non-veterans regarding foreign policies once controlling for other variables. He noted, however, "regarding domestic policy, there are few empirical studies of military veteran opinion" (Teigen, 2012, p. 266). Of the few studies on domestic policies, veterans' opinions mimic those of the general public. Teigen (2012) offered that it is plausible, when subsets are created within the overall population of veterans, more differences will become apparent. Because of how massive the population of veterans is, more acute comparisons are required (Teigen, 2012). His suggestion of the possible difference between veterans' and non-veterans' opinions on domestic policy made prove relevant when evaluating veterans benefits policy. Perhaps veterans will have different opinions on the state of their benefits than non-veteran counterparts (i.e., the general public).

The compilation of this external research leads to several important findings. First, the process of obtaining disability ratings and compensation is slow and assessments can contain errors (Mall, 2013; U.S. Department of Veterans Affairs, 2016). Disability ratings are valuable, such that they are associated with better quality of life, increased use of health benefits, decreased probability of homelessness, less illicit drug use, and more favorable post-service reintegration (Edens et al., 2011; Fried et al., 2015; Sayer et al., 2011). Of veterans receiving health benefits, the greatest reported dissatisfaction was with providers' emotional

support (Wright et al., 2006). This lack of support may be particularly detrimental, as veterans have demonstrated a desire for support (Hundt et al., 2015). Informational social support has been found to mediate the effects of disability on educational attainment, which can in turn increase earnings potential (Angrist, 1993; Smith-Osborne, 2009). Finally, Teigen (2012) provided a reminder that it is important to consider veteran subgroups, such as combat exposure and branch of service, as these variables have been demonstrated to influence wellness (Bagnell et al., 2013; Parker, 2012).

Research Design

The current research study sought to determine if the historical trend of haphazard legislation and limited access to benefits remains an issue within the current system. The theory, which directed the research, asserts that these habitual failures remain present and have created a system with limited access and subpar services for veterans. The extant research has considered the variations in benefits utilization across demographic groups and the utility of the benefits available. However, none of the previous studies have been comprehensive, such that both utilization and the utility of all benefits' categories have been researched within one veteran population. Because the *National Survey of Veterans* from 2010 has come nearest to this goal, it was used as a model for the present survey. An analysis of utilization and utility patterns and variations provided a template for diagnosing the system (U.S. Department of Veterans Affairs & Westat, 2010).

In order to determine whether the present system has extended these past failures, the current study evaluated the perceived utility and utilization patterns of a sample of veterans. An assessment of respondents' utilization of benefits and their reported knowledge of the system helped determine current levels of

accessibility. In order to be able to use benefits, veterans must understand the system and have the ability to access it. In addition, analyses determined if there are differences in accessibility issues across demographic groups. This study also sought to determine the utility of the benefits themselves to further analyze the health of the system. To gauge the effectiveness of these programs, respondents reported their satisfaction levels with the benefits they have utilized. This research also sought to evaluate more general perceptions held by the veteran participants. These perceptions, too, provided support for the theory as they are linked to perceptions about the VA.

It can be expected that utilization will vary across benefits' categories. Because eligibility rules differ across benefits' groups, not all veterans have access to every benefit. Veterans are also not required to use every benefit they are eligible for. As such, veterans pick the benefits that they want to use. It is expected that the selection of these benefits will be not the same across the board. The needs of certain veterans are dependent upon the individual's background. Research has demonstrated that ethnicity may influence which benefits are utilized (Bagnell et al., 2013; Sayer et al., 2011; U.S. Department of Veterans Affairs & Westat, 2010). The nature of a veterans' service (i.e. branch of the military and combat status) will also influence their needs post-service (Bagnell et al., 2013; Parker, 2012). It can be expected, too, that veterans' utilization patterns will differ by age because the needs of veterans change throughout their lifetimes.

H1: There will be variations in the utilization of veterans benefits.

H1(a): There will be variation in benefits use across demographic groups.

H1(b): There will be variations in benefits use across military branch.

H1(c): There will be variations in benefits use between combat veterans and non-combat veterans.

Because it is likely that veterans will have utilized different benefits, variation can be expected in respondents' rankings of the importance of benefits and the benefits' need for improvement. Participants will likely have different experiences with their benefits which will shape the way they perceive their importance or need for revision. Based off the national attention given to the VA health care system and the inherent need of good health, it is likely that health benefits will be ranked as highly important and in definite need of reform. The expected demographic differences in benefits utilization and satisfaction suggests demographic differences in these rankings as well.

H2: Health benefits will be ranked as the most important and the most in need of improvement.

H2(a): There will be differences across demographic groups in rankings of benefits by importance and need for improvement.

It is also expected that there will be variations in satisfaction across the diverse benefits' categories. It has been demonstrated that veterans are more pleased with certain benefits than others. Also, because various benefits are perceived as more indispensable than others by veterans, participants' satisfaction may be more difficult to gain within those categories. The administrative toll also varies by benefit, and satisfaction might be related to the acquisition of benefits. Previous studies have demonstrated differences in satisfaction across veteran gender and ethnicity.

H3: There will be variations in satisfaction across benefits' categories.

H3(a): There will be differences in satisfaction across demographic groups.

Veterans' responses of the appraisal of the issue are expected to be concentrated in the time it takes to receive benefits because this timing factor is closely related to the problem of accessibility. The waitlist scandal in 2014 and other academic studies have demonstrated that efficiency has become a problem within the VA. Because veterans are likely to indicate that health benefits are the most in need of reform, they are likely to use these benefits as a rubric by which to judge the current issues. Although quantity issues have historically faced criticism within educational benefits, this problem seems largely to have been resolved. Some respondents will claim quality issues, but the time variable is expected to be the most important. Because health benefits are likely the most in need of improvement, respondents who utilized health benefits will likely vary in their appraisal of the issue.

H4: The time it takes to receive benefits will be cited at the biggest issue with veterans benefits.

H4(a): Health benefits users will differ from those who do not use health benefits in their perception of the issue with veterans benefits.

Based on the low national attendance rate of veterans in Transition Assistance Program courses, it is expected that respondents will not have high ratings of their personal knowledge of their benefits. Even with this course, because of the complexity of the benefits and the eligibility rules, it is difficult to fully understand the benefits system. These lower ratings of respondents' personal knowledge of their benefits will likely correlate with a lower appraisal of the military's job of educating veterans on their benefits.

H5: Veterans will not have high ratings of their personal knowledge of their benefits.

H5(a): Respondents will report low ratings of the military's job of educating them about their benefits.

Veterans' perceptions of the military's handling of mental health issues are expected to be negative. The disability rating schedule, closely tied to health benefits, is outdated and has not been fully amended to consider mental health conditions. Also, because the system is backlogged with respect to physical health ailments, it is likely that non-visible ailments are even further behind. The military's overall handling of mental health concerns is likely to be informed by the 'get tough' culture of the military. As such, perceptions of the military's job of addressing these issues are likely to be poor. If the culture of the military inhibits its ability to adequately handle these concerns, the benefits in place for mental health are likely to be poor as well.

H6: Ratings of the military's handling of mental health issues will not be high.

H6(a): The benefits in place for mental health conditions will be perceived as inadequate.

There are expected to be correlations between participants' satisfaction with the U.S. Military, satisfaction with the U.S. Government, and perceptions of the general public's favorability toward the veteran population. Because of their interconnectedness, it is likely that satisfaction with the military will be correlated with satisfaction with the government. Veterans who feel that the general public is not favorable to them may attribute this perception to issues within the government, specifically the government's reporting of military-related action.

H7: Satisfaction with the U.S. Military will be correlated with satisfaction with the U.S. Government.

H7(a): Satisfaction with the U.S. Government will be correlated with perceptions of the general public's favorability toward veterans.

If these hypotheses prove to be correct, there will be sufficient evidence to support the theory that persistent accessibility issues still exist within the VA system as a result of reactionary, haphazard policy which impairs the ability of the administrative state to provide services to veterans.

CHAPTER 3: METHODS AND RESULTS

The current study seeks to add to the existing literature evaluating the current state of veterans benefits by providing a firsthand analysis of veterans' perceptions of their federal benefits. The extant research has evaluated veterans' perceptions and the utility of specific benefits (Angrist, 1993; Hundt et al., 2015; Mall, 2013; Smith-Osborne, 2009; Teigen, 2012; Wright et al., 2006), and it has provided an account of which subgroups of veterans utilize each of the benefits available to them (Bagnell et al., 2013; Edens et al., 2011; Fried et al., 2015; Parker, 2012; Sayer et al., 2011; U.S. Department of Veterans Affairs & Westat, 2010). The present study contributes to the existing literature in that it evaluates both the utilization and veteran-perceived utility of federal VA benefits within the same research population using original, survey-driven data. This survey considers demographic and service-related variables deemed relevant by the extant literature and seeks to contribute a deeper understanding of veteran's perceptions of their benefits.

Survey

The 2010 *National Survey of Veterans* questionnaire created by the Department of Veterans Affairs was used as a model by which to design the current survey. Using the national survey as a guide, this instrument asked questions related to military background, benefits use, and demographic characteristics. In addition, the survey included opinion-based questions about the system in its entirety and its individual components. Prior to distribution the survey was then submitted for institutional review where it was cleared for administration by the university at the departmental level. The survey was

administered online using Qualtrics Survey Software. (See Appendix A for a copy of the survey disseminated.)

Participants were recruited from a large public university. This university has an office dedicated to veterans where these students can receive services related to benefits enrollment, course requirements, and outside resources. Researchers provided an active link to the survey along with instructions and an invitation to participate to a university registrar, who is also the Director of Veterans Services for the university. This individual then forwarded the email to a listserv of students registered as veterans. After a 2-week period, a reminder email was sent out to maximize responses.

Before beginning the survey, participants were prompted to confer consent after reading a brief synopsis of the research to be completed. Participants were informed of the voluntary nature of the survey and their ability to discontinue participation at any time. Those who chose to complete the survey were given the opportunity to enter random drawing for a $25 Amazon gift card. The presence of this incentive was made known in the email invite as well as the consent agreement at the beginning of the survey. Participants' email addresses were separated from other data prior to any analysis. After the drawing was completed, the email addresses were permanently deleted from the data set and analyses was performed using aggregated, anonymized data.

Independent Variables

Participants' attributes were recorded using a series of demographic questions. The attributes included gender, year of birth, race/ethnicity, age at time of enlistment, years of service, military branch, current military status, and combat exposure and duration. Regarding military branch, participants were given the

following options: Army, Marine Corps, Air Force, Navy, and Coast Guard. Responses for participants' current status with the military included active duty, discharged, retired, and reserves. An affirmative response to the question "Were you ever deployed in combat?" then prompted the survey to ask respondents "How long, in total, were you deployed to serve in combat?" Answer options for the latter question included 6-month increments. Incoming results from the longitudinal, Millennium Cohort Study by the Department of Defense on the effects of military experience on post-deployment outcomes prompted the inclusion of the survey variables related to military branch, combat exposure, and other experiences (Bagnell et al., 2013).

Dependent Variables of Interest

Veterans were asked to rate both the military's job of educating them about their benefits and their knowledge of all the benefits available to them as a veteran. This was measured using a Likert scale where '1' indicated excellent and '5' indicated terrible. Participants were prompted to select all the benefits they had personally utilized including health benefits, educational benefits/G.I. Bill, employment benefits/vocational training, life insurance, disability compensation, VA home loans, pension payments, and other. Depending upon the benefits they had selected, participants were asked to rate their experience on a Likert scale where '1' indicated extremely satisfied and '5' indicated extremely dissatisfied. In the event that participants selected a response indicating dissatisfaction (either dissatisfied or extremely dissatisfied) they were asked to provide a brief, written explanation for their previous response.

Participants ranked the aforementioned seven benefit categories on a Likert scale where '1' indicated the most important to them and '7' indicated the least

important to them. Participants also ranked the benefit categories by need for improvement, where a '1' indicated the highest need for improvement and a '7' indicated the lowest need for improvement. Veterans were also asked, "Would you say the issues with veterans benefits are more to do with the time it takes to receive benefits, the quality of the benefits once received, or the quantity of the benefits once received?" Participants could select any one of the above answer choices, all of the above, or other. Respondents were also given an opportunity to record any additional comments they wanted to share about their experience with veterans benefits.

Participants were then asked general questions affiliated with their military experience. Veterans rated their overall satisfaction with the U.S. Military and the U.S. Government as a whole on a Likert scale where '1' indicated extremely satisfied and '5' indicated extremely dissatisfied. Participants' overall perceptions about the state of the government and military may affect and/or be affected by their experiences with benefits. An analysis of the intersection of these variables prompts a discussion of how more general perceptions bleed into the perceptions of federal benefits for veterans. Participants' view of the military's job of handling the mental health issues associated with service was also reported.[6] Following this, respondents were then asked to rate the adequacy of the health benefits available to veterans specifically in the area of mental health. A response of '1' indicated extremely adequate and '5' indicated extremely inadequate. An analysis of these responses may indicate a connection between dissatisfaction with the benefits utilized by the respondent and successive dissatisfaction with other services provided by the Department of Veterans Affairs. Veterans rated how they felt the

[6] Participants were not asked specifically if they had utilized mental health services due to concerns about privacy.

public in general feels about the veteran population on a Likert scale where a '1' indicated very favorable and '5' indicated somewhat unfavorable. Participants with dissatisfactory experiences may place the blame on the general public's bleak view of the veteran population.[7] (See Appendix B for a frequency report of responses for all variables.)

Participants

Of the 429 veterans contacted, 87 responses were recorded generating a 20.3% response rate. The majority of participants (72.0%) were male.[8] The average age of respondents was 32.5 years old (SD=9.5), with respondent ages ranging between 20 and 68 years of age. Of the 87 respondents, 48.3% identified as Latinx[9] or Hispanic (42), 36.8% identified as White (32), 8.0% identified as Asian/Asian American (7), 5.7% identified as American Indian or Alaska Native (5), 5.7% identified as Other (5), and 1.1% identified as Black or African American (1). Because the sample size was small for respondents who identified as Asian/Asian American, American Indian or Alaska Native, Black or African American, or Other, this group was consolidated into 'Other' for the purposes of analysis (n=17). Also for the purposes of analysis, the four respondents who identified as both Latinx and White were placed into the Latinx category. As a result, 48.3% of respondents were coded as Latinx (42), 32.2% were coded as White (28) and 19.5% were coded as Other (17).

Regarding military experience and age of enlistment, the majority of respondents (60.0%) reported enlisting between the ages of 18-20 years. Nearly

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[7] When the public is unaccepting of the veteran population, as was the case with the Vietnam War, policies regarding veterans benefits tend to be more conservative as a reflection of public opinion.

[8] Of the national population, 90.3% of veterans are male.

[9] Latinx is a gender-neutral term used to describe Latina, Latino, and Hispanic participants.

one quarter of participants (24.7%) reported enlisting before the age of 18 years. The average amount of years enlisted was 6.75 years (SD=5.05), ranging from 1 year to 22 years.[10] The branch of the military that was the most represented in the data was the Army (42.4%), followed by the Marine Corps (22.4%), the Navy (20.0%), the Air Force (11.8%), and the Coast Guard (3.5%). The majority of participants (52.9%) stated they had been discharged, while 30.6% were in the reserves, and 15.3% were retired. Nearly half of all respondents (48.2%) reported having served in combat. Of these respondents, 68.3% stated they had been deployed between 6 and 18 months, 17.1% had been deployed between 24 and 36 months, and 14.6% had been deployed more than 36 months.

Results

Overall, health benefits were utilized by a majority of respondents (55.2%, n=48). An even larger percentage of participants reported using educational benefits/G.I. Bill (90.0%, n=78). It should be noted that this proportion of educational benefits users is larger than the national average (36.9%) due to the fact that the survey was administered on a college campus and disseminated through the university's registrar's office list of enrolled student veterans. The percentage of respondents who utilized employment benefits/vocational training was 31.0% (n=27). Nearly one quarter of veterans (23.0%) reported having used life insurance benefits through the VA (n=20). Nearly half of respondents (46.0%) indicated that they had utilized disability compensation (n=40). VA home loans were used by 24.1% of veterans (n=21). The least utilized benefit by participants was pension payments; only 9.2% reported use (n=8). The utilization of pension payments is likely low due to the relatively young average age of respondents.

[10] The individual who was in service for only one year was discharged.

To determine the relationship between variables, differences of means tests were ran between participants' attributes and responses to the survey questions. Chi-square analyses were used for the majority of the variables, with the exception of regression models to compare the responses where appropriate. These analyses were completed to provide evidence for the theory that the policy process within the venue of veterans benefits has created accessibility and quality issues with the services provided to the veteran population.

Benefits Use by Participant Attributes

Chi-square analyses were used to test the hypothesis (H1) that there would be differences in benefits use by participant branch, combat exposure, and demographics. The results partially supported this hypothesis as certain statistically significant differences in benefits use across groups were evidenced by statistical analyses. When separated by racial group, differences were present for educational benefits/G.I. bill, life insurance, and VA home loan benefits, as shown in Table 1. Regarding educational benefits/G.I. Bill, respondents identified as Other reported lower rates of benefits use (χ=8.385, p=.015). Upon further analysis it was shown that respondents who identified as Other were statistically different than both White and Latinx respondents (χ=8.282, p=.004), but that there were no differences between White and Latinx respondents. Racial differences in life insurance use approached significance (χ=5.037, p=.081). The differences between respondents who identified as Other and the White and Latinx respondents in life insurance use was statistically significant, such that the Other group reported the highest use (χ=3.948, p=.047). Although Latinx respondents were significantly different than respondents who identified as Other (t=2.321, p=.024), there were no statistically significant differences in life insurance

utilization between Latinx and White respondents. Although there were no statistically significant differences across all three racial groups regarding disability compensation use, White respondents did report a higher percentage of use than non-White respondents (χ=5.564, p=.018). Finally, racial differences in the utilization of VA home loans approached significance (χ=5.524, p=.063). White participants use of VA home loans differed from non-White respondents at a statistically significant level, such that White respondents reported the highest rate of utilization of this benefit (χ=4.935, p=.026).

Table 1

Percent of Benefits Subcategory Use by Respondent Race

Subcategory	White	Latinx	Other
Health Benefits	60.7% (17)	57.1% (24)	41.2% (7)
Education Benefits/ G.I. Bill	96.3%$^{+}$ (26)	95.2%* (40)	70.6% (12)
Employment Benefits/ Vocational Training	32.1% (9)	26.2% (11)	41.2% (7)
Life Insurance	25.0%$^{+}$ (7)	14.3%* (6)	41.2% (7)
Disability Compensation	60.7%$^{\#+}$ (17)	40.5% (17)	35.3% (6)
VA Home Loans	39.3%$^{\#+}$ (11)	19.0% (8)	11.8% (2)
Pension Payments	7.1% (2)	11.9% (5)	5.9% (1)

Note: # indicates significant difference between White and Latinx; + indicates significant difference between White and Other; * indicates significant difference between Latinx and Other

Statistically significant differences were found across age with respect to benefits utilization. Age predicted the use of health benefits, such that older veterans were more likely to have utilized this category of benefits (B=.075, p=.021). The age of the veteran was also related to their use of disability compensation. Again, being of older age was predictive of disability compensation utilization (B=.068, p=.019). Older veterans were also more likely to have utilized

VA home loans (B=.072, p=.009). Finally, being older was a predictor for the use of pension payments (B=.072, p=.022).

As hypothesized (H1c), differences amongst benefits utilization became apparent when comparing participants with combat exposure to participants without combat exposure. Regarding health benefits, 75.6% of combat veterans (n=31) compared to 38.6% of non-combat veterans (n=17) utilized these benefits. These differences were statistically significant (χ=11.803, p=.001). Differences in educational benefits/G.I. Bill use also approached significance (χ=3.521, p=.061). Of the combat veteran respondents, 97.6% utilized educational benefits/G.I. Bill (n=40), while 86.3% of non-combat veteran respondents reported use (n=38). There were statistically significant differences in employment benefits/vocational training use between combat and non-combat veterans (χ=5.384, p=.020). 43.9% of combat veterans reported use of these benefits (n=18), while only 20.5% of non-combat veterans utilized employment benefits/vocational training (n=9). The use of disability compensation differed between these two groups at a statistically significant level (χ=4.188, p=.041). More combat veterans (58.5%, n=24) used disability compensation than non-combat veterans (36.4%, n=16). VA home loan benefits were used more by combat veterans than non-combat veterans (χ=8.729, p=.003), such that 39.0% of combat veterans (n=16) used VA home loans compared to 11.4% of non-combat veterans (n=5).

Comparisons between respondent gender and military branch with respect to benefits utilization were not statistically significant. The hypothesis (H1b) that there would be differences in utilization across military branch was not supported. The only exception was a perceived statistically significant difference between males and females within the pension payment category. Because of the small sample of respondents who reported having utilized pension payment (n=8) and

because female respondents in the data were younger (r=-.23, p=.04) and therefore less likely to be eligible for pension payments, it is likely that this finding has been confounded.

Rankings of Benefits Categories' Importance

Participants were asked to rank the benefits categories in order of importance, such that a '1' indicated the most important and a '7' indicated the least important. Chi-square analyses were used to attempt to validate the hypotheses (H2) that health benefits would be the most important, and that differences would exist across participant attributes (H2a). Overall, 44.87% of participants (n=35) reported that their educational benefits/G.I. Bill were the most important to them. Followed by educational benefits, 20.51% of veterans (n=16) responded that health benefits were the most important. The hypothesis was thus only partially supported because health benefits were ranked as the second most important. Disability compensation was ranked as the most important benefit by 16.67% of respondents (n=13). On the other end of the scale, 33.33% of veterans (n=26) stated that pension payments were the least important. In addition, life insurance was ranked as the least important amongst 29.49% of veteran respondents (n=23). VA home loans (14.10%, n=11) and disability compensation (12.82%, n=10) were also marked as the least important, however, there was the greatest amount of variance within these two subcategories.

Differences in rankings of importance were found across demographic variables (see Table 2 for a comparison of rankings of importance across racial and gender groups). When evaluating the variable in its entirety (answer responses '1-7'), statistically significant differences were found between race and the ranking of health benefits (χ=24.814, p=.016). A new variable was also created to

evaluate the differences in ranking a benefit as the *most* important. Any respondent who ranked the benefit as a '1' was coded as a '1' and the respondents who ranked the benefit as a '2-7' were coded as a '0'. While using this new variable, it was suggested that respondents who identified as Other selected health benefits as the *most* important more often than Latinx respondents at a statistically significant level (t=1.971, p=.054). Differences in ranking of pension payments across racial groups approached significance (χ=20.923, p=.052). This difference was present when evaluations were conducted using the entire Likert scale, but no significant differences were found in rankings of pension payments as the *most* important across racial groups.

Table 2

Number of Respondents Ranking Specified Benefit as the Most Important by Respondent Race

Subcategory	White	Latinx	Other
Health Benefits	18.5% (5)	15.4%* (6)	41.7% (5)
Education Benefits/ G.I. Bill	44.4% (12)	48.7% (19)	33.3% (4)
Employment Benefits/ Vocational Training	0.0% (0)	5.1% (2)	0.0% (0)
Life Insurance	7.4% (2)	7.7% (3)	0.0% (0)
Disability Compensation	22.2% (6)	15.4% (6)	8.3% (1)
VA Home Loans	0.0% (0)	2.6% (1)	8.3% (1)
Pension Payments	7.4% (2)	5.1% (2)	8.3% (1)

Note: * indicates significant difference between Latinx and Other

Gender differences were discovered that approached significance in the overall ranking of the importance of life insurance benefits (χ=11.280, p=.080). There were no other statistically significant differences in male and female perceptions of the importance of certain benefits.

The hypothesis (H2) was also supported, such that the branch of the military in which a veteran served was associated with the respondents' perceptions of the importance of certain benefits. Participants who served in the Army demonstrated a different view on the importance of health benefits (χ=10.923, p=.091). Half of Army veterans (50.0%, n=15) indicated that health benefits were either the most important or the second most important benefit. Non-Army veterans responses demonstrated a more varied view on the importance of health benefits. Navy veterans, when compared to all others, differed in their view on the importance of pension payments (χ=14.314, p=.026). More specifically, being in the Navy was associated with a greater tendency to rank pension payments as the *most* important (χ=4.575, p=.032). Although there were no differences between Marine veterans and others when looking at the ranking of disability compensation in its entirety, there were significant differences between the Marine veterans and all other veterans in the ranking of disability compensation as the *most* important (χ=4.022, p=.045). Respondents who served in the Marines ranked disability compensation as the *most* important more often than all other veterans (31.6% versus 11.9%, respectively).

As predicted, the age of the respondent was also found to be associated with the rankings of importance of benefit categories. Older veterans were more likely to view pension payments as more important (B=-.071, p=.004). A closer look at whether age predicted differences in rankings of pension payments as the *most* important did not produce statistically significant findings. Older veteran participants also reported differences in ranking with respect to the importance of disability compensation, such that older veterans viewed this benefit as more important (B=-.069, p=.005). An evaluation of whether older veterans were also

more likely to rank disability compensation as the *most* important benefit approached statistical significance (B=.053, p=.075).

It is interesting to note that the hypothesis which predicted differences in combat-exposed veterans' rankings of the importance of benefits was not supported. It was expected that because being exposed to combat changed the benefits veterans utilized, it would also change their rankings of the importance of certain benefits. The results indicate that although their utilization varies, combat veterans do not differ in their appraisal of the importance of the various benefits.

Ranking of Benefits Categories' Need for Improvement

Respondents were asked to rank the seven benefits categories in order by need for improvement where '1' indicated the highest need for improvement and '7' indicated the least need for improvement. As hypothesized (H2), health benefits were viewed as the benefit with the highest need for improvement with 41.03% of participants (n=32) ranking it as '1'. In addition, 26.92% of respondents (n=21) stated that disability compensation was in the highest need for improvement. Benefits that participants indicated needed the least amount of improvement included life insurance (28.21%, n=22), VA home loans (23.08%, n=18), and pension payments (23.08%, n=18). Respondents rankings of need for improvement for educational benefits/G.I. Bill and employment benefits/vocational training were varied. As with the ranking of the benefits categories by importance, the ranking of the benefits category by need for improvement was evaluated both in its entirety, and also as a separate variable where individuals who responded that a benefit was in the *most* need for improvement were coded as a '1' and respondents who ranked the benefit as a '2-7' were coded as a '0' for analysis.

The hypotheses which predicted differences in rankings of need for improvement across participant attributes were partially supported. Racial differences in ranking benefits by need for improvement were only significant for pension payment (χ=22.400, p=.033). Analyses to test the difference amongst racial groups in reporting pension payments as the benefit with the *most* need for improvement were not significant. Racial differences between respondents who identified as Other and Latinx respondents regarding ranking disability compensation as the benefit with the *most* need for improvement were marginally significant (t=-1.625, p=.110). There were not across-the-board differences as was expected (see Table 3 for a comparison of the rankings for need for improvement by racial group).

Table 3

Number of Respondents Ranking Specified Benefit as in Greatest Need for Improvement by Respondent Race

Subcategory	White	Latinx	Other
Health Benefits	48.0% (12)	34.1% (14)	50.0% (6)
Education Benefits/ G.I. Bill	8.0% (2)	12.2% (5)	8.3% (1)
Employment Benefits/ Vocational Training	12.0% (3)	14.6% (6)	8.3% (1)
Life Insurance	0.0% (0)	4.9% (2)	8.3% (1)
Disability Compensation	28.0% (7)	31.7% (13)	8.3% (1)
VA Home Loans	0.0% (0)	0.0% (0)	8.3% (1)
Pension Payments	4.0% (1)	2.4% (1)	8.3% (1)

While viewing this variable in its entirety, an association was found between branch of service and the ranking of education benefits/G.I. Bill by need for improvement (χ=36.880, p=.045). Upon closer analysis, it was concluded that a statistically significant difference existed between the Army veterans and all

other veterans with respect to rankings of educational benefits by need for improvement (χ=14.843, p=.022). There were significant differences between the Army veterans' and the non-Army veterans' ranking of the need for improvement for employment benefits/vocational training (χ=14.697, p=.023). Army veterans generally ranked employment benefits as in more need for improvement than did non-Army veterans. Marine veterans differed from all other veterans in their ranking of the need for improvement of life insurance benefits (χ=14.81, p=.039). Non-Marine veterans reported a greater need for improvement of life insurance benefits than did Marine veterans.

Combat veterans and non-combat veterans differed in their perceptions of the need for improvement regarding educational benefits/G.I. Bill (χ=12.613, p=.050). Of the combat veterans, 39.48% (n=15) indicated that educational benefits were the most in need of improvement or the second most in need of improvement. Only 12.5% of the non-combat veterans (n=5) reported that educational benefits were the most in need or the second most in need of improvement. The hypothesis that there would be differences in rankings by combat veterans was only partially supported, as the data suggests that was only true for one benefit category.

No statistically significant differences were found when comparing male and female veteran perceptions of the benefits categories in most need of improvement. There were also no significant findings, such that age could be used to predict which benefits categories would be ranked as the most in need of improvement. Thus, the hypotheses that asserted these differences would be present were not supported.

Experiences with Benefits

It was hypothesized (H3) that there would be variation in satisfaction across the benefits categories, and that there would be variation in satisfaction across gender and ethnicity. To test this, any veteran respondent that indicated that he/she had utilized a particular benefit was prompted to report their satisfaction with the benefit on a Likert scale where '1' indicated extremely satisfied and '5' indicated extremely dissatisfied. Regarding respondents who utilized health benefits, 17.0% reported some degree of dissatisfaction (n=8) and 76.6% reported some degree of satisfaction (n=36). Only 2.6% of education benefits/G.I. Bill users were dissatisfied (n=2) and 87.1% indicated they were satisfied with this benefit (n=67). Of those veteran respondents who used employment benefits/vocational training, none reported dissatisfaction with the benefit and 76.9% reported some degree of satisfaction (n=20). Most participants who utilized life insurance reported that they were neither satisfied nor dissatisfied with their benefit (52.6%, n=10). The other 47.4% were satisfied with their life insurance (n=9). Veterans reported satisfaction with their disability compensation 66.7% of the time (n=26) and dissatisfaction in 10.3% of the responses (n=4). Out of the 20 respondents who has used VA home loans, only one participant reported dissatisfaction. Alternatively, 80.0% of VA home loan users were satisfied (n=16). Regarding pension payments, 75.0% of respondents were satisfied with this benefit (n=6) and the other 25.0% reported being neither satisfied nor dissatisfied with their pension payment (n=2). These variations in satisfaction across the benefits categories confirm the hypothesis (H3) (see Table 4 for a breakdown of benefits experiences).

The greatest variance in levels of satisfaction with benefits categories was found within health benefits and disability compensation (s^2=1.099). Experiences

Table 4

Respondents Satisfaction with Specified Benefit Subcategory

Subcategory	Extremely Dissatisfied	Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Extremely Satisfied
Health Benefits	2.1% (1)	14.9% (7)	6.4% (3)	57.4% (27)	19.1% (9)
Education Benefits/ G.I. Bill	1.3% (1)	1.3% (1)	10.4% (8)	42.9% (33)	44.2% (34)
Employment Benefits/ Vocational Training	0.0% (0)	0.0% (0)	23.1% (6)	34.6% (9)	42.3% (11)
Life Insurance	0.0% (0)	0.0% (0)	52.6% (10)	31.6% (6)	15.8% (3)
Disability Compensation	2.6% (1)	7.7% (3)	23.1% (9)	41.0% (16)	25.6% (10)
VA Home Loans	0.0% (0)	5.0% (1)	15.0% (3)	30.0% (6)	50.0% (10)
Pension Payments	0.0% (0)	0.0% (0)	25.0% (2)	25.0% (2)	50.0% (4)

with life insurance benefits had the least degree of variance (s^2=.579). Responses regarding life insurance were concentrated within two response choices: neither satisfied nor dissatisfied and satisfied.

Respondents who reported dissatisfaction with a benefit subcategory were prompted to provide a text response describing why they were dissatisfied. A major theme surrounding health benefits presented upon evaluating the text responses of those who were dissatisfied. One recurring issue with VA health benefits was that the process was inefficient. One respondent reported:

> I am a combat vet with PTSD and I have left several voicemails with the Mental Health Department af [sic] Fresno VA, where I am usually seen, and have yet to get a call back to schedule an appointment for cronic [sic] care. (Male, White, Coast Guard veteran)

Respondents also indicated that, in combination with the inefficiency, the quality of care received from VA health care facilities was poor. After having

waited to be seen or make appointments, veterans were dissatisfied with the level of attention given to their care:

> Takes to [sic] long to see someone, and once you do they seem to only want to give you meds in hopes it will fix it. Without running any test or looking to see other ways to help. (Male, White, Army veteran)
>
> Too long to get treatment, treatment not always professional. (Older, Male, Latino, Marine Corps veteran)
>
> I feel like my Dr. is incompetent and like I am an inconvenience when I go in for appointments. I get much better care when I go to civilian doctors and hospitals. (Male, White, Army veteran)
>
> I did not have a good experience with my doctor. I felt she talked down at me because of this I decided to go to a non VA Facility for my care. (Army veteran, gender and ethnicity unknown)

One veteran respondent who was dissatisfied with their health benefits indicated that the scope of care available was not satisfactory. The lack of diversification of services provided by VA health care services was reported as an issue:

> Dental would be a huge to be able to get, and more referrals for PT, chiropractor, deep tissue work, acupuncture would be very beneficial as well. (Male, White, Navy veteran)

The two respondents who reported being dissatisfied with their educational benefits/G.I. Bill also provided a description of their dissatisfaction. Both participants indicated that the issues they had with their educational benefits stemmed from the process of obtaining these benefits, not necessarily the quality or quantity of the benefit:

> The VA does not communicate with the Active Army and any discrepancies are dropped or left unanswered altogether. The VA is a very poor performer for govt service. (Male, Other ethnicity, Army veteran)
>
> Wasn't awarded properly and cut short of my benefit. (Younger[11], Female, Latina, Army veteran)

Several veterans also reported dissatisfaction with their disability compensation. As with educational benefits, veterans who were dissatisfied with their disability compensation indicated that the issue has to do with the process of acquiring an accurate disability rating and not so much the compensation itself:

> Took over 50 years and still not compensated adequately. (Older, Male, Latino, Marine Corps veteran)
>
> The process to get disability is a nightmare, and then having to fight for all of the issues I have due to the Navy has been tough. (Young, Female, White, Navy veteran)
>
> Hard to have your percentage raised. and if you try to have it raised, they can also lower your current percentage. (Male, White, Army veteran)
>
> Filing for disability compensation was both confusing and time consuming. My original compensation filing was denied due to problems to coordinate with the VA and the VA hospital for my examinations. Lucky [sic] I found assistance with a local Veterans of Foreign Wars (VFW) member who was able to help me appeal and finalize my claim. I feel that the VA should have been the one to help me in the first place instead having to search out for help. (Male, White, Marine Corps veteran)

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[11] For the purposes of referencing comments, younger veterans are those aged 20-25 and older veterans are those aged 37 or older.

Dissatisfaction was also reported by one respondent who had utilized a VA home loan. This participant indicated that the interest rate on the loan was high, thus making the loan payments too expensive:

> Rates were too high. Only benefit was no down payment was required. I refinanced within 2 years to save money. (Older, Female, Latina, Coast Guard veteran)

A comparison of respondent's satisfaction with their benefits across demographic variables produced a few significant findings. As was hypothesized (H3), an association between participant gender and satisfaction with health benefits approached significance (χ=8.73, p=.068). All female veterans (n=13) reported that they were either satisfied or extremely satisfied with their health benefits. Of the male veterans, 69.7% indicated some degree of satisfaction (n=23), while 21.2% reported being dissatisfied (n=7). The remaining three male veterans who utilized health benefits were neither satisfied nor dissatisfied with their benefits.

The branch of the military, although not expected, proved to be related to satisfaction with benefits categories. Marine veterans reported statistically significant differences in health benefits experiences than non-Marine veterans (χ=12.883, p=.012). Among the Marine veterans, 58.4% reported some degree of satisfaction with their health benefits (n=7). Of the non-Marine veterans, 82.9% indicated they were satisfied with their health benefits (n=29). Marine veterans and non-Marine veterans reported similar proportions of dissatisfaction with their health benefits (16.6% and 17.1%, respectively). Although none of the non-Marine veterans reported being neither satisfied nor dissatisfied with their health benefits, 25.0% of Marine veterans fell into this category.

The final significant finding regarding demographic differences in benefits experiences was related to age. Respondent age was found to be significantly related to experience with pension payments (B=-.053, p=.032). Older participants were found to be more satisfied with their pension payments.

It is interesting to note that the hypothesis which predicted differences in satisfaction with benefits across ethnicity was not supported. It was expected that findings in previous studies, which indicate differences by ethnicity, would be replicated. Within this sample population, respondent ethnicity was not related to their satisfaction with benefits categories.

The Issue with Veterans Benefits

It was hypothesized (H4) that veterans would claim that the issue with their benefits was time related. To test this, veteran respondents were asked to indicate what they believed to be the issue with veterans benefits. Response choices included the time it takes to receive benefits, the quality of benefits once received, the quantity of benefits once received, all of the above, or other. Half of veteran respondents indicated that all of the above issues contributed to the problems experienced with benefits (50.0%, n=41). The time is takes to receive benefits was the second most cited issue (31.7%, n=26). The hypothesis was thus only partially supported. 7.3% of respondents indicated that the issue had to do with the quality of the benefits once received (n=6) and 2.4% of participants believed the issue had to do with the quantity of benefits (n=2). Within the 8.5% of participants who selected other (n=7), text responses included, “lack of information,” “a huge misuse of funds,” “poor communication… from representatives,” and one respondent indicated that, “the issues are different depending on which benefit referred to.”

Male and female veterans differed in their assessment of the issues with benefits (χ=12.209, p=.016). The majority of female veterans indicated that all of the listed issues were contributing to the problems with veterans benefits (78.3%, n=18). The majority of male veterans' assessments of the issue were split between the time is takes to receive benefits (39.0%, n=23) and all of the mentioned issues (39.0%, n=23). Differences approached significance between respondents who reported some degree of dissatisfaction with their benefits and respondents who were satisfied (χ=8.237, p=.083). 75.0% of respondents who were dissatisfied to some degree with their benefits responded that all of the listed issues were contributing to the problems with the benefits system (n=9). Participants who were satisfied with their benefits were split between responses of all of the listed issues (45.7%, n=32) and the time it takes to receive benefits (37.1%, n=26). These differences were not expected during the hypothesis phase but are interesting to consider. Because male and females differed in their satisfaction with their health benefits, it makes sense that their assessment of the problems differed. The results that indicate those dissatisfied with their benefits believe the issue to be with efficiency should be considered important. It is, after all, those who encountered problems that are best equipped to speak to the issues.

The issues with veterans benefits were further evidenced by additional comments made by veterans at the end of the survey. Several text responses indicated that the issue with veterans benefits had to do with the time it took to receive their benefits:

> Once I started my benefits, receiving future benefits was relatively simple. However, changes were difficult to make and the initial process took too long. Like most government institutions, the VA is overworked,

> undermanned, and hampered by significant amounts of "red tape." (Male, White, Navy veteran)
>
> My branch did a good job getting us information about benefits upon discharge from your last unit, problems seem to arise from how long it takes to get these benefits specifically dealing with the VA healthcare. (Younger, Male, Latino, Marine Corps veteran)
>
> Any time there is an error with certifying. Takes forever to get it fixed. (Male, Latino, Marine Corps veteran)

Veteran respondents also indicated that there were issues with the benefits themselves, by way of time restraints and the quality of benefits, that impacted their experiences with the VA. Participants noted that some benefits should have extended periods of eligibility. Comments also addressed the inadequacy of some of the benefits currently provided:

> When I was medically retired I did receive notification that my $400K life insurance policy could be transferable to SGLI. However, because I was so heavily medicated and unable to function, it took over 2 years for me to realize what I needed to do in order to establish that coverage. I missed it by the time I was able to function again and was established at the $250K level. I lost many benefits because I was essentially rushed out of the USAF as a result of medical disability (still 20 year retirement). I didn't have a 30 day TAP with all the classes and briefings and even now I am still just now realizing how many benefits I have actually lost and either have to fight to get back or will just quite simply loose them forever. I didn't transfer my remaining GI Bill benefits because I transition out of the military so quickly. I have to use them or petition for a transfer. (Older, Male, American Indian or Alaska Native, Air Force veteran)

> I heard about this guy, an amputee, that the VA made him get an x-ray of his leg to prove that he didn't have a leg. They could have just looked at his medical records. Also a buddy of mine had to be put on a waitlist to make an appointment. He had to make an appointment to make an appointment. (Younger, Male, White, Navy veteran)
>
> The Post 911 GI bill does not cover a bachelor degree because a lot of vets are coming out having to take remedial class that takes away time from the GI bill, leaving veterans dry when they are so close to getting a degree. The GI bill needs to be extended now that there is no more kicker like the Montgomery GI Bill. (Male, Asian, Marine Corps veteran)
>
> The VA needs to stop giving out pills to mask pain and employ professional to properly un fuck our bodies after we fucked them up during our service, and needs to address mental health by employing real shrinks not pill issuers, pills just mask they don't fix the problem. (Male, White, Navy veteran)
>
> For disability screenings utilize veterans/members who know the life, culture, physical and mental stresses that come with the MOS's. The fact that i gave back, knee, and ankle issues from my time in as a grunt, got screened for them, and were deemed "non service related" is and pardon my french, [sic] complete bullshit. I hiked and patrolled many a mile with x amount of weight of gear and weaponry on my shoulders and for them to say that is absolutely disrespectful. (Male, White, Marine Corps veteran)

Benefits Knowledge

To test the hypothesis (H5) that veterans would rate the military's job of educating them as low, respondents were asked to rate the military's job of

educating them on their federal benefits on a Likert scale where a ‘1’ indicated their education was excellent and a ‘5’ indicated that it was terrible (see Figure 1 for a visualization of these responses). The plurality of respondents indicated that the military’s job of educating them on their benefits was average (32.9%, n=28). The second most commonly reported response indicated the military’s job of educating veterans was good (24.7%, n=21). Following this was the response that the military’s job of educating was poor (22.4%, n=19). Of the remaining respondents, 14.1% stated that the military’s job of educating them was excellent (n=12) and 5.9% reported that it was terrible (n=5). The hypothesis was not fully supported. Although some veterans believed the job was ‘poor’ or ‘terrible’, the plurality thought it was ‘average’.

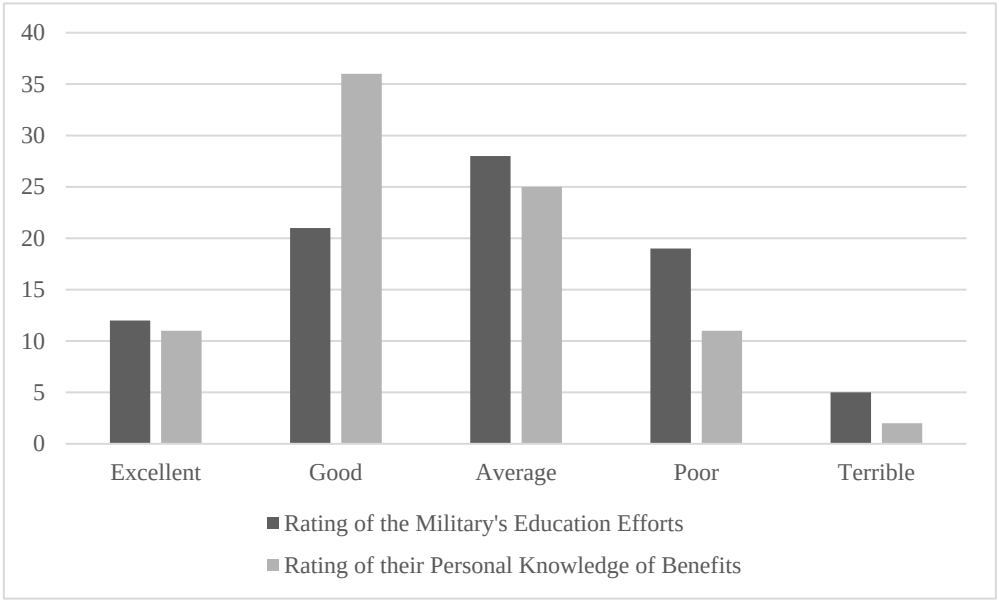

Figure 1. A comparison of respondents’ rating of the military’s job of educating them on their benefits and personal knowledge of their benefits

Respondents who had utilized educational benefits differed in their perception of the military’s job of educating them on their benefits at a level that approached significance (χ=9.186, p=.057). Participants who did not utilize

educational benefits thought that the military's job of educating them on their benefits was either good or poor (42.9% and 57.1%, respectively). Participants who had utilized educational benefits had a more varied view of the military's job of educating them. Of those who utilized educational benefits, 15.4% reported that the military's job was excellent (n=12), 23.1% reported it as good (n=18), 35.9% stated it was average (n=28), 19.2% believed it was poor (n=15), and 6.4% stated it was terrible (n=5). Respondents who had utilized disability compensation also differed in their view of the military's job of educating them on their benefits compared to participants who had not used disability compensation (χ=8.610, p=.072). The responses of participants who had utilized disability compensation followed a more normal, bell-shaped distribution, while participants who had not used disability compensation had a more varied perception of the military's job of educating them on benefits.

In order to compare responses to this question against respondents who reported any degree of dissatisfaction with their benefits, a new variable was created. Any respondent who reported being dissatisfied or extremely dissatisfied with any of the seven benefits categories was coded as a '1' while all other respondents were coded as a '0'. Respondents who reported some dissatisfaction with their benefits were statistically different in their rating of the military's job of educating them on their benefits (χ=25.651, p=.000). None of the respondents dissatisfied with their benefits rated the military's job of educating them on their benefits as good or excellent, and the majority of those respondents who were dissatisfied rated the military's job of educating them as poor (61.5%, n=8). These ratings of the military's job of educating respondents of their benefits were compared across demographic variables, and there were no significant findings to report.

Respondents were also asked to rate their personal knowledge of their benefits on the same Likert scale where a '1' indicated excellent and a '5' indicated terrible. (See Figure 1 for a visualization of these responses.) A plurality of respondents reported that their personal knowledge was good (42.4%, n=36). This did not support the hypothesis (H5) that because of the voluntary nature of benefits courses, veterans' personal knowledge would not be high. The next most common response indicated that respondents' personal knowledge was average (29.4%, n=25). Ratings of both excellent and poor personal knowledge of benefits received the same number of responses (12.9%, n=11, each). Only 2.4% of respondents (n=2) indicated that their personal knowledge of their benefits was terrible.

Respondents who utilized health benefits differed in their rating of their personal knowledge of their benefits (χ=12.195, p=.016). Of the respondents who had utilized health benefits, 64.6% reported either good or excellent personal knowledge of their benefits (n=31). On the contrary, 43.2% of respondents who did not use health benefits indicated that their personal knowledge of their benefits was good or excellent (n=16). Veteran respondents who had utilized health benefits reported greater personal knowledge of their benefits overall. Respondents' ratings of their personal knowledge of their benefits were compared across demographic variables, and there were no significant findings to report. Of particular interest was the finding that respondents who reported some degree of dissatisfaction did *not* differ in their appraisal of their person knowledge when compared to those participants who were satisfied with their benefits.

Respondents' ratings of the military's job of educating them of their benefits were compared to respondents' ratings of their personal knowledge of their benefits using linear regression and Chi-square analyses. Figure 1 provides a

visualization of this relationship. Analyses indicated a relationship between these two variables (χ=61.451, p=.000). The relationship between the variables was linear, such that a participant's rating of the military's job of educating them on their benefits was comparable to that same participant's rating of their personal knowledge of their benefits (B=.452, p=.000).

Respondents desire to see positive change in the military's job of educating servicemembers and veterans of their federal benefits was made known in the additional comments section of the survey. Veteran respondents noted that the benefits were confusing to understand, and that the military should provide more direction for individuals discharging from the service:

> Veterans health benefits and education needs to be shared more. There are plenty of benefits that veterans do not know they are eligible for. (Female, Latina, Marine Corps veteran)
>
> Retired veterans should continue receiving information on benefits they may still be eligible for. (Female, Latina, Army veteran)
>
> Once I found out that I was eligible for benefits I thought the process worked well, it just took way to [sic] long to find out. (Older, Male, White, Navy veteran)
>
> I've noticed that assistance is often needed and necessary to understand benefits available. Possibly making them easier to understand would make it easier for veterans to clearly view what is available for them.
>
> Consultations to view and apply for what the veteran is eligible for would be helpful as well if not already offered. (Younger, Female, Asian, Marine Corps veteran)

> I feel that there are great benefits available to veterans. However, they are not well known- more efforts need to be done to promote these benefits and make it known that they exist. (Female, Latina, Army veteran)

Mental Health and the Military

Participants were asked to rate the military's job of handling mental health issues associated with service on a Likert scale where '1' indicated extremely satisfied and '5' indicated extremely dissatisfied. Of the veteran respondents, 32.5% reported being neither satisfied nor dissatisfied with the military's handling of mental health issues (n=27). 28.9% of participants reported they were somewhat satisfied (n=24) and 8.4% were extremely satisfied (n=7). Of the remaining respondents, 24.1% were somewhat dissatisfied (n=20) and 6.0% were extremely dissatisfied with the military's job of handling mental health issues associated with service (n=5). The hypothesis (H6) was partially supported as these ratings of the military's job were not particularly high. No significant differences were apparent across demographic groups regarding the military's handling of mental health issues.

A respondent's experience with their health benefits was found to be significantly related to their perception of the military's job of handling mental health issues (B=.306, p=.025). The linearity of this finding demonstrates that as experiences with health benefits became less satisfactory, participants rated the military's job of handling mental health issues as less satisfactory as well. This finding is of particular importance because those who use mental health benefits would be classified under the more general veil of a health benefits user.

Participants were then asked, more specifically, to rate the adequacy of benefits available to veterans for mental health purposes. Responses were on a

Likert scale where ‘1’ indicated extremely adequate and ‘5’ indicated extremely inadequate. The distribution of responses was similar to that of the previous variable. The most common response indicated that benefits for mental health issues were neither adequate nor inadequate (37.4%, n=31). Of the respondents who believed the benefits were adequate, 30.1% reported they were somewhat adequate (n=25) and 9.6% stated they were extremely adequate (n=8). Of those who believed the benefits were inadequate, 18.1% indicated they were somewhat inadequate (n=15) and the remaining 4.8% believed they were extremely inadequate (n=4). This did not support the hypothesis (H6) that benefits would be inadequate, as most responses were neutral.

Male and female veterans differed in their rating of the adequacy of health benefits available to veterans specifically in the area of mental health (χ=8.492, p=.075). Male veteran responses had greater variance than did female veteran responses. Of the female veterans, nearly half (47.8%) reported that the benefits available for mental health issues were somewhat adequate (n=11). The plurality for male veterans was situated in the response that benefits were neither adequate nor inadequate, such that 37.3% of responses fell into this category (n=22).

A comparison of satisfaction with health benefits and the adequacy of benefits for mental health issues approached significance (χ=25.409, p=.063). The linear-by-linear association, which tests the trends in the connectedness of these variables, was significant at the p<.01 level. As the data moved towards respondents who were dissatisfied with their health benefits, the trend of the responses of the adequacy of benefits for mental health issues moved toward the rating of extremely inadequate. This same trend was visible when comparing the adequacy of benefits for mental health issues with respondents’ satisfaction with

their educational benefits (χ=42.364, p=.000). The linear-by-linear association of these variables was also significant at the p<.01 level.

Participants' General Perceptions of Military and Government

To test the final hypothesis (H7), participants answered perceptual questions about the U.S. Government, U.S. Military, and the general public's favorability toward them. They were first asked to rate how favorable they believed the general public was toward veterans on a Likert scale were '1' indicated very favorable and '5' indicated very unfavorable. The majority of respondents (51.8%) believed the general public was somewhat favorable toward veterans (n=43). The second most selected response indicated that participants believed the general public was very favorable towards veterans (28.9%, n=24). 13.3% of respondents believed that the general public was neither favorable nor unfavorable towards veterans (n=11). Only 6.0% of respondents believed the general public was somewhat unfavorable towards veterans (n=5) and none of the participants believed the general public was very unfavorable toward veterans.

Respondent age proved to be significantly related to participant's rating of how favorable the public was towards veterans (χ=17.411, p=.043). Respondent age was recoded into an interval-level variable for the purpose of comparison when a clear, linear relationship was not apparent. Respondent age categories were coded as: 20-25, 26-31, 32-37, and 37+. Of the respondents aged 20-25, 78.6% indicated that the general public was favorable toward veterans (n=11). Of the respondents aged 26-31, 90.9% believed the general public was favorable toward veterans (n=30). Of the respondents aged 32-37, only 55.6% believed the general public was favorable toward veterans (n=10). The trend moved upward, once again, and 86.7% of respondents aged 37 or older believed the general public was

favorable toward veterans (n=13). (A discussion of this particular finding can be found in the next chapter.)

Veteran respondents were then asked to rate their satisfaction with the U.S. Military on a Likert scale where ‘1’ indicated extremely satisfied and ‘5’ indicated extremely dissatisfied (see Figure 2 for a visualization of these responses). A plurality of participants reported they were somewhat satisfied with the U.S. Military (42.2%, n=35). The second most commonly reported answer indicated extreme satisfaction with the military (28.9%, n=24). Of respondents, 15.7% indicated they were neither satisfied nor dissatisfied with the U.S. Military (n=9). 10.8% of participants reported that they were somewhat dissatisfied with the military (n=9) and 2.4% of respondents stated they were extremely dissatisfied with the military (n=2).

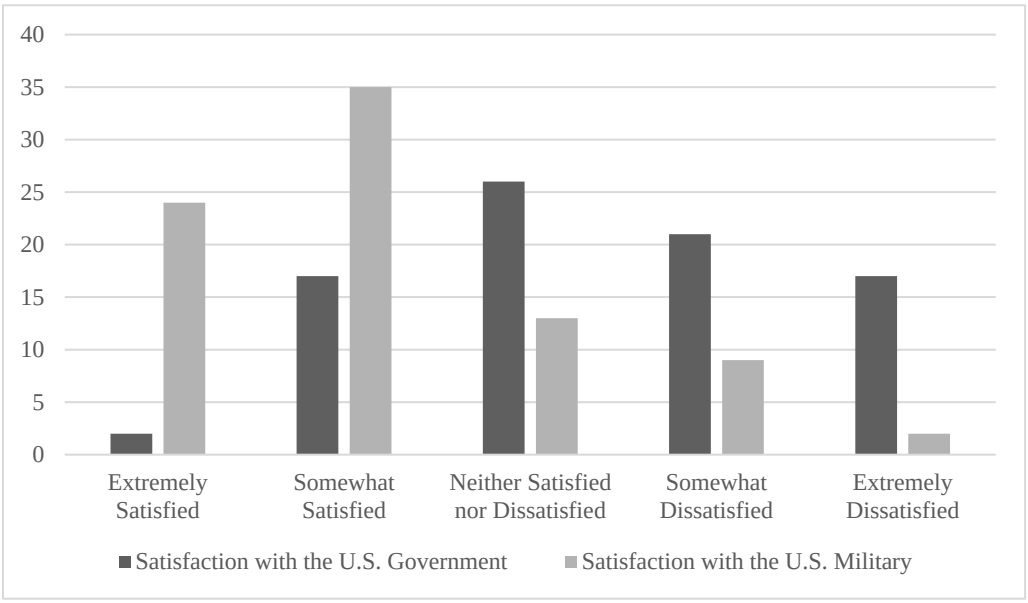

Figure 2. A comparison of respondents’ satisfaction with the U.S. Government and satisfaction with the U.S. Military

Participants were asked to rate their satisfaction with the U.S. Government on the same Likert scale (see Figure 2.) Greater variance in responses for this

variable were observed. The plurality of respondents indicated they were neither satisfied nor dissatisfied with the government (31.3%, n=26). The second most selected response included participants who were somewhat dissatisfied with the U.S. Government (25.3%, n=21). The same percentage of participants who stated they were somewhat satisfied with the government stated they were extremely dissatisfied with the government (20.5%, n=17, each). A small percentage of respondents indicated they were extremely satisfied with the U.S. Government (2.4%, n=2).

An analysis of rates of satisfaction with the U.S. Government by demographic categories produced two significant findings. Respondent age was found to be related to reports of satisfaction with government (B=.036, p=.003). This finding indicates that older veteran respondents were less satisfied with government than were younger veteran respondents. Participants who reported any degree of dissatisfaction with their benefits also reported different rates of satisfaction with the U.S. Government (χ=11.871, p=.018). The linear-by-linear association between these variables was significant at the p<.05 level which demonstrates that respondents with some degree of dissatisfaction with their benefits were more dissatisfied with the U.S. Government than respondents who were satisfied with their benefits.

Respondents' rating of how favorable the general public is toward veterans was significantly related to respondents' rating of satisfaction with the U.S. Military (χ=32.110, p=.001). The linear-by-linear association of these variables was also significant at the p<.05 level which indicates that as responses moved toward a rating of the general public as extremely unfavorable toward veterans, participants reported more dissatisfaction with the military. The hypothesis (H7) that perceptions of the government would correlate with perceptions of the

military was supported. The relationship of participants' rating of the U.S. Military and participants' rating of the U.S. Government was significant (χ=28.135, p=.03). The statistically significant linear-by-linear association of these variables at the p<.01 level suggests that as responses moved toward extreme dissatisfaction with the military, respondents were more dissatisfied with the government. (See Figure 2). Respondents' rating of the general public's favorability toward veterans was not significantly related to respondents' satisfaction with the U.S. Government. Because it was expected this would be significant (H7), it would be interesting to consider what is driving participants' perceptions of the general public's favorability toward them. Perhaps, veterans are more likely to attribute the popular sentiment toward veterans to the military, as there was a significant relationship between those variables.

Additional Comments

Veterans were prompted at the end of the survey to provide any additional comments about their benefits experience they felt noteworthy. Of the 87 respondents, 33 veterans left additional comments. In addition to the description of these comments aforementioned in the results, two other major themes presented within these comments. Veteran respondents indicated that there was a lack of quality assistance from VA employees while trying to obtain federal benefits. Participants suggested that coming into contact with the "right representative" could make all the difference in the benefits that are received:

> There is a huge disconnect in getting veterans plugged into benefits and mental health services that they qualify for. Almost no one can provide an accurate answer as to exactly what you qualify for, the health benefits you will receive, and services that you qualify for. I was told that my dr. [sic] at

> the VA hospital would be the one to refer me to the correct mental health services, yet I was never told by her that I qualify for services at Vet Centers. It seems like they are expecting the wrong people to refer veterans to services. (Older, Male, White, Army veteran)
>
> The ease of receiving education benefits depended entirely on the school. CSU Fresno made it extremely easy to receive my benefits while Fresno City College made it a little more challenging. I also had to do much of the leg work myself in regards to finding what I was eligible for. I discovered a grant open to Guard and Reserve members that nearly paid for my entire tuition. I learned about this through the grapevine from another service member at my base, not a counselor or VA representative. (Male, Latino, Air Force veteran)
>
> It makes all the difference to have someone who is knowledgeable by your side. The DAV[12] is a fantastic resource. (Female, White, Navy veteran)
>
> In filing a claim with the VA, I have had several representatives, most of them want you to do all the work. I do my own claims now because of that lack of interrest [sic] in assistance. (Male, White, Coast Guard veteran)
>
> I have worked with some Voc Rehab [sic] counselors that do a great job and help the vets out, and others that make going to school more work that it is worth. (Male, White, Army veteran)
>
> Friendly and helpful employees always makes the job easier. (Female, Latina, Army veteran)

The final theme that was noted by several veterans in their additional comments was their appreciation of the benefits they are entitled to. Although they

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[12] The Disabled American Veterans (DAV) organization helps veterans with disabilities get connected to services.

are not without their issues, respondents indicated that their federal benefits provided invaluable support for their lives post-service:

> We own a home only thanks to the VA Home Loan. (Male, White, Marine Corps veteran)
>
> Other than the regular administrative difficulties, veteran benefits have provided me with opportunities that would not have been possible in their absence. For example, in the last 3 months I have purchased a safe and beautiful home for my family and graduated from Fresno State. The financial relief provided by veteran benefits have helped me achieve personal goals that have a life long impact. (Male, White, Army veteran)
>
> It's a favorable opportunity for veterans to take advantage of, it provides benefits that sometimes us veterans cant [sic] be able to acquire in [sic] our own thank you for everything you guys have done for us veterans. (Male, Latino, Marine Corps veteran)
>
> I'm happy with services provided by the VA. You just have to really persist to get what you need out of them. (Older, Male, Latino, Army veteran)
>
> I just want to thank the army and the veterans administration for all they have done for me in all my years in the service. (Older, Male, Latino, Army veteran)
>
> I believe the veterans benefits received are fair and well worth it. (Younger, Female, Latina, Army veteran)
>
> I want to thank the Army for all the benefits it has given me in my 20 plus years I have served. (Older, Male, Latino, Army veteran)

These final remarks made by veterans in the additional comments section reaffirm the idea that, although the system is in need of revision, the benefits

provided by the VA are of vital importance to veterans after discharging or retiring from the military.

CHAPTER 4: SUMMARY AND CONCLUSION

The results of this study provide evidence for the contention that a barrier exists for veterans attempting to access benefits from the Department of Veterans Affairs. Although the data indicated that certain benefits (e.g., education benefits/G.I. Bill) are working well in the pursuit of aiding veterans in their lives post-discharge, other responses gathered from this population of veterans suggested that improvements were needed in other areas. The variations in utilization and knowledge of benefits supports the theory that there are persistent issues of accessibility within the system. Because the quality of life created by these benefits can impact veteran's in ways that extend further than the VA, it is important to consider what can be done to improve access.

Discussion of Findings

The fact that the majority of veterans in this study utilized health benefits points toward the conclusion that these benefits are of great value, and perhaps even necessary to sustain certain veterans. It should be considered, as well, that relative to the national population the veterans in this study were younger.[13] Because the use of VA health benefits increases with age, it can be projected that in the future the VA health care system will be just as, if not more, important than it is today. This study also demonstrated that veterans exposed to combat report greater use of their health benefits. Although it is unknown what the future of international relations holds, it would be prudent to prepare for the possibility of another generation of combat veterans and the benefits they will require.

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[13] The average age of veteran respondents in this study was 32.5 years. Nationally, the majority of veterans (63.9%) are 55 years and older.

An even more direct indication of the need to produce reliable health benefits comes from the results of veterans ranking the benefits by importance. Recall that health benefits were ranked as the second most important benefit to veterans, and it is plausible to assume that because the survey was administered through a university, participants may be biased towards their educational benefits/G.I. Bill, which was chosen as the most important. More specifically, Army veterans' responses indicated that health benefits were more important to them than to non-Army veterans. As the Army is the largest branch of the military, it is important to consider their opinion as the majority of veterans discharge from this specific branch.

In addition to being of high importance, the evidence suggests that health benefits are also the most in need of revision. Health benefits were ranked by the plurality of participants as the most in need of improvement. In fact, more than half of veterans responded that health benefits were the most or second most in need of improvement. The largest percentage of dissatisfaction with any one benefit was also reported within the category of health benefits. These findings suggest that revision efforts should be focused on making service improvements within the VA health care system.

The findings regarding mental health and the military also point to the need for improvements in VA health care. On a more general level it appears that efforts should be made to improve the handling of mental health issues systematically as nearly one third of respondents were dissatisfied with how the military deals with this issue. In addition, nearly one quarter of veterans indicated that the benefits in place to address mental health concerns are inadequate. It is important to note that respondents who were dissatisfied with their health benefits were less satisfied with the military's handling of mental health issues and felt that

the benefits in place for mental health were more inadequate. Because mental health benefits are accessed through the overarching health care system, it can be inferred that at least some of those individuals who utilized health care benefits also used mental health services. As such, the perceptions related to mental health of those with experience with health care benefits should be of extra importance.

A similar conclusion can be made in reference to disability compensation. Nearly half of the veterans surveyed reported having used this benefit. Because veterans are eligible for disability compensation for their entire life, assuming no changes in service-connected disability ratings, efforts should be made within this subset of benefits and the bureaucracy in place to manage it in order to maximize effectiveness. The fact that younger veterans are reporting significant utilization of this benefit indicates that disability compensation will continue to be of value for the decades to come. Disability compensation was also cited as the third most important benefit to veteran respondents and was of particular importance to the older veterans in the sample. If the pattern follows that disability compensation is used even more as veterans age, then it is reasonable to assume that this benefit will remain important in the future.

Veterans believed disability compensation was one of the benefits categories in the most need for revision. As was the case with health benefits, the majority of veterans believed disability compensation to be the most in need of improvement or the second most in need of improvement. Disability compensation also received the second highest rate of dissatisfaction among veteran respondents. Of those who had used disability compensation, only two thirds of the sample reported some degree of satisfaction. Following suit, it would be advisable for the Department of Veterans Affairs to begin updating this system.

The findings of this study also suggest the need to reform the manner in which veterans become knowledgeable of their benefits. An understanding of the benefits process is necessary to maximize accessibility. Over a quarter of respondents indicated that the military's job of educating them on their benefits was either poor or terrible. Furthermore, the majority of those who reported any degree of dissatisfaction with their benefits indicated that the military's job was poor. It may be, perhaps, that one element of the dissatisfaction with benefits stems from the military's 'poor' job of educating veterans as this leads to confusion over requirements for eligibility. Further evidence for this claim rests in the finding that the military's job of educating veterans of their benefits was linearly related to a veteran's personal knowledge of their benefits. The results of this study, which demonstrate that veterans' personal knowledge of their benefits is rated slightly better than the military's job of educating them on their benefits, suggest that veterans seek better knowledge and more information on their benefits from an entity outside of the military.

It is interesting to note that the respondents who utilized health benefits reported better personal knowledge of their benefits. This relationship suggests that those who had engaged with the most complex benefit system, VA healthcare, may have increased their knowledge through the process. It was confirmed by the results of this study that the process to obtain health care services is a long and tedious one, and it is possible that this navigational venture extended veterans' education of their benefits. The finding which suggests that those dissatisfied with their benefits did *not* differ in personal knowledge compared to those satisfied with their benefits insinuates that veterans attribute this dissatisfaction to factors outside of their control (military's job of educating them, the time it takes to get

benefits, etc.). In essence, it was not their personal knowledge to blame for their issues with their benefits, but rather the system.

Veterans' perceptions of how the general public perceives them is important when considering the process by which a veteran reintegrates into society. It is reassuring that the vast majority of veterans in this study (80.7%) believed that the public was either somewhat or very favorable towards the veteran population. As made evident by the treatment of Vietnam veterans, the ramifications of returning to domestic soil and being treated with disdain are large. With that being said, there was a subgroup of this sample that felt differently. Of the veteran respondents aged 32-37 years old, only half believed that the general public was either somewhat or very favorable towards veterans. To make sense of this finding, it is relevant to know that during 2004, these respondents were aged 18-23 years old. It was in 2004 that the prisoner abuse at Abu Ghraib and sincere questioning of the United States' purpose in Iraq made international news. Perhaps because these veterans were in service (or beginning their service) during a time when the general public was at odds with the decisions made by the defense department, these veterans perceived less favorability from citizens.

The discrepancy between veterans' satisfaction with the U.S. Military and their satisfaction with the U.S. Government, although not surprising, is interesting to consider. With a culture like the one within the U.S. military, it is expected that there would be an allegiance to the military and pride in having served. The fact that less than one quarter of respondents were satisfied with the government, while nearly three quarters were satisfied with the military, may be indicative of a larger issue. Also relevant is the finding that respondents who reported any dissatisfaction with their benefits reported more overall dissatisfaction with the U.S. Government. This may be driven by the fact that the Department of Veterans

Affairs, although within the executive branch of government, is plausibly viewed by veterans as an entity separate from the Department of Defense (i.e. military).[14] The results of this study suggest that when veterans become dissatisfied with their benefits, this dissatisfaction may spill over into their perceptions of the government.

Implications

These findings indicate that the current system of veterans benefits has not yet separated itself from the historic tendency of rushing legislation through the policy process to the detriment of the administrative state. The results demonstrate that knowledge and accessibility issues still exist within the system, as veteran respondents in the study indicated that their knowledge deficits are the product of the military's inability to properly educate them. This has impacted veterans' utilization of their benefits. Because the problems with access have stemmed from bureaucratic inadequacies as the result of haphazard polices, the utility of these benefits has also been negatively affected. The overarching policy arena must consider these effects when attempting to restructure policy to improve this system. The issue is not that veterans need *more* benefits, but rather they need the administrative infrastructure in place to support their benefits to be reformed.

The majority of veterans believe the issue with their benefits to be systemic, and an even greater majority of veterans who were dissatisfied with their benefits believe the issue involves the time is takes to get benefits, the quality of benefits once received, and the quantity of benefits. These results lead to the conclusion that reform efforts for veterans benefits should encompass a multi-

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[14] This is not to say that the Department of Veterans Affairs and the Department of Defense should be viewed as one in the same, but rather acknowledge that there is a certain degree of intergovernmental relations between the two.

faceted approach. In an effort to increase access to and satisfaction with benefits, the Department of Veterans Affairs, working alongside the military, needs to clarify and update the requirements for benefits and also work to expand veteran knowledge of the benefits available to them.

The first step in the process has to be updating the disability-rating schedule. Because eligibility for health benefits is, in part, tied to a veteran's service-connected disability rating, these ratings need to be modified to meet the demands of the 21st century. Once disability ratings have been modernized, veterans will be better placed within the priority group schedule which determines their access to health benefits. Recall that the disability ratings have not been updated since 1945. Certain aspects of modern warfare and medicine have impacted the issues faced by disabled veterans; advances in technology have saved the lives of severely wounded service members who were likely to have died in previous wars and have left these individuals with complex medical and mobility concerns.

The disability-rating schedule also needs to be simplified to the extent that a reasonable person would be able to have an idea of what disability rating to expect while they are awaiting their claims decision. The complexity of the current disability-rating schedule has been shown to leave some veterans confused and cause others to abandon the prospect of ever receiving the help they need. Although a lack of knowledge can be partially to blame for veterans not applying for disability compensation, it is important to keep in mind that the innumerable steps and medical jargon within the system render it inaccessible to certain veterans. Individuals who are already in a compromised mental state, as the result of a psychological disorder from service, and desperately need services may be at

an even larger disadvantage when it comes to applying for disability compensation.

In addition to simplifying the system, the Department of Veterans Affairs should consider introducing a system ombudsman into the benefits process. This individual, as a street-level bureaucrat, would serve as a guide to help veterans navigate the complexities of the system. Individuals working on the frontlines of policy administration are crucial to the success of government programs (Lipsky, 2012). Although there are non-profit groups in place to help veterans obtain benefits, it would be ideal to have someone from within the organization to serve as a point of contact. A system ombudsman would be able to inform veterans of their benefits, walk them through the application process, and have access to real-time updates of their pending claims. They would be able to listen to and understand a veteran's needs and would facilitate aide to meet those concerns (Stivers, 1994). By working within the system, an ombudsman would have insight that an outsider is not privy to.

Veterans' health benefits are also in need of revision, as indicated by the evidence in this evaluation. Since the waitlist scandal that broke in 2014, some progress has been made to reduce the amount of time veterans wait before being seen in a VA healthcare facility (Molina, 2018). Nonetheless, the 14-day maximum waiting period that was issued by the VA continues to not be met in all facilities (U.S. Department of Veterans Affairs, 2018). The sheer fact that the Department of Veterans Affairs has to keep data on the number of veterans waiting 120 days or more to schedule an appointment indicates a widespread issue with wait times. Streamlining the disability-rating schedule will have an impact on this in the sense that it should be easier for the VA healthcare system to identify the degree of disability and eligibility for care.

Minimizing the time is takes to render a veteran eligible for health benefits must also be met by an increase in the quality of care. Veterans who utilize health benefits have indicated that because scheduling is a concern, appointments seem rushed and physicians do not have enough time to adequately address all of the concerns of their patients. (See below for a discussion of ways future research may handle health care issues.)

As the quality and quantity of benefits and the time it takes to receive benefits improves, it is paramount that veterans are simultaneously better educated about the benefits available to them. The current system in place to educate veterans, the Transition Assistance Program (TAP), offers a voluntary course for servicemembers as they are beginning to discharge from the military. Although the *National Survey of Veterans* of 2010 indicated that the benefits briefing was beneficial, the majority of veterans did not participate. To ensure that all veterans are aware of the multitude of benefits available and the services they may individually quality for, it is recommended that the TAP course is made a requirement for all servicemembers leaving active duty. For those current veterans who discharged from the service already and did not utilize this transition assistance, the TAP course should be made available at local VA centers on a regular basis. The system ombudsman mentioned above would be a critical component of this transition process. They would work with the Department of Veterans Affairs and the Department of Defense to facilitate these transition courses and then be available immediately thereafter to aide in the process of identifying eligibility and applying for benefits. The ombudsman's constant presence and communication in the process helps to further facilitate administrative effectiveness by strengthening their ability to understand the complexities of life after service (Stivers, 1994).

The findings of this study, which suggest that older veterans and combat veterans utilize more federal benefits than their counterparts, should not be seen as evidence to support only providing benefits education courses for these groups. Their increased use of benefits may be the result of several variables. For example, combat veterans are more likely to become disabled as a result of military service and thus are eligible for more benefits. Older veterans are likely to have served longer in the military and as such are eligible for benefits with greater service length requirements. Nevertheless, younger, non-combat veterans should not be excluded from the policy narrative. They are still eligible for certain benefits and deserve to be made knowledgeable of the services they may qualify for. As demonstrated through the complex findings of this study, evaluating a veteran solely on their age and combat status does not paint a full picture of their sacrifices and dedication to the military.

Because younger veterans can even benefit from improved knowledge of their benefits, Veterans Services organizations at universities should take an initiative in this respect. Although these organizations are primarily in place to work with veterans on their educational benefits, they should consider becoming equipped at aiding veterans with other benefits as well. Having a working knowledge of all of the benefits available to veterans could help provide even more opportunities for access for these men and women. Universities would then be better prepared to accommodate the various needs of veteran students.

For as long as the U.S. Military is operative, and for as long as there are any living veterans, society has a legal and a moral obligation to provide services so that veterans may achieve success in life after the military. As a demonstration of allegiance to this duty, the Department of Veterans Affairs must continue to work towards improved benefits and services for veterans. Although there has

been great success by way of educational benefits, VA home loan guarantees, and pension payments, progress is left to be made within the VA healthcare and disability compensation systems. As policies are reformed, the administrative obligations of the bureaucracies simplified, and the level of understanding of benefits amongst veterans increased, the efficacy of veterans benefits will truly be realized.

Limitations and Future Research

One limitation of this study is that it focused in on a narrow sample of the overall veteran population. Although it is important to understand the needs of the younger cohort of veterans in order to plan for the future, we must also consider the older cohort of veterans who are utilizing the most benefits currently. This research is not generalizable to all veterans but can serve as a stepping stone in the process toward optimizing the system of veterans benefits. Because respondents were contacted through a university, it is likely that a subset of veterans who are unable to use educational benefits because of the severity of their disabilities were also missed. It would be interesting to report if this group had any differing perceptions from the study group. The demographics of the university also skewed the demographic breakdown of the study sample. Although Latinx veterans make up less than 10% of the national veteran population, Latinx veterans made up nearly half of the sample in this study. As a result, these findings would be most appropriately generalized to a population with similarly dense Latinx and White populations.

The sample of participants in this survey reported higher than average knowledge of benefits. This is likely due to the fact that all of the veterans contacted had some experience in a university setting. It takes initiative on the part

of the individual veteran to utilize education benefits. As such, it is possible these veterans are seeking out information on the system. Veterans in other subpopulations are likely to report worse understanding of their benefits, comparable to the responses in the *National Survey of Veterans*. The results of this study which indicate that veterans' knowledge of their benefits is 'good' or 'excellent' should be viewed as positively skewed compared to the overall population.

This study was limited in its ability to fully ascertain the utilization of health benefits by participants. Questions related to the degree of disability and the presence of a mental disorder and subsequent services were not included in the survey. Previous research has demonstrated that perceptions are varied among veterans with different disability ratings, and it would have been interesting to see how those variations manifested in the current survey. It can be argued that the research did not paint a full picture of the issues because this population subgroup was not considered separately in analysis. Nevertheless, because a majority of participants had utilized health benefits, it is plausible to assume that some of the perceptions of those individuals with mental health issues were included, at least to a certain extent.

Finally, this research was limited in its ability to make suggestions for reform in the VA health care system based on the questions asked. Future research should determine if an expansion of the current health care system or privatization is most appropriate. Because of the magnitude of such a decision, it would be inappropriate to draw conclusions based on the extant research. If privatization is seriously considered, future studies must determine the costs associated with these changes, the ability of the private system to handle these changes, what should be done with existing structures, and practitioners', administrators', and veterans'

perspectives of such a change. Only then could informed changes be made to increase the efficiency and quality of health care for veterans.

Future research should aim to provide an even greater understanding of the difficulties faced by veterans trying to obtain benefits. Survey questions in future studies of veterans should seek recommendations from veterans of the changes that can be made. Because of their direct experiences with the system, veterans may be able to provide insight that is unobtainable from other sources. There may also be wisdom in determining what is going well with other benefits and then applying that knowledge to the benefits areas with the most need for improvement. Directing these questions towards a larger, more representative sample of veterans can further aid reformation efforts.

Researchers should also consider obtaining input from the administrators who are currently running these benefits programs. They would offer a perspective into the inner workings of the process of securing eligibility for the various benefits. Although veterans themselves are able to tell us that the process is long and tedious, administrators may be better able to explain what makes this process particularly lengthy and laborious. Blame is so often placed on these service providers for their inability to function at an efficient rate. It may be the case, however, that the issues stem from the larger political, legislative system and are simply trickling down to the bureaucracies.

It would be advantageous to replicate this study on a larger scale. The validity of the results would benefit from an expanded population and more responses. Certainly, it would be beneficial to administer the survey across multiple university campuses so that the public university system could tailor their services to veteran students based on the findings. Utilizing this survey instrument on other veteran subgroups could be insightful. It would be useful to study the

responses of elderly veterans, as this study population was much younger, relative to the national veteran population. The study could also be replicated with veterans with severe disabilities. This subgroup could provide more information on the health benefits and disability compensation systems which received the most criticism in this study.

REFERENCES

REFERENCES

Angrist, J. (1993). The effect of veterans benefits on education and earnings. *Industrial & Labor Relations Review, 46*(4), 637-652.

Bagnell, Melissa E, LeardMann, Cynthia A, McMaster, Hope S, Boyko, Edward J, Smith, Besa, Granado, Nisara S, & Smith, Tyler C. (2013). The association of predeployment and deployment-related factors on dimensions of postdeployment wellness in U.S. Military service members. *American Journal of Health Promotion, 28*(2), E56-E66.

Boulton, M. (2012). A price on patriotism: The politics and unintended consequences of the 1966 G.I. Bill. In S. Ortiz (Ed.), *Veterans' policies, veterans' politics* (pp. 241-262). Gainesville, FL: University Press of Florida.

Brown, B. (2014). *The complete guide to veterans' benefits: Everything you need to know explained simply*. Ocala, FL: Atlantic.

Byerly, C. (2012). Army sanctuary for tubercular veterans: Veterans' health care. In S. Ortiz (Ed.), *Veterans' policies, veterans' politics* (pp. 11-37). Gainesville, FL: University Press of Florida.

Campbell, A. (2004). The invisible welfare state: Establishing the phenomenon of twentieth century veteran's benefits. *Journal of Political and Military Sociology, 32*(2), 249-267.

Donovan, R. (1977). *Conflict and crisis: The presidency of Harry S. Truman, 1945-1948* (1st ed.). New York, NY: Norton.

Dortch, C. (2017). *The Post-9/11 veteran's educational assistance act of 2008 (Post-9/11 GI Bill): A primer* (CRS Report No. R42755). Retrieved from Congressional Research Service Website: https://fas.org/sgp/crs/misc/R42755.pdf

Draft National Capital Asset Realignment for Enhanced Services (CARES) Plan: Notice. (2003). *The Federal Register, 68*(161), 50244-50288.

Durham, K. (1932). *Billions for veterans: An analysis of bonus problems - yesterday, today and tomorrow*. New York, NY: Brewer, Warren & Putnam.

Edens, E., Kasprow, W., Tsai, J., & Rosenheck, R. (2011). Association of substance use and VA service-connected disability benefits with risk of homelessness among veterans. *American Journal on Addictions, 20*(5), 412-419.

Evaluation and Data Collection, 38 U.S.C. § 527 (2006).

Finn, T. (2014). *America at war: Concise histories of U.S. military conflicts from Lexington to Afghanistan*. New York, NY: Berkley Caliber.

Fried, D., Helmer, D., Halperin, W., Passannante, M., & Holland, B. (2015). Health and health care service utilization among US veterans denied VA service-connected disability compensation: A review of the literature. *Military Medicine, 180*(10), 1034-1040.

Gordon, S. (2017). *The battle for veterans' healthcare: Dispatches from the frontlines of policy making and patient care*. Ithaca, NY: Cornell Publishing.

Hundt, N., Robinson, A., Arney, J., Stanley, M., & Cully, J. (2015). Veterans' perspectives on benefits and drawbacks of peer support for posttraumatic stress disorder. *Military Medicine, 180*(8), 851-856.

Institute of Medicine (2014). *Veterans and Agent Orange: Update 2010* (8th ed.). Committee to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides, Washington, DC: National Academies Press.

Jennings, A. (2012). "An emblem of distinction": The politics of disability entitlement, 1940-1950. In S. Ortiz (Ed.), *Veterans' policies, veterans' politics* (pp. 94-118). Gainesville, FL: University Press of Florida.

Kinder, J. (2012). Architecture of injury: Disabled veterans, federal policy, and the built environment in the early twentieth century. In S. Ortiz (Ed.), *Veterans' policies, veterans' politics*. (pp. 65-93). Gainesville, FL: University Press of Florida.

Limitations on Assistance Furnished, 38 U.S.C. § 2102 (2012).

Lipsky, M. (2012). Street-level bureaucracy: The critical role of street-level bureaucrats. In J. M. Shafritz and A, C. Hyde, *Classics of public administration,* 7th ed. (pp. 412-419). Boston, MA: Wadsworth, Cengage Learning.

Lisio, D. (1994). *The President and protest: Hoover, MacArthur, and the Bonus Riot* (2nd ed.). New York, NY: Fordham University Press.

Lunch, W., & Sperlich, P. (1979). American public opinion and the war in Vietnam. *The Western Political Quarterly, 32*(1), 21-44.

Mall, S. (2013). The future of veterans' benefits. *National Academy of Elder Law Attorneys*, *9*(2), 167-187.

Molina, A. (2018, January). A systems approach to managing organizational integrity risks: Lessons from the 2014 Veterans Affairs waitlist scandal. *The American Review of Public Administration*,1-14.

Ortiz, S. (2012). *Veterans' policies, veterans' politics*. Gainesville, FL: University Press of Florida.

Parker, C. (2012). Exploring the effects of combat exposure on American civic life. In S. Ortiz (Ed.), *Veterans' policies, veterans' politics*. (pp. 281-300). Gainesville, FL: University Press of Florida.

Pash, M. (2012). "A veteran does not have to stay a veteran forever": Congress and the Korean G.I. Bill. In S. Ortiz (Ed.), *Veterans' policies, veterans' politics* (pp. 222-240). Gainesville, FL: University Press of Florida.

Resch, J. (1982). Federal welfare for Revolutionary War veterans. *Social Service Review, 56*(2), 171-195.

Sayer, N., Frazier, P., Orazem, R., Murdoch, M., Gravely, A., Carlson, K., . . . Noorbaloochi, S. (2011). Military to civilian questionnaire: A measure of postdeployment community reintegration difficulty among veterans using Department of Veterans Affairs medical care. *Journal of Traumatic Stress, 24*(6), 660-670.

Skocpol, T. (1992). *Protecting soldiers and mothers: The political origins of social policy in the United States*. Cambridge, MA. Belknap Press of Harvard University Press.

Smith-Osborne, A. (2009). Does the GI Bill support educational attainment for veterans with disabilities? Implications for current veterans in resuming civilian life. *Journal of Sociology and Social Welfare, 36*(4), 111-125.

Stevens, R. (2012). The invention, stumbling, and reinvention of the modern U.S. veterans health care system, 1918-1924. In S. Ortiz (Ed.), *Veterans' policies, veterans' politics* (pp. 38-64). Gainesville, FL: University Press of Florida.

Stivers, C. (1994). The listening bureaucrat: Responsiveness in public administration. *Public Administration Review, 54*(4), 364-369.

Teigen, J. (2012). Conventional and distinctive policy preferences of early-twenty-first-century veterans. In S. Ortiz (Ed.), *Veterans' policies, veterans' politics*. (pp. 263-280). Gainesville, FL: University Press of Florida.

U.S. Department of Veterans Affairs. (n.d.a.) *VA history in brief*. Retrieved from https://www.va.gov/opa/publications/archives/docs/history_in_brief.pdf

U.S. Department of Veterans Affairs. (n.d.b) *Veterans Benefits Administration*. Retrieved from https://benefits.va.gov/benefits/

U.S. Department of Veterans Affairs. (2013). *2012 highlights for the citizen*. Retrieved from https://www.va.gov/budget/docs/archive/FY-2012_VA-Performance.AccountabilityHighlights.pdf

U.S. Department of Veterans Affairs. (2014). *Federal benefits for veterans, dependents and survivors*. New York, NY: Skyhorse Publishing

U.S. Department of Veterans Affairs (2016). *2016 report to the Secretary of Veterans Affairs*. Retrieved from https://www.va.gov/ADVISORY/Reports/ ReportofACD COct2016.pdf

U. S. Department of Veterans Affairs. (2018). *Pending Appointments Data*. Retrieved from https://www.va.gov/HEALTH/docs/DR92_042018_Public Data_PDF_Pending_Appointments.pdf

U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics. (2016a). *Unique veteran users profile FY 2015*. Retrieved from https://www.va.gov/vetdata/docs/SpecialReports/Profile_of_Unique_Veteran_Users _2015.pdf

U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics. (2016b). *Living veterans by age group, gender, 2015-2045*. Retrieved from https://www.va.gov/vetdata/docs/Demographics/ NewVetpopModel/ 1L_VetPop2016_National.xlsx

U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics. (2017a) *Geographic distribution of VA expenditures for fiscal year 2016*. Retrieved from http://www.va.gov/vetdata/docs/GDX/GDX_FY16.xlsx

U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics. (2017b). *VA utilization profile FY 2016*. Retrieved from https://www .va.gov/vetdata/docs/Quickfacts/VA_Utilization_Profile.pdf

U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics. (2017c). *FY2017 VA disability compensation and pension recipients by county of residence*. Retrieved from https://www.va.gov/vetdata/docs/Special Reports/Comp_n_Pen_by_Cnty_2017.xlsx

U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics. (2018). *Profile of veterans: 2016*. Retrieved from https://www.va.gov/vetdata/docs/SpecialReports/ProfileofVeterans2016.pdf

U.S. Department of Veterans Affairs & Westat. (2010) National survey of veterans, active duty service members, demobilized National Guard and Reserve members, family members, and spouses: Final report. Retrieved from https://www.va.gov/vetdata/docs/SurveysAndStudies/NVSSurveyFinal WeightedReport.pdf

Veterans Administration. (1968). *Annual report, 1968*. Retrieved from https://www.va.gov/vetdata/docs/FY1968.pdf.

Veterans Administration. (1979). *1979 annual report*. Retrieved from https://va.gov/vet data/docs/FY1979.pdf.

Wright, S., Craig, T., Campbell, S., Schaefer, J., & Humble, C. (2006). Patient satisfaction of female and male users of Veterans Health Administration services. *Journal of General Internal Medicine, 21*(S3), S26-S32.

Young, N. (2012). "Do something for the soldier boys": Congress, the G.I. Bill of Rights, and the contours of liberalism. In S. Ortiz (Ed.), *Veterans' policies, veterans' politics* (pp. 199-221). Gainesville, FL: University Press of Florida.

APPENDICES

APPENDIX A: VETERANS' SURVEY

You are invited to take part in a research survey about veterans benefits. Your participation will require approximately 5-7 minutes and is completed online at your computer. There are no known risks or discomforts associated with this survey. Your participation will serve to benefit this field as our results will be presented to the community. At the end of the survey you have the option of entering into a drawing for a $25 Amazon gift card for taking our survey. The email address you provide for the drawing will be kept separate from your survey responses. Your identity will remain anonymous, as your responses cannot be tied to your email address. Taking part in this study is completely voluntary. If you choose to be in the study, you can withdraw at any time without adversely affecting your relationship with anyone at Fresno State. Your responses will be kept strictly confidential, and digital data will be stored in secure computer files. This survey is being conducted by Shelby Elia, a graduate student at Fresno State, under the direction of Dr. Kurt Cline. If you have questions about the survey itself, please contact Shelby at shelbybrisky@mail.fresnostate.edu. If you have any questions about whether you have been treated in an illegal or unethical way, contact the Fresno State Institutional Review Board chair, Dr. Kris Clarke, at (559)278-2985 or kclarke@csufresno.edu. Please feel free to print a copy of this consent page to keep for your records.

What branch of the military did you serve in?

- Navy
- Marine Corps
- Coast Guard
- Army
- Air Force

How many years were/have you been enlisted?

- 1
- 2
- 3

…

- 31

How old were you when you enlisted?

- Under 18
- 18-20
- 21-22
- 23-24
- 25-26
- 27-28
- 29-30
- 31 or older

Are you currently on active duty, discharged, retired, or in the reserves?

- Active Duty
- Discharged
- Retired
- Reserves

Were you ever deployed to serve in combat?

- Yes
- No

  How long, in total, were you deployed to serve in combat?

  - 6 months
  - 1 year
  - 1 year 6 months
  - 2 years
  - 2 years 6 months
  - 3 years
  - More than 3 years

How would you rate the military's job of educating you or informing you of your federal veterans benefits?

- Excellent
- Good
- Average
- Poor
- Terrible

How would you rate your knowledge of <u>all</u> the veterans benefits available to you?

- Excellent
- Good
- Average
- Poor
- Terrible

Which benefits have you personally utilized? Check all that apply

- Health Benefits
- Educational Benefits/ G.I. Bill
- Employment Benefits/Vocational Training
- Life Insurance
- Disability Compensation
- VA Home Loans
- Pension Payments

How would you rate your experience with your health benefits?

- Extremely satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied
- Extremely dissatisfied

In the previous question, you indicated you were dissatisfied with your current health benefits. Could you briefly explain why that is?

How would you rate your experience with your educational benefits/ G.I. Bill?

- Extremely satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied
- Extremely dissatisfied

In the previous question, you indicated you were dissatisfied with your current educational benefits. Could you briefly explain why that is?

_____

How would you rate your experience with your employment benefits/vocational training?

- Extremely satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied
- Extremely dissatisfied

In the previous question, you indicated you were dissatisfied with your current employment benefits. Could you briefly explain why that is?

_____

How would you rate your experience with your life insurance benefits?

- Extremely satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied

- Extremely dissatisfied

In the previous question, you indicated you were dissatisfied with your current life insurance benefits. Could you briefly explain why that is?

_____

How would you rate your experience with your disability compensation?

- Extremely satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied
- Extremely dissatisfied

In the previous question, you indicated you were dissatisfied with your current disability compensation. Could you briefly explain why that is?

_____

How would you rate your experience with your VA home loan?

- Extremely satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied
- Extremely Dissatisfied

In the previous question, you indicated you were dissatisfied with your current VA home loan. Could you briefly explain why that is?

_____

How would you rate your experience with your pension payments?

- Extremely satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied
- Extremely Dissatisfied

In the previous question, you indicated you were dissatisfied with your current pension payments. Could you briefly explain why that is?

_____

How would you rate the military's job of handling the mental health issues associated with service?

- Extremely satisfied
- Somewhat satisfied
- Neither satisfied nor dissatisfied
- Somewhat dissatisfied
- Extremely dissatisfied

How would you rate the adequacy of health benefits available to veterans specifically in the area of mental health?

- Extremely adequate
- Somewhat adequate
- Neither adequate nor inadequate
- Somewhat inadequate
- Extremely inadequate

Please rank the categories of veterans benefits in order of importance to you, where '1' indicates the most important and '7' indicates the least important.

___Health Benefits
___ Educational Benefits/G.I. Bill
___ Employment Benefits/Vocational Training
___ Life Insurance
___ Disability Compensation
___ VA Home Loans
___ Pension Payments

Rank the veterans benefits categories by need for improvement or revision, where '1' indicates the highest need for improvement and '7' indicates the least need for improvement.

___ Health Benefits
___ Educational Benefits/G.I. Bill
___ Employment Benefits/Vocational Training
___ Life Insurance
___ Disability Compensation
___ VA Home Loans
___ Pension Payments

How do you feel the public in general feels about the veteran population?

- Extremely important
- Very important
- Moderately important
- Slightly important
- Not at all important

How would you rate your satisfaction with the U.S. Military as a whole?

- Extremely satisfied
- Somewhat satisfied
- Neither satisfied nor dissatisfied
- Somewhat dissatisfied
- Extremely dissatisfied

How would you rate your satisfaction with the U.S. Government?

- Extremely satisfied
- Somewhat satisfied
- Neither satisfied nor dissatisfied
- Somewhat dissatisfied
- Extremely dissatisfied

Would you say the issues with veterans benefits are more to do with the time it takes to receive benefits, with the quality of benefits once received, or the quantity of benefits once received?

- Time it takes to receive benefits
- Quality of benefits once received
- Quantity of benefits once received
- All of the above
- Other: _____

Are there any additional comments you would like to make about your experience with veterans benefits?

_____

Are you:

- Male
- Female

Which racial or ethnic group(s) do you consider yourself or most closely relate to:

- White
- Black or African American
- American Indian or Alaska Native
- Asian/Asian American
- Native Hawaiian or Pacific Islander
- Latinx or Hispanic
- Other

What is your year of birth?

_____

If interested, you may enter your email address to be included in the drawing of an Amazon gift card.

_____

APPENDIX B: FREQUENCY REPORT

1. What branch of the military did you serve in?

Navy	20.0
Marine Corps	22.4
Coast Guard	3.5
Army	42.4
Air Force	11.8

2. How many years were/have you been enlisted?

Mean	6.8
Minimum	1.0
Maximum	22.0

3. How old were you when you enlisted?

Under 18	24.7
18 - 20	60.0
21-22	8.2
23-24	1.2
25-26	4.7
27-28	0.0
29-30	0.0
31 or older	1.2

4. Are you currently on active duty, discharged, retired, or in the reserves?

Active duty	1.2
Discharged	52.9
Retired	15.3
Reserves	30.6

5a. Were you ever deployed to serve in combat?

Yes	48.2
No	51.8

5b. How long, in total, were you deployed to serve in combat?

6 months	19.5
1 year	26.8
1 year 6 months	22.0

2 years	7.3
2 years 6 months	2.4
3 years	7.3
More than 3 years	14.6

6. How would you rate the military's job of educating you or informing you of your federal veterans benefits?

Excellent	14.1
Good	24.7
Average	32.9
Poor	22.4
Terrible	5.9

7. How would you rate your knowledge of <u>all</u> the veterans benefits available to you?

Excellent	12.9
Good	42.4
Average	29.4
Poor	12.9
Terrible	2.4

8a. Which benefits have you personally utilized? Check all that apply.

Health Benefits	55.2
Educational Benefits/GI Bill	90.0
Employment Benefits	31.0
Life Insurance	23.0
Disability Compensation	46.0
VA Home Loans	24.1
Pension Payments	9.2

8b. How would you rate your experience with your health benefits?

Extremely satisfied	19.2
Satisfied	57.5
Neither satisfied nor dissatisfied	6.4
Dissatisfied	14.9
Extremely dissatisfied	2.1

8c. How would you rate your experience with your educational benefits/GI Bill?

Extremely satisfied	44.2
Satisfied	42.9
Neither satisfied nor dissatisfied	10.4
Dissatisfied	1.3
Extremely dissatisfied	1.3

8d. How would you rate your experience with your employment benefits/vocational training?

Extremely satisfied	42.3
Satisfied	34.6
Neither satisfied nor dissatisfied	23.1
Dissatisfied	0.0
Extremely dissatisfied	0.0

8e. How would you rate your experience with your life insurance benefits?

Extremely satisfied	15.8
Satisfied	31.6
Neither satisfied nor dissatisfied	52.6
Dissatisfied	0.0
Extremely dissatisfied	0.0

8f. How would you rate your experience with your disability compensation?

Extremely satisfied	25.6
Satisfied	41.0
Neither satisfied nor dissatisfied	23.1
Dissatisfied	7.7
Extremely dissatisfied	2.6

8g. How would you rate your experience with your VA Home Loan?

Extremely satisfied	50.0
Satisfied	30.0
Neither satisfied nor dissatisfied	15.0
Dissatisfied	5.0
Extremely dissatisfied	0.0

8h. How would you rate your experience with your pension payments?

Extremely satisfied	50.0
Satisfied	25.0
Neither satisfied nor dissatisfied	25.0
Dissatisfied	0.0
Extremely dissatisfied	0.0

9. How would you rate the military's job of handling the mental health issues associated with service?

Extremely satisfied	8.4
Somewhat satisfied	28.9
Neither satisfied nor dissatisfied	32.5
Somewhat dissatisfied	24.1
Extremely dissatisfied	6.0

10. How would you rate the adequacy of health benefits available to veterans specifically in the area of mental health?

Extremely adequate	9.6
Somewhat adequate	30.1
Neither adequate nor inadequate	37.4
Somewhat inadequate	18.1
Extremely inadequate	4.8

11. Please rank the categories of veterans benefits in order of importance to you, where ‘1’ indicates the most important and '7' indicates the least important.

Health Benefits	Mean=2.96, SD=1.59
Educational Benefits/ GI Bill	Mean=2.12, SD=1.35
Employment Benefits	Mean=4.06, SD=1.44
Life Insurance	Mean=5.31, SD=1.73
Disability Compensation	Mean=3.76, SD=2.01
VA Home Loans	Mean=4.47, SD=1.71
Pension Payments	Mean=5.32, SD=1.80

12. Rank the veterans benefits categories by need for improvement or revision, where '1' indicates the highest need for improvement and '7' indicates the least need for improvement.

Health Benefits	Mean=2.55, SD=1.74
Employment Benefits	Mean=3.60, SD=1.71
Educational Benefits/GI Bill	Mean=3.81, SD=1.81
Disability Compensation	Mean=2.88, SD=1.73
Life Insurance	Mean=4.94, SD=1.90
VA Home Loans	Mean=5.18, SD=1.62
Pension Payments	Mean=5.04, SD=1.63

13. How do you feel the public in general feels about the veteran population?

Extremely important	28.9
Very important	51.8
Moderately important	13.3
Slightly important	6.0
Not at all important	0.0

14. How would you rate your satisfaction with the U.S. Military as a whole?

Extremely satisfied	28.9
Somewhat satisfied	42.2
Neither satisfied nor dissatisfied	15.7
Somewhat dissatisfied	10.8
Extremely dissatisfied	2.4

15. How would you rate your satisfaction with the U.S. Government?

Extremely satisfied	2.4
Somewhat satisfied	20.5
Neither satisfied nor dissatisfied	31.3
Somewhat dissatisfied	25.3
Extremely dissatisfied	20.5

16. Would you say the issues with veterans benefits are more to do with the time it takes to receive benefits, with the quality of benefits once received, or the quantity of benefits once received?

Time it takes to receive benefits	31.7
Quality of benefits once received	7.3
Quantity of benefits once received	2.4
All of the above	50.0
Other	8.5

17. Are you:

Male	72.0
Female	28.0

18. Which racial or ethnic group(s) do you consider yourself or most closely relate to:

White	36.8
Black or African American	1.1
American Indian or Alaska Native	5.7
Asian/Asian American	8.0
Native Hawaiian or Pacific Islander	0.0
Latinx or Hispanic	48.3
Other	5.7

19. What is your age?

Mean	32.5
Minimum	20
Maximum	68