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Foreword

Janet Dolgin

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FOREWORD

*Janet Dolgin**

The articles in this Symposium reflect the presentations of panelists at an April 2016 conference, developed by the Gitenstein Institute for Health Law and Policy (“Gitenstein Institute”) at the Maurice A. Deane School of Law at Hofstra University and by Hofstra’s Master of Public Health Program. The conference, “Mission Critical Veterans Health Summit: Addressing the Invisible Wounds of Our Nation’s Veterans,” was part of the Gitenstein Institute’s Garfunkel Wild Thought Leadership in Action Speaker Series.¹ Convened to address the challenges that face veterans attempting to gain disability and health benefits from the Veterans Administration and seeking effective treatment for physical and mental wounds of war, the conference featured three panels. Two of the panels—“Health Care Issues for Veterans” and “Invisible Wounds: Case Study of PTSD from Several Perspectives”—are represented in this Issue. Many of the themes of the third panel, entitled “Suicide and Suicide-Related Behavior in Service Members and Veterans,” appear in the articles included in this Symposium.

* Jack and Freda Distinguished Professor of Health Care Law, Maurice A. Deane School of Law at Hofstra University; Professor of Science Education, Hofstra Northwell School of Medicine; Director, Gitenstein Institute for Health Law and Policy, Maurice A. Deane School of Law at Hofstra University; Co-Director, Hofstra Bioethics Center. The author is grateful to Corinne Kyriacou, Ph.D., of Hofstra’s Department of Health Professions and Director, Master of Public Health Program, Hofstra University, for her partnership in planning the Symposium from which the articles in this Issue stemmed; to Melissa Kessler, Associate Director, Gitenstein Institute for Health Law and Policy, Maurice A. Deane School of Law at Hofstra University, for her remarkable work developing the Symposium and, more generally, for her far-reaching, creative work for, and commitment to, “Mission Critical Veterans Health Summit: Addressing the Invisible Wounds of Our Nation’s Veterans”; and to Michelle Wallace, Executive Secretary, Gitenstein Institute for Health Law and Policy, Maurice A. Deane School of Law at Hofstra University, for her generous assistance with implementation of the Symposium.

1. The Maurice A. Deane School of Law at Hofstra University and the Gitenstein Institute are grateful to Garfunkel Wild, P.C., for the firm’s support of the Speaker Series and to Garfunkel Wild partner Judith Eisen (Hofstra Law, ’86) and Garfunkel Wild founding member, Robert Wild, who moderated one of the conference sessions.

Each article in this Symposium emphasizes the enormity of unmet needs of the nation's veteran population. Veterans who have returned from combat often need far-ranging medical assistance. The wounds of war are both physical and mental. Among all of the nation's veterans, approximately one-fifth had service-related disabilities as of 2015.²

Anyone who "served in the active military service and who was discharged or released under conditions other than dishonorable is a Veteran" and as such, *may be*, but is not necessarily, eligible for health benefits through the U.S. Department of Veterans Affairs ("VA").³ Despite a common misconception, veterans are not automatically eligible for care through the VA.⁴ Among those who are eligible to receive care within the VA health care system, many must "contribute financially for [that care]."⁵ About a dozen factors can determine whether a particular veteran is actually eligible for VA health care benefits and, if so, at what level.⁶ Moreover, veterans—especially those in a "lower priority group"⁷—may lose coverage if Congress does not appropriate adequate funds to cover all veterans deemed eligible for health benefits in a given year.⁸

Both Kristina Derro and Patricia Roberts focus on the complicated processes through which veterans may apply for—and appeal denials of—disability benefits.⁹ Obtaining or being denied disability benefits can constitute the difference between eligibility and ineligibility for

2. Press Release, Bureau of Labor Statistics, U.S. Dep't of Labor, Employment Situation of Veterans—2015, at 1 (Mar. 22, 2016), <http://www.bls.gov/news.release/pdf/vet.pdf>. The percent is higher—about one-third—for veterans who served in the Gulf War between 2001 and the present. *Id.* In 2015, about nine percent of the veteran population was female. *Id.* at 2. In the same year, only about four percent of World War II veterans were female, but females accounted for roughly eighteen percent of Gulf War veterans. *Id.*

3. *Veterans Eligibility*, U.S. DEP'T VETERANS AFF., <http://www.va.gov/healthbenefits/apply/veterans.asp> (last updated Oct. 5, 2016). Members of the Reserves or National Guard with active duty (other than for training) may also be eligible for VA benefits. *Id.*

4. Kristina Derro, *Health Care Issues for Veterans*, 45 HOFSTRA L. REV. 9, 11-12 (2016).

5. *Id.* at 9.

6. *Veterans Eligibility*, *supra* note 3. Among other things, the following factors increase the level of benefits that a veteran may receive: having been a prisoner of war, having received a Purple Heart Medal, having a "compensable VA awarded service-connected disability of 10% or more," and having low household income. *Id.* For a full list, see *Priority Groups*, U.S. DEP'T VETERANS AFF., http://www.va.gov/healthbenefits/resources/priority_groups.asp (last updated Oct. 3, 2016).

7. A veteran's "priority group" depends on the veteran being categorized through one or more of the criteria that lead to health benefits, such as level of service-connected disability or receipt of the Purple Heart Medal. *Priority Groups*, *supra* note 6.

8. *Health Care Insurance*, U.S. DEP'T VETERANS AFF., <http://www.va.gov/healthbenefits/cost/insurance.asp> (last updated June 3, 2015).

9. Derro, *supra* note 4, at 11-15; Patricia E. Roberts, *PTSD, TBI, and OTH Discharges: A Case Study of a Young Service Member*, 45 HOFSTRA L. REV. 35, 43-45 (2016).

health care through the VA.¹⁰ For over a century, veterans were significantly hampered in submitting and appealing disability claims insofar as attorneys played almost no role in helping veterans gain benefits. This followed mid-nineteenth century legislation under which attorneys' fees were limited to five dollars for assisting veterans in the effort to gain VA benefits.¹¹ Accepting larger sums constituted a "high misdemeanor"—the law specified that conviction could result in a monetary fine or "hard labor not exceeding two years" or both.¹² Congress increased the maximum allowable fee to ten dollars in 1864.¹³ That limit remained in place for well over a century, during which time attorneys rarely assisted veterans or their survivors with benefit claims.¹⁴ Congress apparently intended the rule limiting attorneys' fees for assisting veterans to preclude attorney avarice.¹⁵ Over time, however, the consequences were far more limiting for veterans than for attorneys who simply stopped representing veterans seeking VA benefits.

The law that restricted fees for attorneys was amended only in 1988 with passage of the Veterans' Judicial Review Act.¹⁶ That law gave veterans a right to paid legal representation in appealing Board of Veterans' Appeals ("BVA") decisions to the newly created U.S. Court of Appeals for Veterans Claims ("CAVC").¹⁷ With the creation of the CAVC, veterans were for the first time offered an opportunity to appeal BVA decisions.¹⁸ Further, the Veterans' Judicial Review Act provided

10. See, e.g., 38 U.S.C. § 1110 (2012) (noting that veterans with disabilities incurred or aggravated during active military, naval, or air service are entitled to disability compensation).

11. Act of July 14, 1862, ch. 166, § 6, 12 Stat. 566, 568 (repealed 1864). The provision further provided for an agent or attorney to charge an additional \$1.50 in cases in which an affidavit was filed because supplemental testimony was required. *Id.* The agent or attorney could be paid up to \$1.50 for each such affidavit. *Id.*

12. *Id.* § 7, at 568.

13. Act of July 4, 1864, ch. 247, § 12, 13 Stat. 387, 389 (codified at 38 U.S.C. § 3404(c)(2) (1958)).

14. James D. Ridgway, *The Splendid Isolation Revisited: Lessons from the History of Veterans' Benefits Before Judicial Review*, 3 VETERANS L. REV. 135, 215 (2011).

15. *Id.* at 160. Ridgway reviews the history of veterans' benefits from the colonial period until the passage of the Veterans' Judicial Review Act, Pub. L. No. 100-687, 102 Stat. 4105 (1988) (codified as amended in scattered sections of 38 U.S.C.). Ridgway, *supra* note 14, at 138, 143, 173, 193, 216.

16. See Veterans' Judicial Review Act § 104. The court with appellate review of veterans' benefit claims was first called the U.S. Court of Veterans Appeals. See Veterans Programs Enhancement Act of 1998, Pub. L. No. 105-368, § 511, 112 Stat. 3315, 3341. In 1998, Congress changed its name to the "Court of Appeals for Veterans Claims." *Id.*

17. See 38 U.S.C. §§ 7105, 7251 (2012); Jonathan Creekmore Koltz, *Unstacking the Deck: In Defense of the Veterans Benefits, Healthcare, and Information Technology Act of 2006*, 17 FED. CIR. B.J. 79, 84 (2008). For reference to the CAVC's original name, see *infra* notes 27-28 and accompanying text.

18. Koltz, *supra* note 17, at 84.

that veterans could pay attorneys more than the ten-dollar limit set in the mid-nineteenth century when appealing BVA decisions to the CAVC.¹⁹ In 2006, Congress provided for veterans submitting all administrative appeals to pay attorneys more than a de minimus amount.²⁰ But even today, attorneys and agents are forbidden to accept fees from a veteran submitting a disability claim until the veteran files a “notice of disagreement” with the BVA’s determination.²¹

In short, today, attorneys do represent veterans submitting appeals and are often paid for that work. However, the system remains complicated and can be exasperating. Kristina Derro describes the many levels of possible appeal after the submission of a disability claim to the veteran’s local VA regional office.²² Cases, she reports, “can remain in [the appellate] process for years” as they are “bounced back-and-forth between the regional office and the BVA” in Washington, D.C.²³ Further, it can be terribly difficult to establish that a disability is service-connected. Soldiers are encouraged to remain “stoic” and may thus avoid seeking treatment during service.²⁴ In addition, even in cases in which the veteran received treatment in the field, records may not exist, either because they were never created or not carefully safeguarded.²⁵ The process—both “protracted” and “frustrating”—can hold life-altering consequences for a veteran whose income, health benefits, and sense of self can be affected by the process and its outcome.²⁶ Derro summarizes a complicated, overburdened, and knotty system of rules and practices.

19. *Id.* at 83-84.

20. Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, § 101(a)(5), (e)(3), 120 Stat. 3403, 3405-06 (codified as amended at 38 U.S.C. § 5904). The possibility for veterans to rely on paid lawyers altered patterns developed over many years. *See, e.g.,* *Walters v. Nat’l Ass’n of Radiation Survivors*, 473 U.S. 305, 333-34 (1985) (deciding that veterans had adequate “safeguards” and, thus, did not need the help of attorneys in seeking benefits from the VA).

21. Title 38 of the *United States Code* provides:

Except as provided in paragraph (4), in connection with a proceeding before the Department with respect to benefits under laws administered by the Secretary, a fee may not be charged, allowed, or paid for services of agents and attorneys with respect to services provided before the date on which a notice of disagreement is filed with respect to the case. The limitation in the preceding sentence does not apply to fees charged, allowed, or paid for services provided with respect to proceedings before a court.

38 U.S.C. § 5904(c)(1).

22. Derro, *supra* note 4, at 11, 14-15 (noting that each state has at least one regional office and that there are offices where claims by veterans living outside the United States can be submitted).

23. *Id.* at 12.

24. *Id.* at 13-14.

25. *See id.* at 14.

26. *See id.* at 18.

Soon after its creation in 1988, the U.S. Court of Veterans Appeals²⁷—later renamed the CAVC²⁸—agreed with that assessment. The court described laws controlling veterans’ benefits as a “confusing tapestry.”²⁹ One account, published ten years after passage of the legislation creating CAVC, described the VA claims system as confusing, overburdened, and viewed by veterans as “stacked against them.”³⁰

Patricia Roberts highlights another essential aspect of the process that veterans may face in attempting to gain disability compensation and VA health care. She addresses the intertwined links among a veteran’s benefits, discharge status, and mental health injuries incurred during service.³¹ Roberts considers these issues through a hypothetical case³² in order to illustrate how the military and various service providers (including, especially, attorneys) might best respond to the needs of the veteran (“John Doe”) whose story is told. Mr. Doe, deployed to Iraq, suffered from post-traumatic stress disorder and possible traumatic brain injury (as well as other injuries) as a result of having stepped on an improvised explosive device (“IED”). Mr. Doe, who knew that his emotional world had been turned topsy-turvy, asked for a mental health screening during his post-deployment health assessment. That did not happen. In trying to deal with his mental injuries, Mr. Doe self-medicated. Then, a positive drug test resulted in Mr. Doe’s receiving an “Other than Honorable” discharge—often referred to as a “bad paper” discharge (“BPD”)—from the military.³³ In consequence, Mr. Doe, who desperately needed care to make a successful transition into civilian life, became ineligible for virtually all VA health care benefits³⁴ as well as for almost all other VA benefits.³⁵ Roberts’s analysis suggests that cases

27. Veterans’ Judicial Review Act, Pub. L. No. 100-687, § 301(a), 102 Stat. 4105, 4113 (1988) (codified as amended in scattered sections of 38 U.S.C.).

28. *About the Court*, U.S. CT. APPEALS FOR VETERANS CLAIMS, <https://www.uscourts.cavc.gov/about.php> (last visited Nov. 26, 2016).

29. *Zang v. Brown*, 8 Vet. App. 246, 255 (1995).

30. Koltz, *supra* note 17, at 80 (quoting Keith Snyder, President, Nat’l Org. of Veterans Advocates, Remarks at the Sixteenth Annual Judicial Conference of the United States Court of Appeals for the Federal Circuit (Apr. 6, 1999), in 193 F.R.D. 263, 373 (1999)).

31. See Roberts, *supra* note 9, at 37-38.

32. The hypothetical case, developed by the conference directors of this Symposium, is based on the story of an actual veteran. Details have been altered to mask the identity of that veteran so as to protect the veteran’s privacy.

33. BPDs include Other than Honorable discharges, such as that given to Mr. Doe, as well as “Undesirable, Bad Conduct, and Dishonorable” discharges. Roberts, *supra* note 9, at 41.

34. *Id.* at 41-43. Roberts notes that Mr. Doe might receive “limited counseling and referral services” at a VA center. *Id.* at 43.

35. *Id.* at 44 (noting that Mr. Doe’s Other than Honorable discharge makes him ineligible for “severance, disability compensation, or retirement pay” as well as for Government Issue (“G.I.”) educational benefits, governmental preferential hiring rules, and the Yellow Ribbon Program, in

such as Mr. Doe's require the cooperation of attorneys, psychologists, social workers, and psychiatrists. More importantly, such cases require significant shifts in the military's response to in-service injuries, mental as well as physical, and shifts in the process through which the VA responds to requests for eligibility reviews submitted by veterans discharged with bad paper.

Mayer Bellehsen and Valentina Stoycheva's contribution complements Roberts's discussion about the need of veterans, such as Mr. Doe, for psychological treatment and the need—within the legal processes through which veterans seek status upgrades and disability benefits—for psychological assessment and diagnosis. Bellehsen, Director of the Mildred and Frank Feinberg Division of the Unified Behavioral Health Center for Military Veterans and Their Families (“UBHC”) in New York, and Stoycheva describe a new approach to the mental health needs of veterans and their family members.³⁶ The UBHC presents a powerful model of coordinated care between a public and a private entity. The physical and behavioral health needs of the veteran are treated through a VA Medical Center while the behavioral health needs of the veteran's family members are treated through Northwell Health. This collaborative effort allows both the veteran and the veteran's family members to receive vital care at one location,³⁷ and it thereby facilitates the coordination of care.³⁸

Ranak Trivedi's contribution to this Symposium reflects themes addressed by Bellehsen and Stoycheva's article and adds compelling assessments of two Veterans Health Administration (“VHA”) initiatives. The first—the Primary Care-Mental Health Integration Initiative—was created in response to research showing that patients receiving mental health treatment are better served (as assessed by treatment outcomes) if treated in primary care settings.³⁹ The second initiative—Patient Aligned Care Team (“PACT”)—has been developed in light of a model of a patient-centered “medical home,” available for the primary care of

addition to other programs that benefit veterans).

36. Mayer Bellehsen & Valentina Stoycheva, *Hofstra Mission Critical: The Unified Behavioral Health Center*, 45 HOFSTRA L. REV. 21, 24-25 (2016). UBHC also provides treatment to family members of military personnel on active duty. *Id.* at 28.

37. The partnership—between Northwell Health and the Northport Veterans Administration Medical Center—was facilitated and encouraged by an executive order signed by President Obama in 2012. *Id.* at 24.

38. *Id.* at 25.

39. Ranak Trivedi, *Burden of Mental Illness Among Veterans Seen in VA Primary Care and the Positive Effects of Recent VHA Initiatives*, 45 HOFSTRA L. REV. 29, 31 (2016). More specifically, the success of the initiative was assessed in light of the “screening, detection, and treatment of mental illness.” *Id.*

veterans.⁴⁰ Trivedi reports that the PACT model has resulted in fewer hospitalizations for conditions such as diabetes and heart disease among older veterans⁴¹ with mental illnesses.⁴²

Each of the articles included in this Symposium clarifies the significance of an interdisciplinary focus and cooperation across professional disciplines as service providers respond to the medical, including mental health, needs of veterans. Centralization of services can be essential to that effort. Even in communities that include significant services responding to the needs of veterans, lack of coordination makes it difficult for veterans to identify and gain access to available services. As an illustration, Bellehsen describes one model of cooperation between major health systems: Northwell Health and a VA Medical Center. That model facilitates good care for veterans and veterans' family members within one framework.⁴³ Another model for centralization, Mission Critical, offering a broader array of services, including legal services, is being developed by the Gitenstein Institute. Mission Critical aims to deliver multidisciplinary resources—educational, public health, clinical, legal, and social—at one location in Nassau County.⁴⁴ Such multidisciplinary partnerships and centralization of services further the effort to assist veterans with the transition into civilian life and to assist the family members of those veterans during the period of transition.

Responding effectively and efficiently to veterans' needs and to the needs of their families becomes particularly compelling in light of the inequality that characterizes those who bear the “wounds of war” in the United States today. Based on their review of many empirical studies and several surveys, Douglas Kriner and Francis Shen report that, “even more than previous wars, Iraq and Afghanistan have been working class wars.”⁴⁵ Referring to “[t]wo Americas of military sacrifice,” they report that “both fatal and non-fatal casualties in America’s wars have come from parts of the country that are lower on the socioeconomic ladder.”⁴⁶

40. *Id.* Trivedi notes that the PACT model has resulted in greater patient satisfaction, less burnout among staff, and modest financial benefits. *Id.* at 31-32.

41. The study population consisted of veterans age sixty-five and older with mental illness diagnoses and various physical conditions such as diabetes and heart disease. *Id.* at 32.

42. *Id.*

43. See *supra* text accompanying notes 37-38.

44. See *Mission Critical*, MAURICE A. DEANE SCH. L. HOFSTRA U., <http://www.law.hofstra.edu/news/events/missioncritical/index.html> (last visited Nov. 26, 2016).

45. Douglas L. Kriner & Francis X. Shen, *Invisible Inequality: The Two Americas of Military Sacrifice*, 46 U. MEM. L. REV. 545, 547 (2016).

46. *Id.* at 557.

This inequality shapes public responses to the needs of veterans.⁴⁷ Drawing from this reality, the author of this Foreword suggests that the hurdles veterans now face in obtaining the services they need to successfully reenter civilian life will be significantly ameliorated if—and perhaps *only* if—the nation’s military, now composed of volunteers, is replaced with one composed of draftees—in short, of *everyone*, pursuant to the reinstatement of a draft. We would include in the move to a national draft an option that allows for alternative, as well as military, service. A national draft will direct national attention to the needs of those who serve the nation while they are in service and as they return to civilian society.⁴⁸

47. *See id.* at 578 (noting the “political ramifications of casualty inequality”).

48. Of course, a national draft would serve many other goals as well. A discussion of those goals and their implications is, however, beyond the scope of this Foreword.