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VA HEALTH CARE

Issues Affecting Eligibility Reform

Statement of David P. Baine, Director
Federal Health Care Delivery Issues
Health, Education, and Human Services Division

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss issues affecting eligibility reforms at the Department of Veterans Affairs (VA) health care program. VA has a budget of about $16.2 billion to provide health care services to America's 26.4 million veterans. Eligibility reform would present a significant challenge even with unlimited resources. But with the Congress and VA facing increasing pressures to limit VA health care spending as part of governmentwide efforts to reduce the budget deficit, this challenge has become even greater.

Over the past several years, we have conducted a series of reviews that have detailed problems in administering VA's outpatient eligibility provisions; compared VA benefits and eligibility to those of other public and private health benefits programs; and assessed VA's role in a changing health care marketplace. My comments this morning are based primarily on the results of those reviews.[1]

Specifically, we will discuss

-- the evolution of VA health care eligibility;

-- differences between eligibility for VA health care and eligibility under typical public and private health insurance programs;

-- the problems VA's current eligibility provisions create for veterans and providers;

-- various approaches for reforming VA eligibility; and

-- options for offsetting the costs of eligibility expansions.

In summary, veterans' eligibility for VA health care has evolved over time both in terms of the types of veterans eligible for care and the services they are eligible to receive. VA has gone from a system primarily covering hospital care for veterans with war-related injuries to a system covering a wide array of hospital and other medical services for both wartime and peacetime veterans and both veterans with and without service-connected disabilities. In the process, eligibility for VA care has grown increasingly complex. Where VA once had two services--hospital and domiciliary care--available to all eligible veterans, it now has multiple categories of veterans with eligibility based on such factors as period of service, presence and seriousness of service-connected disabilities, and income. For most veterans, however, eligibility continues to be conditioned on the need for hospital-related care.

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[1]A list of related GAO testimonies and reports is in appendix I.

VA benefits differ from benefits under a typical private health insurance policy in two important ways. First, private health insurance policies are easy for policyholders to understand and providers to administer because they have uniform benefits that apply to all policyholders. In private plans, benefits are typically defined in terms of specific medical services that are covered. In VA, however, benefits are not defined in terms of specific medical services. Rather, they are defined in terms of disabilities. One category of veterans--primarily those with service-connected disabilities rated at 50 percent or more--is eligible to receive any medical service needed to treat a disability, regardless of the cause or severity of the disability. But for veterans in other categories, the services they are eligible to receive on an outpatient basis depends on the types of disabilities for which they are seeking care. Veterans are eligible to receive any needed medical service for treatment of a service-connected disability regardless of the severity of the disability, but are eligible for treatment of other disabilities only if it will obviate the need for hospitalization or is needed in preparation for or as a follow-up to hospital care.

For example, a low-income veteran can receive a tetanus shot at a VA clinic for treatment of a puncture wound that, if left untreated, might result in a serious infection requiring hospital admission for treatment. The same veteran, however, could be denied care if he or she sought a tetanus shot at a VA clinic as a preventive health measure. Similarly, women veterans can obtain treatment for complications relating to a pregnancy, but cannot obtain routine prenatal care or delivery services through the VA health care system.

The second major difference between VA and public and private insurance is that there are no "guaranteed" benefits under the VA health care system. Under insurance programs, policyholders are essentially guaranteed coverage of all medically necessary services in their benefit package. Under the VA system, however, even veterans that the law says "shall" or "must" be provided certain types of health care services can get care only if resources are available. This is because the VA system is funded through a fixed annual appropriation. When funds run out, VA's obligation to provide care ends as well.

VA's eligibility provisions create problems for veterans and providers. Generally, they create uneven and uncertain access to VA health care and limit VA's ability to meet veterans' health care needs. Veterans with similar medical needs, service status, and incomes may get treated or turned away depending on what type of care they seek and where and when they seek care. This creates frustration for veterans who cannot understand what

services they can get from VA and for VA physicians and administrative staff who have to interpret the subjective eligibility provisions.

Because the provision of VA services is conditioned on the availability of space and resources, VA medical centers have developed policies and procedures for rationing care. Medical centers' policies vary, as does the sufficiency of resources, and, as a result, many medical centers turn away veterans for care, while others serve all veterans applying for care. Frequently, this results in a veteran receiving care at one medical center while another veteran with a comparable condition and coverage status is being denied care at a different center. Most veterans turned away obtain needed health care from other sources or obtain care during a subsequent trip to a VA facility. But of a group of 198 veterans we tracked, 15 percent did not obtain the needed health care.

The Congress faces many difficult choices in trying to reform VA's eligibility provisions to address these problems, such as:

-- Should current eligibility distinctions based on factors such as presence and degree of service-connected disability, period of service, and income be changed? If so, how should coverage groups be structured?

-- Should the restrictions on access to outpatient care be altered or removed?

-- Should a uniform benefit package be developed for one or more coverage groups? What benefits should be included for each coverage group?

-- Should the availability of benefits be guaranteed for one or more of the coverage groups?

-- How much should veterans be expected to contribute toward the costs of expanded benefits?

Obviously, the cost of eligibility reform depends on the answers to those questions. For example, one lower cost alternative might (1) maintain existing coverage groups, (2) establish more limited benefit packages for certain coverage groups such as higher income veterans with no service-connected disabilities (hereafter referred to as nonservice-connected veterans), (3) maintain existing space and resource constraints on the availability of care, and (4) increase the cost-sharing requirements for some veterans. Such an alternative would address some of the problems caused by VA's current eligibility

provisions, such as the uncertainty about covered services, but would not fully address other problems, such as the uneven availability of care.

In contrast, a higher cost alternative might (1) establish a single coverage group for all veterans, (2) expand coverage to include all medically necessary services, (3) provide for guaranteed availability of benefits for all veterans, and (4) maintain or decrease veterans' cost sharing.

In choosing among the available alternatives, the Congress faces a difficult policy dilemma. It seems inevitable that either (1) many veterans--including some who currently use VA services--will be turned away because of resource limitations if benefits are not guaranteed or (2) congressional control over VA health care spending will be relinquished if the availability of benefits is guaranteed.

BACKGROUND

The VA health care system was established in 1930, primarily to provide for the rehabilitation and continuing care of veterans injured during wartime service. VA developed its health care system as a direct delivery system with the government owning and operating its own health care facilities. It grew into the nation's largest direct delivery system.

VA now provides a wide range of inpatient, outpatient, and long-term care services to veterans both with and without service-connected disabilities. VA has gradually shifted from a system primarily providing treatment for service-connected disabilities incurred in wartime to a system increasingly focused on the treatment of low-income veterans with medical conditions unrelated to military service. Similarly, VA once treated an almost exclusively male veteran population but is now striving to meet the health care and privacy needs of an increasing number of women veterans.

For fiscal year 1996, VA is seeking an appropriation of about $17 billion to maintain and operate 173 hospitals, 376 outpatient clinics, 136 nursing homes, and 39 domiciliaries. VA facilities are expected to provide inpatient hospital care to 930,000 patients, nursing home care to 35,000 patients, and domiciliary care to 18,700 patients. In addition, VA outpatient clinics are expected to handle 25.3 million outpatient visits. The recently approved Congressional Budget Resolution, however, would essentially freeze the VA medical care appropriation at the fiscal year 1995 spending level--$16.2 billion--for the next 7 years.

ELIGIBILITY FOR VA HEALTH CARE HAS EVOLVED

Eligibility for VA health care has undergone a gradual evolution since the 1930 establishment of VA. Initially, the only veterans eligible for VA care were those (1) with injuries incurred during wartime service or (2) incapable of earning a living because of a permanent disability, tuberculosis, or neuropsychiatric disability suffered after their wartime service. Initially, eligibility was for hospital and domiciliary care only.

Eligibility for hospital care was later expanded to include veterans injured during other than combat duty and subsequently to all veterans without service-connected disabilities. Certain veterans, commonly referred to as "mandatory care" veterans, continued to have the highest priorities for care and are entitled to free VA hospital care. These mandatory care category veterans include those who

-- have service-connected disabilities,
-- were discharged from the military for disabilities that were incurred or aggravated in the line of duty,
-- are former prisoners of war,
-- were exposed to toxic substances or ionizing radiation,
-- served in the Mexican border period or World War I,
-- receive disability compensation,
-- receive nonservice-connected disability pension benefits, and
-- have incomes below the means test threshold (as of January 1995, $20,469 for a single veteran, $24,565 for a veteran with one dependent, plus $1,368 for each additional dependent).

For higher income veterans who do not qualify under these conditions, VA may provide hospital care if space and resources are available. These discretionary care category veterans, however, must pay a part of the cost of the care they receive.

When outpatient care was added to the VA system, eligibility was initially limited to veterans with service-connected disabilities. It was not until 1960 that VA was first authorized to treat nonservice-connected veterans on an outpatient basis. In that year, P.L. 86-639 authorized outpatient treatment for a nonservice-connected disability in preparation for, or to complete treatment of, hospital care. So concerned was the then Administrator of Veterans Affairs about the potential implications of this change that he wrote

> "The possible adverse effects of the proposed legislation should also, I believe, be considered. This bill would for the first time mean that non-service-connected veterans would be receiving outpatient treatment even though we have endeavored to make revisions which would

relate this only to hospital care. The outpatient treatment of the non-service-connected might be an opening wedge to a further extension of this type of medical treatment."

Thirteen years later, the Veterans Health Care Expansion Act of 1973 (P.L. 93-82) further extended outpatient treatment for nonservice-connected veterans, authorizing outpatient treatment for any disability to "obviate the need of hospital admission." Although there have been a number of further revisions to outpatient eligibility since 1973, most veterans' eligibility for ambulatory care services continues to be restricted to hospital-related care.

Appendix II contains a detailed description of VA eligibility requirements.

DIFFERENCES BETWEEN VA AND OTHER HEALTH CARE PROGRAMS ARE SIGNIFICANT

Despite the expansions in VA eligibility that have occurred over the last 65 years, VA continues to focus primarily on treatment of disabilities that would ordinarily require hospitalization. Eligibility for care under the VA health care system differs from eligibility under a typical public or private health insurance program in two key aspects:

-- VA does not have a uniform benefit package. Because public and private insurance policies generally have a uniform benefit package, both policyholders and providers know in advance what services are covered and what, if any, limitations apply to the availability of services. By contrast, the services a veteran is eligible to receive from VA vary depending on such factors as the presence and degree of service-connected disability, income, and the veteran's period of service.

   The uniform benefit package under public and private insurance programs frequently covers preventive health services, such as routine physical examinations and immunizations. By contrast, the VA system is focused on the provision of medical services needed for treatment of a "disability." For example, a woman veteran could obtain treatment for the complications of pregnancy but could not obtain prenatal care or delivery services for a routine pregnancy through the VA health care system.

-- The availability of covered services is not guaranteed under the VA health care system. The terms eligibility and entitlement have different meanings under the VA health care system than under other health benefits programs. For example, all beneficiaries who meet the basic eligibility

requirements for Medicare are entitled to receive all medically necessary care covered under the Medicare part A benefit package. Similarly, those Medicare beneficiaries who enroll for part B benefits are entitled to receive all medically necessary care covered under the part B benefit package. Medicare spending increases as utilization increases, creating guaranteed access to covered services.

Under the VA health care system, however, neither being eligible for nor being entitled to health care services guarantees the availability of needed services. The VA health care system is funded by a fixed annual appropriation; once appropriated funds have been expended, the VA health care system is not required to, and in fact is not allowed to, provide additional health care services--even to veterans "entitled" to VA care. Although title 38 of the U.S. Code contains frequent references to services that "shall" or "must" be provided to mandatory care group veterans, in practical application the terms mean that services "shall" or "must" be provided if adequate resources have been appropriated to pay for the care. Being "entitled" to care essentially gives veterans a higher priority for treatment than merely being "eligible."

VA ELIGIBILITY PROVISIONS FRUSTRATE VETERANS AND LIMIT VA'S ABILITY TO MEET VETERANS' HEALTH CARE NEEDS

VA's complex eligibility and entitlement provisions are a source of frustration for veterans, VA physicians, and VA's administrative staff:

-- Veterans are often uncertain about what services they are eligible to receive and what right they have to demand that VA provide them.

-- Physicians and administrative staff find the eligibility provisions hard to administer.

-- Veterans have uneven access to care because the availability of covered services is not guaranteed.

Because of these problems, veterans may be unable to consistently obtain needed health care services from VA facilities.

Veterans Uncertain About What Services Are Covered

Veterans are often confused by VA's complex eligibility and entitlement provisions. The services they can get from VA depend on such factors as the presence and extent of any service-connected disabilities, their incomes, their periods of service,

and the seriousness of their conditions. Table 1 demonstrates the complexities of VA eligibility.

Table 1: Eligibility for and Entitlement to VA Health Care Benefits

Veteran category	Hospital care	Outpatient care	Nursing home care
Service-connected: 50-100%, for any condition	Entitled	Entitled	Eligible
Service-connected: 0-40%, for a service-connected condition			
Discharged for disability			
Service-connected: 30-40%, for a nonservice-connected condition	Entitled	Entitled, limited to pre- and post-hospitalization and to obviate the need for hospital care	Eligible
Pensioner or income under $12,855			
Injured in VA			
Prisoner of war	Entitled	Eligible	Eligible
World War I & Mexican War veterans			
Pension with aid and attendance			
Service-connected: 0-20%, for a nonservice-connected condition	Entitled	Eligible, limited to pre- and post-hospitalization and to obviate the need for hospital care	Eligible
Nonservice-connected with an income of $12,855-$20,469 (no dependents)			
Agent Orange, radiation, Medicaid-eligible			
Nonservice-connected with income over $20,470	Eligible, with copayment	Eligible, with copayment, limited to pre- and post-hospitalization and to obviate the need for hospital care	Eligible, with copayment

Source: Independent Budget for Veterans Affairs Fiscal Year 1996.

To further add to veterans' confusion about what health care services they are eligible to receive at VA, title 38 of the U.S. Code specifies the types of medical services that can be provided on an outpatient or ambulatory basis. These services include provision of wheelchairs, crutches, eyeglasses, and hearing aids for veterans eligible for comprehensive outpatient services. For other veterans, however, such services are not covered unless they are needed to obviate the need for hospital care. Similarly, there are special eligibility provisions that apply specifically to dental examinations and treatment.

Outpatient Eligibility Requirements Are Difficult to Administer

Veterans are not the only ones confused by VA eligibility and entitlement provisions. Those tasked with applying and enforcing the provisions on a day-to-day basis--VA physicians and administrative staff--express similar frustration in attempting to interpret the provisions. Although the obviate the need for hospitalization criterion is most often cited as the primary source of frustration, VA administrative staff must also enforce a series of other requirements, which add administrative costs not typically incurred under other public or private insurance programs.

VA has broadly defined the statutory eligibility criterion relating to obviating the need for hospitalization. Guidance to medical centers says that eligibility determinations

> "shall be based on the physician's judgment that the medical services to be provided are necessary to evaluate or treat a disability that would normally require hospital admission, or which, if untreated would reasonably be expected to require hospital care in the immediate future. . . ."

To assess medical centers' implementation of this criterion, we used medical profiles of 6 veterans developed from actual medical records and presented them to 19 medical centers for eligibility determinations.[2] At these 19 centers, interpretations of the criterion ranged from permissive (care for any medical condition) to restrictive (care only for certain medical conditions). In other words, from the veteran's perspective, access to VA care will depend greatly on which medical center they visit. For example, if one veteran we profiled had visited all 19 medical centers, he would have been determined eligible by 10 centers but ineligible by 9 others.

Officials at VA's headquarters and medical centers agreed that the "obviate the need of hospital admission" criterion is an ambiguous and inadequately defined concept. A headquarters official stated that because the term has no clinical meaning, its definition can vary among physicians or even with the same physician. A medical center official noted that the criterion

> "...is so vaguely worded that every doctor can come up with one or more interpretations that will suit any situation. . . . Having no clear policy, we have no uniformity. The same patient with the same condition

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[2]VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 16, 1993).

> may be denied care by one physician, only to walk out of the clinic the next day with a handful of prescriptions supplied by the doctor in the next office. . . ."

With thousands of VA physicians making eligibility decisions each working day, the number of potential interpretations is, to say the least, very large.

In addition to interpreting the "obviate the need" provision, VA physicians or administrative staff must evaluate a series of other eligibility requirements before deciding whether individual veterans are eligible for the health care services they seek. For example, they must

-- determine whether the disability for which care is being sought is service-connected or aggravating a service-connected disability because different eligibility and entitlement rules apply to service-connected and nonservice-connected care;

-- determine the disability rating for service-connected veterans because the outpatient services they are eligible for and entitled to depend on their rating;

-- determine the income and assets of nonservice-connected veterans because their eligibility for (and priority for receiving) care depends on a determination of their ability to pay for care; and

-- determine whether their disability may have been related to exposure to toxic substances or environmental hazards during service in Desert Storm or Vietnam, in which case care may be provided without regard to other eligibility provisions.

Having to make such determinations on a case-by-case basis adds to the frustration of VA physicians and administrative staff.

Availability of Outpatient Care Is Uneven

Because the provision of VA outpatient services is conditioned on the availability of space and resources, veterans cannot be assured that health care services are available when they need them. Even veterans "entitled" to care are theoretically limited to health care services that can be provided with available space and resources. If demand for VA care exceeds the capacity of the system or of an individual facility to provide care, then health care services are rationed.

The Congress established general priorities for VA to use in rationing outpatient care when resources are not available to care for all veterans. VA delegated rationing decisions to its

158 medical centers; that is, each must independently make choices about when to and how to ration care.

Using a questionnaire, we obtained information from VA's 158 medical centers on their rationing practices. In fiscal year 1991, 118 centers reported that they rationed outpatient care for nonservice-connected conditions and 40 reported no rationing. Rationing generally occurred because resources did not always match veterans' demands for care.[3]

When the 118 centers rationed care, they also used differing methods. Some rationed care according to economic status, others by medical service, and still others by medical condition. The method used can greatly affect who is turned away. For example, rationing by economic status will help ensure that veterans of similar financial means are served or turned away. On the other hand, rationing by medical service or medical condition helps ensure that veterans with similar medical needs are served or turned away.

The 118 medical centers' varying rationing practices resulted in significant inconsistencies in veterans' access to care both among and within centers. For example, higher income veterans frequently received care at many medical centers, while lower income veterans or those who also had service-connected disabilities were turned away at other centers. Some centers that rationed care by either medical service or medical condition sometimes turned away lower income veterans who needed certain types of services while caring for higher income veterans who needed other types of services.

Some Veterans' Health Conditions Go Untreated

In a 1993 review, we examined veterans' efforts to obtain care from alternative sources when VA medical centers did not provide it.[4] Through discussions with 198 veterans turned away at 6 medical centers, we learned that 85 percent obtained needed care after VA medical centers turned them away. Most obtained care outside the VA system, but some veterans returned to VA for care, either at the same center that turned them away or at another center.

The 198 veterans turned away needed varying levels of medical care. Some had requested medications for chronic medical conditions, such as diabetes or hypertension. Others presented

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[3]GAO/HRD-93-106, July 16, 1993.

[4]VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (GAO/HRD-93-123, July 14, 1993).

new conditions that were as yet undiagnosed. In some cases, the conditions, if left untreated, could be ultimately life threatening, such as high blood pressure or cancer. In other cases, the conditions were potentially less serious, such as psoriasis.

FINANCIAL IMPLICATIONS OF ALTERNATIVE APPROACHES FOR RESTRUCTURING VA HEALTH CARE ELIGIBILITY

A number of approaches could be used to address the problems we just discussed. For example

-- the restrictions on access to ambulatory care could be eliminated,

-- a uniform benefit package could be created,

-- veterans' entitlement to free care could be expanded,

-- funding of veterans' health care could be changed from discretionary to mandatory, or

-- a combination of these approaches could be used.

Such reforms, however, would likely generate significant new workload and could potentially cost billions of dollars. While retaining the discretionary nature of VA health care funding would theoretically give the Congress more control over VA spending, it would, in our opinion, be extremely difficult for the Congress to control the growth in VA appropriations if other changes generate increased workload.

Eliminating the restrictions on access to ambulatory care would simplify administration of health care benefits because VA physicians would no longer need to determine whether a patient would likely end up in the hospital if not treated. Eliminating the restrictions would also promote greater equity by reducing the inconsistencies in eligibility decisions. Finally, eliminating the restrictions would make benefits more understandable by essentially making veterans eligible for the full continuum of inpatient and outpatient care.

Eliminating the restrictions on access to ambulatory care would likely generate significant new workload because over 26 million veterans would be eligible to receive services that previously were reserved primarily for the approximately 465,000 service-connected veterans with disabilities rated at 50 percent or higher. Even many veterans who rely on other health care coverage for most of their needs are likely to take advantage of added VA benefits such as eyeglasses, contact lenses, and hearing aids not typically covered under other health insurance. Another

area where workload would likely increase dramatically is prescription drugs. Medicare does not cover outpatient prescription drugs, making VA an attractive alternative. Medicare-eligible veterans already make significant use of VA outpatient prescriptions even with the current eligibility limitations.[5] Removing the restrictions on access to ambulatory care would likely significantly increase demand for outpatient prescriptions.

One way to control the increase in workload would be to develop a uniform benefit package patterned after public and private health insurance. This would narrow the range of services veterans could obtain from VA, allowing workload reduced by the eliminated services to offset the workload from increased demand for other services. VA could adjust the benefit package on a yearly basis based on the availability of resources.

Creating a uniform benefit package could result in some veterans receiving a narrower range of services than they receive now while others would receive additional benefits. This approach 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 option for addressing this problem would be to establish separate benefit packages for different types of veterans. For example, veterans with disabilities rated at 50 percent or higher might continue to be entitled to any needed outpatient service, while a narrower package of outpatient benefits--perhaps excluding such items as eyeglasses, hearing aids, and prescription drugs--could be provided to higher income nonservice-connected veterans.

The impact of eligibility reforms on VA workload will also depend on the extent to which concurrent changes are made in the accessibility of VA health care services. As it strives to make the transition from a hospital-based system to an ambulatory-care -based system, VA is attempting to bring ambulatory care closer to veterans' homes. Because distance is one of the primary factors affecting veterans' use of VA health care, actions to give veterans access to outpatient care closer to their homes, either through expansion of VA-operated clinics or through contracts with community providers, will likely increase demand for services.

Neither eliminating the restrictions on access to ambulatory care nor creating a uniform benefit package would address the

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

uneven availability of VA health care services caused by resource limitations and inconsistent VA rationing policies. In fact, the increased demand for care generated by such changes would likely heighten the problems VA already faces in trying to equitably distribute available resources.

Eligibility reform that would remove the space and resource constraints would, however, essentially turn VA into an open-ended entitlement program like Medicare. Currently, about 465,000 veterans with service-connected disabilities rated at 50 percent or higher are entitled to free comprehensive outpatient services from VA. Removing the resource constraints and expanding VA entitlement to free comprehensive health care services to all veterans currently eligible for free care (about 9 million to 11 million veterans), as proposed by the Clinton Administration last year, could add billions of dollars to VA's health care budget.

We are also concerned, however, about the practicality of expanding entitlement while retaining current resource constraints because this might force rationing of care to veterans in the mandatory care group. Expanding entitlement to free care while retaining current resource constraints would make it exceedingly difficult for the Congress to set resource levels for the VA health care program that would not fully fund services for veterans in the mandatory care categories. In other words, if the eligibility reforms result in demands for care that exceed available resources, can the Congress realistically be expected to restrict VA's health care funding and tell VA to ration care to veterans entitled to such care? We think that is unlikely.

OPTIONS FOR OFFSETTING THE COSTS OF ELIGIBILITY EXPANSIONS

Several options exist for offsetting the costs of eligibility expansions. First, the use of veteran cost sharing could be increased. For example, VA might be authorized to provide veterans any available health care service without changing veterans' 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 would not, however, significantly strengthen VA's safety net role because lower income, uninsured veterans would likely be unable to pay for many additional health care services even if VA were authorized to provide them.

Similarly, VA could be authorized to increase cost sharing for nursing home care--a discretionary benefit for all veterans--either through increased copayments or estate recoveries. Recoveries could be used to help pay for benefit expansions.

Cost sharing could also be increased by redefining the mandatory care group. In other words, the income levels for inclusion in the mandatory care category could be lowered or copayments imposed for nonservice-connected care provided to veterans with 0- to 20-percent service-connected disabilities.

A second option for paying for eligibility expansions would be to authorize VA to recover from Medicare the costs of services VA facilities provide to Medicare-eligible veterans. Several proposals have been made in the past several years to authorize VA recoveries from Medicare either for all Medicare-eligible veterans or for those with higher incomes. Such proposals appear to offer little promise for offsetting the costs of eligibility expansions. First, many of the services, such as hearing aids and prescription drugs, that Medicare-eligible veterans are likely to obtain from VA are not Medicare-covered services. Second, allowing VA to retain recoveries from Medicare without an offset against VA's appropriation would create strong incentives for VA facilities to shift their priorities toward providing care to veterans with Medicare coverage. VA facilities would essentially receive duplicate payments for care provided to higher income Medicare beneficiaries, unless recoveries were designated to fund services or programs for which VA did not receive an appropriation.

Finally, authorizing VA recoveries from Medicare could further jeopardize the solvency of the Medicare trust fund and increase overall federal health care costs regardless of whether VA is allowed to keep all or a portion of the recoveries. Such an action would essentially transfer funds between federal agencies while adding administrative costs.

One argument frequently used to promote the need for eligibility reform is that the "obviate the need" provision prevents VA from providing care in the most cost-effective setting. The presumed "savings" from removing the restrictions on access to ambulatory care services would then be used to offset the costs of expanded benefits.

We agree that significant savings can accrue from shifting a sizable portion of VA's inpatient workload to other settings. We do not believe, however, that current eligibility provisions prevent VA from shifting much of its current inpatient workload to ambulatory care settings.

The same "obviate the need" provisions discussed earlier as making it difficult for VA physicians to determine whether to provide outpatient care for certain conditions, make it clear that care can be provided to any veteran, regardless of income or other factors, if it would prevent a hospital admission. The eligibility provisions, for example, allow VA to perform cataract

surgery on an outpatient basis to obviate the need for inpatient care. Accordingly, we do not believe it would be appropriate to assume that the management inefficiencies that have prevented VA from effectively implementing the "obviate the need" provision and shifting care to outpatient settings for over 20 years will be eliminated and the planned savings actually realized.

CONCLUSIONS

The VA health care system was neither designed nor intended to be the primary source of health care services for most veterans. It was initially established to meet the special care needs of veterans injured during wartime and those wartime veterans permanently incapacitated and incapable of earning a living. Although the system has evolved since that time, even today it focuses on meeting the comprehensive health care needs of only about 465,000 of the nation's 26.4 million veterans. As a result, few veterans can count on VA as their only source of health care coverage.

Fortunately, 9 out of 10 veterans have other public or private health insurance that meets their basic health care needs. For such veterans, VA eligibility reform might provide an additional option for health care services or additional services not covered under their public or private insurance. For those veterans who do not have other health care options, however, eligibility reform is more important. It could provide them access to comprehensive health care services, including preventive health care services, they currently lack. In other words, they would no longer need to allow their medical conditions to deteriorate to the point where they would qualify for care under the "obviate the need" criterion.

Eligibility reform could significantly increase demand for VA health care services, putting pressures on the Congress to increase VA appropriations and on VA to develop rationing policies that would ensure that limited resources are directed toward those veterans with the highest priority for care and the greatest need for VA health care--those without other public and private health insurance. At the same time, VA would need to ensure that funds needed to provide specialized services, such as treatment of spinal cord injuries, not available through other programs are not diverted to pay for outpatient services for veterans who could get those services through other programs.

The Congress faces many challenges in designing eligibility reforms that will be budget neutral and that will not give veterans false expectations of what services they can obtain from VA. Expanding eligibility without providing adequate funds to pay for the expected increase in demand could increase the number

of veterans turned away from VA facilities. We will be glad to work with this Committee and others in analyzing specific proposals as they are introduced.

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

For more information on this testimony, please call Jim Linz, Assistant Director, at (202) 512-7110. Terry Saiki, Evaluator-in-Charge, and Paul Reynolds, Assistant Director, also contributed to the preparation of the statement.

RELATED GAO PRODUCTS

VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-213, May 9, 1995).

VA Health Care: Retargeting Needed to Better Meet Veterans' Changing Needs (GAO/HEHS-95-39, Apr. 21, 1995).

VA Health Care: Barriers to VA Managed Care (GAO/HEHS-95-84R, Apr. 20, 1995).

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

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

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

ELIGIBILITY FOR AND ENTITLEMENT TO VA HEALTH CARE

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 VA medical care benefits. The amount of required active duty service varies depending on when the person entered the military, and an eligible veteran's entitlement to medical care offered by VA depends on such factors as the presence and extent of a service-connected disability, income, and period or conditions of military service.

Persons enlisting in one of the armed forces after September 7, 1980, and officers commissioned after October 16, 1981, must have completed 2 years of active duty or the full period of their initial service obligation to be eligible for benefits. Veterans discharged at any time because of service-connected disabilities and those discharged for disabilities unrelated to their military service or because of personal hardship near the end of their service obligation are not held to this requirement. Also eligible are members of the armed forces' reserve components who were called to active duty and served the length of time for which they were activated.

Although all veterans meeting the above requirements are "eligible" for VA medical care, VA uses a complex priority system--based on such factors as the presence and extent of any service-connected disability, the incomes of veterans with nonservice-connected disabilities, and the type and purpose of care needed--to determine which veterans receive care within available resources.

HOSPITAL AND NURSING HOME CARE

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 nursing home care to certain veterans with injuries related to their service or whose incomes are below specified levels. These mandatory care category veterans include those who

-- have service-connected disabilities,
-- were discharged from the military for disabilities that were incurred or aggravated in the line of duty,
-- are former prisoners of war,
-- were exposed to certain toxic substances or ionizing radiation,
-- served during the Mexican border period or World War I,

-- receive disability compensation,
-- receive nonservice-connected disability pension benefits, and
-- have incomes below the means test threshold (as of January 1995, $20,469 for a single veteran, $24,565 for a veteran with one dependent, plus $1,368 for each additional dependent).

For higher income veterans who do not qualify under these conditions, VA may provide hospital and nursing home care if space and resources are available. These discretionary care category veterans, however, must pay a part of the cost of the care they receive.

OUTPATIENT CARE

VA provides three levels of outpatient care:

-- comprehensive care, which includes all services needed to treat any medical condition;
-- service-connected care, which is limited treating conditions related to a service-connected disability; and
-- hospital-related care, which provides only the 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.

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

VA must furnish service-connected outpatient care to any veteran for the treatment of conditions related to service-connected disabilities regardless of the veterans' disability rating. VA must also provide all outpatient services needed to treat medical conditions related to injuries suffered as a result of VA hospitalization or while participating in a VA rehabilitation program.

VA must furnish hospital-related outpatient care to veterans (1) with service-connected disabilities rated at 30 or 40 percent and (2) whose annual incomes do not exceed VA's pension rate for veterans in need of regular aid and attendance.

VA may, to the extent resources permit, furnish limited hospital-related outpatient care to veterans not otherwise entitled to outpatient care, providing they agree to pay a part of the cost of care. Most veterans, about two-thirds of all

eligible veterans according a 1990 VA survey, fall into this discretionary category.

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