



PAPERS

FOR THE NEXT

PRESIDENT

NOVEMBER 2015

PASSING THE BATON:

A Bipartisan 2016 Agenda for the
Veteran and Military Community

By Phillip Carter, Dr. Jason Dempsey, Katherine Kidder, and Amy Schafer



Center for a
New American
Security

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ABOUT THIS SERIES

Over the course of the next 18 months the Center for a New American Security will release reports designed to assist the next president and his or her team in crafting a strong, pragmatic, and principled national security agenda. The Papers for the Next President series will explore the most critical regions and topics that the next president will need to address early in his or her tenure and will include actionable recommendations designed to be implemented during the first few months of 2017.

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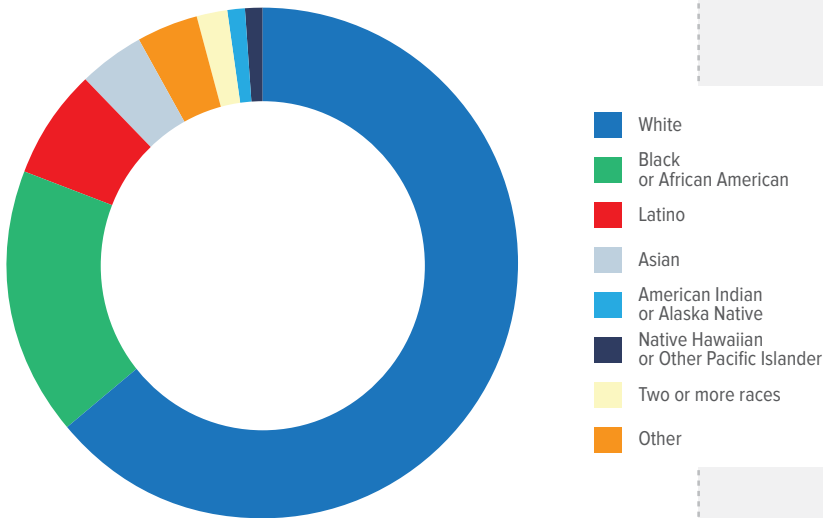


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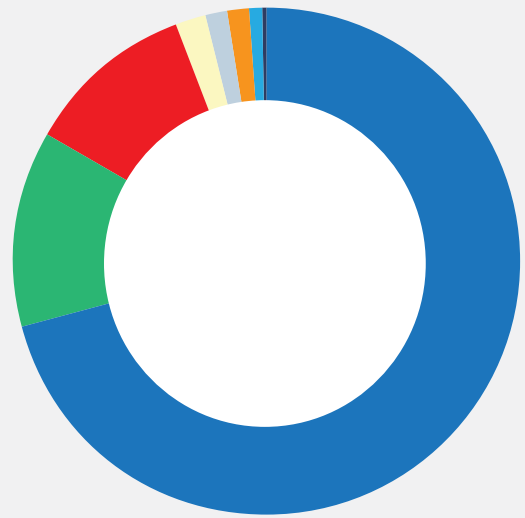
SERVICE MEMBERS

MILITARY SERVICE MEMBERS BY ETHNICITY
(Active Duty and Select Reserve)

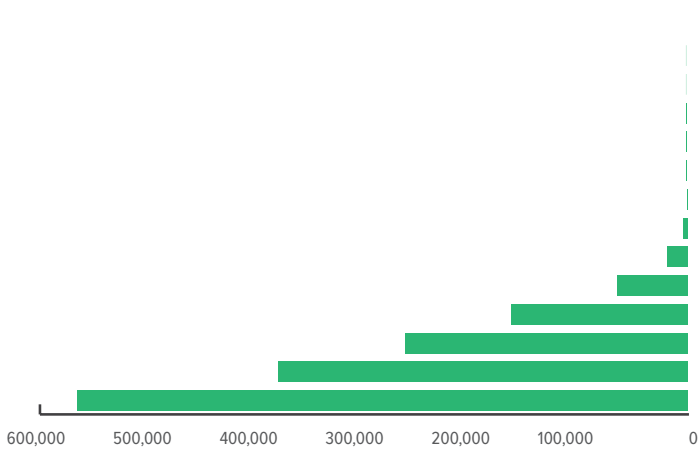


VETERANS

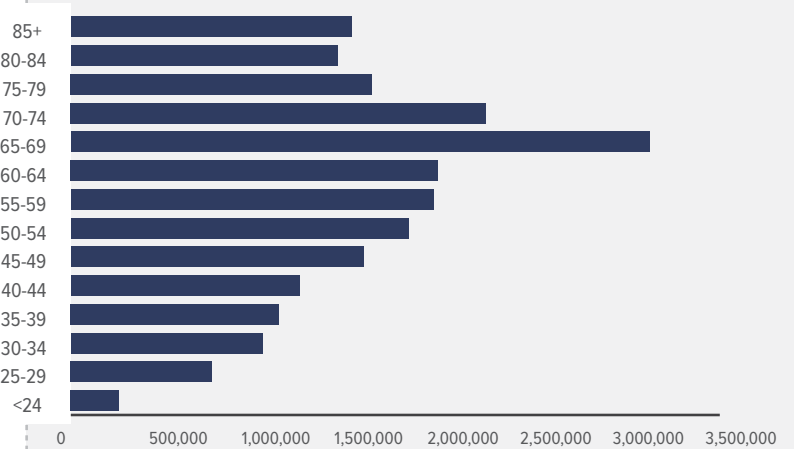
VETERANS BY ETHNICITY



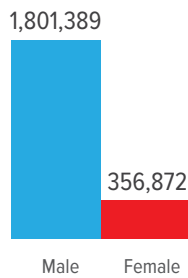
ACTIVE DUTY MILITARY BY AGE



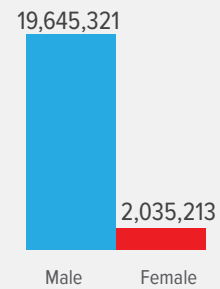
VETERANS BY AGE



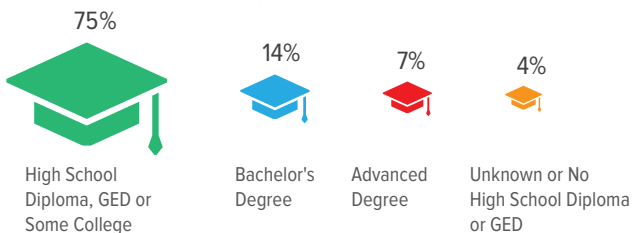
MILITARY SERVICE MEMBERS BY GENDER
(Active Duty and Select Reserve)



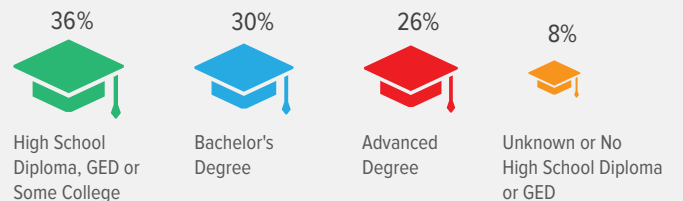
VETERANS BY GENDER



MILITARY SERVICE MEMBERS BY EDUCATION LEVEL
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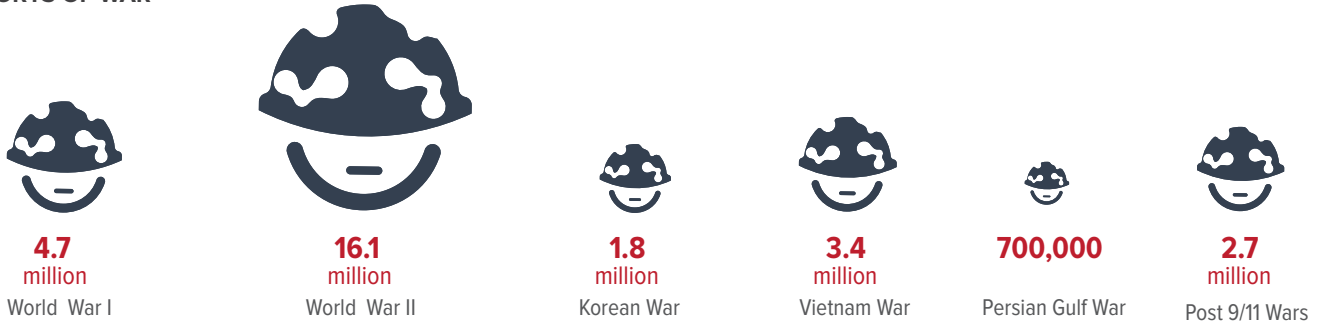


VETERANS BY EDUCATION LEVEL



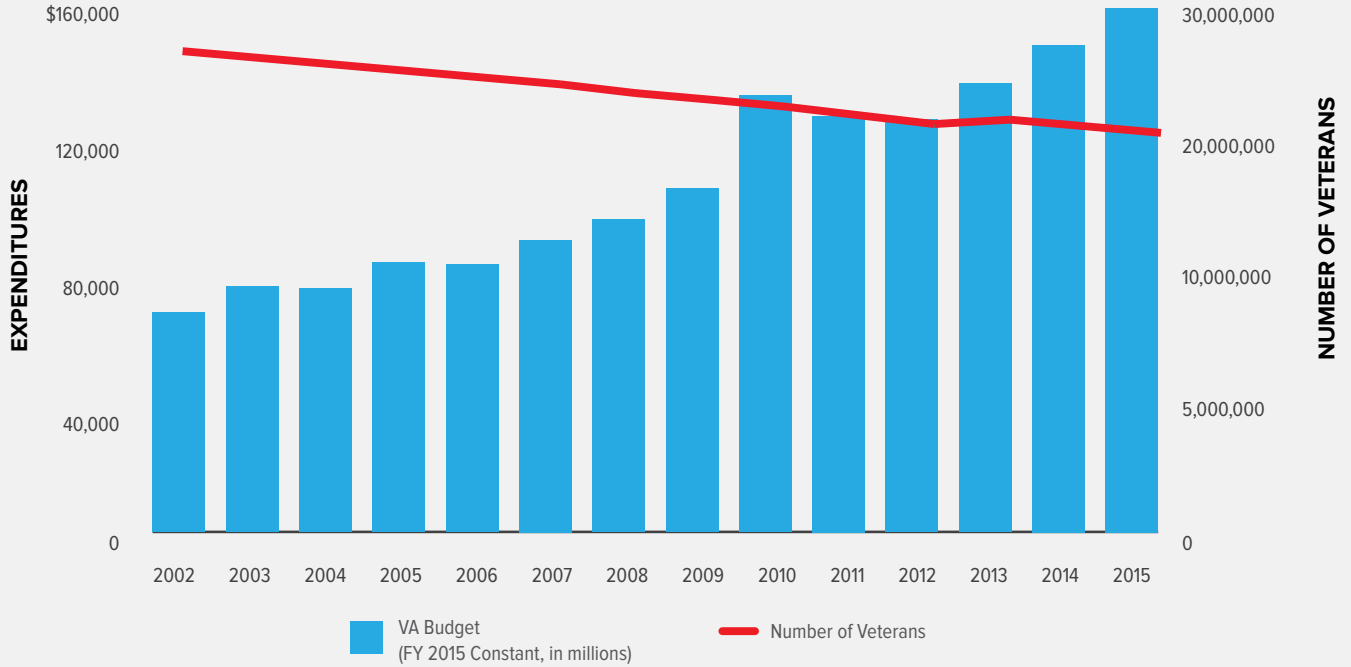
Sources: Department of Veterans Affairs, The Veteran Population Projection Model 2014; Department of Defense, Defense Manpower Data Center; Department of Defense Demographic Profile of the Military Community 2014; American Census Bureau American Community Survey 2013 5-Year Estimates.

COHORTS OF WAR

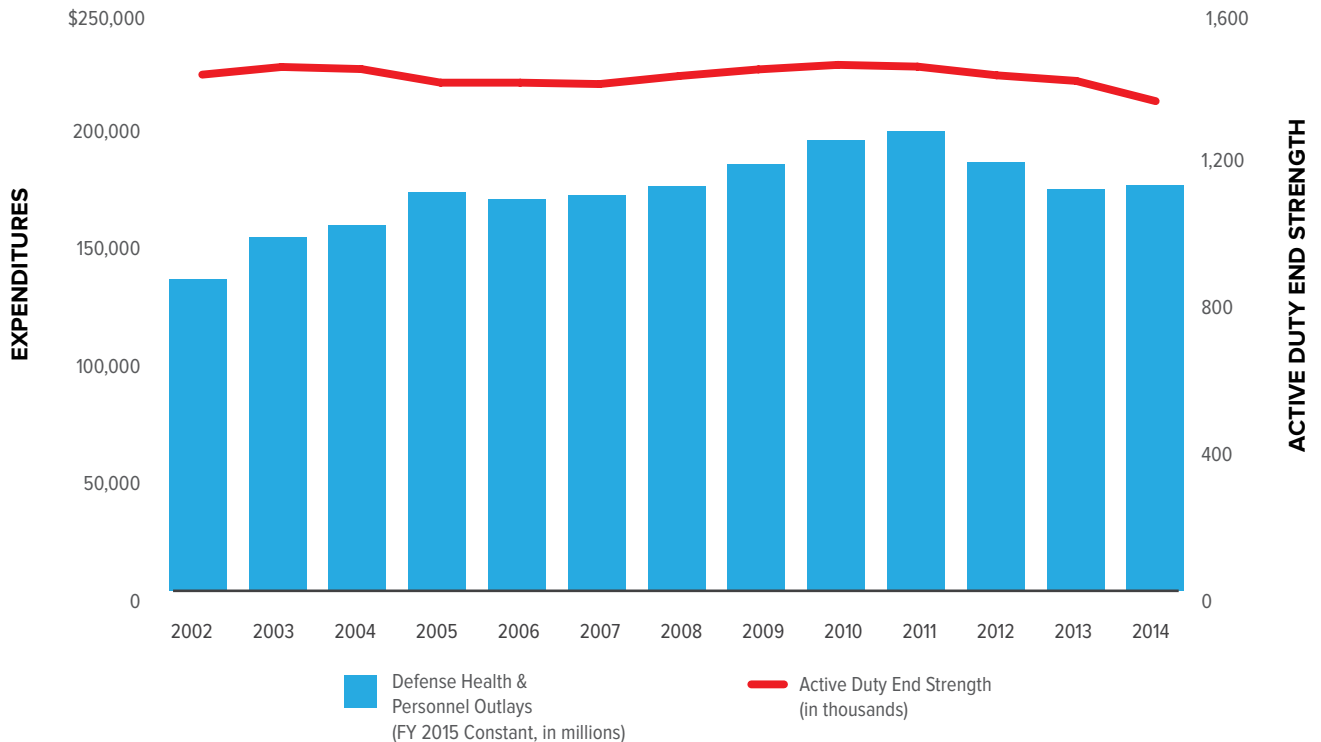


Note: Data for World War I and World War II include all service members who served during those wars, while the Korea, Vietnam, Gulf War and Post-9/11 War numbers include those deployed during those conflicts.

VETERAN POPULATION VS. DEPARTMENT OF VETERANS AFFAIRS BUDGET
(In Millions of Dollars, FY 2015 Constant)



END STRENGTH VS. DEPARTMENT OF DEFENSE BUDGET
(In Millions of Dollars, FY 2015 Constant)



FIRST 100 DAYS AGENDA



Presidential commitment to veteran and military community.

The next president must personally signal his/her commitment to the veteran and military community through speeches, public events, executive orders, and budget submissions. This commitment must be personal to be effective; the next president must use his or her personal presence and participation to convey the importance of this support and its vitality to national security.



Appointment and confirmation of key agency leaders.

During the transition period and before Inauguration Day, the next president should identify and nominate key leaders for DoD, the VA, the Department of Labor, and the Small Business Administration that work on veteran and military personnel issues. These nominees should be identified at the secretarial, deputy secretarial, and assistant secretarial levels before Inauguration Day, with plans in place to more fully staff these agencies at lower levels during the first 100 days of the administration.



Integration of veteran and military personnel issues into key strategy and planning processes.

The next administration should develop an enduring interagency structure for the human component of national security. This structure should be coordinated by a senior director with dual appointments to the National Security Council and Domestic Policy Council, with responsibility for overseeing and coordinating presidential policy and agency action in this field. Military personnel and veteran issues should be integrated into key strategic planning processes and documents, such as the National Security Strategy, and also reflected in key agency strategy documents such as the National Defense Strategy and Quadrennial Defense Review.



Clearly established agency and cross-agency goals. During its transition, and during the first 100 days, the next administration should establish clear goals for itself and its agencies to meet in serving the veteran and military community. To the extent practicable, these should be outcomes-oriented, transparent, and objective, such as reducing unemployment rates for veterans or military spouses, or improving health outcomes for veterans reliant on VA health care. The next administration should continue the practice of using “cross-agency priority goals” to synchronize interagency action where issues cross agency lines. These goals should be used to drive continuous improvement in agency and program performance, and also for accountability of agency leaders and programs.



Commitment to request resources necessary to implement strategy. The next president should personally commit to requesting sufficient resources in his/her first and subsequent budget submissions to meet the resource requirements of this community, as established by the next administration’s goals. This includes, but is not limited to, adequate funding to fully resource the military compensation, defense health, defense operations and maintenance, veteran health, and veterans benefits accounts. To further insulate these critical appropriations from political uncertainty, the next administration should propose the use of advance appropriations, as is done now for veteran health care.



Administration policy. The next administration should use the first 100 days to make clear policy statements to guide its agency performance in supporting the veteran and military community. These early policy statements should include, but not be limited to, a clear statement of support for public-private-nonprofit partnerships in supporting this community, a commitment to better sharing and use of data among government agencies and their partners, and a commitment to focus on outcomes (with accountability measures to ensure that agencies and their partners reach positive outcomes).

FIRST 100 DAYS AGENDA

By Phillip Carter, Dr. Jason Dempsey,
Katherine Kidder, and Amy Schafer

Executive Summary

On January 20, 2017, a new U.S. president will take the oath of office. At that moment, he or she will assume responsibility, as commander in chief of the armed forces, for the nation's 2.4 million active and reserve service members and their 3 million family members. The next president will also inherit the task of supporting the nation's 21 million veterans – a diverse population that has served presidents stretching back to Franklin Delano Roosevelt.

The next president, like those before, will have to grapple with a military that remains forward-deployed and engaged in myriad theaters against a broad array of threats. The needs of the active and reserve force, their families, and the veteran population continue, even as an age of fiscal austerity grips the federal government and affects the ability of federal agencies to serve the veteran and military community. At the same time, demographic, social, economic, and geographic change within the veteran and military community will continue, or even accelerate in some cases, changing the profile for this community.

This paper outlines a bipartisan agenda for the next administration to support the veteran and military community – to serve it as well as it has served the nation. Regardless of who takes office in January 2017, the issues facing this community will continue, and they will become the responsibility of the next president. The key findings and recommendations of this agenda include:

- *Urgent and immediate issues.* This set of issues includes those critical concerns facing the military and veteran community about which there is mostly political consensus, both on the problems and solutions. Transition, economic opportunity, health care access, and mental health provision, as well as support to veterans in crisis like those facing homelessness. No matter who wins in 2016, these issues will demand the next president's attention and require immediate action (or effective continuance of current efforts) and signaling of dedicated oversight from the first day of the next administration.

- *Operational issues.* A combination of factors – from demographic change within the veteran community to pressure from federal budget fights – has exposed fissures, gaps, and tension points within the system that serves the veteran and military community. These include such issues as access to veterans’ health care reform and benefits support, reform of the military personnel system, and connection of the military to society. On these matters, some agreement exists as to the nature or scope of the problems, but there is sharp disagreement on how to address them. These issues deserve attention from the next president; however, the election will likely determine their priority and what answers the next administration favors.
- *Strategic opportunities.* Beyond the specific policy choices to be made by the next administration, there are a number of steps that can be taken by public-, private-, and nonprofit-sector leaders to continue momentum from the past 15 years of support for the veteran and military community. These include opportunities to better share data inside and outside of government, use data to make better decisions affecting this community, and expand public-private-nonprofit partnerships to better serve the nation.

In addition to these points, this paper outlines a “first 100 days” agenda for the next president to immediately signal his/her commitment to the veteran and military community and take those necessary first steps to enable subsequent success. These steps include establishment of White House priorities and staff for this area, appointment and confirmation of key agency leaders, development of budget submissions to fully support this community, and early statements of administration policy on key issues such as funding priorities and the value of public-private partnerships.

Effective support for the veteran and military community matters for many reasons. National security depends on the United States’ ability to recruit, retain, manage, and support its service members and their families. Most veterans do well after service, but some struggle, often needing support to tackle health, economic, and wellness challenges that impede their transition to civilian life. The government has a sacred trust with its

veterans to help with these challenges and support private- and nonprofit-sector efforts to help too. The nation benefits from the successful transition and future success of veterans in myriad ways, including the contributions these veterans make to society after service, and the example they set for future generations weighing whether to join the All-Volunteer Force.

National security depends on the United States’ ability to recruit, retain, manage, and support its service members and their families.

I. The Veteran and Military Landscape

A. Demographics/Geography for Veteran and Military Populations

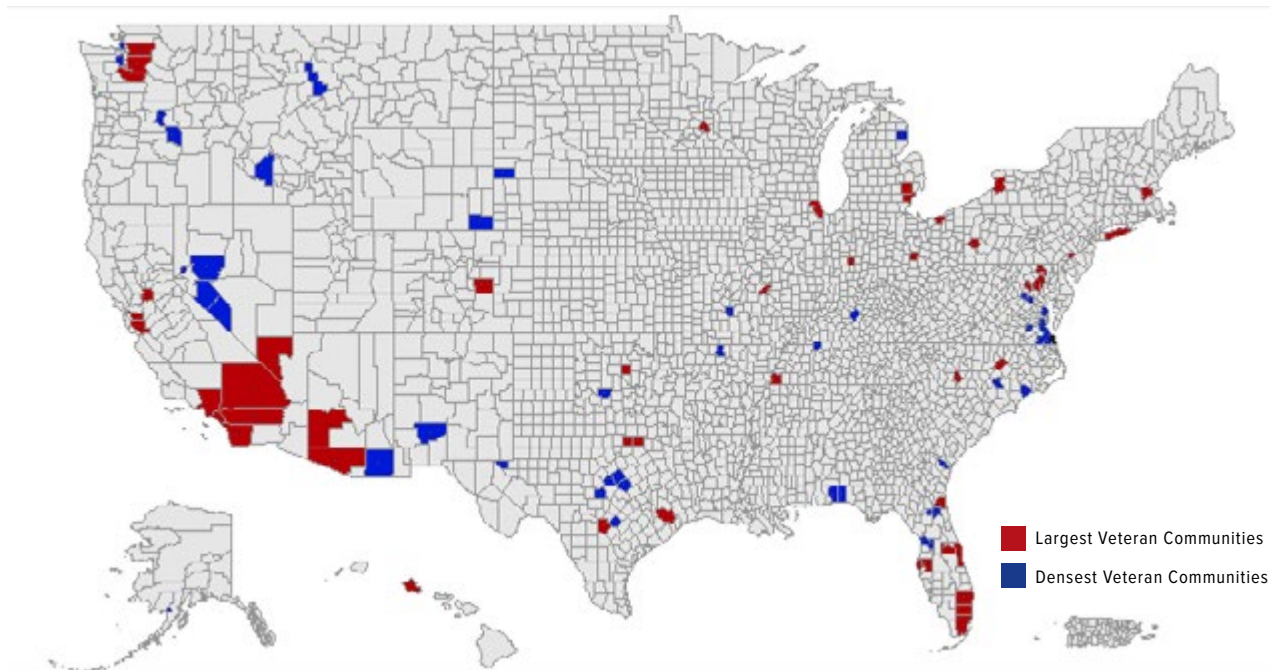
The veteran¹ community includes 21 million men and women, whose service spans from World War II (and even before) through today. This population consists primarily of men who served during the second half of the 20th century, when the force was far less diverse than it is now. The overall veteran population is 92.7 percent male and 7.3 percent female, with a median age of 64. By ethnicity, 79 percent are white, 6 percent are Latino, 11.5 percent are African-American, and 1.4 percent are Asian, with 2.1 percent identified as other. Among male veterans, 66.5 percent are married, while 47.3 percent of female veterans are married.² Veterans are more educated than the national average: 65 percent of the veteran community has received some college education or a college degree, including many who have achieved even higher levels of education. And, on average, veterans' unemployment rates, median income, homeownership rates, and total household wealth all best the national average; however, much of this reflects the proportion of the veteran population who are older, white, and male, who tend to do better on all those metrics for reasons unconnected to military service.

The current active and reserve military looks very different from the veteran population, reflecting demographic changes that have been occurring since the advent of the All-Volunteer Force (AVF) in 1973. Of today's 2.4 million active and reserve troops, 60.9 percent are under the age of 30. Today's force has more gender diversity than the veteran population: 16 percent of today's troops are women. The number of women in the service is expected to rise in years to come, particularly in the Navy and Air Force. Families play a large role in today's military community; currently, 52.6 percent of active and reserve troops are married, and there are approximately 3 million active and reserve military dependents, including spouses and children. The ethnic breakdown of the force is as follows: 71.9 percent white, including Latino; 16.2 percent African-American; 3.5 percent Asian; and 8.4 percent other. Education rates have also increased relative to the overall veteran population. Today, 99

percent of the force has either a high school diploma or GED, 78.6 percent have some college in addition to a high school diploma, and 19 percent have a college degree or higher level of education.³ The selection process for today's AVF enlistee or newly commissioned officer is rigorous enough that it excludes roughly 71 percent of American youth from military service, for reasons relating to education, physical health, fitness, criminal background or substance use.⁴

An important part of the community is the cohort of post-9/11 deployment veterans, including those service members (most of whom have since left the military and become veterans) who have deployed to Iraq, Afghanistan, or other theaters of war. As of July 2015, this cohort included more than 2.7 million service members. For historical perspective, that puts the post-9/11 deployment cohort between the Korean War cohort (1.7 million) and the Vietnam War cohort (3.4 million) in terms of size. Demographically, the post-9/11 deployment cohort was slightly younger than the military as a whole, with a bit more male representation than the military as a whole. These demographic differences stem from the composition of the deployed force, which disproportionately included more combat arms units, where young men are disproportionately assigned.

Geographically, the nation's largest veteran communities exist in large cities such as Los Angeles and New York City, as well as in the nation's Sun Belt regions stretching from Southern California to Florida. These reflect concentrations of large, older veteran populations in the nation's largest population centers and retirement centers. However, in terms of population density, the veteran populace concentrates most around active military bases, reflecting the access to health care and services, as well as the magnetic effect that many base communities exert on recently separated service members and their families.

FIGURE 1: TOP 50 COUNTIES BY NUMBER OF VETERANS AND DENSITY OF VETERANS

Source: Department of Veterans Affairs, VetPop and Geographic Distribution of Expenditures data

B. Agency Budgets and Composition

The Department of Veterans Affairs (VA) budget has risen significantly over the past seven years, even as the total population of veterans has steadily decreased. These budget increases reflect substantially higher rates of utilization by veterans of all generations, as well as increases in the cost of health care, and new benefits such as the Post-9/11 GI Bill. The 2015 VA budget is expected to total \$161 billion, up from slightly under \$89 billion in 2007.⁵ Currently, there are 21 million veterans. Of these, approximately 12 million are eligible to enroll in the VA health care system; approximately 9 million enroll, and roughly 6.5 million actually obtained health care from a VA facility last year. About 4.1 million veterans receive disability compensation from the VA; this population overlaps a great deal with that obtaining VA health care, in part because service-disabled veterans receive priority enrollment in the VA health care system. To serve this vast community, the VA employs 354,045 people spread across 1,834 facilities nationwide, including roughly 300,000 health employees and 21,000 benefits staff.⁶ Over the past several years, the VA has expanded greatly in the economic opportunity and benefits space, building on the mandates of legislation like the 2009 Post-9/11 GI Bill and

the 2011 “VOW to Hire Heroes Act” and numerous executive orders or directives. Most VA appropriations are insulated from the effects of sequestration and congressional gridlock, via the “advance appropriations” mechanism for most health accounts or other mechanisms for veterans benefits accounts. However, the current fiscal environment affects VA’s discretionary spending accounts, impacting its ability to modernize or surge to programs not contained in its health and benefits funding.

The selection process for today’s AVF enlistee or newly commissioned officer is rigorous enough that it excludes roughly 71 percent of American youth.

The Department of Defense (DoD) budget has seen a major increase in personnel outlays since the early 2000s, spending substantially more per service member today than before 9/11.⁷ This growth has resulted from a number of factors, including steady increases in base pay and allowances for service

members, additional pay for deployments over the past 14 years, enlistment and re-enlistment incentives, and increases in the cost of providing health care to more than 9 million DoD health care beneficiaries.⁸ As a component of these costs, DoD-funded military health care expenditures have grown by over \$11 billion since 2005, accounting to nearly 18 percent of total personnel costs in 2012. As the wars in Iraq and Afghanistan come substantially to an end and the Department of Defense labors to make ends meet under sequestration, personnel and health spending have begun to come under greater scrutiny. To cut personnel spending, the services have largely turned to cutting personnel, with the Army and Marine Corps taking the majority of these cuts over the past three years, reducing their size by 80,000 and 20,000, respectively, with more cuts likely over the next few years.⁹ The Pentagon is looking for other ways to cut spending, such as through reductions in civilian staff, adjustments to major procurement programs, and reductions in spending on operations and maintenance. Beyond personnel compensation and health care spending, most support to military personnel and military families comes out of the services' operations and maintenance accounts; thus, any sequestration-driven cuts will likely affect the military's ability to support its current service members and their families.

C. Private- and Nonprofit-Sector Activity

Over the past 14 years, private and nonprofit activity has grown to support the veteran and military community. On the private-sector side, most of these efforts have focused on transition, employment, and economic opportunity issues affecting veterans, as well as corporate philanthropy programs to support the veteran and military community. The nonprofit sector has approached veterans with a broader lens, providing economic support but also working to improve veterans' physical and mental health, support veterans in crisis (such as those facing homelessness or legal issues), better connect veterans to communities and each other, and fill gaps left by government services at all levels.

There are many private-sector initiatives to support transitioning service members and their families as they enter and move through civilian life. Estimates place the number of hiring commitments made by

major corporations and corporate coalitions at more than 1 million since 2009, with more than 850,000 actual hires made against these commitments.¹⁰ The largest and most prominent of these programs focus on employment because of their corporate pedigree, but also out of the belief that employment is a positive protective factor that helps veterans navigate the transition process and avoid health, housing, and other issues. The largest of these is the Hiring Our Heroes initiative, under the auspices of the U.S. Chamber of Commerce,¹¹ which is responsible for nearly 500,000 employed veterans and military spouses thus far. This initiative aims to assist transitioning veterans and also military spouses in finding jobs, leveraging chambers of commerce across the country that can reach small and medium-size firms as well as large ones. The Veterans Job Mission, formerly known as the 100,000 Jobs Mission, originally set out to hire 100,000 veterans by 2020. As of September 30, 2015, this coalition reported hiring nearly 300,000 veterans, across more than 200 companies. Smaller, more focused programs such as Veterans on Wall Street,¹² the construction industry's Home Builders Institute, Vets in Tech,¹³ and other industry-specific initiatives have also gathered steam over the past several years, as have large hiring programs run by the nation's largest firms and labor unions, who themselves have hired tens of thousands of veterans each.

In hiring veterans and military family members, these initiatives have substantially improved the economic outlook for the veteran community, even during difficult economic times. By virtue of their employment, these veterans experienced a more successful transition, with less need for government health and benefits support, many experts believe. And through their activities and communications efforts, these coalitions have conveyed a powerful, positive message to U.S. businesses and business leaders about the value of veterans in the workforce. Although some stigmas and misperceptions about veterans remain among employers,¹⁴ this message has clearly made a positive difference.

During the post-9/11 era, nonprofit organizations focused on the veteran and military community have also done enormous work.¹⁵ Recent research finds there are approximately 42,000 organizations that

have registered with the IRS as primarily focused on the veteran and military community. Two data points about this community stand out regarding this “sea of goodwill.” First, the vast majority of these organizations – nearly 70 percent – have less than \$100,000 in annual revenue; only 235 have annual revenue exceeding \$1 million. Second, roughly 75 percent of the 42,000 nonprofit organizations focused on the veteran and military community are actually separately incorporated and organized chapters of the American Legion, Veterans of Foreign Wars, or similar groups.¹⁶ These two data points suggest that most of the nonprofit organizations serving veterans are these traditional veteran associations, locally incorporated and organized, funded with relatively small budgets. Alongside these traditional veteran service organizations, there exist another 9,000 charitable and advocacy organizations focused on the veteran and military community. These include entities providing supportive housing, mental health care counseling, job placement assistance, alternative medical therapies, sports and recreation activities, advocacy, and public service activities.

As a segment of the overall nonprofit sector, veteran-focused nonprofit organizations make up a staggeringly small fraction of the field, pulling in less than two-tenths of 1 percent of all nonprofit-sector revenue last year.¹⁷ Since 2001, revenue for military- and veteran-serving nonprofits has remained relatively flat, adjusting for inflation, but assets have gone up slightly over the same period. During this time, the total number of organizations has declined slightly, although it’s not clear how much turnover is occurring within the total numbers that are available from the IRS.¹⁸ Notably, however, government funding to the veteran and military nonprofit sector has increased significantly over this period, reflecting the VA’s push to end homelessness and greater DoD support to nonprofits as well. The combination of this government spending and flat overall revenue suggests that individual, corporate, and philanthropic giving to this sector may actually be on the decline. With need expected to continue in the veteran and military community, this suggests a gradual divergence between need and resources. Nonprofits serving the veteran and military community must find ways to access new pools of capital, besides its traditional reservoirs of government funding and philanthropic giving, if it is to survive current trends.

Alongside these developments, there has been increasing discussion among public, private, and nonprofit leaders about how to best measure success and outcomes of the nonprofit organizations serving the veteran community. A number of funders have come together to fund the Veteran Metrics Initiative, a major research project hosted by the Henry M. Jackson Foundation for the Advancement of Military Medicine, to study outcomes among a large sample of veterans for five years and link those outcomes to nonprofit organizational practices. Similarly, a number of funders supported a 2014–15 effort overseen by the George W. Bush Institute to identify best practices among nonprofit organizations that could help inform funders about which organizations to support in the future. However, more effort is needed in this area, both to develop models and best practices for measuring outcomes produced by nonprofit organizations and to catalyze actual measurement of these outcomes and use of that data in decisions about which programs to fund and pursue.

[Veterans hiring coalitions] have conveyed a powerful, positive message to U.S. businesses and business leaders about the value of veterans in the workforce.

II. Issues Facing the Veteran and Military Community

A. Urgent and Immediate Issues

Regardless of who becomes president in January 2017, the next administration will inherit a set of acute issues facing service members, military families, and veterans. These issues are both highly pressing and highly visible because of their human toll. As such, they garner a lot of attention and focus, driving a degree of bipartisan agreement on both the issues and potential solutions. As the next president takes office, it is important that he or she build on the work and successes of the last eight years and keep national attention on these issues as the country disengages from the large-scale wars of the last 14 years and the military services draw down. Further, building upon the efforts of the outgoing administration, the next president can likely find some “quick wins” within the first 100 days in office, while also focusing on those critical issues with the most immediacy for the veteran and military community.

1. TRANSITION, ECONOMIC OPPORTUNITY, AND EDUCATION

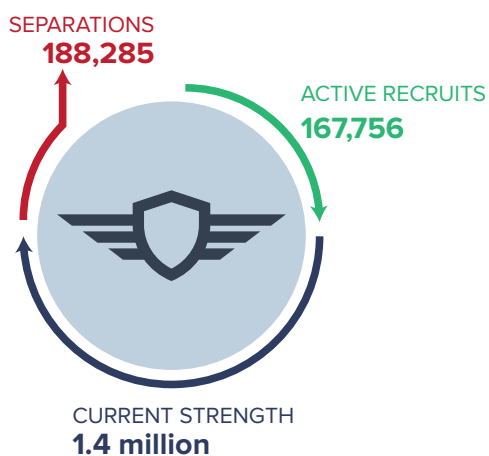
Each year, the U.S. military currently takes in approximately 175,000 new recruits for the active force and 100,000 reservists – and each year, the military discharges approximately the same numbers from the active and reserve components.¹⁹ These numbers can fluctuate (and have) over time, such as during the wartime expansion of the military between 2006 and 2010 and the military downsizing now underway.

This cyclical process of recruitment, service, and separation exists for all militaries, whether they use conscription or voluntary enlistment to fill their ranks. For the U.S. military, this cyclical model sits at the heart of the All-Volunteer Force, driving the services’ approaches to recruiting, retention, talent management, and support for departing service members as well. For much of the AVF’s history, from its inception in 1973 to the current wars, the U.S. government focused primarily on the recruiting and retention parts of this model, relegating employment and transition support to the VA and the Department of Labor (DOL). However, driven by rising public concern about veteran unemployment, and the increasing amounts of unemployment compensation underwritten by the

Pentagon for departing service members,²⁰ the U.S. government has embraced a more active approach to transition and economic issues for military personnel. The military has also begun to recognize a link between the propensity of future recruits to join the service and perceptions of post-service health, economic success, and wellness. This active approach has manifested itself in a revamped and expanded DoD Transition Assistance Program (TAP), a dramatically expanded VA program focused on employment and economic opportunity, partnerships with the private sector for training and employment, tax credits and other incentives for hiring veterans, and enhanced funding for DOL programs focused on veteran employment at the federal, state, and local levels.

Over the past 14 years, the veteran unemployment rate has largely mirrored the national unemployment rate, moving up and down with the economy as a whole, with two major differences. The unemployment rate for the overall veterans population, which is largely an older white male population, has been consistently better than the national average. At the same time, the unemployment rate for young veterans and post-9/11 veterans has been consistently worse than the national average.²¹ This gap indicates that the overall veterans population does well in the workforce, but that younger veterans, particularly those within the first year or two of separation, struggle to find and keep work.

The available data on veteran transition and employment suggests two broad conclusions. First, the current challenges have more to do with transition, training, and initial employment than with long-term unemployment. The overall rate of unemployment for veterans remains substantially better than the national average, reflecting the economic success of a veteran population that is mostly older, mostly male, and mostly white. Within this total veteran population, however, there are substantially higher rates of unemployment among young veterans, particularly those without a college degree. Survey data from a number of veteran organizations indicates that recent veterans feel a great deal of economic insecurity after leaving the service and also report difficulty finding jobs in the locations and industries where they want to look.²² Some research suggests that many

FIGURE 2: FY13 ACTIVE DUTY SERVICE MEMBER TRANSITION

veterans catch up with, and often surpass, their civilian peers; however, more data is necessary to identify the economic issues facing veterans in the years after they transition.

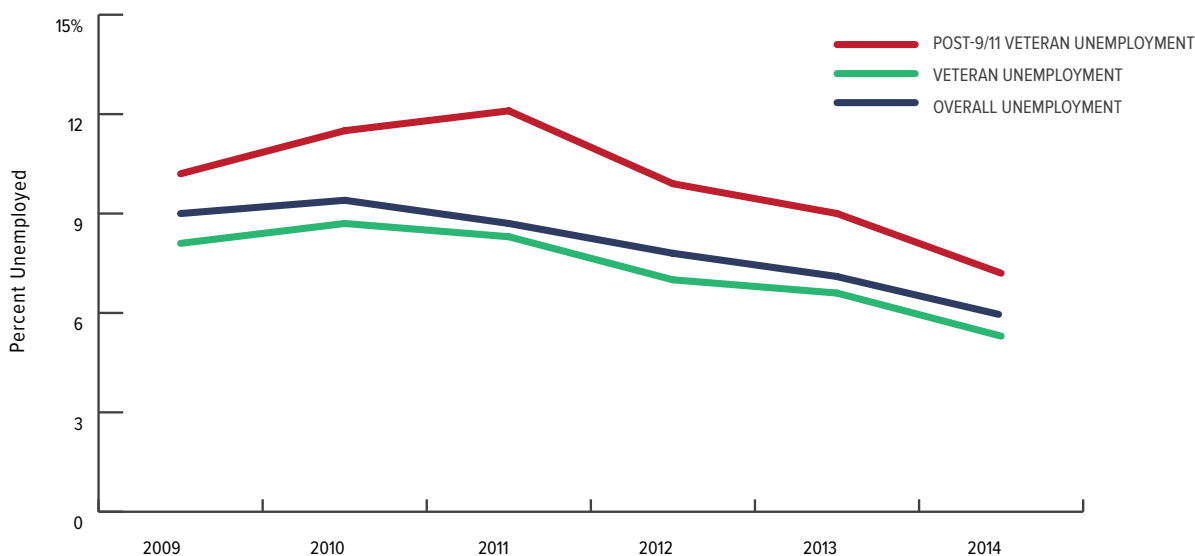
The second observation is that there may be a veteran “underemployment” phenomenon occurring in the labor market today, wherein veterans take jobs beneath their preferred level of utilization and compensation. To some extent, such a problem reflects continuing difficulty in translating military skills, education, training, and experience to the private sector. The underemployment phenomenon may also be driven, in part, by employment programs that rely primarily on a direct skills translation approach, instead of educating and training veterans for careers in the private sector that may differ substantially from their military training and experience but provide greater long-term opportunity. Underemployment may also reflect the differences in social and professional networks between veterans and nonveterans in the workforce, which impede even the best qualified veterans, especially during their first years of transition. It can take time for veterans entering private firms to establish the social trust, mentorship relationships, and other soft connections that enable upward mobility and assignment of greater responsibility.

Income data support these observations regarding veterans economic opportunity. In the aggregate, veteran median income is \$10,076 more than non-veteran median income (\$40,302 as compared to \$30,226.) This broad gap reflects the demographics of the overall veterans community; when adjusted for age and demographic differences, the gap narrows or flips, with veterans earning slightly less than their civilian peers. However, the data also shows that post-9/11 veterans, including those in the 18–24, 25–34, and 35–44 year old age groups, are outperforming previous generations of veterans with respect to income in the 45–54, 55–64, and over 65 age brackets.²³ Minority and female veterans of the post-9/11 era also fare much better than their civilian counterparts, as well as previous generations of minority and female veterans. Although this data requires more study, it suggests there may be an “AVF effect,” whereby better selected, trained, and educated veterans of today’s military outperform previous cohorts of veterans who served in earlier eras.

Each year, the U.S. military currently takes in approximately 175,000 new recruits for the active force and 100,000 reservists – and each year, the military discharges approximately the same numbers from the active and reserve components.

As service members separate, they may experience friction as they relocate, pursue education, or search for jobs. To mitigate these challenges, outgoing troops have access to the DoD Transition Assistance Program and the Transition Goals, Plans, Success (GPS) program during their last months of service, which develop such skills as resume writing, interview skills, and financial planning, among others.²⁴ However, the timing of these services (during a service member’s last weeks or months on active duty) may not be optimal, as service members are caught between closing out their active-duty careers and facing the imminent prospect of unemployment. Likewise, service members go through TAP at their

FIGURE 3: NATIONAL UNEMPLOYMENT RATES AND VETERAN UNEMPLOYMENT RATES, 2009-2014



Source: Bureau of Labor Statistics

last duty station, which is likely not to be the place where they look for employment, diluting this program's value because it cannot connect them with employers or networks where they plan to move after service. Extending service members' access to those programs to 365 days after service (or longer), or allowing them to access TAP resources at bases near their eventual post-service destination, may better serve their needs at the most critical time.²⁵ Continuing to link these services to employers in communities where veterans end up are important too; the services should leverage their reserve components, recruiters, and each service's "Soldier/Sailor/Airman/Marine for Life" programs to bridge the geographic and temporal gap between TAP classes and local job markets. The government should also continue VA and DOL programs that support veterans' economic opportunity in the years after transition too, recognizing that veterans often face job market adjustment years after leaving the military. Collectively, these interventions during the period of veterans transition may stave off future economic difficulty, increasing quality of life for veterans and decreasing the overall cost of service provision (enabling veterans to procure private health insurance through their employers, for example) downstream.

There may be a veteran "underemployment" phenomenon occurring in the labor market today ...

One of the primary transition paths for service members and military families is through higher education. In addition to its transition value, higher education can be a powerful tool for economic mobility as well. Through a variety of programs, including the old Montgomery GI Bill, the VA vocational rehabilitation program, and the Post-9/11 GI Bill, the VA supported 1.1 million veterans and family members pursuing higher education in 2014. Nearly 2 million people have availed themselves of the Post-9/11 GI Bill to date, accounting for more than \$40 billion in educational benefits paid by VA for this program since 2009. However, the data regarding the success of those who have used the programs is mixed; there may be better ways to support veteran transition through higher education. VA data suggests that GI Bill funds are underutilized by veterans, and that just 8 percent of veterans transferred their benefit to family members.²⁶ A recent study found just 51.7 percent of veterans complete their higher educational

goal, and taking slightly longer than civilian peers to do so.²⁷ Data published by the VA suggests completion rates and debt loads vary widely by school.²⁸ Although economic data suggests veterans and family members with higher education earn more than those without, there has been no study linking specific educational pursuits and programs to outcomes, nor any alignment between government programs such as the Post-9/11 GI Bill and these outcomes.

Complicating the picture is the role of for-profit schools such as the University of Phoenix, which, according to the latest VA data, enrolled 49,147 veterans using \$344.3 million in Post-9/11 GI Bill benefits last year. Across the industry, for-profit colleges have reaped \$8.2 billion of the \$40 billion in Post-9/11 GI Bill benefits paid since 2009.²⁹ For-profit colleges such as have also targeted active-duty and reserve troops for their business, taking hundreds of millions of dollars each year in DoD Tuition Assistance.³⁰

For-profit schools offer educational opportunities to many who might not otherwise seek higher education, including non-traditional students like veterans. However, low graduation rates, poor post-graduation employment outcomes, and perceived predatory practices by these institutions have led many advocates to call for tighter regulation and oversight of the for-profit college industry, which in many ways is being fueled by VA and DoD educational benefits. One of the most promising ideas is to close the loophole in the Department of Education's "90-10" rule that allows for-profit schools to exclude DoD and VA revenue from the cap placed on the amount of federal revenue that schools can earn; closing this loophole would eliminate the huge financial incentive for these schools to aggressively pursue veteran and military tuition dollars. In addition, DoD and the VA should weigh suspension of tuition support to schools that provide poor value to veterans and taxpayers, such as those with graduation rates or post-graduation employment rates substantially below average. DoD has begun to do this, with its October 2015 decision to suspend tuition assistance to the University of Phoenix.³¹

Alongside these moves to restrict payments to bad actors, DoD and VA should make education and economic data more transparent, as through the VA's GI

Bill Comparison Tool, to help shape decisions by veterans and their families about where to pursue higher education. VA efforts to encourage and support further utilization of this incredible benefit – which offers a gateway to the American middle class for those who use it – should continue. And, to the extent possible, DoD and VA should partner with the best universities, colleges, and training programs to expand and replicate best practices and support the expansion of educational opportunity that will lead to better long-term outcomes for veterans and their families. Such moves would align well with Defense Secretary Ashton Carter's "force of the future" initiative, which puts a premium on education and training of current service members. DoD should pursue expanded partnerships with the higher education sector, including programs which pair professional military education with civilian higher education to build the human capital of the military.

These issues will remain of vital importance to the health of the AVF and its ability to recruit and retain talent to provide for America's national security, long after the post-9/11 wars fade. Over the next four years, the U.S. military will likely complete its downsizing and return to a regular, cyclical rate of recruiting and discharges for service members. The government must maintain its current active approach to transition and economic opportunity, aiding the transition process through programs such as TAP and support for veterans' economic opportunity.

More important than these programs, however, the government must recognize that the true engine of economic opportunity for veterans is the private sector, not government. The private sector employs more than 98 percent of the nation's 156 million civilian workers.³² No government program can succeed without fully leveraging private sector employers, because these employers are the entities that employ veterans after service, not the government.

The government must do more to partner with private-sector employers to facilitate effective transition and onward movement by service members. However, current ethics and acquisition law and policy impede the government's ability to partner with both private- and nonprofit-sector entities, even for benevolent or important purposes such as this.

The next administration must eliminate those barriers to more effectively leverage the private sector for support of departing service members and their families. The next administration should also actively encourage and support private-sector coalitions that prioritize veteran employment, such as the Veterans Jobs Mission that was created in partnership with the White House's Joining Forces initiative, the Veterans on Wall Street initiative, and others. Alongside these transition paths that lead directly into the workforce, the next administration must also do more to improve the transition paths that lead through higher education. And, to the maximum extent possible, the department should invite select private- and nonprofit-sector partners who demonstrate success to help with the transition process even before discharge, such as through apprenticeship and training programs that occur between the time a service member decides to get out and his/her discharge.

In pursuing these efforts, the government must recognize the economic and national security value of supporting departing service members. Successful veterans contribute to the economy and their communities; a successful veteran population will also bolster long-term perceptions of military service and its value to individuals and communities, creating a virtuous cycle of enlistment, success, and encouragement to future generations.

2. HEALTH CARE

Few notional obligations are more central than that of the government to provide health care (of all kinds) to those wounded, ill, or injured in the line of duty. The government runs a vast network of health care facilities, operated by several different agencies, to care for the nation's 21 million veterans, 2.4 million service members, and their families. The next president will inherit responsibility for this system and the responsibility to care for those who live with the visible and invisible wounds of service.

Access to Health Care

Access to quality health care remains a critical and immediate issue facing the military and veteran community. The VA has struggled to provide necessary medical care to veterans, with wait-time scandals plaguing its health care system – possibly with

The true engine of economic opportunity for veterans is the private sector, not government. The private sector employs more than 98 percent of the nation's 156 million civilian workers.

life-threatening or fatal consequences. A crisis over access to VA health care that began in Phoenix in April 2014 led to the resignation of then-VA Secretary Eric Shinseki the next month, and to the passing of the Veterans Access, Choice, and Accountability Act (VACAA) in August 2014.³³ This law greatly expanded the VA's authorities to purchase private health care when it could not see veterans quickly enough, representing a major change for an agency that has historically resisted efforts to privatize or contract out its health services. These access challenges will likely persist for some time. Though the overall veteran population is in decline, the number of VA patients is expected to increase through 2019, driven by simultaneous increase in demand from young and old veterans.³⁴ Since the passage of VACAA, wait times have actually increased, as more veterans have flooded into the system seeking care.³⁵ VA health care remains one of the areas of "high risk" across the federal government, as rated by the GAO, which cited five key areas of concern: "ambiguous policies and inefficient processes, inadequate oversight and accountability, information technology challenges, inadequate training for VA staff, and unclear resource needs and allocation priorities."³⁶

The DoD has also faced challenges in providing medical care to active-duty troops, reservists, military retirees, and their families, which it does through its systems of military treatment facilities and TRICARE contractors.³⁷ In a 2014 review of the Military Health System (MHS) ordered by then-Defense Secretary Chuck Hagel, despite access standards being met, satisfaction with "getting care quickly" came in below civilian benchmarks. Additionally, TRICARE users who were surveyed ranked the MHS below the civilian benchmark across multiple markers of access, including getting needed care, getting an appointment with a specialist, getting care quickly, and getting timely

routine appointments. Like the VA system, the MHS varies in quality of care across the system, with one of the primary recommendations of the 2014 report being to identify and address outliers in the DoD system that fall far below the average.³⁸

The DoD and VA both struggle with data and record management, a problem that leads to inefficient or absent coordination of care, in addition to potentially harmful duplication of treatment across facilities. The adoption of an integrated patient records system will allow for streamlining and coordination of care. These records systems must have interoperability to allow veterans in transition to move easily between DoD and VA, as well as between these public health systems and the private health systems where the majority of military families and veterans obtain their health care.³⁹ Second, both the DoD and VA must identify and prioritize fixing underperforming facilities – both in terms of access and quality – such as the Phoenix hospital that was the impetus for much of the recent VA overhaul. The MHS report recommends rectification of these low-performing facilities and providers as an important initial step in improving the health care system. A third area for improving access to care is the alignment of resources with need. Ensuring that areas with a high concentration and number of veterans are prioritized within the VA system, while still taking into account the needs of veterans in less dense areas, is a difficult but important step to ensure the agency is meeting the needs of all veterans with its resources. Lastly, to aid in long-term progress in the health care system, focus should be put on growing and empowering leaders to continue improvement and holding leaders accountable for performance within both the DoD and VA health care systems.

Beyond these immediate issues and short-term steps, there remain larger, structural questions regarding how best to deliver health care to the large U.S. population of service members, military families, and veterans. These questions include the optimal mixture of public versus private activity to serve this community, and how the enormous DoD and VA health care systems can more efficiently pursue better health outcomes. We separate these strategic questions from the immediate ones and treat them more fully later in this paper.

Mental Health

The “invisible wounds of war” – ranging from normal post-traumatic stress (PTS) to diagnosed post-traumatic stress disorder (PTSD), traumatic brain injuries (TBIs), and suicide – affect a substantial part of the post-9/11 veteran community. More than 2.7 million service members have deployed since 9/11 to Iraq, Afghanistan, or other theaters of war.⁴⁰ As of April 2015, 1,939,959 of these service members had left active duty; of that population who had left active duty or mobilized reserve status, 1,126,173 sought health care from the VA. Within this much smaller and self-selected population of veterans who had left the service and sought VA care, 640,537 (or roughly 23.7 percent of all post-9/11 deployers) have been diagnosed by VA clinicians with some type of mental health issue, including but not limited to PTSD.⁴¹ This is a subset of the much larger population of post-9/11 deployment cohort, but a substantial one that will continue to need mental health support in years to come.

Access to quality health care remains a critical and immediate issue facing the military and veteran community.

Suicide represents the most extreme manifestation of these invisible wounds. Veteran suicide is a complex issue affecting veterans of all generations. Unfortunately, neither the Department of Defense nor VA maintains authoritative data on the total number of veteran suicides, let alone more granular information about their demographics, service histories, medical histories, and lives that might illuminate the complex reasons for these tragic events. However, recent studies suggest that suicide rates are higher among veterans than nonveterans.⁴² Better data exists for current active and reserve service members, as well as for more recently discharged post-9/11 veterans. In the first three quarters of 2014, there were 200 active-duty suicides and 118 suicides of Guard and reserve personnel.⁴³ A recent study of post-9/11 veterans found that the veteran suicide

rate is approximately 50 percent higher than that of comparable civilian populations, about one veteran suicide a day.⁴⁴ A majority of veterans who die by suicide are men, but female veterans have substantially higher rates of suicide per capita. Female veterans die by suicide at six times the rate of the female civilian population, an alarming statistic that may be linked, in some way, to the scourge of military or military sexual trauma. Among women veterans age 18–29, the suicide rate is 12 times that of civilians.⁴⁵ Notably, the suicide rate among post-9/11 veterans is higher among those who have not deployed to Iraq, Afghanistan, or other theaters of war than it is for those who have. However, this data does not take into account the intensity of combat; there is some anecdotal evidence suggesting extremely high suicide rates within units and cohorts that saw particularly intense combat.⁴⁶

The VA spent \$6.6 billion on mental health in FY2014 and plans to spend \$7.1 billion – about 12 percent of its entire \$59 billion health care budget for the year – on mental health in FY2015. These expenditures make VA the largest provider for mental health care and research in the nation, as well as the most significant investor in mental health research. Additionally, the VA spent \$229 million on treatment and research on traumatic brain injury for all veterans in 2014, an estimated \$54 million of which focused on post-9/11 veterans.

Notwithstanding this massive spending, the VA has struggled to meet the demand for veterans' mental health care. Veterans using the VA system have experienced significant problems obtaining timely mental health care. To address this, the VA implemented new mental health provider hiring initiatives, built new health care facilities, and established new contracts for procurement of non-VA mental health care. After the Phoenix VA scandal of 2014, which arose out of long waits for VA health care that were exposed by VA whistleblowers, Congress created the Veterans Choice program, allowing veterans to seek care from non-VA providers when their wait times or facility distances exceeded certain specified goals. However, VA facility construction delays, continued shortages of mental health providers, and concerns about the VA's preferred modalities of mental health care, suggest that the aforementioned solutions do not provide a quick fix.⁴⁷ The VA has also struggled to partner effectively with private and nonprofit care providers, with the net

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effect that funds appropriated for non-VA care under the Veterans Choice program have gone underutilized. Both the DoD and VA have also struggled to fully leverage alternative and innovative therapies, even when such therapies have a base of evidence to support their use. Finally, the entire sector continues to work to reduce the stigma surrounding mental health problems, which often inhibits treatment and translates into bias against those who have sought help. However, surveys suggest that stigma remains a prominent challenge for the veteran and military community and that more can be done by all to further reduce the social barriers to seeking help for mental health issues.

3. CRISIS SUPPORT

Alongside transition and health care, there exists a broader category of support to veterans, service members, and military family members in crisis that will become the responsibility of the next administration. We include four broad areas here: support during deployments; support to wounded, ill, and injured service members; support to caregivers; and support to veterans facing housing or legal crises. These kinds of support are very different, often requiring public and private action tailored to the facts of individual cases. The difficulty of offering such bespoke support and the urgency of the situations for the individuals involved make these issues challenging for even the best-functioning public and private bureaucracies. Because of that, these issues merit inclusion in this agenda and for the next administration.

Support to Wounded/Ill/Injured Service Members and Veterans

As a result of nearly 15 years of war, the United States now has a number of seriously wounded, ill, and injured service members and veterans who will likely require some measure of public-, private-, and nonprofit-sector support for their lifetimes. Thanks to changes in warfare, improvements in body and vehicle armor, and advances in battlefield medicine, the casualty rates and mortality rates from today's conflicts have been low by comparison with Vietnam and World War II.⁴⁸ Nonetheless, the list of those injured or killed in America's post-9/11 wars remains long, and the rolls continue to grow thanks to such things as traumatic brain injury or environmental exposure that manifest themselves long after troops return home.

As of this July, 52,351 individuals have been wounded in action in the post-9/11 conflicts. Of these injuries, there have been 1,645 battle-injury major limb amputations and 327,299 total traumatic brain injuries to include 8,287 in the "penetrating or severe" category as a result of the Global War on Terror.⁴⁹ However, this statistic includes only those traumatic brain injuries diagnosed by DoD during service members' time on active duty and is heavily biased toward injuries in training, not combat injuries. The full extent of TBI within the force will likely never be known. VA claims data of the post-9/11 cohort suggests that, in addition to these combat injuries, hundreds of thousands of veterans are coming home with service-connected injuries and illnesses. The most prevalent medical complaint among post-9/11 veterans is musculoskeletal issues – a catchall that includes everything from injuries during physical training to back injuries from wearing body armor in combat. The second most prevalent medical complaint is for mental health issues; the third most prevalent is for unspecified illness. A number of research reports suggest that long-term illness relating to deployment exposures, including gastrointestinal disorders, skin diseases, and respiratory illness, may be a significant issue for post-9/11 veterans in decades to come.⁵⁰

According to a 2014 survey by the Wounded Warrior Project (WWP), a nonprofit organization with nearly 80,000 members (who, based on this group's

membership criteria, are post-9/11 veterans with service-connected injuries or illnesses), 55.2 percent of wounded, ill, or injured post-9/11 veterans are under 35 years old.⁵¹ Nearly 30 percent of surveyed WWP veterans indicate the need of "aid and attendance of another person because of their post 9/11 injuries and health problems" and "28 percent need more than 40 hours of aid per week."⁵² These veterans report significant life challenges resulting from their service-connected injuries and illnesses. This survey data suggests that as the current cohort of veterans ages, these conditions will require continuing care.

Thanks to changes in warfare, improvements in body and vehicle armor, and advances in battlefield medicine, the casualty rates and mortality rates from today's conflicts have been low by comparison with Vietnam and World War II.

Due to advances in modern medicine, traumatic battlefield injuries are no longer necessarily fatal. However, this creates an imperative for renewed research and support by the DoD and VA to serve wounded, ill, and injured veterans and their families for the duration of their lives. Such support must continue to include the infrastructure that has evolved over the past several years to support the most severely wounded, ill, and injured service members and veterans. Even though the Iraq and Afghanistan wars may have largely ended, and the throughput of casualties is lower, this population cannot afford for DoD or VA to eliminate this infrastructure for the sake of efficiency. Some of the best advances in care for this population have resulted from programs such as the use of care coordinators and command structures to guide troops and families through the complex bureaucratic processes associated with medical evaluation, separation, retirement, and disability assessment. These programs must continue and evolve with this population's needs over time.

As the wounded, ill, and injured population transitions out of the military and into the veteran population, the capabilities that have developed in DoD (such as Walter Reed National Military Medical Center's world-class prosthetics clinic) must transition to or be replicated at the VA. The VA currently operates a handful of polytrauma facilities around the country; these must remain in operation and export their practices and capabilities to other VA facilities where a critical mass of severely wounded, ill, and injured veterans reside. Finally, the government must continue to lead the research community for service-connected issues. DoD and VA already spend more than any other entity on research into PTSD, TBI, prosthetics, and other areas of service-connected medicine. This must continue, and broaden to include other areas of medical inquiry that can anticipate the needs of this generation. DoD and VA should launch a joint, comprehensive, long-term longitudinal study to identify and better understand illnesses and injuries within the post-9/11 cohort, including latent issues that may not present themselves until much later in life, and inform policymakers and clinical leaders for decades to come.

Deployment and Transition Support for Families

The post-9/11 military is a professional force with longer terms of service, on average, than previous generations of the U.S. military. One important trend within this force over time has been the gradual "family-ification" of the force, a direct consequence of its professionalization, increases in compensation and benefits over time, and the longer terms of service. According to the latest DoD demographics report, the active and reserve military had 2,978,341 spouses, children, and adult dependents (living alongside a uniformed military population of 2.4 million).⁵³ Within the military, 51.8 percent of the force was married, and 42.7 percent of service members had children. An important consequence of the shift to an All-Volunteer Force has been the creation of a large military family population that carries many burdens of service too, and for whom there are far fewer government support systems like the VA, especially after service. As post-9/11 veterans leave the service, their families transition to civilian life with them. This transition presents several challenges for families. Reintegrating into civilian society can mean moving

off of a military installation, leaving one's military community, and losing one's identity as a military spouse or child. As VA services focus on individual veterans' needs, family support disappears when service members become veterans.⁵⁴ Additionally, there are over 5 million military and veteran caregivers, predominantly consisting of spouses and parents. This role is exceptionally challenging for the 1.1 million post-9/11 caregivers, who tend to be younger, employed, more isolated, and dealing with more mental health and substance abuse issues compared with pre-9/11 and civilian caregivers.⁵⁵

If U.S. military engagement continues on the same trajectory in the short term, the nature of deployment support will remain important, as the United States will still have service members deployed in harm's way, even if such deployments fade from public consciousness. The scale of operations in Iraq and Afghanistan meant that large units deployed for periods typically ranging from six months (Marine Corps, Navy, and Air Force) through 12 months (Army). Of those who deployed, 45.6 percent did so two or more times, and 2 percent of service members deployed more than five times.⁵⁶ The deployment tempo had significant implications for families, including an increased need for child care resources (as the non-deployed spouse is effectively single-parenting) and post-deployment reintegration counseling services. Over the course of the past 15 years, a number of programs were revitalized or created to support families during deployments, including grants for respite child care through Armed Services YMCAs, financial planning, counseling services, peer-to-peer support programs, and training on effective coping mechanisms under stress.⁵⁷

Recent operations, such as Operation Inherent Resolve (targeting ISIS)⁵⁸ and Operation United Assistance (in support of Ebola eradication in West Africa),⁵⁹ as well as the political propensity to use special forces as a surgical tool of foreign policy,⁶⁰ mean that the nature of deployments is changing, both for service members and for their families. These deployments typically consist of much smaller units than the large-scale brigade combat teams deployed in Operation Iraqi Freedom and Operation Enduring Freedom. Additionally, these operations may involve shorter deployments at a higher tempo, altering the

impact on families. While the limited scope of operations means that a smaller portion of the active, Guard, and reserve communities may be affected by deployments than in years past, their needs may become more acute as their experience becomes less common, even within the military community. It is important that the next administration bring attention to the continued sacrifices of both uniformed personnel and their families and that resources be provided for family support programs.

As conflicts overseas have been drawing to a close and budget issues continue to plague the DoD, support to military families is an issue many fear will fade from view. There is a general sense that appropriations to support base operations, military housing, and family support are under fiscal pressure and that they are likely to decline further in years to come as the large-scale deployments of Iraq and Afghanistan fade away. This sense is fueled by news stories regarding planned cuts to defense commissaries and other services that support military families.

More broadly, military family advocacy groups have expressed concern over proposed changes to military pay and benefits recommended by the Military Compensation and Retirement Modernization Commission (MCRMC) and cost-saving proposals made by the DoD. These include changing DoD's current retirement model from a "defined benefits" pension paid at 20 years of service to a "defined contribution" system that looks more like a civilian 401(k) retirement plan, and making changes to the military's TRICARE health insurance system, among others. There is a fierce backlash against proposed changes that groups feel violate the "social contract" made with those who join the armed services, specifically surrounding diminished basic pay increases, changes to the basic allowance for housing, and the pilot program to privatize the commissary system.⁶¹ However, two key recommendations have received widespread support from advocacy groups. First, the MCRMC recommended improving the access to childcare on military installations to ensure need is met within 90 days, reducing the current waitlists that prevent many military families from having access to affordable child care. The second recommendation is that a nationwide military student-identifier be implemented and used to track academic

progress of military dependents and better identify the particular challenges they face. Both of these recommendations reflect an awareness of the toll that 14 years of conflict has taken on military families, as well as the need to continue supporting these families in meaningful ways that complement military readiness.

Transition and post-service support will continue to matter for military families into the foreseeable future.

Transition and post-service support will continue to matter for military families into the foreseeable future as well. By contrast with its support to service members, government support to military family members ends on the day of discharge. With few exceptions, the VA's statutory mandate does not extend to provide health care and benefits to military spouses or children. Likewise, most federal hiring programs, contracting preferences, and other veteran-support programs do not extend to veteran families,⁶² despite evidence that spouses endure many hardships associated with military service, including mental health stress and economic difficulty, and that these difficulties persist after service. And to the extent that spouses or children are included in programs, such as transition assistance classes, they are added on a space-available basis. Military family needs do not stop at discharge; they continue for years after transition. The next administration should consider further expanding certain public-sector programs to support military spouses and children after separation, such as hiring preferences or TAP or post-service access (on a subsidized or no-cost basis) to TRICARE during the critical first 12 to 24 months after transition when veterans face the greatest economic uncertainty. The next administration should also commit to maintaining the transferability of the Post-9/11 GI Bill for military family members. Transferability is a vital benefit that plays a key retention role; it also opens the gateway to America's middle class to millions of family members whose lives of service have made it more difficult to set aside funds for higher education.

Alongside these governmental efforts, the private and non-profit sectors can continue their efforts to support military families too. The private sector and nonprofit sector can pick up the baton to support these families with transition education, hiring, health care, and economic support programs that fill the gap left by the absence of government support. There is a particular role for the higher education sector to play in helping military family members fully leverage GI Bill benefits transferred from service members to family members. These benefits currently go underutilized; greater support and encouragement can help hundreds of thousands (if not millions) of military family members through funded pursuit of higher education.

Support to military families will remain an immediate issue as long as the United States has forces deployed around the world – which is to say for the foreseeable future. However, in many ways the immediate issues surrounding support programs are linked to broader questions regarding pay and benefits, housing support, health care, and post-service support for military families. These larger questions are important too, because of the extent to which today’s force includes families, and they overlap with important questions regarding the structure and sustainability of the All-Volunteer Force itself, discussed further in this paper.

*Caregiver Support Resources*⁶³

A significant number of wounded, ill, and injured service members and veterans require part- or full-time care from a caregiver.⁶⁴ It is estimated that there are at least 5.5 million individuals caring for service members and veterans of all eras, and 1.1 million individuals providing care for wounded, ill, and injured post-9/11 service members and veterans.⁶⁵ Demographically, caregivers for this latter cohort differ greatly from caregivers of past eras. Whereas caregivers for civilians and pre-9/11-era veterans tend to be children of the care recipient, caregivers for post-9/11 veterans are more likely to be spouses or parents of the recipient.⁶⁶ The long-term costs associated with caregiving are significant, too. According to a recent RAND study, the value of duties performed by post-9/11 caregivers can be estimated at roughly \$3 billion annually. At the same time, the burden of caregiving, as measured in the costs of lost productivity among post-9/11 caregivers, total roughly \$6 billion each year. These trends have long-term implications, as

the increased strain of caregiving on a marriage makes the caregiving relationship susceptible to divorce and as parents serving as caregivers begin to face their own age-related health issues. Further, military caregivers across the spectrum face broader impacts of caregiving on their own health, mental health, and finances, with increased rates of depression, work absenteeism, and difficulty accessing health care (as the wounded, ill, and injured veterans are covered by the VA but their caregivers are more than likely not).⁶⁷

Given the dual sacrifice many of these caregivers have made – first during the period of war, and then as caregivers for the effects of war – there is a social imperative to provide for military and veteran caregivers. The federal government can assist by expanding health care access and increasing awareness of options available to caregivers under the Affordable Care Act, as well as the VA’s authorities to provide support to caregivers. Both the government and the nonprofit sector can provide caregivers with respite care, including temporary caregivers (to include nurses and nursing assistants), as well as support for nonmedical care (such as home care and errand-running). Employers can also build employee assistance programs and flexible workplaces that enable caregivers to better meet the demands of both the workplace and their caregiving responsibilities.⁶⁸

Homelessness

Near the beginning of the Obama administration, then-VA Secretary Shinseki announced a VA plan to end veteran homelessness by 2015. Between 2010 and 2014, annual point-in-time (PIT) counts indicated that veteran homelessness went down by 33 percent, thanks in large part to billions of dollars supporting homeless veterans with housing, health care, job training, and support for vouchers jointly offered with the Department of Housing and Urban Development (HUD).⁶⁹ The most recent Annual Homeless Assessment Report accounted for 578,424 homeless individuals, including 399,113 in residential programs and 179,311 in unsheltered locations.⁷⁰ Of these, 49,933 were veterans – an 11 percent decrease from the 2013 PIT count. Within the current homeless veteran population, 4,722 (or 9.5 percent) were female.

The size and persistence of the homeless veteran population, as well as structural problems like a shortage of affordable housing, make it unlikely that the nation will reach “hard zero” in 2015 or 2016. In recognition of that,

and alongside other developments in thinking about homelessness, a number of public, private, and non-profit leaders have articulated a new goal: “functional zero.”⁷¹ This goal contrasts with the “hard zero” goal by focusing on the capacity of the community system to house homeless people, rather than just the counting of homeless individuals on the streets. Doing so accounts for a highly dynamic homeless population (including veterans) that is constantly in geographic, demographic, and economic flux. The “functional zero” goal sets forth a formula: “At any point in time, the number of veterans experiencing sheltered and unsheltered homelessness will be no greater than the current monthly housing placement rate for veterans experiencing homelessness.”⁷² In practice, this definitional shift helps focus public-, private-, and nonprofit-sector attention on the broader system of housing, enabling better decisionmaking about how to allocate resources for more efficient and effective housing solutions. To date, a number of communities have embraced “functional zero” as their goal, including Washington, Los Angeles, Denver, Phoenix, and New Orleans. Many of these communities evaluate their progress toward “functional zero” using publicly available, online dashboards that can inform policymakers and community leaders about their efforts.

It is a tragedy that any man or woman who has worn this country’s uniform should sleep on the streets, unable to provide shelter, or worse, unable to battle substance abuse or mental health problems that may relate to service. For a variety of complex reasons, it may never be possible to immediately and permanently house every veteran and eliminate veteran homelessness forever. However, the government’s herculean efforts over the past six years, led by VA and HUD, have shown the ability to make progress. These programs must continue, at their current scale, to sustain these successes and sustain the nonprofit organizations that depend on government support (and cannot necessarily obtain this support from the private or philanthropic sectors) to provide these services. Beyond this continued funding, the government must continue to expand its partnerships with the private and nonprofit sectors in this area. These partnerships will take many forms, from the provision of excess VA land on favorable terms to organizations combating veteran homelessness (as in Los Angeles), to less formal partnerships such as the linkage of

supporting housing organizations to VA clinical resources through handshakes and agreements to cross-refer veterans. Finally, the next administration must encourage the kind of community redesign efforts that are at the heart of “functional zero” – looking at how communities can work more efficiently to immediately house those in crisis and address systemic housing supply and demand problems.

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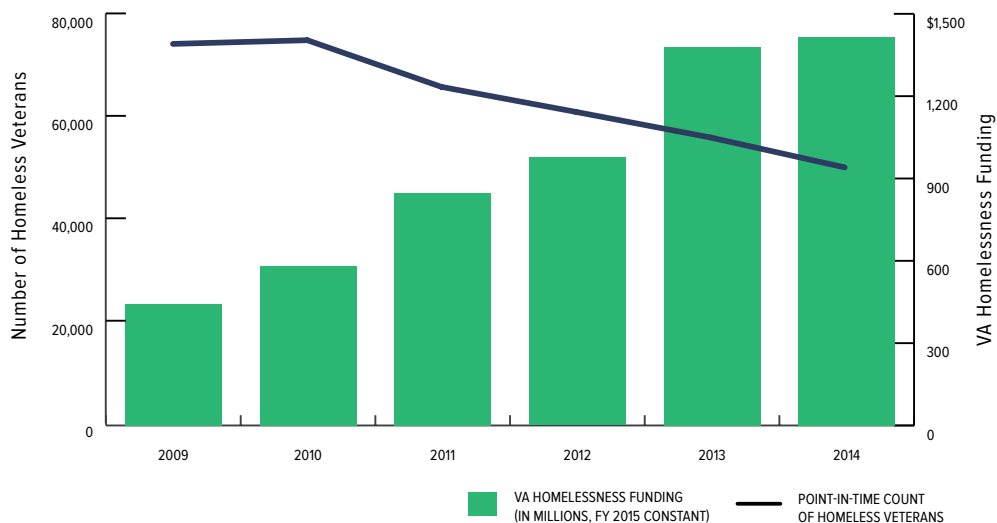
4. LEGAL SUPPORT

Legal issues present a particularly difficult obstacle to veterans struggling in civilian life, often because such issues are inextricably intertwined with economic issues, substance use, mental health issues, or criminal justice system involvement. Because of the eligibility criteria for veterans’ health and benefits programs codified in U.S. law, legal issues can often impede veterans from getting care that might help them overcome these problems, creating a catch-22 for many who are the most in need. Three areas of legal activity belong on the agenda for the next administration: criminal justice, support to veterans with “bad paper,” and access to veterans’ support and benefits. In each of these areas, legal support has a “force multiplier” effect, helping veterans avoid worse outcomes or helping them access support and benefits, all far greater in value than the cost of the legal services or intervention.

Criminal Justice and Veterans Courts

According to the most recent study by the Justice Department (using data now more than 10 years old), veterans constitute a significant part of the federal and state prison populations, although the incarceration rate for veterans is lower for all ages except veterans ages 35–54. Adjusting for age, veterans

FIGURE 4: POINT-IN-TIME COUNT OF HOMELESS VETERANS VS. VA AND HUD FUNDING FOR VETERAN HOMELESSNESS



have an incarceration rate approximately 10 percent lower than the rate for nonveterans.⁷³ The data also shows a long-term decline in both the number and percentage of veterans who are incarcerated, reflecting shifts in the veteran population and society as a whole. And, notably, the latest Justice Department data finds no causal link between military service and subsequent criminal justice involvement or substance abuse.

Notwithstanding this generally positive story about the overall veteran population, a number of communities have seen veterans run afoul of the law within their jurisdiction, often for relatively minor offenses. Out of a desire to help these veterans and conserve scarce law enforcement resources, many communities have begun veterans courts programs.

The first veterans courts, created in 2008 and modeled on substance abuse and mental health treatment courts, offer an alternative to incarceration for veterans whose offenses are believed to be associated with combat stresses, such as PTSD/TBI.⁷⁴ Typically a treatment program is offered in lieu of a prison sentence, to help veterans rehabilitate and receive the treatment they need. Veterans courts programs use a combination of tools to facilitate recovery, including regular court appearances, drug

testing, and mandatory treatment sessions.⁷⁵ These courts have shown success in reducing recidivism and aiding veterans in breaking patterns of substance abuse through effective treatment.⁷⁶ These courts also work in combination with the VA to coordinate treatment and often pair veterans with a veteran mentor to provide support and guidance throughout the process.⁷⁷ At last count, there were more than 220 such programs across the United States, most operating as a partnership of the local judiciary, law enforcement agencies, prosecutors and public defenders, lawyers, and veterans agencies, including the VA's hospitals and clinics.

... legal issues can often impede veterans from getting care that might help them overcome these problems, creating a catch-22 for many who are the most in need.

By most accounts, these courts are working as designed, diverting veterans into treatment or support programs so they avoid long-term incarceration or criminal justice system involvement. The courts also conserve scarce resources at the municipal and

county level, because these diversion programs are more efficient than incarceration. More research is needed, however, to determine the efficacy rates for these interventions and the factors that make some programs work better than others. At a national level, the federal Bureau of Justice Statistics should update its statistical survey of state and prison populations to determine the current extent of the incarcerated veteran population, given the enormous change that has taken place within the veteran population since 2004. At a local level, communities should continue to invest in these programs, which efficiently divert veterans from long-term justice system involvement. The VA should also continue to partner with local, private, and nonprofit organizations to support these courts however possible, recognizing that they can have a positive impact on long-term veteran outcomes.

“Bad Paper” Discharges

Veterans who receive “other than honorable” or “dishonorable” discharges from the armed services may not be eligible for any of the benefits associated with their veteran status or for services offered by the VA. When transitioning to civilian life, many of these veterans struggle but are unable to receive the support they need, increasing the likelihood that they will face homelessness or incarceration. The lack of support can place the burden of aiding transition solely on their communities. Substance abuse, driving under the influence, missing duty, or insubordination are all legitimate grounds for military discipline – but they can also result from the stresses of service.⁷⁸ The reasons for receiving “bad paper” can vary greatly, with many veterans from the Vietnam cohort having faced dishonorable discharge for what is now recognized as PTSD. In recent years, the DoD has allowed such veterans to challenge their discharge status; however, it can be exceedingly difficult to provide sufficient proof, and even successful challenges do not erase the years of stigma and struggle associated with a “DD 214.”⁷⁹ “Bad paper” has become a growing issue for the post-9/11 cohort, as misconduct discharges from the Army have increased by over 25 percent since 2009, particularly at large bases that are home to combat units.⁸⁰ Many combat wounds are unseen, and may not be detected until they manifest themselves in some behavioral incident; DoD must be vigilant in assuring that those suffering are

not abandoned. It is critical that the ramifications of “bad paper” are understood and that greater care is exercised in discharging service members.

Access to legal services can make a difference for veterans with “bad paper.” They can contest the justness of the discharge itself in certain situations, such as when it was issued under old policies (such as “don’t ask, don’t tell”) or where the underlying circumstances relate in some way to military service. In fall 2014, then-Defense Secretary Hagel directed the boards that oversee the correction of military records to take into account whether a veteran had PTSD when evaluating misconduct that resulted in a “bad paper” discharge. In these proceedings to correct discharges, legal representation can make a decisive difference, because the burden of proof rests entirely on the veteran, and he/she must overcome a “presumption of regularity” for discharges that is difficult to do in practice.

Likewise, legal representation can make a difference for veterans seeking care and support from the VA. The VA’s statutory and regulatory mandate extends generally to veterans whose service was “under conditions other than dishonorable.”⁸¹ Although the VA has no authority to change or upgrade a discharge, it can itself look at the “character of service” for a particular veteran to “assess the entire period of the claimant’s enlistment(s) to assess the quality of the service and to determine whether the individual is deserving of veterans benefits.”⁸² As in discharge upgrade proceedings, in “character of service” determinations, legal representation makes a difference. Veterans represented by counsel, or assisted by counsel in the development of their case, have a substantial advantage in a highly legalistic process.

Claims Backlog

Like access to health care, access to veterans benefits remains a stubborn problem affecting the veteran community. This problem has been exacerbated by the dramatic increases in the rate of veterans filing claims for VA benefits over the past several years, in compared to rates in previous decades. Since 2010, reducing the VA’s disability claims backlog (defined as claims pending more than 125 days) has been a key priority of the VA, with the goal of eliminating all backlogged claims by 2015.⁸³ After a concerted push

from the VA, the backlog declined from over 600,000 claims in March 2013 to less than 100,000 in August 2015, its lowest levels since the VA began tracking such data in 2007.⁸⁴ As of September 26, 2015, the backlog had fallen even further, with 75,444 claims pending; a processing rate of approximately 5,800 claims a week would be necessary to clear the slate by 2016.⁸⁵

As the VA has made progress on reducing its claims backlog, it has created a smaller but potentially more difficult appeals backlog. VA's backlog of claims appeals has mushroomed during this period, from 181,300 in January 2010 to 319,016 in October 2015, with the agency taking years to adjudicate the average claims appeal.⁸⁶ Critics allege that this surge in appeals reflects a decision to emphasize speed over accuracy in the effort to reduce the claims backlog.⁸⁷ However the VA's accuracy data suggests the appeals backlog growth results from a more complex set of factors, including pursuit of additional compensation by veterans, a process that resets itself each time veterans submit new information, and extremely complicated (some might say Kafkaesque) appeals procedures that make cases difficult to adjudicate in a timely manner. The appeals backlog will be, in many ways, harder to address than the claims backlog because of these factors, and the relative lack of resources afforded the appeals system (versus the claims system itself).

The appeals backlog will be, in many ways, harder to address than the claims backlog.

At the height of its efforts to combat the claims backlog, the VA made progress by transforming its computing systems, fast-tracking simple claims, and instituting mandatory overtime and other surge efforts, among other things. These actions succeeded in getting the backlog under control. The next administration must continue to keep an eye on this backlog as an indicator of veteran access to government benefits and consider using these tools again if needed. Similarly, the government must anticipate future waves of claim activity from future cohorts of veterans. The current backlog resulted from parallel

waves of claims filed by older veterans of the Vietnam and previous eras, and younger veterans of the post-9/11 era. These waves were predictable, and the VA can do more in the future to respond quickly to escalating demand before it reaches crisis levels. Similarly, the VA must continue and expand efforts to transform its benefits systems, such as by streamlining systems, combining DoD and VA disability evaluations wherever possible, and linking VA's disability systems to those run by the Social Security Administration to create even greater interagency and societal synergies. These transformative efforts should potentially include redesign of the current VA disability appeals system, which produces untenable outcomes for both veterans and the agency. Justice delayed is justice denied for many veterans; the system must be redesigned to produce faster adjudications with greater transparency and accuracy.

B. Operational and Medium-Term Issues

Alongside the immediate issues that will face the next president and his/her team, a number of larger, more strategic issues will also demand attention over the next four years. These include deeper questions about how to restructure the VA and DoD health and benefits systems to more systematically address access and quality issues, as well as much broader questions about the sustainability and design of the future military force. Although some political consensus exists about the immediate issues – both as to the problems and many of the solutions – far less political consensus surrounds these strategic questions. On some of these, such as the optimal design for veteran health care, disagreement reflects broader political division over how best to design national health care. The following section outlines an agenda for these areas; where appropriate, we sketch competing alternatives that have emerged from different political perspectives.

1. VA REFORM

The VA is the second-largest federal agency by budget and headcount, with responsibility to support more than 21 million veterans. This agency has evolved over the nation's history from a tiny collection of fragmented pension and compensation programs in the late 18th and 19th centuries to the nation's largest single-payor health care system and benefits

bureaucracy. With that growth has come growing pains, though, including the VA's difficulties with providing timely access to health care and benefits over the past several years. Beyond applying more leadership or resources to fix the VA, the next administration will have the opportunity to reform (or transform) this agency, and its approaches to serving veterans. The section below outlines the most prominent of these choices facing the next administration.

VA Health Reform

On one level, remedying access to VA health care is an urgent issue that can be fixed through addition of more clinical personnel and procurement of more private-sector care. But on a deeper level, the existence of chronic access problems within the VA reflects deeper structural issues that will likely worsen over time. These structural issues arise from changing veteran demographics, changes in the U.S. health care market (and the behavior of veterans and family members in that market), an aging and frayed VA infrastructure, mismatch between resources and requirements, and questions about how best to optimize the blend of public and private activity to serve veterans.

Since the 2014 scandal involving access to the VA's medical center in Phoenix, two main paths have emerged for reform of the VA health system. The first has been advanced by the VA under the auspices of its "MyVA" plan for making the VA more customer-centric, including a new set of VA health reform proposals released in November 2015. A competing vision has come from the right, in the form of plans to radically transform the public-private mixture of VA health care. There have been two main permutations of this option: the VA Choice Act passed by Congress in September 2014, which directed the VA to greatly expand its procurement of health care from the private sector to mitigate access challenges, and more radical plans, such as those advanced by Concerned Veterans for America, that would change the fundamental structure of VA and direct that increasingly more care be provided by private providers.

The "MyVA" Option

One path toward better outcomes for VA patients is to fully resource and improve the existing VA structure and delivery model. Components of this strategy include further investments in human capital (doctors, nurses, and case managers, for example), infrastructure, and technology to fully identify and meet patient demands. This option continues to leverage the vast economy of scale brought by the VA as an integrated health care system, as well as the value of this integrated system for care coordination. In this model, the onus for care remains primarily with the federal government. Although VA would continue to contract out for certain services, such as specialty care when it cannot timely provide an appointment, the VA would itself remain the primary care provider in this model.

The VA launched its "MyVA" initiative in September 2014 to optimize veteran experience while increasing the efficiency of the overtaxed VA system and reform the system while it faces enormous strain from inside and out. The five goals or "areas of improvement" for the MyVA system as outlined by the VA include "improving the veteran experience, improving the employee experience so they can better serve veterans, improving internal support services, establishing a culture of continuous improvement, enhancing strategic partnerships."⁸⁸ Ultimately, the MyVA approach focuses on improving the veteran experience in order to drive greater utilization of VA services by veterans, with greater efficiency and efficacy, in order to improve veterans' quality of life.⁸⁹ In parallel, and under intense Congressional pressure, the VA has also moved to improve its system for purchasing care. In November 2015, the VA released its plan to consolidate contracting programs, improve coordination of care, and better share data between public, private and non-profit providers, among other facets.⁹⁰

However, significant questions remain as to the linkage between the veteran experience and veteran outcomes such as longevity and wealth, and whether the MyVA reforms will do enough to fix a VA under such enormous strain. Critics also question the VA's ability to reform itself, especially given its slow progress thus far implementing the

Choice Act reforms. It also may be difficult to measure the reforms' success, let alone do so over the short term while veterans are most anxious to see reform. The VA's vision of improved governance will not only require adequate resourcing, but further require mechanisms for evaluating outcomes and making structural adjustments where necessary.

The Privatization Option

The other broad option for VA health reform entails outsourcing part or all of veteran health care to the private sector.⁹¹ A significant chunk of the VA's health care budget – approximately 10 percent, or \$5 billion of \$50 billion – goes to purchase services outside of VA facilities for veterans. However, in the wake of the Phoenix scandal, Congress and veterans advocates demanded that more be purchased outside the VA to alleviate long wait times or other issues. The privatization option would continue this evolution, shifting a far greater proportion of the VA's health care for 6.5 million veterans to the private sector. Under one such plan, the majority of VA health care would come to be provided by the private sector, with the VA paying for such care like an insurance company.⁹² The remaining VA health care bureaucracy would focus on research, education, and training for clinical personnel and running special programs like those for homeless veterans.

Historically, the VA's health care system has focused primarily on the delivery of medical care. Unlike other large federal agencies, it retained most services and positions during the “reinventing government” movement of the 1990s and 2000s, during which other agencies such as DoD outsourced significant parts of their work to the private sector. The VA health system employs nearly 300,000 people spread among 150 medical centers and more than 800 outpatient clinics across the country. Until recently, the VA only procured care from the private sector by exception, such as when it needed to provide specialty care to a veteran somewhere that no VA specialist existed, or in emergencies.

Proponents of increased veteran choice or privatization of veteran health services argue that the current VA health enterprise cannot reform itself enough to serve veterans and that the best solutions to providing timely, quality health care lie in the private sector. In addition, the imposition of competitive pressure to the veteran

health care market will drive better outcomes, as well as lower costs, by forcing the VA to compete with other providers. Further, by expanding available options to include care provided in the private sector, veterans will acquire more agency within the system to make decisions on their own, informed by the relative cost, quality, and availability of any given health care option. In doing so, Veterans Health Administration (VHA) patient volume will likely decrease,⁹³ particularly as veterans with nonservice-connected ailments (who make up the majority of the VA patient population) seek care elsewhere. This would enable the VA to focus its resources on care for the population at the heart of its statutory and historical mandate: those veterans with service-connected injuries or illnesses, indigent veterans, and those with service-related medical issues where VA excels, such as prosthetic care or mental health care.

The concept of privatizing veteran health care has drawn significant criticism, particularly by veteran service organizations⁹⁴ as well as the current VA Secretary Bob McDonald.⁹⁵ Among the many concerns with privatization are an insufficient focus on patient outcomes (versus efficiency and cost savings), a lack of private-sector medical expertise and experience regarding service-related health issues, and concerns about who will coordinate veterans' care in a fragmented marketplace. In addition, broader questions arise about what will happen to the VA health care enterprise if it loses patients and funding to the private sector, and how that might affect VA health research or clinical training.

The broader questions regarding access to veterans health care have drawn a wide array of answers from different parts of the political spectrum. Republican leaders in Congress, and vying for the presidency in 2016, have publicly stated their support for varying levels of privatization as the cure for the VA's ailments.⁹⁶ On the Democratic side, key Congressional leaders and presidential candidates have signaled their support for continued reform of the VA, dismissing calls for further privatization of the agency.⁹⁷ Although it's likely that either side will moderate its position upon assuming office, given the challenges of governing (versus campaigning), there appears to be such a sharp contrast in both parties' rhetoric with respect to VA health care reform that the election might represent a sharp choice for voters on this subject.

Other Options for VA Reform: Changes to Eligibility, Changes to the Cost Structure

Alongside the broad choice framed above, at least two other broad options deserve mention. One includes adjusting or narrowing the current scope of VA care to better align supply and demand; the second involves changes to the cost structure to better leverage the rest of the health care market, or at least make choices by veterans between systems cost-neutral.

Scope of Eligibility as a Lever. Currently, the scope of eligibility for VA health care is broad. Service members who served at least 180 days on active duty and left the military under any condition other than dishonorable may be eligible for VA health care.⁹⁸ The VA health care system originally provided care only for service-connected or combat-related injuries and conditions; it subsequently expanded to provide health care for indigent veterans as well. However, during the second half of the 20th century, access expanded to include all eligible veterans and began to include the provision of primary and specialty care to veterans for conditions that were not service-connected. Today, nearly all of the nation's 21 million veterans are eligible for VA health care. However, whether they can enroll in the VA health care system, and get access to care, is a complicated question that depends on where in VA's priority system they may be placed based on their having a service-connected condition, wartime service status, and income, among other factors, as shown in the accompanying text box.

Over the past decade, the VA has struggled with whether to enroll veterans toward the bottom end of this spectrum, in Priority Groups 7 and 8. In January 2003, then-VA Secretary Anthony Principi closed the doors of the VA to Priority Group 8 veterans in order to maintain "its focus on the health care needs of its core group of veterans – those with service-connected disabilities, the indigent and those with special health care needs."⁹⁹ In March 2009, shortly after the Obama administration took office, then-VA Secretary Shinseki proposed reopening VA health enrollment to veterans without a service-connected condition in Priority Group 8.¹⁰⁰ Such an expansion found political favor on Capitol Hill as well, with Congress directing the VA to open its rolls to Priority

Group 8 veterans in certain circumstances.¹⁰¹ As these historical precedents show, the VA and Congress have, over time, adjusted the aperture of VA health care to include or exclude veterans based on policy preferences and available resources. According to a recent study, "59 percent of the current unique VHA patients do not have a service-connected disability,"¹⁰² indicating that there are potential efficiencies to be gained by narrowing the scope of access. Future VA leaders and congressional leaders may choose to do so as well, particularly if VA resources remain flat (or decline) and there is a desire to focus the VA health care system on those veterans with service-connected ailments or no other health care options based on their means.

Changes in Cost Structure. A second pathway to reform involves changing the cost structure of the VA health care system. This would sidestep the MyVA-versus-privatization debate to some extent by focusing on making the current system more sustainable from a fiscal perspective and better harmonizing the VA health care system with the larger health care market. One idea involves shifting more health care costs to veterans, or their private insurers, to allow the VA to leverage the fact that most veterans have alternate health care coverage they can use to offset VA health care costs. This idea has particular resonance in the wake of the Affordable Care Act, because of the ability that law gives veterans to procure private health care coverage that could be then used to purchase VA health care for nonservice-connected conditions. A second idea involves adjusting costs for veterans seeking VA health care, to harmonize the cost of VA health care with the out-of-pocket costs for veterans seeking care elsewhere. Currently, the VA's heavily subsidized system stands out in the health care market because it offers quality health care at very low (or no) out-of-pocket cost.¹⁰³ This cost inequality drives health care choices by veterans in many ways that are not always optimal from an efficiency or care quality standpoint for veterans, the VA, or society. Consequently, some have argued that cost uniformity would help veterans make choices on better grounds, such as quality or availability, versus cost.¹⁰⁴ However, insofar as the current VA cost structure reflects a long-standing desire to provide low-cost health care to veterans, particularly those with service-connected ailments, this idea is unlikely to gain political traction.

FIGURE 5: VA PRIORITY GROUPS

Priority Group 1:

- Veterans with VA-rated service-connected disabilities 50 percent or more disabling
- Veterans determined by VA to be unemployable due to service-connected conditions

Priority Group 2:

- Veterans with VA-rated service-connected disabilities 30 percent or 40 percent disabling

Priority Group 3:

- Veterans who are former prisoners of war
- Veterans awarded a Purple Heart medal
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans awarded special eligibility classification under 38 U.S.C. § 1151, “benefits for individuals disabled by treatment or vocational rehabilitation”
- Veterans awarded the Medal of Honor

Priority Group 4:

- Veterans who are receiving aid and attendance or household benefits from VA
- Veterans who have been determined by VA to be catastrophically disabled

Priority Group 5:

- Nonservice-connected veterans and noncompensable service-connected veterans rated 0 percent disabled by VA with annual income below the VA’s and geographically adjusted income limits
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid programs

Priority Group 6:

- Compensable 0 percent service-connected veterans
- Veterans who served in the Vietnam and the first Persian Gulf War
- Veterans who served in a theater of combat operations after November 11, 1998, as follows:
 - » Currently enrolled veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge.
 - » Combat veterans who were discharged between January 2009 and January 2011 and did not enroll in the VA health care during their five-year period of eligibility have an additional one year to enroll and receive care. The additional one-year eligibility period began February 12, 2015, with the signing of the Clay Hunt Suicide Prevention for American Veterans Act.

Priority Group 7:

- Veterans with gross household income below the geographically adjusted income limits for their resident location and who agree to pay copays.

Priority Group 8:

- Veterans with gross household income above the VA and the geographically adjusted income limits for their resident location and who agree to pay copays

Source: Drawn from http://www.va.gov/HEALTHBENEFITS/resources/priority_groups.asp

2. BENEFITS REFORM

The majority of the VA's spending – \$95.3 billion (56 percent) of \$168.8 billion requested for FY2016 – goes to fund veterans benefits programs such as disability compensation, survivor pensions, and GI Bill educational benefits.¹⁰⁵ For the most part, these benefits programs represent mandatory spending; once a veteran's entitlement is determined, such as through the adjudication of a service-connected disability, the VA must pay the benefits as a matter of law, with little or no discretion. Currently, 4.1 million veterans receive VA disability compensation, with nearly 12 percent of these veterans rated at 100 percent disabled. In addition, 295,368 veterans receive VA pensions by virtue of their service and economic status; 370,990 veteran spouses receive dependent indemnity compensation from the VA. Although the veteran population has declined sharply over the past decade, the number of veterans receiving compensation has increased, reflecting twin waves of claims by Vietnam-era veterans reaching retirement age and post-9/11 veterans returning home from service. Currently, veterans seeking VA disability claim, on average, more than eight disabling conditions, as compared with the one or two disabling conditions claimed by World War II veterans.¹⁰⁶

Because of the scale of these programs in terms of beneficiaries and dollars expended and the potential value they represent if leveraged to produce better outcomes for veterans and the VA, a number of reform ideas have surfaced over the past several years to reshape the veterans benefits system. Some focus on cost savings and fiscal responsibility, such as through reducing fraud in the system; others focus on leveraging the benefits to drive better outcomes, such as by incentivizing wellness for veterans receiving disability compensation.

Arguments against the current benefits structure target the label of “permanently disabled” for conditions that are treatable – and that, when treated, will increase the veteran's quality of life. Further, the current structure of the VA claims process incentivizes veterans to claim disability and further adjust their disability rating upward over time. Critics indicate that the focus of the current system is not rehabilitation and reintegration – that instead,

the system pays veterans “to stop working.”¹⁰⁷

Indeed, some evidence suggests that the current VA disability system incentivizes veterans to leave the workforce.¹⁰⁸ Others state that “to some degree, this philosophy encourages veterans to see themselves as incapacitated.”¹⁰⁹ Additionally, some experts highlight that if the provision of benefits is supposed to increase positive outcomes for veterans in terms of both health and wellness, the current system fails to achieve that because of the sharp separation between the Veterans Benefits Administration (VBA) and the Veterans Health Administration (VHA), the VA's benefits and health care bureaucracies. For example, currently, veterans receiving benefits for PTSD through the VBA are not necessarily encouraged or incentivized for treatment through VHA, let alone encouraged to seek treatment that would treat their PTSD and potentially improve their lives.

VA disability benefits serve an important function, fulfilling society's obligation to those who have served the country and, in so doing who have been injured in such a way that their capacity for earnings has been permanently lost.¹¹⁰ No monetary compensation can ever offset the pain, suffering, or loss associated with many service-connected injuries and illnesses, particularly the most severe – and yet, the nation has an obligation to try to compensate those who have sacrificed on its behalf. Notwithstanding this obligation, however, there exists an opportunity to compensate those who have earned veterans benefits, whether through disability or other means, and also lift up these populations to achieve long-term health and wellness. In the next administration, the VA should examine alternate proposals to redesign veterans benefits in ways that provide immediate support for temporarily debilitating conditions, lifelong support for those who need it, and an opportunity to achieve long-term improvements in health, earnings, and wellness as well. The VA should also embrace an integrated approach to health care and benefits, one focused on the veteran instead of the VA's decades-old internal bureaucratic divisions. Ultimately, the VA should consider an integrated systems model that does away with its internal subagencies organized along functional lines, in favor of a regionally aligned structure that can be organized and aligned by geography in order to focus on veteran outcomes.

Further, the VA should continue research on evidence-based practices to promote wellness and leverage the enormous body of private-sector learning from the past few decades of health care and health insurance work.¹¹¹ Where the evidence suggests veterans would benefit, the VA should look for opportunities to leverage its benefits programs to incentivize wellness, such as by adding incentives or benefits for healthy living that will improve and extend veterans' lives.¹¹²

3. ALL-VOLUNTEER FORCE (AVF) REFORM

The AVF was created in 1973, after the Nixon administration's decision to end conscription (the draft) at the close of the Vietnam War. The movement to the AVF has created a more professional U.S. military, both in war and in peace.¹¹³ It also comes with costs, both financial and societal. To compete for talent with other sectors, military pay growth has outpaced civilian pay growth for most of the past 40 years.¹¹⁴ From a societal perspective, the creation of the AVF has deepened the civil-military divide, as a small segment of population is called upon to provide for the national security of an increasingly detached society.

The movement to the AVF, led in part by Milton Friedman and other leading economists of the day, built the force around market principles, leveraging monetary incentives to recruit, retain, and manage the force. However, this market approach has not been implemented to its full potential within the military personnel management system. Once a recruit takes the oath of enlistment or the oath of office, his or her career becomes centrally managed.¹¹⁵ Critical elements of military service, including selection for promotion, assignment to positions, and relocation, are centrally decided, with limited input from the individual service member. Increasingly, centrally managed careers are becoming a liability for retention of the best and brightest.

Changing demographics within the military are further forcing a critical rethinking of how military careers are managed. Of particular significance is the growing presence of millennials,¹¹⁶ who bring new expectations and priorities to the workplace, including the desire for increased agency¹¹⁷ and work-life balance, and a shift away from the traditional nuclear, one-career family.¹¹⁸

The confluence of rapid personnel cost growth, decreasing defense budgets, and postwar drawdown means that a smaller, leaner military will have to meet the challenges of a volatile, unpredictable world. The human capital of the military will be a critical ingredient of its future readiness. As the United States enters a new era, the AVF must arguably evolve from the force that now exists to one that uses 21st-century approaches to recruiting, retention, education, training, and personnel management to provide the human capital that will enrich, sustain, and lead the U.S. military for decades to come.

Talent Management

Talent management, including the processes of assignments, selection, and promotion, has been the focus of the private sector for decades. However, the military has failed to capitalize on a number of the best talent management practices from the private sector.¹¹⁹ Today's military aspires to put the right person in the right job at the right time. In practice, because of its size, complexity, and inertia, today's military manages its talent using antiquated 20th century systems that treat every service member as a cog in a vast machine. As one service member said in a recent working group, we ironically run the American military with a Soviet-style personnel system. The wars in Iraq and Afghanistan showed the shortcomings of this system; it could not manage deployment stresses well by spreading the burdens of service evenly, let alone select the best persons to serve in critical jobs or develop critical human capital pathways (such as those for Arabic linguists or civil affairs specialists).

True talent management includes better stewarding of personnel resources to maximize the return on every dollar spent. One way the military can improve upon its personnel management is with better data collection and evaluation practices, which can provide the information necessary to help the services better match their human capital to the needs of the service – and national security. Unfortunately, today's military personnel system gathers, reports, and presents relatively poor information about performance, failing to leverage the vast amounts of data within the military to help commanders and service leaders visualize their human capital resources. The next administration's Pentagon leadership should critically examine

the military's current evaluation architecture and pursue alternative models that would better integrate and use the vast quantities of performance, personnel, and readiness data available. A better evaluation system would support the services as they seek to put the right person in the right job at the right time and place, and also better support longer-term talent management efforts such as determinations about what educational and training programs make the most sense for the military.

Perhaps the most innovative reform idea is to increase individual choice within the military personnel management system. Undergirding many of the reasons individuals choose to separate from military service is the frustration that they lack agency in the assignment process. Developing better market-based tools and processes, such as allowing commanders to interview and hire their own key staff instead of having them assigned, may increase both individual satisfaction and unit performance. Pilot programs such as the Army's "Green Pages" provide insight into the effectiveness of regulated market mechanisms for talent management.¹²⁰ Furthermore, giving service members more control over their geographic assignments (and the length of time in those locations) may serve as a valuable retention tool for those service members contemplating separation from military service due to the strain of multiple moves. Given that the military invests significantly in training individual service members, especially in such training-intensive career paths as pilots, there is potential for a larger return on the substantial investment made in their training.

Compensation and Retirement Reform

Since the AVF's creation, it has relied primarily on cash and noncash compensation to recruit and retain service members. The service's basic model for compensation has changed little in four decades: base pay plus a series of allowances for housing, subsistence, and proficiency; retention bonuses that vary based on the needs of the service; and a generous defined-benefits pension to those who serve for 20 years or longer. This system compensates service members well and is arguably necessary to sustain the AVF given today's demands on the force. However, the current model costs a great deal and

has increasingly diverged from norms in the American economy for compensation and benefits. A full treatment of this issue is beyond the scope of this report. Nonetheless, the tensions within this system must be addressed by the next administration because they will only become greater over time. These issues' importance is surpassed only by their political delicacy. Past efforts to adjust military compensation or benefits have been fraught with political peril, for leaders from both sides of the aisle that have pursued them.

Congress created the Military Compensation Retirement and Modernization Commission¹²¹ in 2013 to address these issues and the need for reform; the MCRMC suggested modest changes to the retirement and health care benefits. Among the most revolutionary recommendations is a change in the military retirement system that would grant some retirement benefits to all service members and a shift to a defined-contribution system, rather than the defined benefit, for the minority (17 percent)¹²² who retire at 20 years. An incremental step toward this reform was passed as part of the FY2016 National Defense Authorization Act and will likely become law between now and the next administration. However, the next administration should consider an even more forward-leaning approach to military compensation, including more flexible pay and benefits instead of the "one size fits all" rank/grade/pay structure. Such a structure might allow for compensation based on performance or target certain high-demand skill sets, rather than a simple determination of time-in-grade, and also begin to align compensation and benefits with performance.

Military Health Care Reform

Next to cash compensation, health care is the most important (and costly) benefit provided to service members and their families. As such, the military health care system (TRICARE) should result in health outcomes equal to or greater than the private sector. TRICARE has been expanded to cover more beneficiaries than ever before, and made less expensive for those already enrolled. From 2001 to 2012, there has been a 74 percent increase in health care costs borne by DoD.¹²³ Much of this owes to the changes in the beneficiary population and cost structure of

the benefit; since 2000, TRICARE benefits have been expanded to cover more people and reduce (or maintain as constant) costs for enrollees. Despite its ambitious goal and extensive budget, the Military Health System faces widespread criticism over the quality and accessibility of care, in addition to suffering from a lack of communication across services.¹²⁴ Many military hospitals show a high rate of post-surgery and maternal health complications.¹²⁵

Both the rising costs and the presence of inadequate medical care in the military health system are an impetus toward innovation. Though the military bureaucracy can be difficult to change, the planned 2017 reprocurement of the TRICARE contracts allow a rare opportunity to reduce costs and improve care through adoption of “pay for performance” or “fee-for-value” models.

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Such models tie health care financing to patient outcomes, rather than basing payments simply on patient throughput. The benefits of this approach are twofold: Patients receive better care, and health care costs decrease. Unlike the fee-for-service model, which incentivizes doctors and health care systems to increase throughput and thereby boost profit, the fee-for-value model no longer encourages overutilization.¹²⁶ Tangibly, this should make it easier for service members and their families to be seen and improve both their health care outcomes and satisfaction once treated. Given the sacrifices service members and their families make for the nation, such outcomes are well-deserved. DoD also stands to gain the added benefit of a more efficient use of scarce resources and the potential for reinvestment of newly recovered cost savings into battlefield capabilities.

C. Strategic Opportunities for the Next Administration

Beyond the immediate and operational issues, there exists another tier of strategic issues affecting the veteran and military community that the next administration should engage with. These offer some of the greatest opportunities for better governance and better outcomes – both for this community and society at large.

1. BETTER DATA-SHARING

Data regarding service members, military families, and veterans should inform everything the public, private and nonprofit sectors do to serve this community. In an ideal world, data would help to illuminate needs, show the distribution of resources, and inform the future allocation of resources across sector. However, this vision is rarely realized for the veteran and military community because of a failure to share data within the government, with trusted partners, and with society at large. This failure reflects a broad array of legal and regulatory obstacles, from concerns about sharing national security information to health privacy concerns to ethical concerns about providing federal data to nonfederal entities. At the end of the day, however, these obstacles act as the tail wagging the dog, frustrating and blinding efforts to serve the veteran and military community.

The examples for this failure are legion. Department of Defense and VA offices worked for years to share data regarding suicides within the veteran and military population; this data is still not fully shared, nor linked to relevant service and demographic information such as unit and degree of combat exposure.¹²⁷ On the economic side, the government has the theoretical capability to track receipt of unemployment compensation by departing service members and link that receipt to service histories, training records, location, and other data. With narrow exceptions, however, the Department of Defense, Department of Labor, state unemployment agencies, and others have failed to share such data, let alone act upon it. Similarly, there exists no permanent data-sharing framework among the IRS, Department of Defense, Department of Labor, and other agencies for data regarding wage and employment patterns that could inform veteran transition efforts. On a

grander scale, no federal agency currently identifies departing service members and shares that data with outside entities (such as employers or educational institutions) interested in helping those troops transition to civilian life. Despite widespread recognition of the value private and nonprofit entities provide in the transition process, the Department of Defense also does not provide aggregate data that might inform their efforts or help large organizations and companies decide how and where to allocate their efforts supporting transitioning veterans.

A better data-sharing framework is needed to make federal agencies work more effectively and efficiently; it would also fuel partnership with state and local governments, as well as with the private and nonprofit sectors. This framework should be built around three concentric circles, in order to balance privacy and data-sharing concerns with the imperative to better serve veterans and military families.

Government to Government. Within the federal government, and with trusted state and local government partners, the government should default to a position of sharing *all* data that could reasonably inform government decisionmaking or action. For example, the VA should have secure access to DoD's personnel, pay, health, and other related databases regarding veterans, as should state departments of veterans affairs that may serve these veterans when they come home to communities. Similarly, DoD, the VA, the Department of Labor, IRS, and state unemployment agencies should share data in order to identify veteran unemployment as it occurs, in order to respond in time to make a difference.

Government to Trusted Partner. The federal government does not (and cannot) serve veterans in a vacuum; to succeed, it must rely on a broad array of private and nonprofit organizations. The government does share data with many of these organizations, usually under the auspices of a government contract or grant agreement. That practice should be embraced and expanded to all trusted partners that play an integral role in the transition and support process for the veteran and military community with appropriate security and privacy protections. The federal government should use data as fuel for public-private partnerships, building data-sharing into

their core, to inform the activities of each partner and ultimately serve veterans better. Partners like the U.S. Chamber of Commerce, employer coalitions, and others should have access to more granular data about service members that would enable them to align their activities to where the need is most acute.

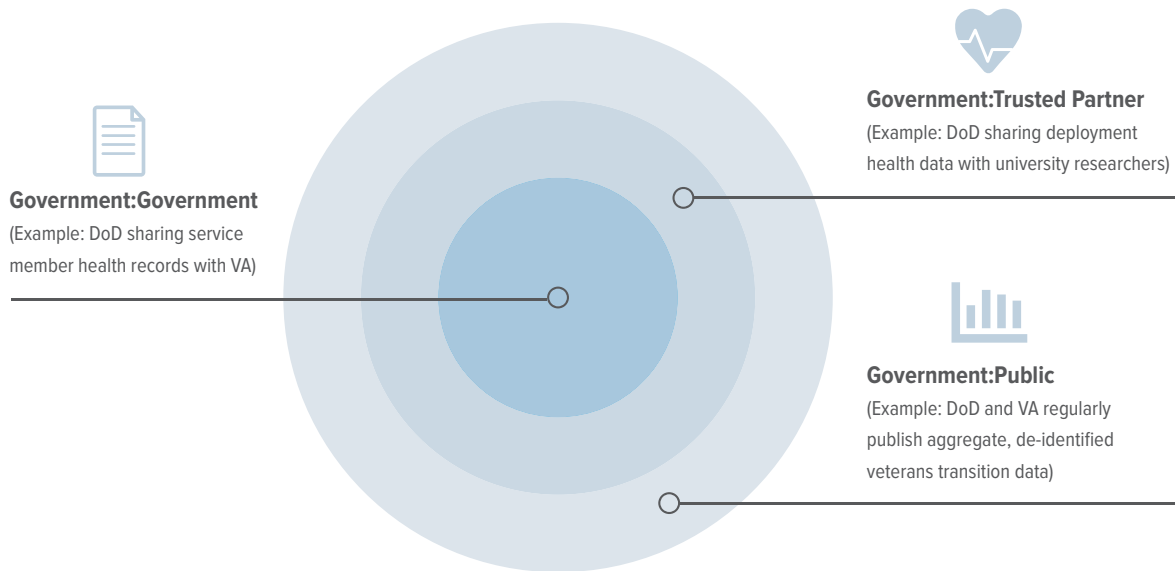
Government to Public. To the maximum extent practicable, the government should make aggregate or anonymized data regarding the veteran and military population public. This will help to inform the broad array of public, private, and nonprofit actors that serve the veterans community but often lack basic data to guide their efforts. Further, by creating and releasing such data, the government will create a virtual laboratory for research and analysis by universities, research labs, private corporations, and others that can also be leveraged to support veterans.

2. NEAR-REAL-TIME NEEDS ASSESSMENT

Closely related to the problem of data-sharing is the problem of data use by federal agencies to drive activity. Bluntly stated, there are few mechanisms to identify needs, challenges, and gaps within the veteran and military community and allocate resources to those places. Although myriad feedback mechanisms exist at the local level, and scandals can illuminate unmet needs too, these often distort as much as they reveal. The veteran and military community needs a capability that can assess and analyze needs in near-real-time, fueled by data about this community, in a way that can facilitate action by public, private, and nonprofit actors.

Historically, the best mechanisms for this analysis have been surveys conducted on a short- or long-term basis. Short-term surveys such as the Bureau of Labor Statistics' monthly unemployment report or regular surveys conducted by veteran organizations and the press provide useful information about the population at a point in time. Long-term surveys and longitudinal studies, such as the National Vietnam Veterans Readjustment Study, yield substantially more insight into the deeper issues affecting this community. However, these long-term studies take many years to complete, and more sometimes to glean insight from. Public health registries, such as those kept by the VA for exposure to various toxins, can function similarly to long-term surveys and

FIGURE 5. DATA SHARING FRAMEWORK



longitudinal studies. However, these registries often miss issues because they require veterans or family members to opt in, and because they typically cover only a specific population. The decennial census provides a great deal of insight for the population as a whole but occurs so infrequently as to frustrate policymakers and researchers. Also, in 2010, the census did not ask questions related to veteran status; to be useful for this community, the 2020 census must include veteran status (broadly defined) as part of its demographic questionnaire in order to provide relevant and actionable data for this community.

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There is an opportunity for the next administration to lead on development of new approaches that can provide near-real-time data to drive public, private, and nonprofit support for the veteran and military community. Too many issues (employment, mental health, physical health, etc.) in this space suffer from a lack of detailed, actionable data that can inform action. And yet in this era of big data, tools are available to better identify needs and gaps and allocate resources in near-real-time to focus on these issues. The public, private, and nonprofit sectors should lead the way to develop cutting-edge, innovative tools to identify issues within the veteran community and fix them. Three examples illustrate the potential here.

Economic Dashboard. In cooperation with the government, the private sector and nonprofit sector work together to innovate a new method for assessing unemployment and economic health, to provide more accurate, reliable, and timely data than the current Labor Department monthly surveys. Such tools could leverage 21st-century economic research tools, commercial data, aggregate data provided by public agencies, social media, employer information, state unemployment filing information, and other sources. This tool could help inform economic initiatives focused on veterans but could also test new models of economic analysis and understanding that could be useful for all of society as well.

Health Registry and Dashboard. The VA and private health sector should work together to develop a long-term public health surveillance system to identify health issues that will affect veterans over time and quickly surge resources to research and treat them. The United States should never again wait 20 to 30 years to confront things like Agent Orange and Gulf War I syndrome – while recognizing that the potential exists for similar long-term health issues in the post-9/11 veteran population.¹²⁸ As with the economic dashboard, there is enormous potential for the use of such tools to serve the civilian population once developed, but it makes sense to begin within the veteran and military community because of the extent of government involvement in this space and the vast amounts of data already collected by the government regarding the health of veterans and service members.

Program and Agency Evaluation. A third use case involves building data tools to understand the effects and outcomes of public, private, and nonprofit programs in order to determine what works best and why. In even the most sensitive of areas, such as transition, mental health care, and prevention of suicide, the government spends billions of dollars with scant evidence of its programs' outcomes.¹²⁹ At the agency level, the VA oversees enormous programs for the delivery of health and benefits but does little to evaluate how well these programs contribute to the overall health and wellness of veterans.¹³⁰ The government should, in close collaboration with the private and nonprofit sectors, develop agreed-upon measures of outcomes for veteran wellness, including health, economic success, and other factors. The government should measure these outcomes for all veterans and gauge the effectiveness of its programs based on how well they affect these outcomes. Where programs fail to achieve desired effects or outcomes, government leaders should change or cancel programs, reallocating increasingly scarce resources to programs that do successfully improve outcomes for veterans and military families.

3. FUTURE PLANNING AND RESOURCE ALLOCATION

The VA bases much of its future resource allocation and geographic footprint on trends in the veteran population. The VA's current population projections

extend through 2040, tracing the rough contours where the nation's veterans will be. While these projections are a useful baseline for planning to meet the long-term needs of the population, there are a few critical components the projections fail to take into account. First, the model assumes no future large-scale war. Second, it may not accurately take into account demographic changes. Third, the projections assume no large-scale geographic redistribution of veterans. And fourth, the models do not capture potential health and quality-of-life changes that may affect veteran lifespans. Thus, the current projections can be expanded upon to create a more realistic range of alternate futures and options for meeting the needs of those veterans.¹³¹

Shifting Demographics. The demographic composition of the All-Volunteer Force is visibly changing, both in ethnicity and in gender. For purposes of strategic planning of resources, changes in gender composition are perhaps the most significant. The female proportion of the veteran population rests now at 7.3 percent but is projected to constitute 16 percent of the total veteran population by 2025.¹³² This is a reflection of two separate trends: the increasing number of women joining the military and the rapid decline of the World War II, Korea, and Vietnam-era veteran cohorts, which were near-exclusively male and reflected a much larger force. The growing presence of women within the veteran population bears implications for long-term planning and resourcing issues, such as the need for more women's health clinics or new benefits models.

Shifting Geography. Another consideration for long-term planning is the geographic footprint of the VA, particularly VA hospitals and clinics. Current trends in the overall U.S. population suggest an increasingly urban population,¹³³ a trend that is likely to affect the veteran population as well. As the trends in where veterans settle shift, so too will their demand for VA health care and other services. Given the long time it takes the VA to build or lease new facilities and move manpower, and the political difficulties the agency faces in moving resources around the map, the VA needs to start planning for new VA facilities in high-growth areas or thinking through new ways to deliver services.

Medical and Lifestyle Interventions. Current VA population projections are largely actuarial and depend (at least in part) on average life spans. The VA has an opportunity to change these assumed life spans for the better with interventions in health care and lifestyle changes, in essence “bending the curve” of these projections. The VA can use similar efforts as other large health care systems, such as wellness incentive programs and tobacco cessation assistance, to increase overall veteran health and decrease risks for such conditions as diabetes and heart disease.¹³⁴ Such programs have the potential to extend veterans’ lives, reduce the prevalence of chronic conditions, and defray costs over the long term.

4. EFFECTIVE PUBLIC, PRIVATE, AND NONPROFIT PARTNERSHIPS

The federal government does an enormous amount to serve the veteran and military community, spending more than \$300 billion each year on military personnel and veterans’ health and benefits. Yet, for all its money and sprawling bureaucracy, the federal government cannot – and should not – go it alone in helping veterans and military families navigate their transition and onward movement as civilians.

Employment, economic opportunity, education, and training for veterans and military families are indisputably the province of the private and nonprofit sectors. The private sector is the great employer of America, not the federal government; within the private sector, small businesses hire the majority of American employees, not Fortune 500 companies. Similarly, the private and nonprofit educational sector is the great provider of classroom experience and knowledge to America, not the federal government. Any and all efforts to support veterans should proceed from the premise that public-private-nonprofit and federal-state-local partnerships are necessary to succeed. Further, this partner activity should be championed as one more way these sectors can contribute to national security, alongside the participation of their employees, the businesses or programs they run, the taxes they pay, and their other contributions.

Unfortunately, the federal government has struggled to partner effectively and sustainably with private and nonprofit entities during the past 14 years. These

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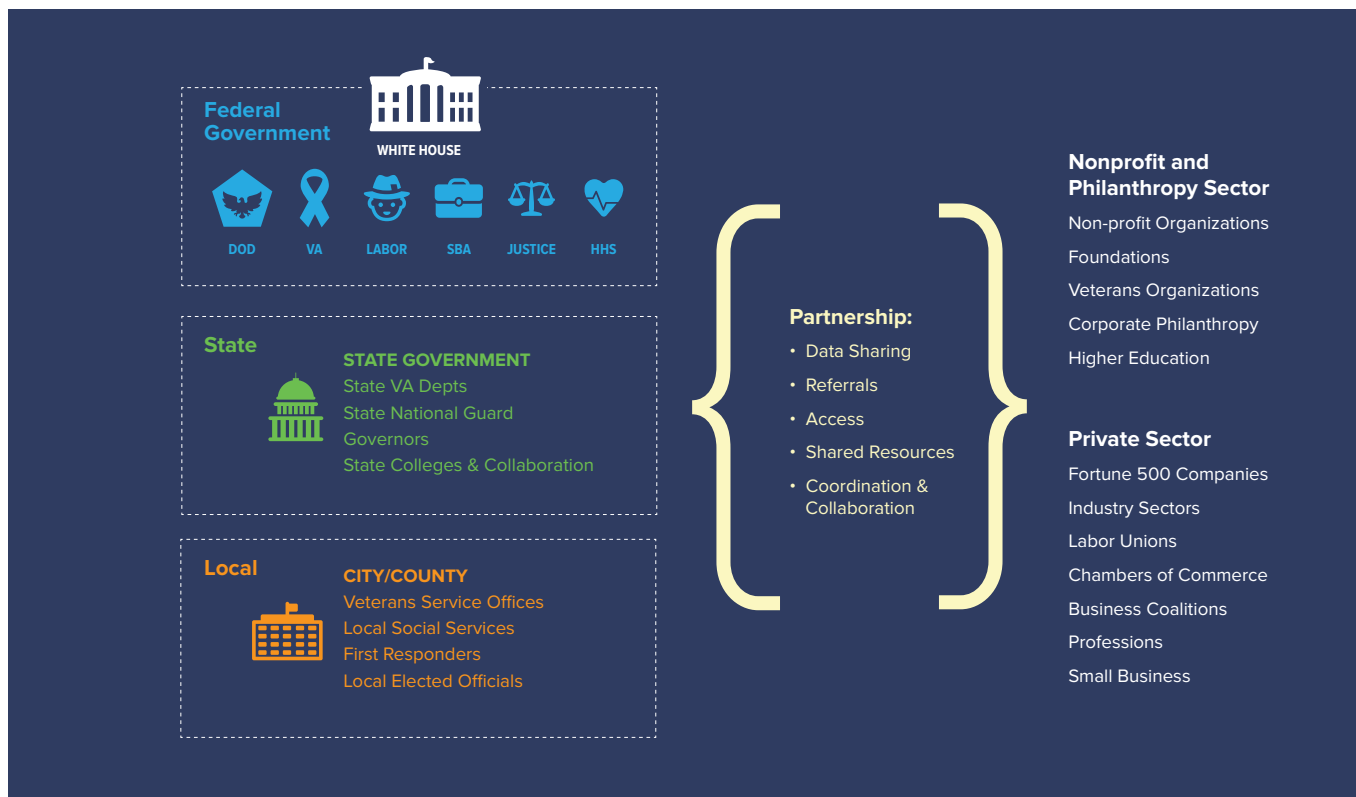
efforts have been impeded by a thicket of ethics and acquisition rules, as well as a vision of how these partnerships could support agency missions and promote better veteran outcomes too. Both the Department of Defense and VA have recently pioneered innovative partnership approaches that work within existing legal structures; the permanence and long-term outcomes of these efforts remain to be seen.¹³⁵

The next administration must make clear policy supporting these partnerships as a legal and policy matter and then erect an architecture that supports them in practice.¹³⁶ Where necessary, the next administration should amend the federal ethics regulations¹³⁷ and federal acquisition regulations¹³⁸ to enable agencies to work with nonfederal entities for certain purposes such as veterans’ transition, health care, and economic opportunity. The partnership architecture should include a governance structure, ideally linking agency leaders with private- and nonprofit-sector leaders through formal advisory and governance boards with interlocking membership.¹³⁹ In some cases, the federal government may fuel these partnerships simply with its blessing or participation; in others, the government may provide data, base access, or funding for activities that produce successful outcomes.

5. IDENTIFYING AND MEASURING OUTCOMES

To assure that the nation is adequately caring for those who serve in uniform, it is increasingly necessary to define what outcomes for the veteran community should be. There exists broad disagreement about what the outcomes ought to be. For example, veteran unemployment rates are frequently compared with civilian unemployment rates, generally with the implication that parity is the goal. However,

FIGURE 6: EFFECTIVE PUBLIC, PRIVATE, AND NONPROFIT PARTNERSHIP FRAMEWORK



given the amount of resources the nation has invested in its service members, should the measure of success actually be better rates of employment among veterans than the overall population? Given the emphasis on physical activity in the military, should veterans have better health outcomes (such as lower rates of diabetes and cardiac disease) than the general population? Until desired outcomes are articulated, it is difficult to measure how successfully programs are attaining these outcomes.¹⁴⁰

Once desired outcomes are framed, it is equally important for the government, private sector, and nonprofit sector to adequately measure how well programs designed to meet the needs of veterans are attaining those outcomes. For example, given the amount of public funding dedicated to veterans' health and benefits, the VA should be able to demonstrate how veterans are performing across metrics of health and wealth – and, if current programs are not improving veterans' lives along those metrics, be able to change its programs in ways that improve

outcomes. Nonprofits serving the military and veteran community should also be able to demonstrate how recipients of their services are performing across a similar range of metrics. Philanthropy can serve an important role in driving such outcomes-based processes and measurement by demanding performance evaluation as a condition of funding to nonprofits.

Conclusion

While these challenges are daunting, they are not unlike those faced by presidents in earlier eras. The world is always unstable. Budgets are always uncertain. And yet the American military always rises to meet challenges to national security. The nation and its economy embrace those who have served and do so far better today than for past generations, though there is still room to improve.

The next president and his/her administration will struggle with some unique challenges too. First among these will be the aftermath of the first protracted conflicts fought by the All-Volunteer Force. While the draft ended over four decades ago, the last 14 years have tested the structure of the defense establishment, the veteran community, and the very nature of the contract between the military and the public it serves.

With the advent of the AVF, the United States decided to forgo the tradition of conscription during times of conflict and instead rely on a market model to fill the ranks. After some initial growing pains in the late 1970s and into the early 1980s, this model worked well to sustain a highly trained and ready force capable of overwhelming its enemies at the outset of armed conflict. However, this model relies on monetary incentives to recruit and maintain personnel, and manages those personnel under a centralized personnel system that remains largely unchanged from the 1950s. These factors have led to significant challenges to the long-term health of the modern military, and its connections to the society it serves. The next president must identify concrete ways to sustain the AVF when incentives to serve are blurred and joining the military is simultaneously an economic choice and a patriotic commitment. With so few Americans in uniform, the tendency of a distant public during a time of war has been to shower the military with resources and praise. And while praise continues to flow, finding the resources to sustain the military, as currently configured, and to support the veteran community will be increasingly challenging. Defining the expectations and rewards of service in a way that appropriately honors service and provides compensation is a collective challenge that must be addressed by all Americans, regardless of whether they wear a uniform.

There is broad agreement on the political spectrum regarding general support for the military and veteran community. When surveyed, most Americans say they support the military, or they admire veterans, and say so at higher levels than almost any time in U.S. history. There is near universal support for the proposition that the nation must provide for its wounded, ill and injured veterans, and prioritize their support over other competing fiscal demands. Similarly, politicians of all stripes effusively praise the military and often work to outdo each other in providing benefits to this community. For the majority of the years since 9/11, Congress has increased the military pay raise proposed by the president in the course of its legislative process. However, beyond this praise, there exist sharp points of disagreement that must ultimately be debated and decided in order to align the nation's ends, ways, and means in support of this community. In concrete terms, this means deciding issues such as the scope of the VA's health care mission, and which veterans get seen and prioritized, in order to set the VA budget properly. This also means adjusting certain programs to accommodate changed reality, like expanding transition programs to include military spouses, recognizing the evolution of military families since these programs' inception. And, ultimately, the nation should commit to supporting the AVF well enough that the example of each generation serves to inspire subsequent generations of Americans to serve.

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