United States General Accounting Office

GAO

Testimony

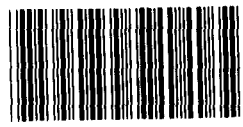
Before the Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs
House of Representatives

For Release
on Delivery
Expected at
9:00 a.m. EDT
Wednesday,
March 3, 1993

VETERANS' HEALTH CARE

Potential Effects of Health Reforms on VA Construction

Statement of David P. Baine, Director
Federal Health Care Delivery Issues
Human Resources Division



GAO/T-HRD-93-7

SUMMARY

GAO believes that the Congress should proceed cautiously with construction of additional VA health care facilities until reforms to the nation's health care system and VA eligibility take shape. This is because of the uncertainty surrounding the potential effects of such reforms on demand for VA health care. First, any national health care reform that expands insurance coverage among veterans could substantially reduce demand for VA-sponsored care. GAO estimates that under a nationwide universal coverage plan, for example, demand for VA inpatient care could drop 50 percent. Reform of VA's system for determining eligibility for health care could similarly have dramatic effects on VA utilization. For example, the number of outpatient visits, which totaled about 22 million in fiscal year 1991, could increase to 24 million to 57 million if the Congress adopts any of the reform proposals VA developed.

A limitation on construction of additional VA health care facilities, however, does not have to mean an interruption in meeting the health care needs of America's veterans. Rather, the Congress and VA could take the opportunity to test alternative methods of delivering services to veterans that could, at least on an interim basis, provide veterans acute care services in their home communities years earlier than could be provided through new construction.

The Congress could consider authorizing VA to conduct such demonstration projects in one or more locations where unused capacity exists in community or military hospitals. Possible locations include Hawaii, northern California, and east central Florida.

Mr. Chairman and Members of the Subcommittee,

We are pleased to be here today to discuss several issues relating to the Department of Veterans Affairs' (VA's) health facilities construction program. Our testimony this morning primarily concerns the need for and size of VA construction projects if proposed health care reforms--reforms to reduce the number of uninsured Americans and revise the eligibility system for VA health care--are implemented. In addition, I will discuss the extent to which VA considers construction alternatives, such as the availability of state and community resources, when it determines the need for VA construction projects.

Mr. Chairman, it is our overall belief that the Congress should proceed cautiously with construction of additional VA capacity until reforms to the nation's health care system and VA eligibility take shape. This does not, however, have to mean an interruption in meeting the health care needs of America's veterans. Rather, a limitation on the construction of new VA medical care capacity could provide an opportunity to test alternative methods of delivering services to veterans. Use of alternative delivery methods could, at least on an interim basis, provide veterans acute care services in their home communities years earlier than could be provided through construction of new or replacement VA facilities. Through demonstration projects, VA could determine whether (1) veterans are satisfied with the new methods of providing care and (2) services can be provided closer to veterans' homes without increasing health care costs.

Our views are based on our work over the past 3 years. During this period, we have assessed VA's plans for constructing medical centers in Hawaii, northern California (as a replacement for the closed Martinez medical center), and east central Florida. In each location, there are two common conditions: (1) veteran populations are split between two or more population centers, making it difficult for one VA hospital to effectively meet the inpatient care needs of all veterans, and (2) adequate capacity exists in nearby community and/or military hospitals to meet these needs. These local conditions create the potential for VA to provide outpatient care through its clinics in each population center, but provide inpatient hospital care through contracts or sharing agreements with community or military hospitals. As I will discuss later, such demonstrations could be structured in several ways.

Let me turn now to some of the potential effects that reform of the nation's health care system could have on future demand for VA health care services.

NATIONAL HEALTH REFORM COULD REDUCE DEMAND FOR CARE IN VA FACILITIES

Any program that would expand insurance coverage among veterans could substantially reduce demand for VA-sponsored care.

For example, last year we estimated that demand for VA inpatient services, as measured by days-of-care provided to veterans, could drop by 18 percent if employers nationwide were mandated to either provide health insurance coverage for their workers or pay a tax that would be used to obtain the coverage. Similarly, demand for outpatient services could drop by about 9 percent.[1]

Our estimates are based on the premise that veterans obtaining alternate health insurance under employer mandates would, over time, reduce their use of VA health care to the lower rates that characterize veterans who now have private health insurance. For example, veterans without private coverage were eight times more likely to use VA inpatient care than veterans with private health insurance. Although several factors, such as the differences in the incomes of the employed-insured and employed-uninsured, could reduce the effect of employer mandates, we believe that there would be significant decreases in demand for VA care if employer mandates were implemented.

Under a nationwide universal coverage plan, we estimate that the effect could be even greater--demand for VA inpatient care could drop by 50 percent. Likewise, use of VA outpatient care could drop by 40 percent. Under a universal health insurance plan, veterans who would not be covered by employer mandates--including unemployed, retired, and part-time workers--would be provided coverage.

Because veterans with private insurance tend to use VA care at a lower rate than veterans with public insurance; that is, Medicare or Medicaid, the decrease in demand for VA services might vary depending on whether the universal plan resembled a private or public plan. In either case, we believe that the decrease would be substantial.

Reform of the nation's health care system could also have significant effects on demand for VA-supported nursing home care. Most health care programs, other than VA and Medicaid, currently provide limited coverage of long-term nursing home care. If the reformed health care system includes long-term nursing home coverage, it could lead to a decline in demand for VA-supported care. The extent of the decline in demand for VA care would likely depend largely on the extent of cost sharing imposed under any new program.

Conversion of excess hospital beds to other uses, such as nursing home care, could also reduce the need for and cost of future nursing home construction. This is because it costs about twice as much to construct new nursing homes as it does to convert

---

[1]VA Health Care: Alternative Health Insurance Reduces Demand for VA Care (GAO/HRD-92-79, June 30, 1992).

existing hospital beds to nursing home beds.[2] In addition, conversions of excess health care capacity to nursing homes can generally be accomplished faster than new construction.

As you can see, under either employer health insurance mandates or some form of universal coverage, there would likely be a significant decline in demand for VA health care services. Such a decline could create significant excess capacity in VA facilities.

REFORM OF VA ELIGIBILITY COULD AFFECT FUTURE DEMAND FOR VA SERVICES

Just as reform of the nation's health care system could affect demand for VA health care services, so too could reform of the VA eligibility system itself. This issue is likely to be the subject of extensive congressional debate before this and other committees in the coming year. The decisions made on eligibility reform, like the decisions on how to reform the nation's health care system, could have a significant effect on future demand for VA health care. Let me explain.

VA's Commission on the Future Structure of Veterans Health Care recommended major reform of VA eligibility in its November 1991 report to the Secretary. The Commission noted that eligibility rules are complex and confusing. VA eligibility differs for hospital care, outpatient care, and long-term care, and varies according to the veteran's status and the type of care needed. As a result, a veteran eligible for hospital care may not be eligible for outpatient care other than to prepare for or as a followup to hospital care. Similarly, a veteran may be able to obtain outpatient care for a service-connected disability but not for nonservice-connected conditions.

In March 1992, the Deputy Secretary of Veterans Affairs established a task force to develop proposals for eligibility reform. The task force developed four alternative proposals for reforming VA health care eligibility. The task force predicts widely varying VA workloads depending on which, if any of the proposals, is adopted. For example, the predicted number of inpatient hospital patients treated ranges from 1 million to about 3 million; the number of outpatient visits ranges from 24 million to 57 million, and the average daily census of long-term care patients ranges from 70 million to 593 million.

Our point in mentioning these numbers is not to comment on the merits or costs of the various eligibility reform options. Rather, we want to emphasize the uncertainty that surrounds the future

---

[2]VA Health Care: Improvements Needed in Nursing Home Planning (GAO/HRD-90-98, June 12, 1990).

structure of the VA system. Until the Congress reaches decisions on eligibility reforms, predicting how many hospital and nursing home beds will be needed in the future or, for that matter, how large outpatient clinics should be is impossible. It is this uncertainty that leads us to conclude that construction of additional capacity should, at this time, be approached with caution to avoid overbuilding.

To this point, I have focused only on the uncertainty surrounding future demand for VA services. I would like to turn now to one of the recurring factors that we have noticed concerning VA's construction planning process--inadequate consideration of alternatives to new VA construction.

VA DOES NOT ADEQUATELY CONSIDER COMMUNITY AND MILITARY RESOURCES

For more than 10 years we have been recommending that VA consider the availability of community and state nursing homes in its facility construction process. Using such resources to the maximum extent possible is important because care in community nursing homes costs VA about half of what it costs to provide care in VA nursing homes.[3] Care in state veterans homes is even more cost effective for VA; VA pays a per diem of about $22 for nursing home care in state veterans homes and 65 percent of the cost of constructing and renovating state homes.

In addition, to the extent VA can increase its use of community nursing homes and state veterans homes, it can avoid the costs of constructing VA nursing homes. VA expects to spend about $13 million to construct a 120-bed nursing home in east central Florida.

While most of our work has focused on use of state and community nursing homes as an alternative to construction of VA nursing homes, we found during recent reviews of VA's planning for the construction of three medical centers that existing capacities in community and military hospitals appeared to be adequate to meet VA's acute care needs. As I mentioned earlier, one common feature of all three projects is that the veteran population is split between two or more major population centers, making it difficult to adequately serve veterans with one facility. What follows are our primary findings for the three areas under consideration for new medical centers.

-- Northern California: The veteran population is roughly split between the East Bay (Oakland) and Sacramento areas, approximately 70 miles apart. Although there is no VA inpatient

[3]Average obligations per patient day were $155 for VA nursing home care units and $79 for community nursing homes in fiscal year 1990.

hospital capacity in the northern California catchment area as a result of the closure of the Martinez medical center, there is significant unused capacity in community hospitals located near the Oakland, Martinez, and Sacramento VA outpatient clinics. For example, two community hospitals within 10-15 miles of the Martinez clinic told VA in 1991, shortly before the Martinez hospital closed, that they each had adequate capacity to absorb the entire Martinez medical, surgical, and neurological workload. Similarly, officials at the University of California (Davis) hospital in Sacramento indicated that they were expanding the facility and would consider leasing six floors of the planned bed tower to VA for an indefinite period.

-- East central Florida: The veteran population is split between three population centers--Orlando, Daytona Beach, and Cocoa/Melbourne. The nearest VA medical centers are in Tampa, about 80 miles west of Orlando, and Gainesville, more than 100 miles northwest of Daytona Beach. There are, however, about 2,100 empty community hospital beds in the Orlando and Cocoa/Melbourne areas on any given day, a local health planning agency reported in 1989. Only one Orange County hospital had had an occupancy rate above 60 percent. Similarly, a Volusia County (Daytona Beach) official told VA in 1991 that an entire 300 bed hospital was available for VA use. Finally, unused capacity exists at the Orlando Naval Hospital.

-- Hawaii: About 22 percent of the veteran population is located on the outer islands. Because there is currently no VA hospital in Hawaii, veterans are authorized to use either the Tripler Army Medical Center, which was renovated with adequate capacity to meet VA's current and anticipated needs, or community hospitals on Oahu and the outer islands. The Administrator of Hawaii's health planning agency told us that there is no shortage of acute care beds in Hawaii. Excess capacity is so prevalent that local officials estimate it could be as long as 15 years before a certificate of need is approved for private construction of additional acute care capacity.

While none of the three areas I just described currently has a VA hospital, each area appears to have adequate capacity in its nearby community and military hospitals to meet VA's needs. However, the cost advantages of providing inpatient hospital care in community facilities are not as clear as the advantages of providing nursing home care in community nursing homes. Reliable data are not available to show whether providing care in VA hospitals is less costly than in private sector hospitals.

The Congress faces a dilemma: If VA hospitals are built to meet the current health care needs of veterans in these three areas, the hospitals could have significant excess capacity before they even open; on the other hand, if construction is delayed until

health reforms take shape, the health care needs of an aging veteran population might go unmet.

DEMONSTRATION PROJECTS COULD IMPROVE VETERANS ACCESS TO ACUTE CARE WHILE DECISIONS ARE MADE ON REFORMS

One potential way to deal with that dilemma would be to test alternative means of meeting the health care needs of veterans and improving access to hospital care. For example, the acknowledged excess hospital capacities in the non-VA sector in northern California, east central Florida, and Hawaii provide excellent opportunities to test the feasibility of contracting for inpatient care at community or military hospitals. By contracting for care in such hospitals in Orlando, Daytona Beach, and Cocoa/Melbourne, for example, veterans in all three communities could obtain hospital care close to their homes. Similarly, because VA operates northern California outpatient clinics in Oakland, Sacramento, Martinez, and Redding, it could potentially contract to meet the inpatient care needs of veterans in each community. Finally, as we pointed out in our report on the need for a VA hospital in Hawaii, VA could enter into a joint venture with the Department of Defense (DOD) at the Tripler Army medical center to meet the hospital needs of veterans living on Oahu in existing wards and continue to meet the hospital needs of veterans on the outer islands through contracts with community hospitals.

Several options could be tested: Under one option, VA physicians from the outpatient clinic, like private physicians, could obtain patient admitting rights to community hospitals. Such an option was proposed by one of the hospitals offering to care for veterans following the closure of the Martinez hospital. The private hospitals would supply nursing and other personnel. The VA patients could, depending on the contract, be treated on separate wards or interspersed with other hospital patients. Another option would be for VA to contract for space in existing facilities and staff and operate the space itself. Yet another option would be to contract for all inpatient services.

Demonstrations such as these could (1) test the cost effectiveness of alternative delivery methods and (2) assess differences in veteran satisfaction under the options.

In summary, VA, like other federal departments and agencies, is likely to face severe budget constraints during the next several years. Because of the uncertainty concerning future demand for VA services, we believe it would be prudent to delay most construction of additional capacity until the effects of health care and eligibility reforms can be more fully assessed. This would free up funds for deficit reduction without affecting current VA health care services and prevent construction of VA facilities that could quickly lead to excess capacity. To prevent construction delays

from adversely affecting veterans, the Congress could authorize VA to conduct one or more demonstration projects to test the concept of contracting for acute care services in community facilities in proximity to VA outpatient clinics.

- - - - -

Mr. Chairman, this concludes my prepared statement. We will be happy to answer any questions that you or the other Members of the Subcommittee may have.

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20884-6015

or visit:

Room 1000
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000 or by using fax number (301) 258-4066.

United States
General Accounting Office
Washington, D.C. 20548

Official Business
Penalty for Private Use $300

First-Class Mail
Postage & Fees Paid
GAO
Permit No. G100