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VA HEALTH CARE

Retargeting Needed to Better Meet Veterans' Changing Needs





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The Honorable Frank H. Murkowski
United States Senate

The Honorable Lane Evans
House of Representatives

This report provides information on (1) how well existing public and private health benefits programs and the Department of Veterans Affairs (VA) health care system are meeting the health care needs of veterans, (2) why most veterans have never used VA health care services, (3) whether the VA health care system is structured to enable VA to best meet the needs of veterans, and (4) what options are available for reconfiguring the VA health care system to better meet veterans' needs.

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A handwritten signature in black ink that reads "David P. Baine". The signature is written in a cursive style.

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Executive Summary

Purpose

The Department of Veterans Affairs (VA) has a \$16 billion health care budget. It faces increasing pressures to contain or reduce health care spending as part of governmentwide efforts to reduce the budget deficit. VA's health care system also faces increasing challenges from a changing health care marketplace. First, changes in the availability of public and private health insurance can have significant effects on veterans' demand for VA health care services. Second, the veteran population is aging and declining, causing increasing demand for long-term care services and decreasing demand for acute hospital care. Finally, cost-containment measures in other public and private health benefits programs that limit beneficiaries' choice of providers, increase cost sharing, or limit covered services could affect future demand for VA care and the types of services that veterans seek from VA.

Senator Frank H. Murkowski and Representative Lane Evans asked GAO to determine whether veterans' health care needs are being adequately addressed in this fast changing health care marketplace. In doing so, GAO determined

- how well existing public and private health benefits programs and the VA health care system are meeting the health care needs of veterans,
- why most veterans have never used VA health care services,
- whether the VA health care system is structured to enable VA to best meet the needs of veterans, and
- what options are available for reconfiguring the VA health care system to better meet veterans' needs.

Background

The veterans' health care system was originally established primarily to treat war-related injuries and help rehabilitate veterans with such service-connected disabilities as blindness, paralysis, and loss of limb. VA became a national leader in such fields as blind rehabilitation, prosthetics, and treatment of spinal cord injury. It also grew into the nation's largest direct delivery system with 171 hospitals, 182 independent outpatient clinics, 128 nursing homes, and 38 domiciliaries.

Gradually, VA shifted from a system that provided treatment primarily for service-connected disabilities to a system focusing primarily on treatment of low-income veterans with no service-connected disabilities. In 1991, about 2.2 million veterans made more than 20 million outpatient visits to VA health care facilities and had more than 970,000 hospital stays. Of these veterans, about 1 million had service-connected disabilities and 1.2 million

had no disabling conditions relating to military service. Even the service-connected veterans, however, obtained treatments primarily for conditions unrelated to their service-connected disabilities.

Significant changes have occurred in health coverage in the 60 years following the establishment of VA's direct delivery system. The availability of private health insurance emerged and public health benefits programs such as Medicare, Medicaid, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) were established to help selected groups such as the elderly, low-income, and military retirees and dependents pay for health care services.

Such changes can have unforeseen repercussions. For example, decreases in the availability of private health insurance could increase demand for VA care. On the other hand, state or nationwide health reforms that would decrease the number of uninsured could decrease demand for VA care. In addition, barring a build up of military forces, the number of veterans will decrease by about 50 percent between 1990 and 2040. Consistent with this trend and other factors, such as the movement toward ambulatory care, VA acute care hospital discharges dropped about 13 percent between 1988 and 1992. Such declines suggest that VA will have to either (1) capture a steadily increasing marketshare of the veteran population or (2) expand treatment to nonveterans if it is to maintain utilization at VA hospitals.

Dramatic changes are occurring in both private and public health insurance programs that could make it even more difficult for VA to maintain its acute care system. These changes affect where health care services are provided, how their appropriateness is ensured, and how they are paid for. Among the most significant trends in other health care programs is the move toward managed care.¹ Consistent with this trend and in an effort to strengthen its competitive position, VA is already moving toward a managed care system.

Results in Brief

Many veterans have health care needs that are not adequately addressed through current health care programs, including the VA health care system. For example:

¹The term managed care applies broadly to any system of health care delivery that influences the utilization and cost of services and measures performance of the system and its providers. Important elements of managed care include utilization review, case management, provider contracting, and information technology.

- About one-third of the nation's homeless are veterans, nearly one-half of whom have serious mental illnesses, suffer from substance abuse, or both. The homeless have limited access to health care services and may not seek medical treatment.
- About 38 percent of male and 25 percent of female Vietnam veterans with Post Traumatic Stress Disorder (PTSD) have not sought treatment from either VA or non-VA medical facilities.²
- About 191,000 low-income, uninsured veterans with no apparent health care options indicated in a 1987 VA survey that they had never used VA health care facilities because they were not aware that they were eligible for VA care or they had concerns about the quality or accessibility of VA health care.³

VA cannot adequately address many of these health care needs because (1) it relies primarily on direct delivery of health care services in VA-owned and VA-operated facilities, (2) its complex eligibility and entitlement provisions limit the services veterans can get from VA facilities, and (3) space and resource limitations prevent eligible veterans from obtaining covered services.

In GAO's view, changes need to be made in the veterans' health care system to enable it to better meet veterans' health care needs. To make optimum use of limited health care resources, such changes would need to be designed to complement rather than duplicate coverage provided through other public and private health benefits programs. VA's plans for restructuring the VA health care system, however, focus primarily on preserving and expanding VA's acute care mission rather than retargeting VA programs and resources to enable VA to fill the gaps in veterans' coverage under other public and private health benefits programs. GAO presents several options for restructuring VA's health care system to enable it to better meet the health care needs of veterans.

²PTSD refers to such symptoms as nightmares, intrusive recollections or memories, flashbacks, anxiety, or sudden reactions after exposure to traumatic conditions.

³VA contracted with a private firm to conduct a new survey of veterans, but data were not available when we completed our analysis.

Principal Findings

Public and Private Health Insurance Programs Do Not Meet All Veterans' Needs

Public and private health insurance programs do not—and cannot be expected to—meet all of the health care needs of veterans. About 2.6 million of the nation's veterans have neither public nor private health insurance to help pay for basic health care items and services. This includes about one-third of the country's homeless. Nearly one-half of the homeless have serious mental illnesses, suffer from substance abuse, or both.

Even veterans with public or private insurance can have unmet health care needs. For example, they may have undiagnosed or untreated problems with substance abuse or mental illness. Fewer than 15 percent of the estimated 18 million Americans with alcoholism receive treatment. Similarly, alcoholism is a frequently undiagnosed and untreated health problem of veterans using VA medical centers.

Unmet needs can also arise if high out-of-pocket costs limit access to needed health care services. Out-of-pocket costs can arise from health insurance premiums, copayments and deductibles, charges above approved rates, and charges for noncovered services or services that exceed coverage limits.

Many Low-Income and Uninsured Veterans Have Never Used VA Services

GAO's analysis of VA's 1987 Survey of Veterans identified about 855,000 low-income and uninsured veterans who indicated that they had never used VA health care services. About 191,000 of these veterans identified no other health care options available to them but indicated that they had not used VA because they were not aware that they were eligible for VA care or because of concerns about the accessibility or quality of VA health care.⁵ Of the 191,000, only about 10,000 indicated that they had never needed health care.

Structure of VA Health Care System Limits Its Ability to Meet Veterans' Needs

The structure of the VA health care system limits VA's ability to meet veterans' health care needs. First, its reliance on direct delivery of health care services rather than financing of health care services provided by private physicians and facilities limits the accessibility of VA health care services. Second, the complex eligibility and entitlement provisions in title

⁵The remaining veterans did not indicate why they had not used VA health care services.

38 of the U.S. Code restrict veterans' access to many VA health care services. This is particularly true for outpatient care; most veterans are limited to receiving services to prepare for, obviate the need for, or as a followup to hospital care.

Finally, specialized services are frequently unavailable because of the lack of space or resources. For example, waiting lists for inpatient PTSD treatment have averaged between 900 and 1,000 for the past 3 years.

Most Veterans Using VA Facilities Have Other Health Care Options

About 58 percent of veterans who used VA health care facilities in 1990 also had coverage under one or more public or private health benefits programs. For example, 47 percent of VA users were Medicare-eligible and 12 percent were eligible for treatment under CHAMPUS, in Department of Defense (DOD) health care facilities, or both. In addition, 33 percent of VA users reported having private health insurance coverage.

VA Restructuring Efforts Need to Focus on Veterans' Health Care Needs

VA's restructuring efforts focus primarily on preserving or expanding VA's direct care system rather than on how to better meet the changing health care needs of veterans. For example, VA is developing plans to test the use of full-service health care plans in states that implement health reforms. Under such plans, most VA resources would be directed toward duplicating coverages that veterans would have under other health plans, essentially shifting costs from public and private programs to VA. With limited resources, it may be more cost effective for VA to focus on providing services to uninsured veterans in states that have not implemented major health reforms aimed at reducing the number of uninsured or to provide or pay for services not covered under such state reform programs. By taking advantage of veterans' alternative coverage, VA could provide veterans more extensive health care coverage with available resources.

Among the options that could be explored for improving VA's ability to fulfill its safety net mission in states not implementing health reforms are expanding VA's current fee basis program;⁵ expanding an existing federal health care program, such as Medicare or CHAMPUS; or authorizing veterans to enroll in the Federal Employees Health Benefits Program. Changes in eligibility for VA care should be an integral part of any such changes.

⁵The fee-basis program enables certain veterans, primarily those with service-connected disabilities, to get care from non-VA providers at VA expense if VA facilities are geographically inaccessible or unable to provide the needed service.

There are also restructuring options that could be considered in states that implement health reforms. For example, VA acute care resources could be retargeted to (1) increase outreach to homeless veterans; (2) expand services for substance abuse treatment and mental health counseling not extensively covered under the state program; (3) identify and treat more veterans with PTSD; (4) expand health benefits not covered under the state program; or (5) expand long-term care services. Other options for financing increased long-term care services are estate recoveries and greater beneficiary cost-sharing.

Recommendations

In light of current efforts to reduce the budget deficit while improving health services, GAO recommends among other things that the Secretary of Veterans Affairs, in concert with veterans service organizations and other federal and state agencies with jurisdiction over health benefits programs, (1) identify and evaluate options to better target VA resources to meet the health care needs of veterans and (2) develop legislative proposals to restructure the veterans health benefits program.

Agency Comments

VA did not agree with GAO's recommendations and said that they would result in the dismantling of VA's patient care and other missions. VA questioned the accuracy and appropriateness of much of the data presented in the report. While GAO agrees that its recommendations could result in significant changes in VA's direct patient care mission, they would strengthen VA's role in ensuring that veterans' health care needs are met either through VA or other programs.

VA's comments about the accuracy and appropriateness of the report data are unfounded. For example, VA said that factual errors exist in the discussion of eligibility, but VA officials with whom GAO followed up could cite no examples. In other criticisms, VA attributed GAO's analyses to the wrong source when the source was clearly indicated in the report, and took issue with a statement that does not appear in the report. (See pages 50 to 54 and app. II.)

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Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
	Department of Defense
DOD	Department of Defense
DRG	Diagnostic Related Groupings
DSS	Decision Support System
FY	fiscal year
HCFA	Health Care Financing Administration
HCMI	Homeless Chronically Mentally Ill program
HMO	health maintenance organization
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
PTSD	post traumatic stress disorder
RPM	Resource Planning Methodology
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Background

The Department of Veterans Affairs health care system was originally established primarily to treat war-related injuries and help rehabilitate veterans with such service-connected disabilities as blindness, paralysis, and loss of limb. Because the private sector lacked the resources and expertise to treat large numbers of returning war casualties, veterans hospitals were established to meet the special care needs of America's veterans. VA became a national leader in such fields as blind rehabilitation, prosthetics, and treatment of spinal cord injury. It also grew into the nation's largest direct delivery system with a \$16 billion budget to maintain and operate 171 hospitals, 182 independent outpatient clinics, 128 nursing homes, and 38 domiciliaries.⁷

As war injuries healed, demand for acute care services declined and the needs of service-connected veterans increasingly shifted from treatment of the war injuries to treatment of the lingering effects of those injuries. Due in part to the declining demands for care by service-connected veterans and in part to the limited public and private insurance coverage available to low-income people, including veterans, the Congress, over time, developed a second, safety net, mission for VA. VA would, to the extent space and resources remained after meeting the health care needs of service-connected veterans, provide hospital care to nonservice-connected veterans lacking the resources to pay for such care from non-VA providers.

Gradually, VA shifted from a system primarily providing treatment for service-connected disabilities to a system primarily focusing on treatment of nonservice-connected disabilities. In 1991, about 2.2 million veterans made more than 20 million outpatient visits to VA health care facilities and had more than 970,000 hospital stays. Of these veterans, about 1 million had service-connected disabilities and 1.2 million had no disabling conditions relating to military service. Even the service-connected veterans, however, obtained treatments primarily for conditions unrelated to their service-connected disabilities.

Significant changes have occurred in the availability of health coverage in the 60 years following the establishment of VA's direct delivery system. Foremost among these changes has been the growth of public and private health insurance programs. Private health insurance, virtually unknown at the time the VA system was created, began to emerge with the creation of the first Blue Cross and Blue Shield plans in the 1930s. Similarly, public health benefits programs were established to help selected groups pay for

⁷Includes independent, satellite, community-based, rural outreach, and mobile clinics. Does not include outpatient clinics operated as part of a medical center.

health care services. These programs include the Civilian Health and Medical Program of the Uniformed Services, which covers military retirees and their dependents and dependents of active duty military personnel; Medicare, which covers most persons age 65 or older and certain disabled persons under age 65; and Medicaid, which covers many low-income persons. With the growth of public and private insurance programs, about 9 out of 10 veterans now have coverage under one or more public or private health benefits programs in addition to their VA health benefits.⁸

When multiple health programs exist, changes in one program can have unforeseen repercussions on the others. For example, decreases in the availability of private health insurance could increase demand for VA care. In recent years, the number of uninsured Americans has steadily increased and, in 1993, an estimated 37 million were uninsured. On the other hand, health reforms in individual states or nationwide that would decrease the number of uninsured could decrease demand for VA care because veterans would not be as dependent on VA for their care. For example, under a universal health care program, demand for VA hospital care could decrease by about 50 percent.⁹

The availability of alternative health insurance, however, is not the only factor that could decrease future demand for VA acute hospital services. Barring wars or a build up of military forces, the number of veterans will decrease by about 50 percent between 1990 and 2040. Consistent with this trend and other factors, such as the movement toward ambulatory care, VA acute care hospital discharges, which increased steadily from 1984 to 1988, dropped about 13 percent between 1988 and 1992. Such declines suggest that VA will have to either (1) capture a steadily increasing marketshare of the veteran population or (2) expand treatment to nonveterans if it is to maintain utilization at VA hospitals.

Dramatic changes in both private and public health insurance programs could make maintaining its acute care system even more difficult for VA. These changes affect where health care services are provided, how the appropriateness of health care services is ensured, and how beneficiaries pay for health care services. Among the most significant trends in other health care programs is the move toward managed care.

⁸Veterans' Health Care: Most Care Provided Through Non-VA Programs (GAO/HEHS-94-104BR, Apr. 25, 1994).

⁹VA Health Care: Alternative Health Insurance Reduces Demand for VA Health Care (GAO/HRD-92-79, June 30, 1992).

The term managed care applies broadly to any system of health care delivery that influences the utilization and cost of services and measures performance of the system and its providers. The goal of managed care is a health care system that delivers value by giving people access to quality cost-effective health care. Managed care arrangements range from incorporating selected elements of managed care—typically preadmission screening and utilization review—in traditional fee-for-service health insurance plans to establishing health maintenance organizations (HMO) or other capitated managed health care plans.¹⁰

Both the private sector and public health benefits programs are increasingly moving toward managed care. Enrollment in HMOs increased from 9 million in 1982 to nearly 40 million in 1992. Similarly, many states, including Arizona, Oregon, California, and Illinois, have turned to managed care to help control Medicaid spending. In addition, the Department of Defense is implementing a nationwide managed care system—TRICARE—for military dependents and retirees.

Consistent with the trend toward managed care in other private and public health benefits programs and in an effort to strengthen its competitive position, VA is already moving toward a managed care system. For example, VA

- developed a new Resource Planning Methodology (RPM) that contains incentives for medical facilities to provide care in the most cost-effective setting;
- plans to reorganize its health care facilities into geographic networks, known as Veterans Integrated Service Networks (VISN), to trim unnecessary management layers, consolidate redundant medical services, and use available community services;
- is implementing a Decision Support System (DSS) that will provide data on patterns of care and patient outcomes as well as their resource and cost implications;
- is developing proposals to reform eligibility for VA care to enable VA facilities to provide care in the most cost-effective settings; and
- is developing pilot projects that would enable VA to participate under state health reform projects such as those planned in Washington and Minnesota.

¹⁰HMOs are entities that provide, offer, or arrange for coverage of designated health services needed by plan members for a fixed, prepaid premium.

Washington state's Health Services Act of 1993 enacted a series of reforms intended to provide universal coverage for all residents by July 1999. The act is based on managed competition with price controls and would establish a uniform benefit package. The plan's reforms, which include employer mandates, health insurance purchasing cooperatives, and expanded public programs, will be phased in over several years.

Tennessee inaugurated TennCare, a capitated managed care system covering its Medicaid and uninsured populations, on January 1, 1994. Although veterans were initially excluded from the program because of their VA eligibility, they can now enroll in TennCare if they meet eligibility requirements. An analysis of the TennCare plan by a local VA medical center concluded that VA could lose a major portion of its low-income workload.

The future of these and other state reform efforts, like the prospects for national health care reforms, is uncertain.

Scope and Methodology

Senator Frank H. Murkowski and Representative Lane Evans asked us, in separate requests, to determine whether veterans' health care needs are being adequately addressed in the fast changing health care marketplace.¹¹

To respond to the requests, we examined the following questions:

- How well do public and private health insurance currently meet the health care needs of veterans?
- Why have most veterans, including many whose health care needs are not met through other public or private health insurance programs, never used VA health care services?
- Is the VA health care system structured to meet the needs of veterans unable to obtain all the health care services they need through other programs?
- Are VA resources effectively targeted toward veterans with the greatest health care needs?

¹¹Senator Murkowski was the Ranking Minority Member of the Senate Committee on Veterans' Affairs and Representative Evans was the Chairman of the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs at the time they made their requests.

To determine how well existing public and private health benefits programs and VA address veterans' health care needs, we relied primarily on published studies, including

- Report of the Commission on the Future Structure of Veterans Health Care (1991);
- Strategy 2000: The VA Responsibility in Tomorrow's National Health Care System, (1992) prepared by the Paralyzed Veterans of America;
- Veterans Health Care: Implications of Other Countries' Reforms for the United States (GAO/HEHS-94-210BR, Sept. 27, 1994);
- Health Security Act: Analysis of Veterans' Health Care Provisions (GAO/HEHS-94-205FS, July 15, 1994); and
- VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (GAO/HRD-93-94, July 29, 1993).

Data on veterans' use of the Department of Veterans Affairs were obtained through analysis of VA's 1987 Survey of Veterans. The survey database contains the latest comprehensive data on veterans' opinions and use of VA services.¹² We also used the survey to estimate the number of veterans who have not used VA for health care and the reasons why. To determine potential veteran unmet health needs we analyzed the survey data to determine what portion of veterans not using VA lacked health insurance and indicated that they chose not to use VA because they were not aware that they were eligible for VA care or because they had concerns about the accessibility or quality of care in VA health care facilities.

We relied on prior GAO studies in determining whether (1) VA is structured to meet the health care needs of veterans and (2) VA resources are effectively targeted toward veterans with the greatest health care needs. (See the related GAO products section for a list of relevant reports and testimonies.)

¹²The Census Bureau conducted the 1987 Survey of Veterans based on its Current Population Survey, a monthly nationwide survey designed to obtain information on the employment status and other characteristics of the population. Each month, one-eighth of the households in the Current Population Survey are dropped from the sample and replaced by new households. Veterans who were rotated out of the Current Population Survey between April 1986 and January 1987 were included in the 1987 Survey of Veterans. A total of 11,439 veterans were sampled. Among other things, the survey contains information on the number of veterans, their employment status, their health insurance coverage, and their reasons for not using VA health care. A VA contractor completed an independent study in 1989, validating the survey methodology.

VA contracted with a private firm to conduct a new survey of veterans. The survey was recently completed; however, the results were not available at the time we completed our audit work. VA officials said that the contractor who conducted the survey indicated the results were not significantly different from the 1987 Survey of Veterans.

Chapter 1
Introduction

Our work was conducted between July 1993 and January 1995 in accordance with generally accepted government auditing standards.

Public and Private Health Insurance Programs Do Not Meet All Health Care Needs of Veterans

Public and private health insurance programs do not—and cannot be expected to—meet all the health care needs of veterans. Like other uninsured Americans, the estimated 2.6 million uninsured veterans may be unable to afford basic health care services for themselves and their families. But even those with public or private health insurance or both can incur high out-of-pocket costs that force them to delay or forego needed care. In addition to premiums, copayments, and deductibles, veterans can be liable for the full costs of health care services that their insurance does not cover or that exceed the limits of their coverage. Still other veterans may have health problems, such as substance abuse or PTSD, that are undiagnosed or for which they have not sought treatment. All these problems—lack of insurance, high out-of-pocket costs, and substance abuse and other mental health problems—make the estimated 150,000 to 250,000 homeless veterans a particularly vulnerable population.

About 2.6 Million Veterans Are Uninsured

About 2.6 million veterans (about 9 percent of the veteran population) had neither public nor private health insurance in 1990 to help pay for needed health care items and services.¹³ Without a demonstrated ability to pay for care, individuals' access to health care is restricted, increasing their vulnerability to the consequences of poor health. Lacking insurance, people often postpone obtaining care until their conditions become more serious and require more costly medical services.

Substance Abuse, PTSD Problems Frequently Go Undiagnosed and Untreated

Veterans, like the general public, can have undiagnosed and, therefore, untreated health care conditions. Two health problems that frequently go untreated—substance abuse and PTSD—are frequently related to military service.

Substance abuse is a frequently overlooked health problem in the United States despite its significant medical, economic, social, and legal consequences. For example, an estimated 18 million Americans are either alcoholics or are problem drinkers, but fewer than 15 percent of them receive treatment. Similarly, alcoholism is a frequently undiagnosed and untreated health problem of veterans using VA medical centers.

In 1990, we surveyed veterans applying for care at five VA medical centers during a 10-day period to determine the extent of alcoholism among

¹³See *Veterans' Health Care* (GAO/HEHS-94-104BR, Apr. 25, 1994).

veterans.¹⁴ Information obtained from 29 percent of the veterans we surveyed strongly indicated that they had alcoholism. An additional 14 percent provided information that raised suspicions of alcohol abuse problems. The five medical centers provided alcohol treatment to fewer than 3 percent of veterans applying for medical care during fiscal year 1990.

PTSD can have disruptive effects on family life, work, and leisure activities. Veterans with PTSD experience such symptoms as nightmares, intrusive recollections or memories, flashbacks, anxiety, or sudden reactions after exposure to traumatic conditions. Although PTSD is most commonly associated with Vietnam combat, it has also been diagnosed in World War II and Korean Conflict veterans, and among many of the medical personnel who served in Vietnam.

In 1988, the National Vietnam Veterans Readjustment Study, a comprehensive national epidemiological survey, reported that an estimated 480,000 Vietnam veterans were suffering from PTSD. The study also reported that 38 percent of male veterans and 25 percent of female veterans who served in Vietnam and have PTSD had not sought mental health treatment from VA or from non-VA medical facilities.

Medicare and Private Health Insurance Provide Limited Coverage of Long-Term Care Services

Medicare and private insurance provide only limited coverage for nursing home and long-term psychiatric care. For example, skilled nursing home care under both Medicare and private health insurance is limited to short-term post-acute care. Neither Medicare nor private insurance offers intermediate nursing home care or custodial care.¹⁵ As a result, veterans who need long-term care for chronic conditions cannot obtain it through either Medicare or private insurance. Medicaid covers long-term nursing home care but requires individuals to spend most of their income and assets on nursing home care before they can qualify for Medicaid and to apply most of their income toward the cost of their care while in nursing homes.

¹⁴See VA Health Care: Alcoholism Screening Procedures Should Be Improved (GAO/HRD-91-71, Mar. 27, 1991).

¹⁵Intermediate care is provided in nursing homes but is less intensive than skilled nursing home care. Patients require supervision, protection, and assistance but only occasional skilled nursing or skilled rehabilitation. Custodial care refers to care that is primarily for the purpose of helping the patient in meeting daily living or personal needs and can be provided by people without professional skill or training in nursing homes or domiciliaries.

Another aspect of long-term care where veterans can have unmet needs is long-term hospital care. Medicare limits inpatient medical and surgical care to 90 days during any benefit period.¹⁶ For illnesses requiring more than 90 days of hospitalization, Medicare beneficiaries are allowed 60 extra hospital days, called reserve days, during a benefit period but the reserve days are not renewable.

Medicare and private health insurance limits on inpatient mental health care can also cause unmet veteran health needs. Medicare covers no more than 190 days in a psychiatric hospital per lifetime. The limits on care in a hospital, including the reserve days, apply to both inpatient medical and surgical care and inpatient mental health care. According to the Bureau of Labor Statistics, 75 percent of private health insurance enrollees had limits on inpatient mental health care; 50 percent had limits on days of care. In addition, 38 percent had a maximum dollar benefit, usually per lifetime but occasionally per year.

Many Health Care Needs Are Not Covered Under Veterans' Public or Private Insurance

Although most private health insurance and Medicare cover a wide range of health care services, certain health care items and services are not extensively covered. Thus, even veterans with private insurance or Medicare coverage may have unmet health care needs if they cannot afford to pay for such care. These areas of unmet needs include the following:

- Medicare-eligible veterans can have unmet needs for outpatient drugs. Medicare is the only major health benefits program that does not routinely cover outpatient drugs.¹⁷ Medicare covers primarily drugs and medical supplies furnished while a beneficiary is receiving inpatient care and injections administered in a doctor's office.
- Dental care is not extensively covered under either Medicare or private health insurance. Medicare does not cover routine dental care; about one-third of private health insurance policies do not provide dental coverage. Of those private health insurance policies with dental coverage, over four-fifths have an annual maximum plan benefit, most commonly \$1,000.
- Home health care is covered to some extent under virtually all health benefits programs, but most programs are oriented toward skilled care.

¹⁶A benefit period begins with admission to a hospital and ends when the beneficiary has been out of the medical facility for 60 days.

¹⁷Outpatient drugs are those drugs and medical supplies intended for use on an outpatient or at-home basis.

Veterans can, therefore, have unmet needs for assistance if they have chronic health care problems that require the assistance of others but do not require skilled care.

- Vision care is not extensively covered under either Medicare or private health insurance. Although both will pay for cataract surgery and lens implants or glasses associated with such surgery, they do not generally pay for routine eye examinations, eyeglasses, or contact lenses. Medicare provides no coverage for such services while about 35 percent of private health insurance policies provide such coverage.

Veterans May Forgo Treatment Because of High Out-Of-Pocket Costs

Veterans, particularly those with low incomes, may forgo needed medical treatment because they cannot afford the high out-of-pocket costs associated with the care. Even with health insurance, out-of-pocket health care costs can amount to thousands of dollars a year. Such costs come from many sources, including Medicare part B or private health insurance premiums, copayments, deductibles, physician charges that exceed authorized payment levels, and payments for noncovered services.

Medicare and private health insurance generally have copayments, deductibles, or both for inpatient and outpatient care. For example, for inpatient care in 1991, Medicare beneficiaries paid a \$628 deductible per benefit period and 20 percent of approved professional charges; for stays of over 60 days, beneficiaries paid copayments of \$157 for the 61st through 90th day and \$314 for the 91st through 150th day. For outpatient care, Medicare beneficiaries have a \$100 deductible and pay 20 percent of approved charges.

While most private insurance does not have a deductible for inpatient hospital care, over 70 percent of private insurance requires copayments for hospital stays—most often 20 percent of room and board and 20 percent of professional charges. Finally, private health insurance typically has both deductibles and copayments for outpatient care. For example, the Bureau of Labor Statistics reports that 95 percent of participants in private insurance plans have a deductible, usually \$100.¹⁸ Over 90 percent have copayments for outpatient medical care, usually 20 percent.

Copayments and deductibles can be costly and discourage veterans from seeking needed care. For example, for a 10-day hospital stay with major

¹⁸Most participants pay two to three times the individual rate for a family; \$200 to \$300 being the most common deductible amount.

surgery costing \$10,500, a service-connected or low-income veteran would pay nothing through VA, \$1,208 through Medicare, and \$2,180 through a typical private insurance plan. For minor surgery in a physician's office requiring an approved office visit and surgical fee totaling \$90 and two outpatient prescription medications totaling \$75, a service-connected or low-income veteran would pay \$4 under VA, \$93 under Medicare, and \$33 under a typical private health insurance plan.¹⁹

The cost of private health insurance can also be significant, particularly if the veteran is unemployed, works for an employer that does not provide health insurance, or is self-employed. Such veterans would have to pay the full cost of their health insurance. Even if veterans are employed, they may have health care premiums to pay. An increasing number of private sector employees contribute toward the cost of their insurance coverage. In 1991, private health insurance premiums for enrollees averaged about \$324 for single policies and \$1,164 for family coverage.

Medicare part B premiums and Medicare supplemental insurance (so called Medigap policies) are potential sources of out-of-pocket costs for elderly veterans. Medicare part B premiums are about \$493 a year per beneficiary. Medigap policies can be as high as \$1,500 a year.

Because Medicare provides only minimal coverage of long-term care services for the chronically ill elderly, those needing such care can incur high out-of-pocket costs. For example, nursing home care costs average over \$30,000 a year.

Beneficiaries are also liable for the full costs of any services not covered under their health insurance. As discussed above, these items and services frequently include eyeglasses, prescription drugs, and dental care. The Health Care Financing Administration (HCFA) reports that in fiscal year 1991, Medicare beneficiaries incurred over \$15 billion in out-of-pocket expenses for outpatient prescription drugs, an average of \$538 for each Medicare enrollee.

Finally, beneficiaries can incur high out-of-pocket charges when a provider charges more than the Medicare- or private-health-insurance-approved rate. In fiscal year 1991, Medicare beneficiaries were liable for over \$2 billion in charges by providers in excess of Medicare-approved rates. Even with Medigap policies, veterans are not protected from such

¹⁹See VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (GAO/HRD-93-94, July 29, 1993).

charges because policies generally cover only copayments and deductibles, not charges above Medicare-approved rates.

Homeless Veterans Frequently Have Unmet Health Care Needs

Veterans are generally thought to constitute about 150,000 to 250,000 of the estimated 500,000 to 600,000 homeless people who live on the streets or in shelters.²⁰ According to VA officials, about 40 percent of homeless veterans suffer from serious mental illness and, with considerable overlap, about 50 percent suffer from alcohol or other drug abuse. In addition, about 10 percent suffer from PTSD. The homeless generally have neither public nor private health insurance.

²⁰Homelessness: Demand for Services to Homeless Veterans Exceeds VA Program Capacity (GAO/HEHS-94-98, Feb. 23, 1994).

Veterans Have Multiple Reasons for Not Using VA, but Most Prefer Non-VA Health Care

Although public and private health insurance programs do not meet all the health care needs of veterans, most veterans—both insured and uninsured—have never used VA health care services. Veterans cited a range of reasons for not using VA health care facilities, most frequently indicating that they preferred non-VA care and had the resources to pay for such care. Both the percentage of veterans using VA and the reasons for not using VA varied by category of veterans.

Most Veterans Have Never Used VA Health Care Facilities

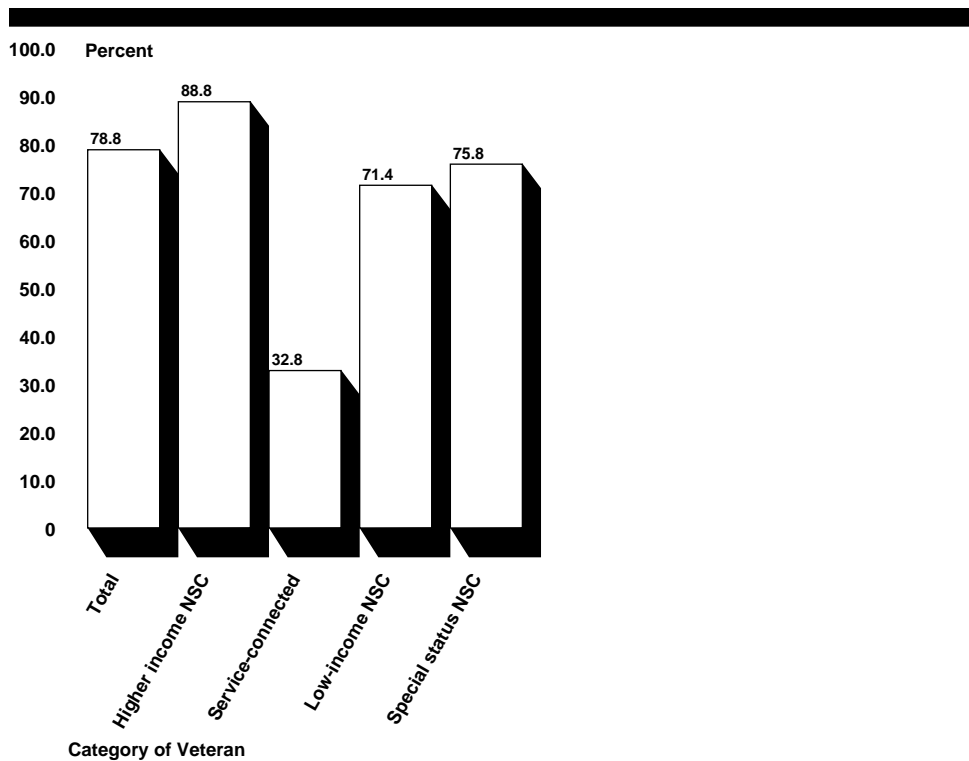
About 8 out of 10 veterans have never used VA health care services, but the likelihood of VA use varied significantly by veteran demographics, our analysis of VA's 1987 Survey of Veterans shows. Most likely to have used VA health care were veterans with service-connected disabilities, in poor health, without health insurance, with low incomes, and over 75 years old. Specifically, we found the following:

- Over 70 percent of low-income veterans without service-connected disabilities and 30 percent of veterans with service-connected disabilities had never used VA facilities. (See fig. 3.1.)
- About 45 percent of veterans who considered themselves to be in poor health had never used VA health care compared with over 88 percent of veterans who considered their health to be excellent. (See fig. 3.2.)
- The percentage of veterans having never used VA health care facilities decreased with age, from about 78 percent of veterans between 25 and 34 years old to about 68 percent of veterans 75 years old or older. (See fig. 3.3.)
- Over 82 percent of veterans with health insurance had never used VA, compared with about 56 percent of veterans with no health insurance.²¹ Consistent with VA's role as a safety net, veterans with no health insurance were six times more likely to seek care at a VA medical center than were veterans with health insurance. About 42 percent were estimated by VA to be medically indigent. (See fig. 3.4.)
- The likelihood of VA use also decreased as veterans' incomes increased, but most veterans in all income categories had never used VA health care. Over 63 percent of veterans with incomes under \$10,000 had never used VA compared with over 88 percent of those with incomes of \$40,000 or more. (See fig. 3.5.)

²¹In 1990, with the creation and expansion of public and private health benefits programs, about 25.6 million of the nation's estimated 28.2 million veterans (almost 91 percent) had public or private health care coverage or both in addition to their VA coverage. Over 81 percent of veterans (22.9 million) had private health insurance; 26 percent (7.4 million) had Medicare coverage; 5.1 percent (1.4 million) had coverage under CHAMPUS; and 1.6 percent (0.4 million) had Medicaid coverage. (See GAO/HEHS-94-104BR, Apr. 25, 1994.)

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Figure 3.1: Percentage of Veterans Who Have Never Used VA Health Care, by Service Connected Status

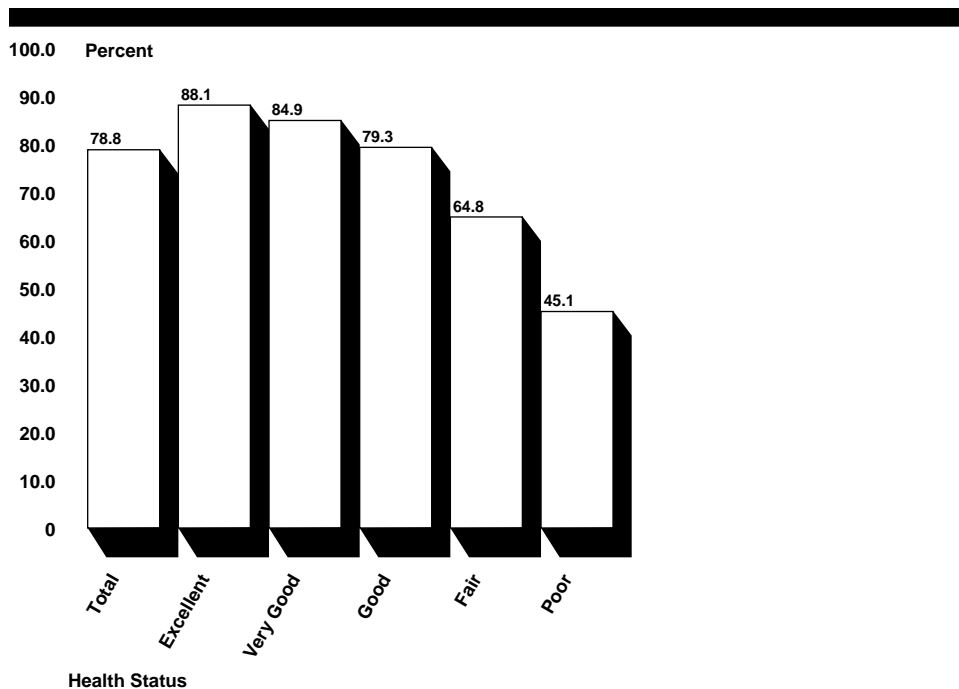


Note: NSC = nonservice-connected.

Source: Based on VA's 1987 Survey of Veterans. Special status veterans include World War I veterans, former prisoners of war, and veterans exposed to toxic substances or ionizing radiation.

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Figure 3.2: Percentage of Veterans Who Have Never Used VA Health Care, by Health Status

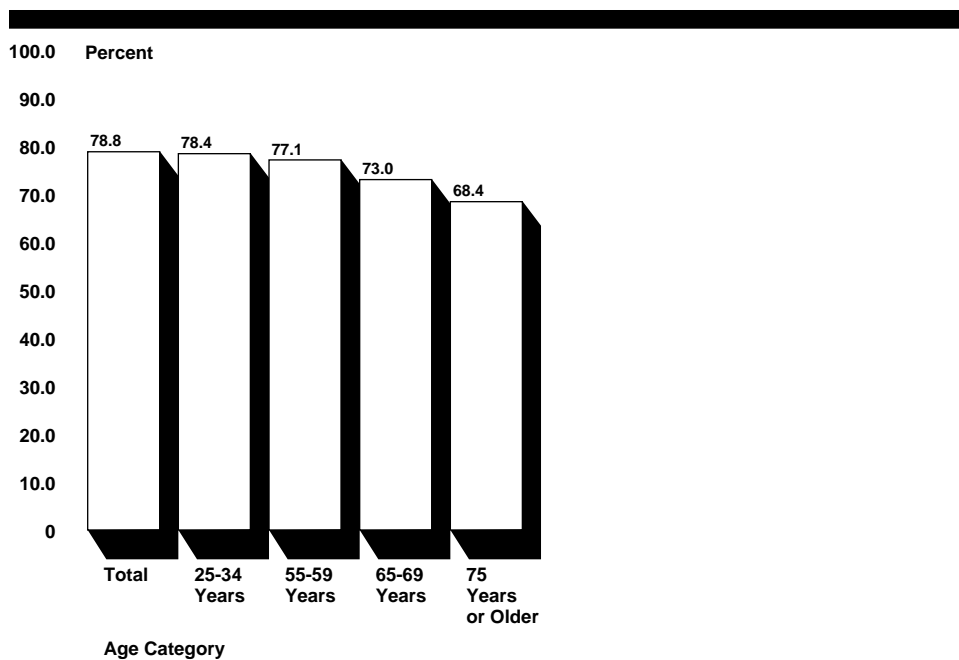


Note: Health status is self-reported by veterans.

Source: Based on VA's 1987 Survey of Veterans.

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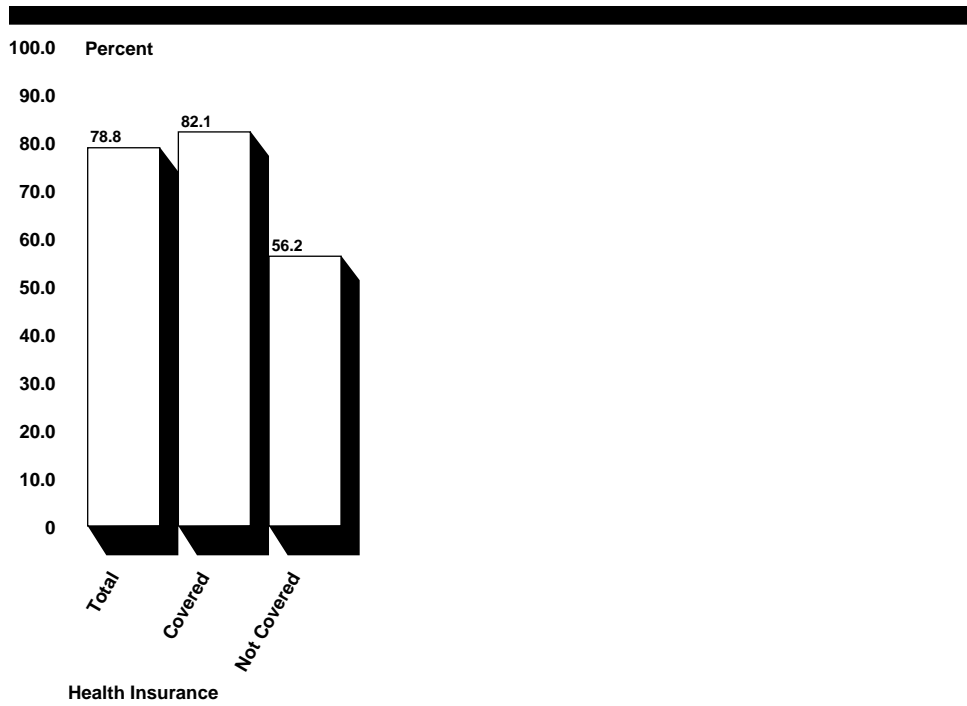
Figure 3.3: Percentage of Veterans Who Have Never Used VA Health Care, by Age



Source: Based on VA's 1987 Survey of Veterans.

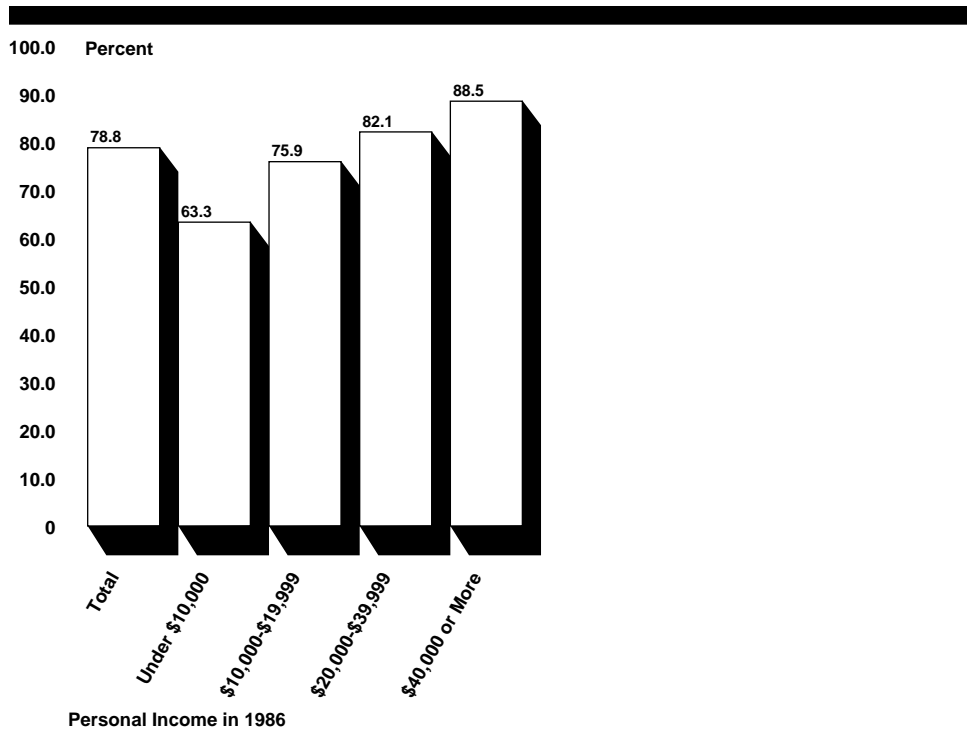
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Figure 3.4: Percentage of Veterans Who Have Never Used VA Health Care, by Insurance Coverage



Source: Based on VA's 1987 Survey of Veterans.

Figure 3.5: Percentage of Veterans
Who Have Never Used VA Health Care,
by Personal Income



Source: Based on VA's 1987 Survey of Veterans.

Veterans Cite Variety of Reasons for Not Using VA Health Care

Veterans responding to VA's 1987 Survey of Veterans cited a variety of reasons for not using VA health care services, but most indicated preference for or ability to pay for care elsewhere (see table 3.1). Many veterans cited multiple reasons for not using VA health care facilities. For example, about 45 percent of those who indicated that they used their own physician also indicated that they did not use VA because they had adequate health insurance.

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Table 3.1 Veterans' Reasons for Not Using VA Health Care Facilities

Reason for not using a VA facility	Percent of veterans citing reason
Used own physician	42.6
Have adequate health insurance	32.4
Didn't know was eligible	17.9
Never needed medical care	13.4
Preferred treatment elsewhere	9.5
Lived too far from a VA facility	8.5
Sent elsewhere by doctor	6.7
Never been sick	6.0
Not eligible for VA care	5.2
Too long a wait/red tape	4.7
Used Medicaid/Medicare	4.6
Poor VA quality of care	3.8
Entitled to DOD care	2.5
Accident/emergency admission	2.3
VA refused care	1.3
VA didn't offer needed care	0.8
Lack of privacy	0.4
VA inadequate for women	0.2
Treated elsewhere at VA expense	0.1
Other reasons	3.9

Source: VA's 1987 Survey of Veterans.

Reasons for Not Using VA Vary by Veteran Demographics

The reasons veterans gave for not using VA health care facilities varied based on demographic characteristics of the veterans. For example:

- Younger veterans and nonservice-connected veterans with low incomes were the least likely to cite use of their own physician as a reason for not using VA. About 32 percent of veterans between the ages of 25 and 34 cited "Used Own Physician" as a reason for not using VA compared to 53 percent of veterans between the ages of 70 and 74. Similarly, about 36 percent of nonservice-connected veterans with low incomes cited the use of their own physician as a reason for not using VA, whereas about 47 percent of service-connected and higher income nonservice-connected veterans cited the use of their own physician as a reason for not using VA.
- Service-connected veterans and older veterans, the two groups of veterans most likely to use VA health care, appeared to be more aware of their veterans' health care benefits. About 7.5 percent of service-connected

veterans cited “Didn’t Know Was Eligible” as a reason for not using VA, compared with 19.6 percent of higher-income nonservice-connected veterans. Similarly, about 12 percent of veterans between the ages of 70 and 74 cited “Didn’t Know Was Eligible” as a reason for not using VA, compared with over 22 percent of veterans between the ages of 25 and 34.

- Low-income veterans and younger veterans were generally the least likely to cite having adequate health insurance as a reason for not using VA health care. About 23 percent of veterans with incomes below \$10,000 identified adequate health insurance as a reason for not using VA compared with about 43 percent of those with incomes of \$40,000 or more. Similarly, about 22 percent of veterans between 25 and 34 years old identified adequate insurance as a reason for not using VA compared with about 37 percent of veterans between 55 and 59 years old.
- Not surprisingly, there were strong correlations between the frequency with which veterans cited “Never Needed Medical Care” as a reason for not seeking VA care and veterans’ ages and health status. About 22 percent of veterans who perceived their health status as excellent cited “Never Needed Medical Care” as a reason for not using VA compared with only 0.2 percent of those who perceived their health as poor. Similarly, about 23 percent of veterans between 25 and 34 years old indicated that they never needed medical care, but only about 4 percent of veterans 75 years old or older said they had never needed medical care. Veterans with service-connected disabilities were also less likely to cite “Never Needed Medical Care” than low-income nonservice-connected veterans (7 percent compared with 17 percent).
- Distance from a VA facility appears to be a significant barrier to use of VA health care for veterans with service-connected disabilities, elderly veterans, veterans in poor health, and veterans with incomes of less than \$10,000. About 13 percent of veterans between 70 and 74 years old cited distance as a reason for not using VA compared with fewer than 7 percent of veterans between 25 and 34 years old. Of service-connected veterans, 20 percent cited distance as a reason for not using VA, compared with about 7 percent of higher-income nonservice-connected veterans. Only about 4 percent of veterans reporting their health status as excellent cited distance as a reason for not using VA, whereas 22 percent of veterans in poor health cited distance from a VA facility as a reason for not using VA. Finally, about 13 percent of veterans with incomes below \$10,000 cited distance as a reason for not using VA, whereas 6 percent of those earning \$40,000 or more said distance was one of the reasons they did not use VA.
- Service-connected veterans were the most likely to indicate that they “Preferred Treatment Elsewhere” as a reason for not using VA care. Over 17 percent of service-connected veterans said that they preferred to obtain

treatment elsewhere; overall 9.5 percent of veterans cited such a preference as a reason for not using VA care.

Many Low-Income, Uninsured Veterans Do Not Use VA Because of Eligibility, Quality, or Access Concerns

VA's 1987 Survey of Veterans estimated that 21 million veterans had never used VA health care services. About 18.1 million of the 21 million veterans cited reasons for not using VA that suggested that they had other health care options. Still, about 2.9 million veterans with no apparent health care options chose not to use VA because VA health care was not accessible, they were not aware of their VA eligibility, or they had concerns about the quality of VA care.

When taking the 1987 Survey of Veterans, veterans who indicated that they had not used VA health care services were given a list of 20 possible reasons why they had not used VA services and asked to select all that applied. We analyzed the responses to determine how many veterans cited reasons related to accessibility, eligibility, or quality but not reasons related to having health care options. Veterans who gave reasons indicating that they preferred treatment elsewhere, used their own physicians, or had adequate insurance, were considered to have health care options and were excluded from further analysis even if they cited concerns about quality or access as additional reasons for not using VA health care. Based on this analysis, we estimate that 2.9 million veterans not indicating options for care chose not to use VA health care for reasons related to quality, accessibility, or unawareness of eligibility.

We then conducted further analysis of the Survey of Veterans data to estimate the incomes and health insurance coverage of such veterans. On the basis of this analysis, we estimate that 320,000 of the 2.9 million veterans who chose not to use VA because they had concerns about the accessibility or quality of VA care or because they lacked knowledge about their VA eligibility, do not have health insurance; about 191,000 of these veterans have incomes below \$15,000.

The 320,000 uninsured veterans, especially the 191,000 with low incomes, represent a potentially medically underserved population because of their lack of access to VA medical centers or unwillingness to use them.²² As discussed in chapter 2, the uninsured use significantly fewer health care services than those with health insurance. As a result, those uninsured and low-income veterans who do not use VA because they are not aware of

²²An additional 220,000 veterans were uninsured and did not give reasons for why they chose not to use VA.

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their eligibility or have concerns about the quality or accessibility of VA care are potentially medically underserved. Only about 10,000 of the 191,000 low-income uninsured veterans indicated that they had never needed medical care.

Structure of the VA Health Care System Limits Its Ability to Meet Veterans' Health Care Needs

The VA health care system is not currently structured to meet the health care needs of most veterans. For example:

- Although virtually all veterans are eligible for at least some VA health care, most veterans are not eligible for comprehensive outpatient services. Access to many other benefits is linked to care in a VA hospital, limiting the availability of needed care.
- Unlike private health insurance and most public health benefits programs such as Medicare and Medicaid, being eligible for VA care does not guarantee the availability of care. Most care is dependent on the availability of space and resources. Several specialized VA programs have waiting lists because of space or resource limits.
- VA's direct delivery approach to providing health care services limits the availability of services. VA has limited authority to supplement care available in its facilities by purchasing care from other providers.

Complex Eligibility and Entitlement Provisions Limit Access to Care

Complex eligibility and entitlement requirements limit veterans' access to many health care services. Although all veterans are eligible for some VA health care, most veterans cannot rely on VA as their sole source of health care. This is because most veterans (1) are not eligible for comprehensive outpatient services, (2) are eligible for the services only to the extent that space and resources are available, or (3) must have treatment initiated in a VA hospital to be eligible to receive the service.

Other health benefits programs define a set of covered services and entitle everyone to the full range of services. VA has a broader range of covered services than most health insurance plans, but no veteran is currently entitled to the full range of VA services.

All Veterans Are Eligible for Some VA Health Care Services

Any person who served on active duty in the uniformed services for the minimum amount of time specified by law and who was discharged, released, or retired under "other than dishonorable conditions" is eligible for at least some VA health care benefits.²³ For example, all veterans are eligible for VA hospital and nursing home care, although the provision of care is based on the availability of space and resources as discussed below.

²³The amount of required active duty service varies depending upon when the person entered the military.

Most Veterans Have Limited Coverage of Outpatient Services

Only those veterans with service-connected disabilities rated at 50 percent or more are currently entitled to comprehensive outpatient services. VA may provide comprehensive outpatient care to veterans who (1) are former prisoners of war, (2) served during World War I or the Mexican border period, (3) are housebound or in need of aid and attendance, or (4) are participants in VA-approved vocational rehabilitation programs.

VA must furnish all outpatient services needed for treatment of conditions related to any veteran's service-connected disability regardless of the veteran's disability rating. VA must also provide hospital-related outpatient care to veterans (1) with service-connected disabilities rated at 30 or 40 percent or (2) whose annual incomes do not exceed VA's pension rate for veterans in need of regular aid and attendance.^{24,25} VA may, to the extent resources permit, furnish hospital-related outpatient care to all veterans not otherwise entitled to outpatient care. Additional restrictions apply to the availability of dental care.

Eligibility for Some Services Linked to Receipt of Hospital Care

Eligibility for some VA health care services is linked to receipt of hospital care in a VA facility. For example, dental care is available to veterans with nonservice-connected disabilities only if the veteran was examined and had treatment started while an inpatient. Similarly, veterans with nonservice-connected conditions must be admitted to a VA hospital before they can receive VA-supported community nursing home care. Finally, access to some services, such as vision and hearing care, is limited because of the "obviate the need" requirements discussed above. In other words, most veterans can obtain those services only if they are needed to obviate the need for inpatient care, are provided while they are inpatients, or are provided as a followup to inpatient care.

Entitlement to Care Limited to Available Space and Resources

Even those veterans eligible for care in the VA system can obtain care only if space and resources are available. VA uses a complex priority system to determine which veterans receive care within available space and resources. For example, priority for receiving VA hospital and nursing home care is divided into two categories—mandatory and discretionary. VA must provide hospital care and if space and resources are available may provide cost-free nursing home care to veterans in the mandatory

²⁴Hospital-related refers to those outpatient services needed to (1) prepare for a hospital admission, (2) obviate the need for a hospital admission, or (3) complete treatment begun during a hospital stay.

²⁵In 1991, the income limits were \$11,409 or less for veterans with no dependents or \$13,620 or less if married or single with one dependent plus \$1,213 for each additional dependent.

category. VA may provide hospital and nursing home care to those in the discretionary category if space and resources are available in VA facilities.

Included in the mandatory care category are veterans who

- have service-connected disabilities,
- are former prisoners of war,
- served during the Mexican border period or World War I,
- were exposed to certain toxic substances or radiation and need treatment for related conditions, or
- have nonservice-connected disabilities and are unable to defray the cost of care. Veterans eligible for Medicaid, receiving a VA pension, or having financial resources below a prescribed level are considered unable to defray the cost of necessary care.

Priority for receiving outpatient services is similarly divided into mandatory and discretionary categories. All service-connected veterans must be provided outpatient care related to their service-connected disabilities, but only service-connected veterans with disabilities rated at 30 percent or higher and nonservice-connected veterans with incomes below the maximum VA pension rate are in the mandatory care category for other covered outpatient care services. Other nonservice-connected veterans and service-connected veterans with disabilities rated at 20 percent or less are in the discretionary care category for covered nonservice-connected outpatient care.

Lack of Space and Resources Limits Availability of Care

Because of space and resource limitations, VA is not able to provide care needed by some veterans. Specific data on unmet needs are not generated by VA, but there are indications that space and resource restrictions are limiting VA's ability to meet veterans' health care needs.

- In 1992, the VA Eligibility Reform Task Force developed estimates of the potential demand for nursing home care if current resource constraints were removed.²⁶ The task force estimated that if resource constraints were removed, the projected nursing home daily census would rise from approximately 36,000 patients to about 59,000 patients, an increase of about 60 percent.
- Specialized VA PTSD programs are operating at or beyond capacity and waiting lists exist particularly for inpatient treatment. Treatment waiting

²⁶The Task Force applied nursing home usage patterns among individuals in the general population who share the same characteristics as veterans to the historic VA nursing home user population. Characteristics included age, gender, and levels of disability.

lists have hovered between 900 and 1,000 veterans for the past 3 years. While VA has been able to reduce the waiting lists, the number of veterans seeking PTSD care continues to increase even though the Vietnam war ended 20 years ago.

- Limited resources make it difficult for VA to care for homeless veterans. VA's current programs constitute a small portion of what is likely needed to fully address the needs of the homeless veteran population. For example, in the San Francisco area, the Homeless Chronically Mentally Ill (HCMI) program, established to locate and provide clinical care to mentally ill homeless veterans, has only 11 beds available to meet the needs of an estimated 2,000 to 3,300 homeless veterans in the area. Similarly, veterans may wait up to 2 months before being admitted to a residential program.

A similar situation exists in Washington, D.C. Its HCMI has an average of 11 contract beds to serve an estimated 3,300 to 6,700 homeless veterans. Eligible veterans wait up to 6 weeks for admission to the program.

- A lack of resources prevents VA from operating programs for homeless veterans in some areas. In Flint, Michigan, VA decided not to start a homeless veterans outreach program because medical services were not available close enough to the community. The distance to the nearest medical center (Saginaw, Michigan) was too great and would be a barrier to getting medical care to the homeless who do not have the means to travel long distances. Similarly, Pensacola, Florida, VA personnel did not do outreach in the homeless community because the VA outpatient clinic was at capacity.
- In April 1994, VA reported that its substance abuse programs were providing services near their capacity as of January 1, 1992. Extended care programs were more restrictive in their admissions and maintained longer waiting lists.
- VA's current goal is to meet the nursing home needs of only 16 percent of veterans needing such care through its own facilities, contracts with community nursing homes, and per diem payments to state veterans' homes. The remaining 84 percent of veterans needing nursing home care, once their Medicare or private health insurance coverage is exhausted, must either pay for their care out-of-pocket, forego needed care, or spend their income and assets on care until they qualify for Medicaid. Once they qualify for Medicaid, most of their income must be applied toward the cost of their care.

Reliance on Direct Delivery Limits Ability to Meet Veterans Health Care Needs

Although VA operates one of the largest health care systems in the country, its reliance on the direct delivery of services limits its ability to meet the health care needs of veterans not living close to a VA facility. In addition, the capabilities of individual VA hospitals and outpatient clinics vary significantly. As a result, veterans living close to a VA facility may not be able to obtain the health care services they need from that facility. Although VA will reimburse some veterans for travel to another VA facility, it generally will not purchase the service locally.

Unlike VA, DOD's direct delivery system has a backup system—CHAMPUS—to help finance services for certain beneficiaries who either live too far from a DOD facility or cannot obtain the health care services they need from a nearby DOD facility. Through the combination of direct delivery and financed care, the DOD system provides dependents of active duty personnel and retirees and their dependents access to a uniform set of benefits.²⁷

By contrast, veterans do not currently have equal access to VA benefits even within eligibility categories. Those veterans living closest to comprehensive VA facilities have better access to VA benefits than do those veterans living near VA hospitals offering more limited services. Veterans living in areas that do not have nearby VA facilities have even more limited access to VA services.

As discussed in chapter 3, veterans in poor health, veterans with service-connected disabilities, elderly veterans, and low-income veterans were most likely to cite distance from a VA facility as a reason they do not use VA care. These groups are among the veterans who should have the highest priorities for VA care.

²⁷CHAMPUS eligibility ends at age 65.

Most VA Users Have Other Health Care Options

Although VA is an important safety net for many veterans, most VA users have other health care options. Over one-half are covered for acute care services under other public health benefits programs and about one-third under private health insurance. In addition, many of the veterans using VA health care facilities have incomes of \$20,000 or more and may have adequate resources to pay for all or a portion of their care from private providers. Finally, many VA nursing home patients could have qualified for Medicaid through that program's spend-down provisions.

Over One-Half of VA Users Covered Under Other Public or Private Health Benefits Programs

About 58 percent of the veterans who used VA health care services in 1990 had other public or private health care coverage; many had coverage under multiple programs. In fact, veterans using VA health services were more likely to have other federal health care coverage than those veterans who do not use VA. For example, 47 percent of the veterans who used the VA system in 1990 were Medicare-eligible, even though only 26 percent of all veterans were Medicare-eligible. Because VA does not receive payments from Medicare, a significant portion of VA resources are spent providing health care services to veterans who could have obtained the same services through Medicare, but with higher out-of-pocket costs.²⁸

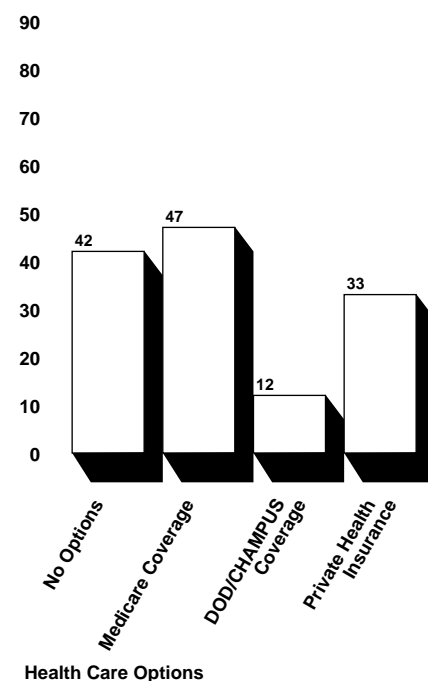
While Medicare was the primary source of alternate federal coverage, about 12 percent of veterans using VA health care services during 1990 were eligible for care from DOD, CHAMPUS, or both. Military retirees lose their CHAMPUS eligibility when they become Medicare-eligible but can continue to use DOD health care facilities on a space-available basis.

Finally, VA's 1988 Survey of Medical System Users found that about one-third of VA users had private health insurance. (See fig. 5.1.)

²⁸Medicare-eligible veterans also tend to use VA for services such as prescription drugs and long-term nursing home and psychiatric care not generally available through Medicare. See Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS-95-13, Oct. 24, 1994).

Figure 5.1: Health Care Options of Veterans Using VA Health Care During 1990

100 Percent of VA Users With Coverage



Notes: Percentages do not add to 100 because some veterans have multiple coverages.

Data on private health insurance coverage and the percentage of veterans with no health care options are from the VA Survey of Medical System Users.

Data on Medicaid and the Indian Health Service were not readily available.

Significant Resources Used to Provide Care to Veterans With Incomes Above \$20,000

VA spends a significant portion of its health care resources providing inpatient and outpatient care to veterans with incomes of \$20,000 or more. About one-third (716,000) of the 2.2 million VA users in 1991 had incomes of \$20,000 or more. Among both single and married veterans, users with service-connected disabilities tended to have higher incomes than nonservice-connected users.

Still, about 15 percent (319,000) of the 2.2 million veterans using VA medical centers in 1991 were nonservice-connected veterans with incomes of \$20,000 or more. About 11 percent (91,520) of the single nonservice-connected veterans (832,000) and 57 percent (227,430) of married nonservice-connected veterans (399,000) using VA medical centers

in 1991 had incomes of \$20,000 or more. Among married nonservice-connected veterans using VA medical centers, 21 percent (84,000) had incomes of \$40,000 or more and 16 percent (64,000) had incomes between \$30,000 and \$39,999.

Veterans Have Medicaid Coverage for Nursing Home Care

Veterans, like other Americans, can qualify for Medicaid assistance in paying for nursing home care if they lack the income and resources to pay for such care. VA spends over \$1 billion a year to provide nursing home care, a discretionary benefit for all veterans, including those with service-connected disabilities.

To be eligible for nursing home care under Medicaid, persons must meet specified income and asset limits, which vary by state. Frequently, persons enter nursing homes as private-pay patients and convert to Medicaid after having spent their available income and resources on nursing home care. And, once eligible, patients must apply their income, with certain exceptions, toward the cost of their nursing home care on an ongoing basis. Medicaid pays the difference between the Medicaid payment rate and the amount of the recipients' income applied toward the cost of care.²⁹

All veterans with a medical need for nursing home care are eligible to receive such care in VA and community facilities to the extent that space and resources are available.³⁰ Unlike Medicaid, which requires beneficiaries to spend most of their income and assets on nursing home or other health care services before Medicaid assists them in paying for additional nursing home care, the VA nursing home program has no spend-down requirements and minimal cost sharing. Generally, veterans with service-connected disabilities and those nonservice-connected veterans with incomes below designated levels (about \$20,000) are not required to contribute toward the cost of their nursing home care. Those higher income nonservice-connected veterans required to contribute toward the cost of their care make copayments averaging \$12 a day.

In fiscal year 1991, VA provided nursing home care to about 47,000 veterans in VA facilities and 28,000 veterans in contract community facilities at a

²⁹There are no limits on the length of stay under Medicaid's nursing home benefit.

³⁰Veterans who do not have a service-connected disability are limited to 6 months in community nursing homes, but there is no limit on length of stay in VA-operated nursing homes for either service-connected or nonservice-connected veterans.

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combined cost of almost \$1.2 billion. VA recovered less than one-tenth of 1 percent of its costs to provide nursing home care through copayments.

Retargeting Needed to Enable VA to Better Meet Veterans' Changing Health Care Needs

Since establishment of the VA health care system over 60 years ago, significant changes have occurred in how Americans obtain their health care, where they get it, and how they pay for it. Major changes have also occurred in veterans' health care needs; veterans who once needed acute treatment for brain trauma, spinal cord injuries, and other war-related injuries increasingly need treatment for the lingering effects of those disabilities. In addition, the rapidly aging World War II veteran population increasingly needs long-term rather than acute care services.

The changes that have already occurred—and the potential for further changes through reform of the health care system either nationally or in individual states—provide an opportunity to reevaluate the VA health care system and determine how it can be changed to better meet the changing health care needs of veterans. Such an evaluation should not be constrained by the current VA structure. Rather, it should start with a clean slate and determine how a veterans health benefits program should be designed in today's health care environment. In addition, it should be conducted in concert with governmentwide efforts to reduce the budget deficit while improving services to veterans in response to recommendations contained in the National Performance Review.³¹

Just as it is unlikely that either national or state health care reforms will address all the health care needs of Americans, it is also unlikely that the VA health care system will ever have adequate resources to meet every health care need of veterans. As a result, it is important that the VA system (1) have clear priorities for how limited health care resources will be targeted and (2) be designed to supplement rather than unnecessarily duplicate health care coverage available under other programs.

VA's restructuring efforts, however, have focused primarily on how to preserve its direct delivery system rather than on how to better target its limited resources toward meeting the changing health care needs of veterans. For example, VA's efforts (1) do not focus on outreach to better inform low-income uninsured veterans of their eligibility for VA care, (2) do not explore ways to expand the availability of nursing home care to an aging population, and (3) do not consider shifting resources to expand the availability of specialized services not extensively covered under other health care programs.

³¹The National Performance Review, under the direction of the Vice President, is a major management reform initiative by the administration and is intended to identify ways to make the government work better and cost less.

Changes Needed If VA Is to Fulfill Its Safety Net Mission

Beyond its obligation to treat service-connected disabilities and the lingering effects of such disabilities, one of VA's highest priorities is to serve as a safety net for veterans—both those with service-connected and those with nonservice-connected disabilities—unable to afford basic health care services. VA cannot adequately fulfill its safety net mission because it is constrained by its direct delivery structure and eligibility and entitlement provisions.

Eligibility Reform

Clearly, eligibility reform is an essential ingredient in any effort to improve VA's ability to fulfill its safety net mission. As discussed in chapter 4, VA eligibility reform would be needed to enable VA to provide a uniform set of services to all veterans. Currently, about 450,000 veterans are entitled to free comprehensive VA health care services.³² Expanding this entitlement to all veterans currently eligible for some free care could add billions of dollars to VA's health care budget.³³ One option for limiting the cost of any eligibility expansion is the use of cost sharing to offset the costs of the expanded benefits. For example, VA might be authorized to provide veterans any available health care service without changing existing eligibility for free care. In other words, veterans could purchase, or use their private health insurance to purchase, additional health care services from VA. Such a change, however, would not significantly strengthen VA's safety net role because low-income and uninsured veterans would likely be unable to pay for many additional health care services even if VA were authorized to provide them.

Another option would be to reform eligibility to create a uniform benefits package but narrow the scope of services included in the benefits package. In other words, some veterans would get additional benefits while others would receive a narrower range of free services. This approach, however, would essentially take some benefits away from service-connected veterans with the greatest disabilities and give additional benefits to service-connected veterans with lesser disabilities and to nonservice-connected veterans.

One potential way to pay for eligibility expansions would be to authorize VA to recover from Medicare the costs of services VA facilities provide to

³²Nursing home care is an optional benefit for all veterans.

³³VA Health Care Reform: Financial Implications of the Proposed Health Security Act (GAO/T-HEHS-94-148, May 5, 1994).

Veterans' Health Care: Efforts to Make VA Competitive May Create Significant Risks (GAO/T-HEHS-94-197, June 29, 1994).

Medicare-eligible veterans. Such recoveries, however, would not improve VA's ability to fulfill its safety net mission unless VA were allowed to keep the recovered funds in addition to its appropriation. In other words, if the recoveries are returned to the Department of the Treasury, then services provided to Medicare-eligible veterans would reduce rather than enhance the funds available to treat low-income and uninsured veterans.

On the other hand, allowing VA to retain recoveries from Medicare would create a strong incentive for VA facilities to shift their priorities toward providing care to veterans with Medicare coverage. More important, while it would make additional funds available for providing care to low-income and uninsured veterans, it could also significantly increase the overall costs of the VA system. In addition, authorizing VA recoveries from Medicare could increase overall federal health care costs regardless of whether VA is allowed to keep all or a portion of the recoveries. This is because it would essentially transfer funds between federal agencies while adding administrative costs.

Increased Outreach

With large numbers of service-connected and low-income veterans being unaware of their eligibility for VA health care, eligibility reform alone will not enable VA to improve services to all low-income and uninsured veterans. VA needs to expand outreach to such veterans to ensure that they are aware of their eligibility for VA care, particularly in those states not implementing health reforms.

Improved Accessibility

Similarly, as discussed in chapter 3, many veterans do not use VA simply because VA facilities are not accessible. Potential options for making VA health care benefits more accessible include

- expanding VA's fee basis program or establishing a new VA health financing program to provide veterans unable to use VA facilities access to non-VA acute care services;
- converting VA facilities into managed care plans and contracting with private providers to improve availability of VA services;
- expanding an existing federal health care program, such as CHAMPUS or Medicare, to provide coverage for veterans;
- authorizing veterans to enroll in the Federal Employees Health Benefits Program, with subsidies provided for low-income veterans;
- giving veterans vouchers to purchase health insurance; and
- expanding VA's direct delivery system to reach more veterans.

Changes in veterans benefits that would improve access to community providers have significant implications both for maintenance of the direct delivery system and for VA costs.³⁴ In addition, to the extent such changes involve other public or private health insurance programs, costs to those programs and total government costs might be affected.

Two options for limiting the cost of such expanded access would be to (1) make VA coverage secondary to any other public or private coverage or (2) limit coverage to those veterans not having other public or private health insurance. For example, Medicare-eligible veterans might continue to be restricted to use of VA facilities on a space- and resource-available basis much as military retirees are under CHAMPUS. Once a military retiree becomes Medicare-eligible, he or she can continue to use DOD facilities on a space-available basis but is no longer eligible for CHAMPUS. In effect, the costs of care for Medicare-eligible military retirees are shifted from CHAMPUS to Medicare.

A VA health financing benefit could similarly be structured in such a way that veterans' entitlement to the financing benefits would terminate for all or some veterans when they become Medicare-eligible. Another option that could be explored would be to convert VA coverage to supplement Medicare for low-income or service-connected veterans. In other words, VA could pay the copayments and deductibles for low-income and service-connected veterans eligible for Medicare.

Special Care Needs of Veterans Should Be Targeted

As discussed in chapters 3 and 4, veterans have a variety of special care needs that VA is unable to adequately meet because of resource constraints and limited outreach efforts. Neither national nor state health reforms are likely to adequately address these special care needs in the foreseeable future. For example, veterans who are homeless or suffer from a mental illness such as PTSD would continue to be less likely to seek health care. In addition, veterans would continue to be undertreated for ailments that are not well diagnosed, such as alcoholism.

Because VA may no longer need to meet the basic health care needs of most veterans in states that implement comprehensive health reforms, it has the opportunity to recreate itself in a way that targets the specific

³⁴Veterans' Health Care: Implications of Other Countries' Reforms for the United States (GAO/HEHS-94-210BR, Sept. 27, 1994).

needs of veterans in those states, diverts scarce resources to strengthen its ability to fulfill its safety net mission in other states, or both. For example:

- VA could serve as an outreach agent to medically underserved populations, such as homeless veterans. Outreach workers could enroll the homeless in non-VA plans to ensure that they receive needed health care services.
- VA could shift resources to programs that address specific veteran needs. For example, VA could expand the availability of PTSD programs, including intensive outreach to affected veterans and readily available treatment facilities.
- VA could expand the availability of health benefits not covered under the minimum benefits package established under a state health reform program. For example, veterans could be offered a dental or vision plan if such services were not covered under the minimum benefits package.

Cost Sharing Could Increase Availability of Long-Term Care Benefits

Although VA currently lacks adequate resources to meet the long-term care needs of the aging veteran population, it could serve more veterans with available funds by (1) adopting the copayment practices used by state veterans' homes, (2) establishing an estate recovery program patterned after those operated by increasing numbers of state Medicaid programs, or (3) creating a mixture of both practices.

In fiscal year 1990, VA offset—through copayments of \$260,389—less than one-tenth of 1 percent of its costs to provide nursing home care and domiciliary care in VA and community facilities. In comparison, eight states that charge for care offset from 4 to 43 percent of state veterans' home operating costs through copayments.³⁵ If VA had offset similar percentages, its yearly recoveries would have been between \$43 million and \$464 million depending on which state copayment provisions were adopted.

The states were able to offset a larger percentage of their operating costs through copayments than VA because

- more veterans were required to make copayments and
- veterans who contributed toward the cost of their care were typically required to make larger copayments.

³⁵In 1991, 39 of the 40 states with veterans homes required veterans to contribute to the cost of their care; only Georgia did not require veterans to make copayments.

Safeguards were used in each of the eight states to help prevent copayments from impoverishing a veteran's spouse or dependent children and to help ensure that veterans capable of returning home retain sufficient financial resources to return to the community.³⁶

VA could also offset a significant portion of its nursing home and domiciliary care costs if it had the same authority states were given to operate estate recovery programs under Medicaid. Estate recovery, a process through which a government agency recovers the costs of services provided to a beneficiary by filing a legal claim against the beneficiary's estate, can be used by VA only to collect unpaid nursing home copayments. Because few veterans are required to make copayments and those who are required to contribute toward the cost of their care make only nominal payments, VA has never attempted to recover its costs for providing nursing home care from veterans' estates.

By contrast, states are authorized by title XIX of the Social Security Act to recover part of the nursing home costs paid by Medicaid from recipients' estates if the Medicaid recipient had no surviving spouse or children under 21 years old, blind, or totally and permanently disabled. Individuals are not allowed to give away or transfer ownership of assets for less than fair market value within 30 months of applying for Medicaid eligibility if the intent of such action is to qualify for Medicaid.

Estate recovery programs can offset a significant portion of the costs of providing nursing home care to residents who own homes. In six states that did not have estate recovery programs, we estimated that estate recovery programs could potentially recover 68 percent of the Medicaid nursing home benefits paid for recipients who owned homes.³⁷

The potential for recovering nursing home and domiciliary costs through estate recoveries may be greater for veterans than for Medicaid recipients. This is because (1) home ownership—the primary asset of most elderly persons—is significantly higher among elderly veterans than among Medicaid nursing home recipients and (2) veterans living in VA facilities generally contribute much less of their incomes toward the cost of their care than do Medicaid recipients, allowing veterans to build bigger estates.

³⁶VA Health Care: Offsetting Long-Term Care Costs by Adopting State Copayment Practices (GAO/HRD-92-96, Aug. 12, 1992).

³⁷Medicaid: Recoveries From Nursing Home Residents' Estates Could Offset Program Costs (GAO/HRD-89-56, Mar. 7, 1989).

Veterans using VA-supported nursing homes appear to have hundreds of millions of dollars in assets that could, upon their death or the death of their surviving spouses or dependent children, be used to help offset VA's costs for providing care or to expand the availability of VA-supported nursing home care.³⁸

VA's Restructuring Directed Toward Competition With Private Sector Rather Than Veterans' Needs

While many options are available for improving health care services for veterans, VA has focused its restructuring efforts more on preserving VA's direct delivery system than on addressing the changing health care needs of veterans. First, plans developed during the 103rd Congress based on the administration's ill-fated Health Security Act (H.R. 3600) would have turned VA health care facilities into a series of prepaid managed care plans providing essentially the same health care services that would have been available to veterans through enrollment in any of the competing health plans. VA's plans, we reported, could have actually decreased VA's ability to meet the special care needs of veterans.

Second, in seeking proposals for pilot projects in states implementing health reforms, VA again focused on competing as a full-service managed care plan.³⁹ The July 1994 VA Solicitation for Proposals for State Health Care Reform Pilot Projects did not seek proposals that would retarget VA resources in the states to services not covered under the state reform program. Rather, it sought proposals focusing on development of VA health plans competing to provide the same basic benefit package veterans would receive under other health plans. In addition, pilot projects were not solicited from VA medical centers in states not implementing health reforms.

Conclusions

Regardless of whether there are national or state health care reforms, major changes are needed in the VA health care system to enable it to better meet the health care needs of veterans. VA's current and past efforts, however, have focused more on options for preserving the VA direct delivery system than on restructuring VA health care benefits to meet the changing health care needs of veterans. Nowhere is this clearer than in VA's current effort to develop pilot projects in states planning to implement comprehensive health care reforms.

³⁸VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (GAO/HRD-93-68, July 27, 1993).

³⁹Legislation to authorize the pilot projects was considered but not enacted during the 103rd Congress. VA expects to propose similar legislation during the 104th Congress.

In states implementing comprehensive health reforms, virtually all veterans would have basic acute care coverage even if there was no VA health care system. VA, however, wants to create and pilot test VA managed care plans to compete with private sector health plans providing essentially the same benefits. In states that do not plan health reforms to cover the uninsured, however, large numbers of low-income veterans are likely to continue to be without health care options. In our opinion, VA should focus its restructuring efforts on pilot testing ways to ensure that all veterans in states not planning health care reforms have at least one accessible health care option before trying to compete to provide veterans in states implementing health reforms an additional health care option.

State health reforms also provide VA the opportunity to pilot test other restructuring options that would transform the VA system into a form of supplementary insurance program to complement rather than duplicate coverage available under other programs.

Recommendations to the Secretary of Veterans Affairs

In light of governmentwide efforts to reduce the budget deficit and improve services to the public, we recommend that the Secretary of Veterans Affairs, in concert with veterans service organizations and other federal and state agencies with jurisdiction over health benefits programs, (1) identify and evaluate options to better target VA resources to meet the health care needs of veterans and (2) develop legislative proposals to restructure the veterans health benefits program.

In considering options, the Secretary should, to the extent feasible, retarget VA resources toward supplementing rather than duplicating health care services available under other public and private health benefits programs. In addition, the Secretary should assess the costs associated with any expansion of VA eligibility and identify and evaluate options for paying for any such expansions.

Finally, the Secretary should reevaluate VA's role in meeting the long-term care needs of an aging veteran population and explore options, such as estate recoveries and cost sharing, for paying for any expanded role.

VA Comments and Our Evaluation

The Secretary of Veterans Affairs, by letter dated February 22, 1995, said that VA does not agree with our recommendations that it (1) identify and evaluate options to better target VA resources to meet the health care

needs of veterans and (2) develop legislative proposals to restructure the veterans health benefits program.

Potential Effects of GAO's Recommendations

Our recommendations would, the Secretary said, result in dismantling VA's patient care and other missions (medical research, medical education, and military backup), relegate VA to a largely administrative role as a "niche" provider, and mainstream veterans into a fragmented private health care system. Our report, according to the Secretary, denies the significant contributions VA has made to the overall quality of our nation's health and VA's long-standing commitments to veterans' health care.

We agree that VA has made significant contributions to the nation's health through its research and medical education missions but see no reason why such missions could not be maintained or even enhanced under a restructured veterans health care program. For example, if the VA system was restructured to focus on direct delivery of services such as blind rehabilitation and spinal cord injury treatment not extensively covered under other public and private programs, VA could fund research and support medical education relating to those medical specialties. This would further strengthen VA's already prominent position in these areas.

VA's military backup mission could be similarly redefined to focus on those areas, such as blind rehabilitation and spinal cord injury treatment, where community facilities lack the ability and/or capacity to absorb returning casualties. Likewise, enhancing VA's ability to treat PTSD would improve VA's ability to provide backup support to DOD in any future conflict. Support for such war-related stress is not likely to be widely available in the private sector. In our opinion, such retargeting would strengthen, not weaken, VA's role as a backup to DOD.

Chapter 6 identifies several options for improving veterans' access to health care but it was not our intent to identify and evaluate an exhaustive list of options and recommend one alternative. Rather, we have recommended that VA identify and evaluate options. Moreover, the options discussed range from expanding VA's direct delivery system to reach more veterans to offering veterans vouchers to be used in purchasing care from private sector providers. Although VA has not submitted legislative proposals to the new Congress for restructuring veterans health benefits, we included VA's plans for converting VA facilities into managed care plans as an option based on the administration's proposal under last year's Health Security Act.

Obviously, many factors need to be considered in identifying and evaluating options including (1) how well veterans' health care needs would be addressed (considering both care available through VA and through other sources), (2) the effects on health care costs through both VA and other public and private insurance programs, (3) how VA's role in medical education, research, and military backup would be affected, and (4) how VA facilities and staff would be affected. Although VA's secondary missions and the existing VA direct care infrastructure are important factors to consider in evaluating options, we do not believe that they should preclude consideration of other options. In our opinion, VA needs to determine how veterans can be assured the availability of the widest range of services at the lowest cost to the government. In other words, VA needs to focus more on ensuring that veterans obtain needed health care services than on ensuring that VA, rather than some other health care provider or managed care plan, pays for that care.

VA Efforts to Address Changing Needs

VA said that our report does not acknowledge its efforts to address veterans' changing health care needs and redefine VA's role in the marketplace. VA is, the Secretary said, redefining its health care system to ensure that all veterans' health care needs are effectively assessed and met. VA said that it is positioning itself to compete and increase its market share of those veterans who, for whatever reason, do not currently use VA. Specifically, VA said that it has developed a number of initiatives for improving access to care including a review of eligibility rules. These initiatives, VA said, would allow it to provide managed care and primary care to more veterans in a cost effective manner. Its proposals will, according to VA, promote continuity of care and eliminate veterans' confusion about their eligibility.

Our report discusses (see pages 3 and 14) VA's plans to move toward a managed care system and its efforts to develop pilot projects to test managed care in states implementing comprehensive health reforms. Because VA has not submitted specific legislative proposals for eligibility reform or released details of its planned reorganization, we are unable to fully discuss those efforts. We have, however, expanded the discussion on page 14 to acknowledge that these and other initiatives are ongoing.

VA, in its comments, indicates no plans to assess the costs associated with its planned eligibility expansion or to evaluate options for paying for any such expansions. As discussed in our reports and testimonies on the eligibility and entitlement provisions VA supported as part of last year's

proposed Health Security Act, the administration significantly underestimated the budgetary implications of the provisions.

VA's Role in Health Reform Debate

Our report, according to VA, fails to acknowledge that much of VA's effort during the national health care reform debate was designed to rationally provide for equity of access to VA health care and to allow veterans a choice of providers, goals that continue for VA, despite the failure of national reforms.

As discussed above, our reports and testimonies on the veterans' provisions of the administration's proposed Health Security Act detailed numerous concerns about the provisions. For example, the eligibility provisions could have required tens of billions of dollars in additional VA appropriations and yet reduced access to specialized services such as blind rehabilitation and spinal cord injury treatment. We chose not to discuss the weaknesses in VA's proposal during the national health care debate because the administration has identified no plans to reintroduce the Health Security Act.

VA Coverage in States With Health Reforms

VA disagreed with our suggestion that it limit its health care coverage in states that have enacted health care reform legislation or provide coverage only to those veterans who lack private or other public health insurance. To do so would, according to VA, discriminate against veterans who have earned the right to a national standard of health care services and remove the safety net for veterans.

In an era of limited government resources, we believe it imprudent to invest additional resources in an attempt to attract veterans away from other health care plans and, in effect, shift resources from other payers to the federal government. For veterans, other than those with service-connected disabilities rated at 50 percent or higher, the "national standard of health care services" to which veterans currently have a right is lower than the standard to which veterans and other residents would be entitled under the state reform proposals. Veterans in states implementing comprehensive reforms no longer need VA as a safety net (other than those veterans not covered under the state reforms). As discussed in chapter 3, however, there are many veterans in states not implementing comprehensive reforms who are falling through holes in VA's safety net. In our opinion, VA should focus on closing holes in its safety net before developing plans to increase its market share of privately insured veterans.

Accuracy and
Appropriateness of
Supporting Data

Finally, VA said that our report is based on (1) unsupported supposition about what will happen with health care delivery in the public and private sectors, (2) factual errors in the discussion of VA eligibility, and (3) questionable interpretation of data. VA provided a detailed listing of concerns about the accuracy and appropriateness of data in our report.

After careful review of VA's additional comments and followup with VA officials, we found nearly all of VA's concerns about the accuracy and appropriateness of our supporting data to be unfounded. Specifically,

- VA said that there were factual errors in our discussion of eligibility. The additional VA comments cited no examples of factual errors, and the VA officials we followed up with could cite none.
- VA said that our report stated that only 1 in 10 veterans use VA health care. The report contained no such statement.
- VA said we inappropriately used the 1987 Survey of Veterans for analyzing substance abuse treatment in VA. Our analysis was based on detailed assessments at five VA medical centers not on the 1987 Survey of Veterans (see p. 18).
- VA criticized us for using data on private health insurance coverage of hospital inpatients rather than data on all users. We used the VA Survey of Medical System Users which states that “. . . one in three medical system users . . . have any private health insurance.”

Appendix II contains a detailed analysis of VA's additional comments.

Comments From the Department of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

FEB 22 1995

Mr. David P. Baine
Director, Federal Health Care
Delivery Issues
U. S. General Accounting Office
441 G Street, Northwest
Washington, DC 20548

Dear Mr. Baine:

This is in response to your draft report, **VA HEALTH CARE: Retargeting Needed to Better Meet Veterans' Changing Needs** (GAO/HEHS-95-39). This report defines a new and extremely limited mission for the Department of Veterans Affairs (VA), Veterans Health Administration (VHA), and does not recognize that VA's mandate encompasses much more. VA has four legislated missions relating to health care: patient care, medical research, medical education, and back-up to the Department of Defense. I do not concur with GAO's recommendation that will fundamentally alter this long-standing commitment VA has with our nation's veterans as well as the public itself.

As we face the challenges of the future, VA is actively addressing veterans' changing health care needs and redefining VA's role in the marketplace with the Congress, the President, the States, veterans service organizations, and individual veterans. We are doing this through a number of initiatives for improving access to care and enhancing an already effective integrated health care system, including review of eligibility rules.

GAO proposes to dismantle VA's current integrated system and promote fragmentary "niche" care based on specific conditions, such as Post Traumatic Stress Disorder. This is the antithesis of high quality clinical practice, which emphasizes treatment of the patient's total needs and continuity of care. GAO's options would, in effect, mainstream veterans into a fragmented private care system and eliminate their freedom to choose VA care unless they have specific diagnoses.



Putting Veterans First

**Appendix I
Comments From the Department of
Veterans Affairs**

2.

Mr. David P. Baine

Furthermore, I disagree with GAO's suggestion that VA in any way limit its health care coverage in states that have enacted health care reform legislation or only to those veterans who lack private or other public health insurance. To do so would discriminate against veterans who have earned the right to a national standard of health care services and remove the "safety net" for veterans.

In addition, GAO's proposed options are based on unsupported supposition about what will happen with health care delivery in the public and private sectors; factual errors about current VA care, e.g., the discussion of eligibility; questionable interpretation of data, such as the determination that quality of care was a major reason why surveyed veterans did not use VA, although the data actually indicate only 3.8% of veterans surveyed viewed this as an issue; and, lack of any cost/operational analyses to support the options. VA has developed initiatives that would allow us to provide managed and primary care to more veterans in a cost effective manner. This proposal will promote continuity of care and eliminate veterans' confusion about their eligibility, which 17.9% of veterans surveyed cited as a reason for not using VA.

VA is also redefining our health care system to assure that all veterans' health care needs are effectively assessed, and met. At the same time, through proposed pilot studies, national performance review initiatives, and other independent studies, we are positioning ourselves to compete and increase our market share of those veterans, who for whatever reason, do not currently use VA. GAO does not recognize these efforts. GAO also fails to acknowledge that much of VA's effort during the national health care reform debate was designed to rationally provide for equity of access to VA health care and to allow veterans choices of providers, goals that continue for VA, despite the failure of national reforms.

The enclosure details some of my serious concerns with the report, identifies a number of factual errors and clarifies some erroneous assumptions contained in the report. Thank you for the opportunity to comment on your report.

Sincerely yours,



Jesse Brown

Enclosure
JB/vz

Evaluation of Additional VA Comments

VA's additional comments noted on the following pages are copied from the enclosure that accompanied its February 22, 1995, letter to GAO. References to pages in the draft report have been changed to refer to pages in the final report. Each section of VA comments is followed by our evaluation.

VA Comment 1

For example, veterans who are eligible for Medicare and required to use that program for their health care needs would be subjected to deductibles, copayments, and time-eligibility rules that are both costly to the veteran and ultimately restrictive on the amount of services the veteran could receive. As the report indicates, outpatient prescriptions, dental and vision care, nursing home care, and long-term psychiatric care are either not covered or only partly covered by Medicare. Denying them these services can only increase unmet need. It seems inconceivable that the report states that veterans may forgo treatment because of high out-of-pocket costs on one page and then concludes that veterans should be subjected to out-of-pocket costs as dictated by their insurers.

GAO Evaluation

We did not conclude or recommend that eligible veterans should be restricted to use of the Medicare program and forced to endure the shortcomings of that program. Our discussion of potential changes in the relationship between VA and other health benefits programs was presented in the context of the significant cost implications of expanding access through the VA health care system. We mentioned two options for limiting the cost of such expanded access: VA coverage (1) might be made secondary to any other public or private health insurance or (2) might be limited to those veterans not having other public or private health insurance.

With respect to Medicare, we stated that a new VA health financing benefit could, like CHAMPUS, be structured to terminate for all or some veterans when they become Medicare-eligible. We made no such suggestion with respect to termination of veterans benefits under the current direct delivery system. In fact, we suggested that Medicare-eligible veterans might continue to use VA facilities on a space and resource availability basis much as military retirees use DOD facilities once their CHAMPUS eligibility ends. We went on to suggest that another option that could be explored would be to convert VA coverage to supplement Medicare for low-income or service-connected veterans or both.

We point out in chapter 2 that veterans may forgo treatment under public and private health insurance programs because of high out-of-pocket costs stemming from deductibles and copayments. We also point out that some medical services such as outpatient prescription drugs and long-term care are not covered under these programs. Such shortcomings in Medicare coverage and coverage under other health insurance programs are the types of unmet health care needs that the VA medical system might be restructured to more effectively address.

VA Comment 2

In discussing veterans' reasons for not using VA, (page 32), the ordering of the reference to quality, accessibility, and awareness is misleading. It implies that quality was a primary issue, when, in fact, Table 3.1 indicates that only 3.8% of veterans cited poor quality as a factor. Eleven other issues were rated as having higher impact on choice. VA's respondent rate with respect to quality of care compares favorably with that of the private sector. This is consistent with recent findings of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which document that the care provided in the VA system compares exceptionally well with private sector counterparts.

GAO Evaluation

The data VA cites are not comparable. Table 3.1 summarizes the reasons the estimated 21 million veterans (including both high- and low-income and insured and uninsured veterans) who had never used VA health care services gave for not using VA. As discussed on page 32, we conducted further analyses of the 1987 Survey of Veterans to determine how many veterans cited reasons related to accessibility, eligibility, or quality but not reasons indicating that they had health care options in addition to VA. This analysis identified 18.1 million nonusers who cited reasons indicating that they had other health care options. The estimated 2.9 million veterans not indicating options for care chose not to use VA health care for reasons related to accessibility of VA care, unawareness of their eligibility for VA care, or concerns about the quality of VA care. Wording on page 32 has been revised to reemphasize that most veterans cited reasons for not using VA health care that suggest that they had other health care options.

VA Comment 3

In one of numerous examples of poor data analyses and presentation, GAO mixes data about VA **inpatient** users with **all** users (Figure 5.1). It appears more to GAO's purpose to report the much lower private health insurance coverage rate of VA's inpatients (33%) rather than the rate for all users

(71%). Similarly, GAO reports the much higher “no coverage” rate of VA inpatients rather than for all VA users (12%).

GAO Evaluation

As indicated in the footnote to figure 5.1, our data on private health insurance coverage came from the VA Survey of Medical System Users which states “[o]nly one in three VA medical system users (33%) have any private health insurance . . .” The major veterans service organizations cite this same statistic in their 1996 Independent Budget.

We obtained and reviewed backup documentation for VA’s estimates of private health insurance coverage of VA users. VA based its estimates largely on responses to a question in the 1987 Survey of Veterans that VA had previously advised us was unreliable. In its analysis, VA counted as VA outpatient users those veterans who responded affirmatively to a question about whether they had gone “[t]o a private, non-VA doctor, clinic, health maintenance organization, or other medical facility AT VA EXPENSE.” The question was intended to determine how many veterans had used the fee-basis program.

As VA noted in its comments on our 1992 report VA Health Care: Alternative Health Insurance Reduces Demand for VA Care, significantly more veterans answered this question affirmatively than answered the preceding question concerning use of VA outpatient clinics. In fact, the survey projected that significantly more veterans had used the fee-basis program in the preceding year than there were total fee-basis visits in that year. VA, both in its comments on our 1992 report, and in the analysis supporting its estimate that 71 percent of VA users have private health insurance, assumed that the veterans who incorrectly interpreted the fee-basis question intended to indicate that they had used VA outpatient clinics.

We noted VA’s concern about the accuracy of the questionnaire responses in our 1992 report but noted that we did not believe it would be appropriate to combine the responses to the two questions as an estimate of VA outpatient users because it would also include those veterans who understood the question and used only fee-basis care. Subsequently, we conducted further analyses of the health insurance coverage of respondents to the two questions VA cited and the question that immediately followed them that asked the veterans whether they had gone “[t]o a private, non-VA doctor, clinic, health maintenance organization, hospital (outpatient), or other medical facility AT YOUR OWN EXPENSE OR COVERED BY INSURANCE?”

This analysis showed dramatic differences between the insurance coverages of veterans who indicated that they had used a VA clinic and those that indicated that they had used a private facility at VA expense. For example, 39 percent of those who indicated that they had used a VA clinic had no public or private insurance while only 6 percent of those who indicated that they used a private doctor at VA expense said that they had no health care coverage. Similarly, 34 percent of veterans who indicated that they used VA clinics said that they had only private health insurance while 67 percent of those who indicated that they used a private doctor at VA expense said that they had only private health insurance. The insurance coverages of veterans who indicated that they used private doctors at their own expense or covered by insurance, however, are very close to the coverages of veterans who said they used non-VA doctors at VA expense.

Because so many veterans answered the defective question affirmatively (1,963,813) compared with those who indicated that they used VA clinics (1,323,377), their responses overwhelmed VA's analysis once VA assumed that both groups should be counted as VA clinic users. This problem with VA's analysis was previously brought to the attention of VA officials but apparently continues to form the basis for analyses by VA's Health Care Transition Office.

Contrary to VA's suggestion, it would have been more to our purpose in chapter 5, entitled "Most VA Users Have Other Health Care Options," to have used higher estimates of veterans' private insurance coverage, such as those VA cites. But we do not believe such estimates are supportable.

VA Comment 4

GAO states that there is significantly improved health insurance available today than when VA was established in 1930. While this statement is generally true, questions of affordability and accessibility of that insurance for many veterans are not addressed. Medicare copayments, which are quite high, are out of reach for many veterans, and those copayments do not include coverage for prescriptions.

GAO Evaluation

We agree that health insurance remains unavailable to many veterans for a variety of reasons, but disagree with VA's assertion that our report does not address questions about the availability and affordability of health insurance. Chapter 2 specifically focuses on the 2.6 million veterans who had neither public nor private health insurance in 1990 and discusses the effects that out-of-pocket costs and coverage limits can have on insured

veterans' access to health care services. It is such unmet needs that we are suggesting VA focus on rather than competing to provide services already available to veterans through other programs.

VA Comment 5

Access to Medicaid requires that veterans, in essence, spend all of their assets before they are eligible for services such as long term care. Forcing veterans to spend all assets before eligibility is granted is not acceptable.

GAO Evaluation

By providing essentially cost-free nursing home care (VA recovers less than one-tenth of one percent of its nursing home costs through copayments), VA limits the number of veterans it can serve within available resources. With available resources, VA currently provides nursing home care to only about 16 percent of veterans in need of such care, essentially forcing most veterans who need nursing home care to either pay for their own nursing home care or spend all of their income and assets on health care and become Medicaid eligible.

In other words, VA, by directing all of its nursing home care resources toward providing essentially cost-free care to 16 percent of veterans needing such care, is, in effect, forcing the remaining 84 percent of veterans needing nursing home care to do what it terms "not acceptable."

VA Comment 6

Many veterans would not be eligible for many existing health insurance programs due to pre-existing conditions. On page 40, GAO notes that 15% of veterans using VA have incomes over \$20,000. That still leaves a substantial 85% of veterans (many of whom have families) with annual incomes of less than \$20,000.

GAO Evaluation

We agree and believe that VA should focus its limited resources on helping veterans who lack other health care options. As discussed in chapter 4, about 191,000 low-income and uninsured veterans with no other apparent health care options have not used VA health care because they are not aware of their eligibility, VA care is not accessible to them, or they have concerns about the quality of VA care. In our opinion, VA should focus its restructuring efforts on identifying and serving such veterans before attempting to attract privately insured veterans and Medicare-eligible veterans away from their private sector providers.

VA Comment 7

The GAO cites previously published report findings as being factual, when, in fact, VHA criticized GAO's methodology and findings in our official responses. For example, a GAO report suggesting a potential 50% decline in demand for VA care in the event of national health insurance implementation has substantial weaknesses and methodological faults.

GAO Evaluation

VA's comments on our earlier reports were included and fully evaluated in those reports. Our methodology and findings in the report VA cites were thoroughly reevaluated in response to VA's comments and found to be sound.

VA Comment 8

GAO states that only one in ten veterans use VA health care services. This is a misrepresentation of statistics. The preliminary 1994 National Survey of Veterans reveals that of all veterans surveyed, 54.8% received some kind of medical care in 1992. This means that of approximately 27.4 million veterans, 15 million received health care in 1992. During this period, VA provided medical care to approximately 20% of all veterans requiring medical care.

GAO Evaluation

Our draft report neither stated nor implied that only 1 in 10 veterans use VA health care services.

VA Comment 9

GAO states that the 1994 National Survey of Veterans is not expected to produce substantially different results. However, the 1994 survey was redesigned in such a manner as to overcome the deficiencies of the 1987 survey. For example, the initial survey was a simple random survey which under-sampled in several veteran categories. In contrast, the new survey has a stratified random sample and employed under- and over-sampling for the first time. This technique will produce more statistically valid estimates.

GAO Evaluation

We repeatedly attempted to obtain data from the 1994 survey to determine whether there have been significant changes in veteran responses, but were told that data were not yet available. However, a VA official involved in designing and analyzing the 1994 survey told us that the 1994 survey results appear not to be significantly different than the 1987 survey results.

VA Comment 10

Many of the assumptions GAO makes in this report have cost ramifications. For example, on page 4, GAO states that VA should design its health care to complement rather than duplicate coverage provided through other public and private health benefits programs. It is very likely that redesigning VA's health care system to complement public and private sector programs will result in an increase in the overall costs to provide care, since some entity will have to pick up the costs of the basic benefits that had been provided (if, in fact, they would be available at all to many veterans).

GAO Evaluation

In authorizing VA recoveries from private health insurance, the Congress determined that VA does not have the primary responsibility for paying for health care services provided to privately insured veterans except in the case of care provided for service-connected conditions. In our opinion, VA should be concerned with designing veterans health care benefits that will give the largest number of veterans the broadest array of services with the lowest out-of-pocket costs within available resources, regardless of source of payment. In other words, we see nothing wrong with a VA case manager referring a veteran to a community-run meals-on-wheels program or substance abuse program if it will conserve VA resources and expand VA's ability to meet veterans' health care needs. Overall health care costs are likely to increase only to the extent that retargeting VA health care programs is successful in expanding services provided to veterans. In our opinion, using VA resources to expand services to veterans is appropriate. The costs of doing such might be covered by savings from eliminating duplicative, competing services.

VA Comment 11

GAO also suggests that the Fee Basis Program could be expanded to improve access, and though not explicitly stated in the text, the implication is that a decrease in the number of employees would result. It is true that Fee Basis could be expanded. However, it must also be realized that care delivered in the Fee Basis Program is significantly more expensive per patient than that delivered by VA personnel. This is one reason why the Department maintains tight eligibility controls for this program.

GAO Evaluation

VA provides no data to support its statement that fee-basis care is significantly more expensive than outpatient care delivered by VA personnel. Although performing valid cost comparisons is complicated, readily available data suggest that VA's statement is questionable. In fiscal

year 1994, VA paid an average of \$96 per fee-basis visit. By comparison, VA's fiscal year 1994 billing rate for outpatient care provided in a VA clinic was \$158.

VA Comment 12

GAO also suggests that VA focus on care for the homeless, PTSD, chronic psychiatry and long term care patients. VA continues to expand services to veterans in these areas. Nevertheless, GAO fails to acknowledge that it is not for VA alone to address what are major societal problems and shortcomings in the general health care system.

GAO Evaluation

As stated on pages 18 and 43, it is unlikely that either public and private health insurance or the veterans health program will ever have adequate resources to meet all of the health care needs of every veteran. As a result, it is important that the VA system have clear priorities for how limited health care resources will be targeted and designed to supplement rather than unnecessarily duplicate health care coverage available under other programs. We do not agree with VA, however, that it does not have primary responsibility for treating service-related PTSD.

VA Comment 13

GAO states (page 5) that alcoholism is a frequently undiagnosed and untreated problem of veterans using VA medical centers. Although there are undoubtedly many undiagnosed substance abusers among veterans, substance abuse continues to be the most frequent of the Diagnostic Related Groupings (DRG) in VA. It is diagnosed at a much higher rate in VA than in the private sector. However, diagnosis of a substance abuse problem does not preclude the common refusal of patients to undergo treatment.

GAO Evaluation

On both page 5 and page 18, our discussions of substance abuse begin with statistics showing that substance abuse is a frequently undiagnosed and untreated problem in the general public. For example, we point out that less than 15 percent of the estimated 18 million Americans with alcoholism receive treatment. Information on VA is presented to show that VA is not adequately filling the gap created through public and private health insurance, rather than to compare the relative effectiveness of two programs, neither of which is adequately meeting the health care needs of veterans.

VA Comment 14

In other areas of the report, GAO inappropriately bases estimates of the extent of undiagnosed, untreated alcoholism on the responses contained in the 1987 Survey of Veterans, rather than on a clinician's diagnosis or assessment. This is unsupported.

GAO Evaluation

We did not use the 1987 Survey of Veterans to estimate the extent of undiagnosed, untreated substance abuse. Our estimates of the extent of undiagnosed, untreated substance abuse are, as stated on page 18, based on our 1990 survey of veterans applying for care at five VA medical centers during a 10-day period. In that study we applied a generally accepted alcoholism screening instrument to over 2,200 veterans and met with 20 VA physicians responsible for their care.

VA Comment 15

On page 3, GAO links the decreasing number of veterans with the decrease in the number of discharges since 1988 (through 1992). The causal relationship between these two facts is just that. Other important factors, such as the rapid movement towards ambulatory care and improved utilization management, have also led to a decrease in the number of non-acute admissions. Utilization of acute care beds has been decreasing rapidly in private sector facilities, as well, and the VA phenomenon must be interpreted in light of the overall trend in health care.

In contrast, a review of outpatient workload during this same time period reflected an increase of 9%. This is not mentioned in the report nor is there any correlation made with new unique veterans or with deaths. In addition, during this same period, laws governing VA medical benefits were significantly changed. P.L. 100-322 added additional criteria for income screening when providing outpatient care to certain veterans. Because this period showed great inconsistency in the manner in which access to care was addressed, the validity of access/use data from this time frame is questionable.

GAO Evaluation

We agree that many factors contribute to changes in VA's inpatient workload and have revised the discussion on page 3 to show that a number of factors contribute to the decline in VA discharges. These factors, however, highlight the challenge facing VA's acute care hospitals. Regardless of the reasons for declining inpatient hospital utilization, VA will have to either capture an ever increasing market share of the veteran

population or open its facilities to nonveterans if it is to maintain its acute care utilization.

VA Comment 16

GAO reviewers appear to be unaware of the fact that although long term care needs do increase as people age, so to [sic] does the need for acute care. Older people have a higher rate of acute episodes and take longer to recover. This is not discussed in the report.

GAO Evaluation

We agree that the elderly have increased acute hospital needs. The focus of our report, however, is on health care needs that are not met through existing public and private health insurance programs or VA. We do not believe acute hospital care is generally an unmet need because virtually all elderly veterans have Medicare part A coverage providing comprehensive acute hospital coverage. We also recognize in chapter 2 that out-of-pocket costs under Medicare can be a barrier to access for low-income veterans. We believe paying such out-of-pocket costs (to the extent they are not paid through the Medicaid program or Medicare supplemental policies) would be an appropriate focus for the VA health care system.

VA Comment 17

Plans for reorganization of the field and VA Central Office have the potential to decentralize decision-making and to allow determination of the most effective means of meeting veteran health care needs, whether through VA resources or through contract arrangements with private providers. Additional plans to have more community based clinics will provide access to care for those veterans who do not live within reasonable proximity to a medical center.

GAO Evaluation

Details of VA's planned reorganization have not been made available. As a result, we are unable to evaluate the extent to which such a reorganization would be responsive to our report recommendation or the extent to which it would improve services to veterans. As described in VA's comments, however, the reorganization appears to be focused more on expanding VA's direct delivery system than on developing a veterans benefits program that supplements those programs.

VA Comment 18

The [fourth] paragraph on page 2 states that gradually VA has shifted to "a system focusing primarily on treatment of low income veterans with no

service-connected disabilities.” This statement is followed by data that indicate that nearly half of veterans served in 1991 had service connected disabilities. These statements imply that this is inappropriate utilization of services without any supporting data to validate this line of reasoning.

GAO Evaluation

In providing background on the patient population served by VA, we are not implying that the shift away from treating service-connected disabilities toward treatment of low-income veterans for nonservice-connected disabilities is “inappropriate.” The information is presented to demonstrate that VA hospitals are, by and large, competing to provide veterans the same acute care services available to them in private sector hospitals. The primary difference between VA acute care services and private sector services is the source of payment.

VA Comment 19

The third paragraph on page 4 states that “VA cannot adequately address many of these health care needs because of its reliance on direct delivery of health care services in VA owned and operated facilities.” There is no acknowledgement by GAO of the many alternative VHA provisions for care, including fee-basis services, contract hospitalization, community and state home programs, and services secured through sharing agreements with affiliates and the Department of Defense. Neither does GAO recognize that VHA has issued a directive to implement primary care in every VHA facility by FY 1996 along with the expansion of access points to care. The impression left by GAO is that VA is serving veterans solely from within the existing infrastructure. The report also does not mention or consider community-based care as a long-term care option. Hospital Based Home Care, Home Health Services, Adult Day Health Care, and Community Residential care need to be recognized.

GAO Evaluation

We agree that VA has numerous community-based options, but use of these options is limited. For example, VA points out elsewhere in its comments that it intentionally makes limited use of its fee-basis program. Similarly, VA spends only about \$100 million of its \$16 billion health care budget on contract hospitalization, using the program primarily for emergency admissions. We have, however, revised the statement on page 4 to indicate that VA relies “primarily” on direct delivery.

VA Comment 20

On page 34, the report states that VA “has a broader range of covered services than most health insurance plans, but no veteran is currently entitled to the full range of VA services.” While this statement may be accurate, veterans with 100% service-connected disabilities are eligible for the full range of services. The only services not fully available to veterans with disabilities of 50% or more are certain dental procedures.

GAO Evaluation

Our statement is accurate. Chapter 4 explains the difference between eligibility and entitlement to VA health care and points out that veterans with service-connected disabilities rated at 50 percent or higher are entitled to comprehensive outpatient and inpatient hospital services. They are eligible for, but not entitled to, nursing home care.

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Evan L. Stoll conducted the computer analyses of data from VA's 1987 Survey of Veterans.

Related GAO Products

Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Reform (GAO/HEHS-95-14, Dec. 23, 1994).

Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS-95-13, Oct. 24, 1994).

Veterans' Health Care: Implications of Other Countries' Reforms for the United States (GAO/HEHS-94-210BR, Sept. 27, 1994).

Health Security Act: Analysis of Veterans' Health Care Provisions (GAO/HEHS-94-205FS, July 15, 1994).

Veterans' Health Care: Efforts to Make VA Competitive May Create Significant Risks (GAO/T-HEHS-94-197, June 29, 1994).

VA Health Care: VA and the Health Security Act (GAO/HEHS-94-159R, May 9, 1994).

VA Health Care Reform: Financial Implications of the Proposed Health Security Act (GAO/T-HEHS-94-148, May 5, 1994).

Veterans' Health Care: Most Care Provided Through Non-VA Programs (GAO/HEHS-94-104BR, Apr. 25, 1994).

VA Health Care: Veteran's Perceptions of VA Services and Its Role in Health Reform (GAO/T-HEHS-94-150, Apr. 20, 1994).

VA Health Care: A Profile of Veterans Using VA Medical Centers in 1991 (GAO/HEHS-94-113FS, Mar. 29, 1994).

Homelessness: Demand for Services to Homeless Veterans Exceeds VA Program Capacity (GAO/HEHS-94-98, Feb. 23, 1994).

VA Health Care: Restructuring Ambulatory Care System Would Improve Service to Veterans (GAO/HRD-94-4, Oct. 15, 1993).

VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (GAO/HRD-93-94, July 29, 1993).

Veterans Affairs: Accessibility of Outpatient Care at VA Medical Centers (GAO/T-HRD-93-29, July 21, 1993).

Related GAO Products

VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (GAO/HRD-93-123, June 30 1993).

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

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