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VA HEALTH CARE

Approaches for Developing Budget-Neutral Eligibility Reform

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Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss proposals to reform eligibility for Department of Veterans Affairs (VA) health care benefits. 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 the administration of VA's outpatient eligibility provisions, compared VA benefits and eligibility with 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 and ongoing work for this Committee.[1]

Specifically, we will discuss

- the problems VA's current eligibility and contracting provisions create for veterans and providers,
- the relationship between inappropriate admissions to VA hospitals and VA eligibility provisions,
- legislative proposals to reform VA eligibility and contracting rules and their potential impact on the deficit, and
- options for achieving budget-neutral eligibility reform.

Summary

In summary, VA health care has gradually evolved from a system primarily providing hospital care to veterans injured during wartime service to a system increasingly focused on the treatment of low-income veterans with medical conditions unrelated to military service. For most veterans, eligibility for veterans' health benefits is still limited primarily to hospital-related care.

Budget-neutral reforms of VA eligibility provisions could enable VA to function more like a private insurer and provider. Unlike private insurance, VA does not have a well-defined, uniform benefit package and does not guarantee the availability of covered services. In addition, a VA facility is not allowed to provide a noncovered service even if it has the resources to provide the care and the veteran is willing to pay for it. This often places VA physicians in the position of having to either (1) ignore the

[1]A list of related GAO products is in app. II.

law and provide noncovered services for free or (2) turn away veterans even though VA may have the space and resources to provide the needed health care services.

Generally, VA's current eligibility provisions 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 frustrates veterans, who cannot understand what services they can get from VA, and VA physicians and administrative staff, who have to interpret the subjective eligibility provisions.

During the past year, four major bills were introduced to reform VA eligibility. These bills would eliminate the current restrictions on veterans' eligibility for outpatient care, essentially making all 26.4 million veterans eligible for comprehensive outpatient care, whereas fewer than 1 million are currently eligible. In addition, the bills would increase the number of veterans in the mandatory category for comprehensive outpatient care (that is, the category for which the law says VA "shall" or "must" provide covered services) from 465,000 to between 9 million and 11 million. The bills generally would not address most of the other problems with current VA eligibility provisions, such as the lack of guaranteed funding.

Although we support the need for reform, we do not believe any of the four major eligibility reform proposals achieves budget neutrality. For example, making all 26.4 million veterans eligible for comprehensive outpatient care would likely generate significant new demand for both outpatient and inpatient care. These increases are likely to come both from VA users previously unable to obtain all of their health care services from VA and from veterans seeking care from VA for the first time.

In addition, the synergistic effects of other needed changes in the VA health care system will likely heighten the effects of eligibility expansions on future demand for care. For example, VA's plans to make its health care more accessible to veterans will probably generate new demands for care. Generally, when VA opens a new outpatient clinic, a large proportion of the users are new to the VA system. In addition, current VA users living near the new clinic tend to use VA services more often. Similarly, actions taken to improve customer service, such as installation of bedside telephones, reducing waiting times, and establishing primary care teams, will likely attract new users.

Nine out of 10 veterans have other public or private insurance that they typically use to purchase care from private sector providers. As a result, changes in the VA system to expand benefits, improve accessibility, and improve customer service will put VA in more direct competition with private sector providers and insurers. Because the proposed eligibility expansions would offer 9 million to 11 million veterans comprehensive free care, VA could gain a strong competitive advantage over private sector providers.

Because the bills would not provide for major new sources of revenue to help pay for the expanded services, their enactment would place considerable pressure on the Congress to appropriate additional funds to meet the increased demand. It would be particularly problematic for the Congress not to appropriate funds to meet the health care demands of the large group of veterans who would be added to the mandatory category for comprehensive outpatient care.

VA and the Congressional Budget Office (CBO) have arrived at starkly different assessments of the potential budgetary impact of the proposal included in the House of Representatives' budget reconciliation package last year. VA concluded that the bill would be budget neutral and might save $268 million a year.[2] By contrast, CBO estimated that the bill could add $3 billion or more to the deficit.

We find CBO's arguments more compelling for two principal reasons. First, CBO's estimate predicts that significant increases in demand for outpatient care would likely result from enactment of the bill, whereas VA estimates no increase. Second, VA's cost analysis is sensitive to a series of assumptions. Changing the assumptions can quickly turn a potential savings into a potential cost increase. For example, VA assumed that it would divert 20 percent of hospital patients to outpatient care through eligibility reform and that 7 days of hospital care would be avoided for every patient diverted. One to 3 days seems a more likely length of stay for patients who do not need a hospital level of care but are admitted to VA hospitals just to provide them services they are not eligible to receive as outpatients. Avoiding an average of 3 days of hospital care, rather than 7, would turn a claimed savings of $268 million into a cost increase of $167 million under VA's formula.

In addition, VA has provided little evidence to support its assumption that eligibility reform would enable it to divert 20 percent of its hospital

[2]The eligibility reform provisions were later dropped during the House and Senate Conference.

patients to outpatient clinics. In fact, studies done by VA and others show little evidence to link nonacute admissions to problems with VA eligibility provisions. Generally, nonacute admissions result from conservative physician practices and the lack of outpatient care capabilities. Unlike the private sector, where insurers often require policyholders to obtain approval from an external reviewer before they are admitted to hospitals, VA has no preadmission certification program. While hundreds of millions of dollars may be saved by reducing inappropriate admissions to VA hospitals, we believe that such savings should not be "spent" before administrative actions, such as establishment of an external preadmission certification program, are in place to ensure that nonacute admissions are, in fact, reduced.

Although the current proposals are not budget neutral, many approaches could be used to help design budget-neutral eligibility reform. These approaches include

- increasing veterans' cost sharing or allowing VA to sell noncovered services to veterans;
- establishing uniform, but more limited, benefit packages; and
- expanding eligibility for some veterans but reducing or eliminating eligibility for others.

Through the use of a combination of these approaches, we believe budget-neutral eligibility reform can and should be developed.

Background

For fiscal year 1996, VA sought 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 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. Final action on VA's fiscal year 1996 appropriation is pending.

The VA health care system consists of (1) a health benefits program and (2) a health care delivery program. The two programs are closely intertwined. For example, VA outpatient clinics are not allowed to use available resources to provide services to many veterans because (1) the services, such as prosthetics, are not covered under the veterans' health

care benefits and (2) the clinics are not permitted under the law to sell such noncovered services to veterans.

In administering the veterans' health benefits program, VA's responsibilities are similar to those of the Health Care Financing Administration (HCFA) in administering Medicare benefits and to those of private health insurance companies in administering health insurance policies. For example, VA is responsible for determining (1) which benefits veterans are eligible to receive, (2) whether and how much veterans must contribute toward the cost of their care, (3) whether the health care services veterans need are covered under their benefits, and (4) where veterans obtain covered services (that is, whether they must use VA-operated facilities or can obtain needed services from other providers at VA expense). Similarly, VA, like HCFA and private insurers, is responsible for ensuring that the health benefits provided to its "policyholders"—veterans—are (1) medically necessary and (2) provided in the most appropriate care setting (such as a hospital, nursing home, or outpatient clinic).

In operating a health care delivery program, VA's role is similar to that of the major private sector health care delivery networks, such as those operated by Columbia/Hospital Corporation of America and Humana. For example, VA strives to ensure that its facilities (1) provide care of an acceptable quality, (2) are used to their optimum capacity, (3) are located where they are accessible to its target population, (4) provide good customer service, (5) offer potential patients services and amenities comparable to competing facilities, and (6) operate effective billing and collection systems.

Significant Changes Occurring in the Veteran Population

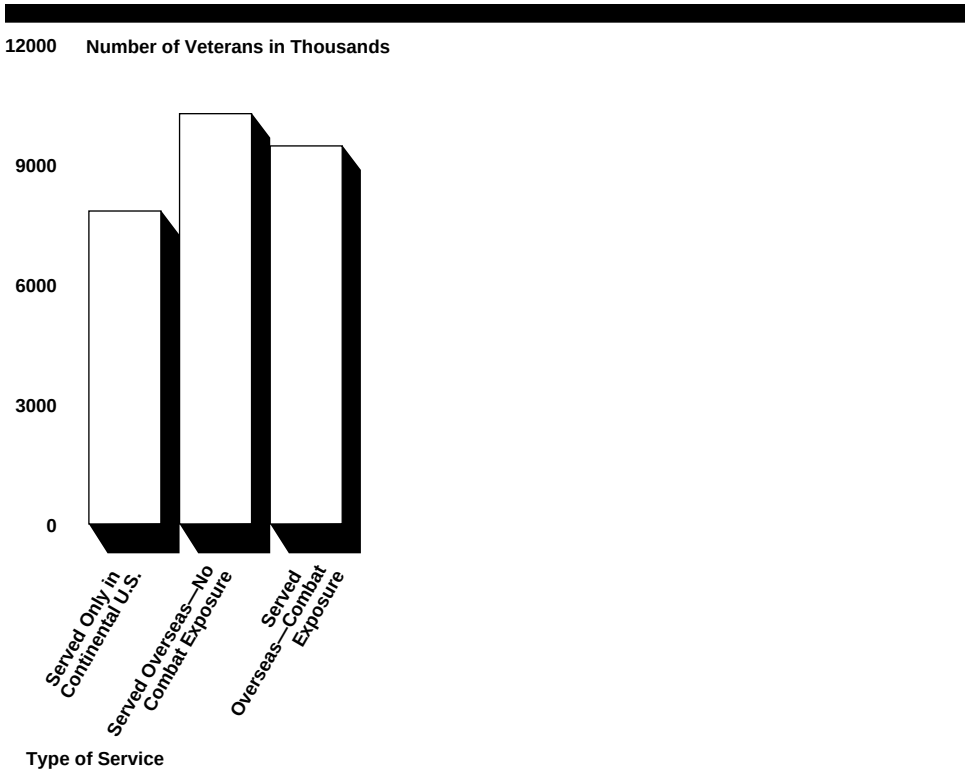
The veteran population, which totaled about 26.4 million in 1995, is both declining and aging. Between 1990 and 2010, VA projects the veteran population will decline 26 percent. The decline will be most notable among veterans under 65 years of age—from about 20.0 million to 11.5 million. By contrast, the number of veterans aged 85 and older will increase more than eight-fold. At that time, veterans aged 85 and older will make up about 6 percent of the veteran population.

Coinciding with the overall decline in the number of veterans is a decline in the percentage of veterans who served during wartime. VA projects the total number of wartime veterans to decline from 21 million in 1990 to 13.6 million in 2010. Even more dramatic is the shift in the number of wartime veterans by period of service. By 1995, deaths of World War II

veterans had accelerated to the point that Vietnam-era veterans outnumbered World War II veterans by about 826,000. By 2010, Persian Gulf veterans are expected to outnumber both Korean War and World War II veterans.

Most veterans who served during wartime had no combat exposure. About 35 percent of U.S. veterans were actually exposed to combat. (See fig. 1.)

Figure 1: Combat Exposure of Veterans, 1992

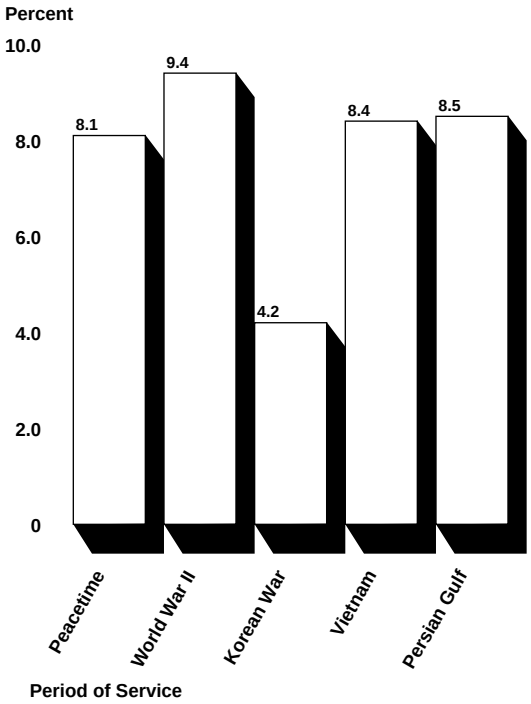


Source: Based on data from VA's National Survey of Veterans (Washington, D.C.: National Center for Veteran Analysis and Statistics, VA, 1995).

About 8.3 percent of veterans have compensable service-connected disabilities. Surprisingly, veterans who served during peacetime are almost twice as likely to have service-connected disabilities as veterans of the

Korean War and only slightly less likely to have service-connected disabilities than Vietnam-era veterans. (See fig. 2.)

Figure 2: Veterans With Service-Connected Disabilities, by Period of Service, 1994

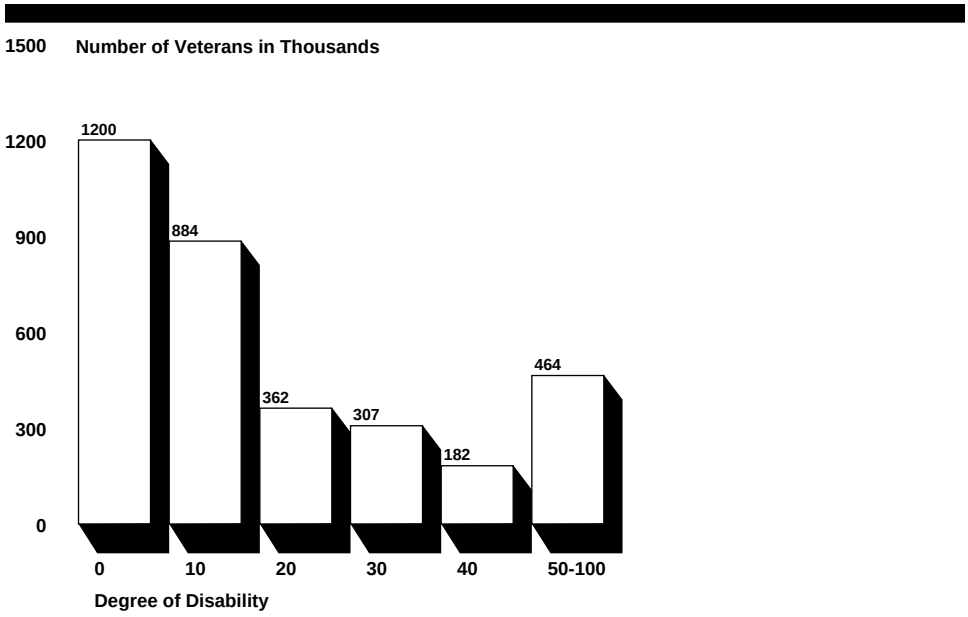


Source: Data are from the Annual Report of the Secretary of Veterans Affairs, Fiscal Year 1994 (Washington, D.C.: 1995).

Of the more than 2.2 million veterans with compensable service-connected disabilities, over half have disability ratings of 10 or 20 percent. Of the remaining veterans with service-connected disabilities, about 488,000 had disabilities rated at 30 or 40 percent.[3] (See fig. 3.)

[3]A service-connected disability is one that results from an injury or disease or other physical or mental impairment incurred or aggravated during military service. VA determines whether veterans have service-connected disabilities and, for those with such disabilities, assigns ratings of from 0 to 100 on the basis of the severity of the disability. These ratings form the basis for determining both the amount of compensation paid to the veterans and the types of health care services for which they are eligible.

Figure 3: Veterans With Service-Connected Disability Ratings, by Degree of Disability, 1994



Note: Numbers include an estimated 1.2 million veterans with noncompensable service-connected disabilities.

Source: Data are from the Annual Report of the Secretary of Veterans Affairs, Fiscal Year 1994.

Eligibility for VA Health Care Benefits

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 currently eligible for VA health care benefits. Although all veterans meeting the basic requirements are "eligible" for hospital, nursing home, and at least some outpatient care, the VA law establishes 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 services are covered and which veterans receive care within available resources.

The distinction between covered and noncovered services in discussing veterans' health benefits is important because VA facilities are generally restricted to providing "covered" services to veterans. As a result, VA facilities are not allowed to provide other services directly to veterans or

others even if they have the capacity to provide the services and the patient agrees to pay for them.[4]

Certain veterans, commonly referred to as Category A, or mandatory care category, veterans, have the highest priority for hospital and nursing home care. More specifically, VA must provide hospital care, and, if space and resources are available, may provide nursing home care to veterans 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 or $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 veterans, commonly known as Category C, or discretionary care category, veterans, must pay a part of the cost of the care they receive.

VA also provides three basic levels of outpatient care benefits:

- comprehensive care, which includes all services needed to treat any medical condition;
- service-connected care, which is limited to 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.

Separate mandatory and discretionary categories apply to outpatient care. Only veterans with service-connected disabilities rated at 50 percent or higher (about 465,000 veterans) are in the mandatory category for comprehensive outpatient care. All veterans with service-connected

[4]Studies by the VA Office of Inspector General indicate that about 56 percent of the discretionary care outpatient visits VA facilities provide are for noncovered services that the veterans were not eligible to receive.

disabilities are in the mandatory care category for treatments related to their disabilities; they are also eligible for hospital-related care of nonservice-connected conditions, but, with the exception of veterans with disabilities rated at 30 or 40 percent, they are in the discretionary care category. Most veterans with no service-connected disabilities are eligible only for hospital-related outpatient care and, with few exceptions, are in the discretionary care category.

Table 1 summarizes VA eligibility provisions.

Table 1: Mandatory and Discretionary VA Health Care Benefits

Veteran category	Hospital care	Outpatient care	Nursing home care
Service-connected disabilities rated 50-100%, for any condition	Mandatory	Mandatory	Discretionary
Service-connected disabilities rated 0-40%, for a service-connected condition	Mandatory	Mandatory	Discretionary
Discharged for disability	Mandatory	Mandatory	Discretionary
Service-connected disabilities rated 30-40%, for a nonservice-connected condition	Mandatory	Mandatory, limited to hospital-related care	Discretionary
Pensioner or has income under $12,855	Mandatory	Mandatory, limited to hospital-related care	Discretionary
Injured in VA	Mandatory	Mandatory, limited to hospital-related care	Discretionary
Prisoner of war	Mandatory	Discretionary	Discretionary
World War I or Mexican Border Period veteran	Mandatory	Discretionary	Discretionary
Pensioner receiving aid and attendance payments	Mandatory	Discretionary	Discretionary
Service-connected disabilities rated 0-20%, for a nonservice-connected condition	Mandatory	Discretionary, limited to hospital-related care	Discretionary
Nonservice-connected, with an income of $12,855-$20,470 (no dependents)	Mandatory	Discretionary, limited to hospital-related care	Discretionary
Exposed to Agent Orange or radiation, or Medicaid-eligible	Mandatory	Discretionary, limited to hospital-related care	Discretionary
Nonservice-connected with income over $20,470	Discretionary, with copayment	Discretionary, with copayment, limited to hospital-related care	Discretionary, with copayment

Source: Based on data from Independent Budget for Department of Veterans Affairs, Fiscal Year 1996, prepared by the major veterans' service organizations.

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 health

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.

Originally, 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.

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 veterans with nonservice-connected disabilities 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."

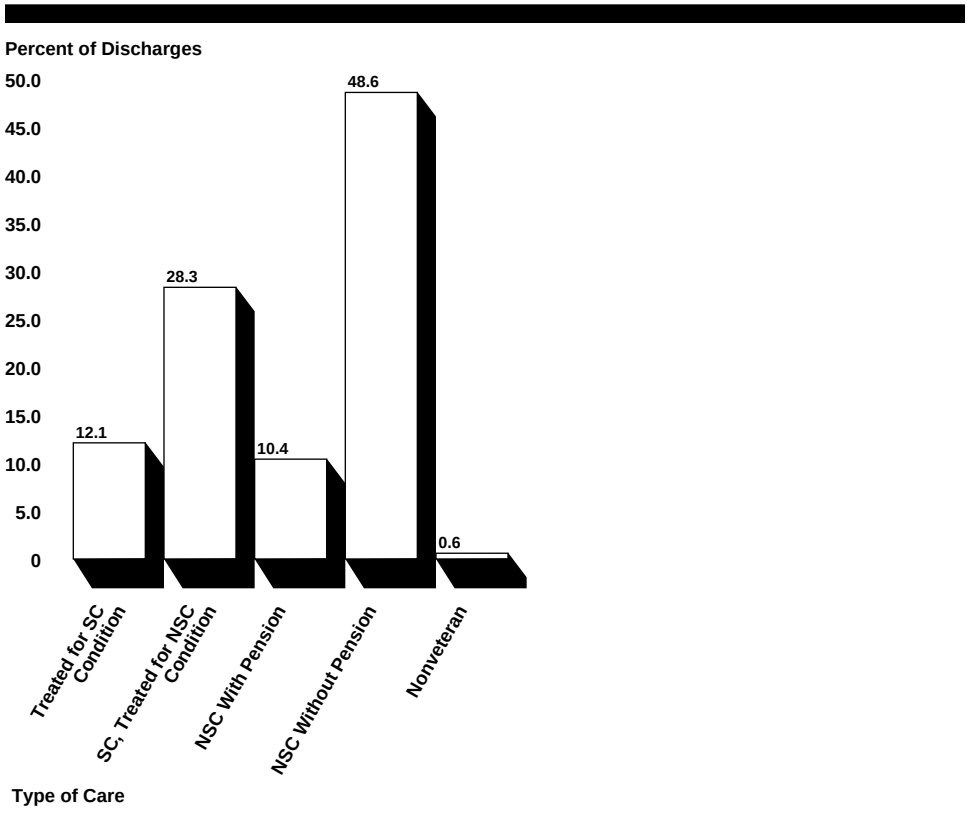
Thirteen years later, the Veterans Health Care Expansion Act of 1973 (P.L. 93-82) further extended outpatient treatment for veterans with nonservice-connected disabilities, authorizing outpatient treatment for any disability to "obviate the need of hospital admission." Although there have been a number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

VA System Increasingly Focuses on Veterans With No Service-Connected Disabilities

With the gradual evolution of VA eligibility, the VA system 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 veterans with 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. For example, in fiscal year 1995, only about

12 percent of VA hospital patients were treated for service-connected disabilities. By contrast, about 59 percent of the patients treated had no service-connected disabilities. (See fig. 4.)

Figure 4: VA Hospital Users by Purpose of Treatment, FY 1995



Note: SC = service connected; NSC = nonservice connected.

Source: Data are from draft tables prepared for VA's Annual Report of the Secretary of Veterans Affairs, Fiscal Year 1995, expected to be issued in April 1996.

VA Options as a Health Care Provider Are Limited

VA has limited authority to (1) buy health care services from non-VA providers and (2) sell health care services either to veterans or others. Generally, veterans can use their health benefits only in VA-operated health care facilities. There are several exceptions that allow VA to purchase care from non-VA providers:

- VA-operated nursing home and domiciliary care is augmented by contracts with community nursing homes and by per diem payments for veterans in state-operated veterans' homes.
- VA pays private sector physicians and other health care providers to provide services to certain veterans when the services needed are unavailable within the VA system or when the veterans live too far from a VA facility (commonly referred to as fee-basis care). The authorization to use fee-basis physicians is primarily limited to service-connected veterans.
- VA pays for hospitalization in non-VA facilities in medical emergencies. Patients are expected to transfer to VA hospitals when their conditions stabilize.
- Veterans treated in VA facilities can be provided scarce medical specialist services from other public and private providers through sharing agreements and contracts between VA and non-VA providers.
- VA hospitals have limited authority to contract with other providers for specialized medical resources, including equipment, personnel, or techniques, that because of costs, limited availability, or unusual nature are unique in the medical community.

Similarly, as a health care provider, VA can sell health care services only on an exception basis. Specifically, VA hospitals and outpatient clinics can sell

- health care services to the Department of Defense (DOD) and other federal health care facilities and
- specialized medical resources to nonfederal hospitals, clinics, and medical schools.[5]

VA cannot, however, sell health care services directly to either veterans or nonveterans.

VA Eligibility Provisions Frustrate Veterans and Limit VA's Ability to Meet Veterans' Health Care Needs

Unlike public and private health insurance, the VA health benefits program does not (1) have a well-defined benefit package or (2) entitle veterans to, or guarantee the availability of, covered services. Similarly, as a health care provider, VA, unlike private sector providers, is severely limited in its ability to both buy health care services from and sell health care services to individuals and other providers. These differences help make VA's eligibility provisions a source of frustration for veterans, VA physicians, and VA's administrative staff. The problems created by these provisions include the following:

[5]Medical resources can be sold to DOD and the private sector only if the sale does not adversely affect health care services available to veterans.

- 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.
- Physicians are put in the untenable position of having to deny needed, but noncovered, health care services to veterans.

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

Veterans Are Uncertain About What Services Are Covered

Because public and private insurance policies generally have a defined benefit package, both policyholders and providers know in advance what services are covered and what, if any, limitations apply to the availability of services. Defined benefit packages also preserve insurers' flexibility in responding to funding constraints by allowing them to adjust covered benefits on the basis of funds available. An insurer might offer multiple policies with varying benefits, but individuals with the same policy have the same benefits.

Like private insurance, VA essentially offers multiple health benefit "policies" with varying benefits. Unlike private insurance, however, veterans with the same "policy" will not necessarily receive the same services. Only those veterans whose "policy" covers all medically necessary care—primarily those veterans with service-connected disabilities rated at 50 percent or more—have clearly defined, uniform benefits. Because coverage of outpatient services for most veterans varies on the basis of their medical conditions, a veteran may be eligible to receive different services at different times. For example, if a veteran with no service-connected disabilities is scheduled for admission to a VA hospital for elective surgery, he or she is eligible to receive any outpatient service needed to prepare for the hospital admission, including a physical examination with X rays and blood tests. However, if the same veteran sought a routine physical examination from a VA outpatient clinic, he or she would not be eligible for an examination, X rays, or blood tests because there is no apparent need for hospital-related care.

Because of the lack of a well-defined benefit package, veterans are often confused by VA's complex eligibility provisions. The services they can get from VA depend on such factors as the presence and extent of any

service-connected disability, income, period of service, and the seriousness of the condition. To further add to veterans' confusion about which health care services they are eligible to receive from VA, title 38 of the U.S. Code specifies the types of medical services that cannot be provided on an outpatient basis. For example, VA outpatient clinics cannot provide

- prosthetic devices, such as wheelchairs, crutches, eyeglasses, and hearing aids, to veterans not eligible for comprehensive outpatient services;
- dental care to most veterans unless they were examined and had their treatments started while in a VA hospital; and
- routine prenatal care and delivery services through the VA health care system.

Outpatient Eligibility Requirements Are Difficult to Administer

Veterans are not the only ones confused by VA eligibility provisions. Those tasked with applying and enforcing the provisions daily—VA physicians and administrative staff—express similar frustration in attempting to interpret the provisions. Although the criterion to obviate the need for hospitalization 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 six veterans developed from actual medical records and presented them to 19 medical centers for eligibility determinations.[6] 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 he or she

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

visits. 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 criterion to obviate the need for hospital admission 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 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 criterion, 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 rules apply to service-connected and nonservice-connected care;
- determine the disability rating for veterans with service-connected disabilities because the outpatient services they are eligible for and their priority for care depend on their rating; and
- determine the income and assets of veterans with no service-connected disabilities because their eligibility for (and priority for receiving) care depends on a determination of their ability to pay for care.

Availability of Outpatient Care Is Uneven

Under private health insurance, Medicare, and Medicaid, the availability of covered services is guaranteed. 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. As an entitlement program, Medicare spending

increases as utilization increases, creating guaranteed access to covered services.

Under the VA health care system, however, being in the mandatory care category does not entitle veterans to, or guarantee 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 in the mandatory care category. 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 them. Being in the mandatory care category essentially gives veterans a higher priority for treatment than veterans in the discretionary care category.

In effect, veterans, rather than the government, assume a significant portion of the financial risk in the VA health care system because there is no guarantee that sufficient funds will be appropriated to enable the government to provide services to all veterans seeking care. Historically, however, sufficient funds have been appropriated to meet the health care needs of all veterans in the mandatory care category and most of those in the discretionary care categories.

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 in the mandatory care category 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 medical centers; that is, each must independently make choices about when 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.[7]

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 treated the same way.

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.

Restrictions on Providing Noncovered Services Adds to Frustration

One major source of frustration for VA facilities is their inability to provide needed health care services to veterans when those services are not covered under their veterans' benefits. Unlike private sector physicians, who can generally provide any available outpatient service to any patient willing to pay, VA facilities and physicians are generally unable to provide noncovered services to veterans. In the private sector, physicians and clinics can sell their services to any person regardless of whether the service is covered by insurance. Essentially, the patient assumes the financial responsibility for any services not covered under his or her health insurance or for any charges that exceed insurance coverage.

Although VA health care facilities are primarily restricted to use by veterans, VA actually has greater authority to sell health care services to nonveterans through sharing agreements than it does to sell these same services to veterans. Specifically, VA hospitals and clinics cannot, under current law, sell veterans those services not covered under their veterans' health care benefits even if they (1) have public or private insurance that

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

would pay for the care or (2) agree to pay for the services out of their own funds.

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.[8] Through discussions with 198 veterans turned away at six 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 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.

Studies Do Not Show Strong Link Between Eligibility Provisions and Nonacute Admissions

VA hospitals too often serve patients whose care could be more efficiently provided in alternative settings, such as an outpatient clinic or nursing home. VA, the major veterans' service organizations, and the Vice President's National Performance Review attribute many of the inappropriate admissions to VA's eligibility provisions, citing (1) studies showing that over 40 percent of admissions could have been avoided through use of outpatient care and (2) anecdotes, such as the one about a patient who had to be admitted to the hospital to get a pair of crutches. Our review, however, found little basis for linking most inappropriate hospitalizations to VA eligibility provisions.

In 1985, we reported that about 43 percent of the days of care medical and surgical patients spent in the VA hospitals reviewed could have been avoided.[9] Since then, a number of studies by VA researchers and VA's Office of Inspector General (IG) have found similar problems.

For example, a 1991 VA-funded study of admissions to VA acute medical and surgical bed sections estimated that 43 percent (+/- 3 percent) of

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

[9]Better Patient Management Practices Could Reduce Length of Stay in VA Hospitals (GAO/HRD-85-52, Aug. 8, 1985).

admissions were nonacute. Nonacute admissions in the 50 randomly selected VA hospitals studied ranged from 25 to 72 percent. The study suggested several reasons why there is a higher rate of nonacute admissions to VA hospitals than private sector hospitals, including the following:

- VA facilities do not have the necessary financial incentives to make the transition to outpatient care.
- VA, unlike the private sector, does not have formal mechanisms to control nonacute admissions, such as mandatory preadmission review.
- VA, unlike the private sector, has a significantly expanded social mission that may influence the use of patient resources.[10]

A 1993 study by VA researchers reported similar findings. At the 24 VA hospitals studied, 47 percent of admissions and 45 percent of days of care in acute medical wards were nonacute; 64 percent of admissions and 34 percent of days of care in surgical wards were nonacute.

Reasons cited for nonacute admissions and days of care included nonavailability of outpatient care, conservative physician practices, inadequate discharge planning, and social factors. The authors suggested that VA establish a systemwide utilization review program. VA, however, has not established either an internal utilization review requirement or contracted for external reviews.

We recently testified that establishing preadmission certification procedures similar to those used by private health insurers could save VA hundreds of millions of dollars by reducing nonacute admissions to VA hospitals. We noted that all fee-for-service health plans participating in the Federal Employees Health Benefits Program are required to operate a preadmission certification program to help limit nonacute admissions and days of care. VA's Under Secretary for Health announced plans to implement a preadmission certification program at the same hearing.[11]

Although the VA study also cited eligibility as contributing to some inappropriate admissions and days of care, the study identified only minor changes needed in VA eligibility provisions. Specifically, it recommended

[10]For example, VA facilities may admit patients who travel long distances for care or keep veterans in the hospital longer than medically necessary because they lack a social support system to assist them after they are discharged.

[11]Testimony before the Subcommittee on VA, HUD, and Independent Agencies, Senate Committee on Appropriations, on March 8, 1996.

changes in the law to (1) allow veterans with nonservice-connected disabilities to be placed in VA-supported community nursing homes without first being admitted to a VA hospital and (2) allow prosthetic devices to be furnished to veterans on an outpatient basis.

Trying to link the studies discussed here to VA eligibility provisions is, in our view, inappropriate because the studies did not contain the types of data needed to make such a link. In other words, the studies did not determine whether the patients inappropriately admitted to VA hospitals had service-connected or nonservice-connected disabilities, whether they were in the mandatory or discretionary care category for outpatient care, or whether they would have been eligible to receive the services they needed on an outpatient basis. Had such information been included in the studies, it would be possible to determine whether a higher incidence of nonacute admissions occurred for veterans in the discretionary care category for outpatient care than for those in the mandatory care category.[12]

Similarly, while the anecdotes VA cites represent real limitations in VA eligibility provisions that need to be addressed, VA lacks data to show how many inappropriate hospital admissions resulted from the limitations. For example, how many of the approximately 7,000 patients admitted to VA hospitals in fiscal year 1994 for fractures of the arms and legs were treated on an outpatient basis and then admitted for the purpose of providing crutches? Only 765 of the 7,000 admissions were for 1 day, the most likely length of stay for patients admitted to enable VA to give them a pair of crutches or other routine outpatient care.

Studies by the VA IG show limited enforcement of outpatient eligibility provisions. VA's IG estimated that over half of the outpatient visits of veterans in the discretionary care category were to receive services that were not covered under the veterans' VA benefits. This suggests that VA physicians are more likely to "stretch" the outpatient benefit to provide crutches to veterans with broken legs than to admit the veteran to the hospital for that purpose.

[12]This is a limitation in how the study can be used, not a deficiency in how the study was conducted.

Proposed Bills Would Eliminate Restrictions on Outpatient Eligibility, but Other Problems Would Continue

Eligibility reform proposals introduced during the past year would eliminate the restrictions on veterans' access to outpatient care. In doing so, however, the proposals would likely generate significant new demand for VA outpatient care services. In addition, the bills generally do not address the other provisions in current law that contribute to inappropriate use of VA health care resources and uneven access to health care services. (See table 2.)

Table 2: Key Provisions of VA Eligibility Reform Proposals

	Bill/sponsor			
Key provisions	**S. 1345 (VA)**	**S. 1563 (veterans' service organizations)**	**H.R. 1385 (Montgomery/ Edwards)**	**H.R. 2491 (House Veterans' Affairs)**
Creates an entitlement to VA care/guarantees availability of care	No	No	No	No
Expands the number of veterans in the mandatory care category	Yes	Yes	Yes	Yes
Creates a uniform benefit package/eliminates obviate-the-need provision	Yes	Yes	Yes	Yes
Reforms contracting provisions	Yes	No	No	Yes
Other provisions	— Expands the definition of covered services to include virtually any necessary inpatient or outpatient care, drugs, supplies, or appliances — Allows VA to retain a portion of third-party recoveries	— Includes nursing home care as mandatory service — Mandatory care category would include catastrophically disabled veterans — Allows adult dependents to become eligible for VA care, provided they reimburse VA — Allows VA to bill and retain collections from Medicare	— Requires VA to provide veterans similar access regardless of their home state — Allows VA to use a system of enrollment and priorities for care — Allows VA to retain a portion of third-party recoveries to expand outpatient care	— Requires VA to establish a system of annual enrollment based on priorities for care — Creates a new category of priority for catastrophically disabled veterans

Bills Would Create a Uniform Benefit Package

Each of the four major bills introduced during the past year would create a uniform benefit package by eliminating the obviate-the-need restriction on

coverage of outpatient care. The bills would make all 26 million veterans eligible for comprehensive outpatient services. In addition, the four bills would expand the number of veterans in the mandatory care category for comprehensive outpatient care from about 465,000 to 9 million to 11 million veterans.

Eliminating the obviate-the-need restriction 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 he or she was not treated. Eliminating the restriction would also promote greater equity by reducing the inconsistencies in eligibility decisions. Finally, eliminating the restriction would make benefits more understandable by essentially making veterans eligible for the full continuum of inpatient and outpatient care.

Other Major Restrictions Not Addressed in Most Bills

Most of the bills do not address the other major restrictions on VA eligibility and the ability of VA to provide noncovered services to veterans. Specifics follow:

- VA would continue to be unable to provide noncovered services directly to veterans under all of the bills. Because all veterans would become eligible for comprehensive outpatient services, there would be fewer noncovered services.
- Current restrictions on provision of dental, prenatal, and maternity care would not be changed under any of the proposals.
- S. 1345 would remove the restriction on direct admission of veterans with no service-connected disabilities to community nursing homes.
- All of the bills would retain the discretionary funding of VA health care. H.R. 1385 would, however, require VA to ensure that veterans have reasonably similar access to VA health care regardless of where they live.
- Only H.R. 1385 specifically addresses the uneven availability of VA care. That bill would require VA to expand its capacity to provide outpatient care and allocate resources to its facilities in a way that would give veterans access to care that is reasonably similar regardless of where they live. The other bills do not address the uneven availability of VA health care services caused by resource limitations, VA's limited provider network, and inconsistent VA rationing policies.

Appendix I contains a more detailed description of the major provisions of the four bills.

Eligibility Reform Bills Not Likely to Be Budget Neutral

By making all 26.4 million veterans eligible for comprehensive outpatient care, the four bills would likely generate significant new demand for both outpatient and inpatient care. The increased demand could be heightened by the synergistic effects of other changes in the VA health care system to improve access and customer service and expand contracting.

The bills would, however, provide little or no new sources of revenue to offset the costs of the new services. This would put increased pressure on the Congress to appropriate funds to meet the health care demands generated through eligibility expansions, particularly for the 9 million to 11 million additional veterans who would be placed in the mandatory care category for comprehensive outpatient benefits. Although VA and CBO arrived at strikingly different conclusions about the budgetary effects of the bills, we find CBO's arguments more compelling because they address the potential increased demand.

Bills Represent a Major Expansion of Outpatient Eligibility

Under the four bills, over 26 million veterans would become eligible to receive services that currently are available primarily to the approximately 465,000 veterans with service-connected 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 attempt to take advantage of added VA benefits such as prescription drugs, which are not typically covered under other health insurance. 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.[13] Removing the restrictions on access to outpatient care would likely significantly increase demand for outpatient prescriptions.

Another area where workload would likely increase dramatically is prosthetic devices, such as eyeglasses, contact lenses, and hearing aids. In addressing the restriction in current law on provision of crutches to veterans with broken legs, the four bills would also eliminate the restriction on provision of other prosthetic devices, such as eyeglasses, contact lenses, and hearing aids. H.R. 2491 would, however, give the Secretary of Veterans Affairs the authority to restrict the provision of eyeglasses, contact lenses, and hearing aids.

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

Other Improvements in VA Health Care System Could Heighten Increased Demand

If concurrent changes are made in the accessibility of VA health care services, in VA customer service, and in the extent to which veterans are allowed to use private providers under contract to VA, the impact of eligibility reforms on demand for VA care will likely be heightened. 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.

Similarly, our reports over the past 5 years have identified continuing problems in VA customer service, including long waiting times, poor staff attitudes, and lack of such amenities as bedside telephones. As part of its response to the National Performance Review, VA has developed detailed plans to improve customer service that include installing bedside telephones, reducing waiting times, and training staff. These efforts are likely to help VA retain current users and will likely attract new users as VA's reputation for customer service improves.

Finally, increased contracting with private sector providers closer to veterans' homes could attract new users. Both S. 1345 and H.R. 2491 would expand VA's authority to contract with private sector providers. Such contracting might enable veterans to use the same physicians, clinics, and hospitals they use now but have VA rather than their private insurance or Medicare pay for the care.

Bills Would Provide Few New Sources of Revenues

Three of the bills—H.R. 2491, S. 1345, and S. 1563—would provide new sources of revenue, but they would not offset the costs of eligibility expansions. The provisions in those bills, which would allow VA to retain certain third-party recoveries, would not be used to offset VA appropriations and therefore would not change the budgetary impact of these reform proposals. The bills essentially assume that eligibility reform will not require new sources of revenue because they will generate significant savings by making it possible for VA to treat on an outpatient basis 20 to 40 percent of veterans currently in VA hospitals. These savings would then be used to pay for the increased outpatient workload generated by the patients diverted to outpatient care. There is, however, little evidence to suggest that eligibility reform alone will result in significant numbers of veterans being diverted to outpatient care.

Controlling Budgetary Increases Would Be Difficult

Expanding the number of veterans in the mandatory care category while retaining current resource constraints might force rationing of care to veterans in the mandatory care group. Expanding the mandatory care category would place great pressure on the Congress to fully fund services for veterans in the mandatory care category. Historically, the Congress has fully funded both VA's mandatory and discretionary workload.

Considering the significant portion of VA resources currently used to provide services to veterans in the discretionary care category and the limited data VA provides the Congress on which to base funding decisions, it would be exceedingly difficult for the Congress to appropriate funds for the care of only a portion of the veterans in the mandatory care category. About 15 percent of veterans using VA medical centers have no service-connected disabilities and have incomes that place them in the discretionary care category for both inpatient and outpatient care. But VA does not differentiate between services provided to veterans in the mandatory and discretionary care categories in justifying its budget request. As a result, the Congress has little basis for determining which portion of VA's discretionary workload to fund.

Although two proposals (H.R. 2491 and H.R. 1385) propose establishment of an enrollment process, such a process may jeopardize VA's safety net mission. Because low-income veterans are typically the fourth highest priority for care in the proposed enrollment process, reforms that provide a richer benefit package or increase the number of higher-priority veterans, or a combination of both, could reduce funds available to treat low-income veterans.

For example, under the new definition of health care in S. 1345, veterans in the top three priority categories would be in the mandatory care category for virtually any service offered by VA. Further, VA would be required to provide comprehensive care to about 3 million veterans previously eligible for limited outpatient care. Under the VA proposal, about 1.8 million veterans currently eligible for limited outpatient care would be placed in the highest-priority group for comprehensive care. The VA proposal would also place veterans with noncompensable service-connected disabilities (estimated to number about 1.2 million) above low-income veterans with no service-connected disabilities in the priority ranking of veterans in the mandatory care category.[14]

[14]Other proposals generally would not provide a special status to such "0 percent" veterans—those with noncompensable service-connected disabilities.

Only after the needs are met for the top three priority categories could VA fund care for low-income veterans. We are concerned that sufficient funds might not be available to fulfill VA's safety net mission after meeting the expanded demands for care of higher-priority veterans. Because most of the reform proposals do not address the uneven availability of VA services, however, the increased demand for care generated by eligibility expansions would likely heighten the problems VA already faces in trying to equitably distribute available resources.

CBO's Cost Estimate Is More Compelling Than VA's

VA and CBO estimated the budgetary impact of H.R. 2491, the most modest of the reform proposals, with strikingly different results:

- VA concluded that because the bill was similar to the administration's proposal, it would be budget neutral, generating net savings of $268 million that could be reinvested to expand outpatient care or construct new facilities.
- CBO estimated that the bill could add $3 billion or more to the deficit annually.

A number of problems have been identified with both cost estimates that reduce their usefulness in assessing the potential impact of the bill on VA's budget. We agree with CBO's overall conclusion, however, that any broad expansion in benefits will generate significant new demand for VA health care that could potentially add billions to the budget deficit.

VA's Estimate Is Based on Questionable Assumptions

VA did not adequately consider the increased demand for outpatient care likely to be generated by the eligibility expansions, incorrectly assumed a strong link between inappropriate admissions to VA hospitals and VA eligibility provisions that would be addressed through the reform proposals, and made a number of questionable assumptions in its calculations.

VA developed a complex formula for estimating the cost effects of eligibility reform based on its overall assumption that eligibility reform would enable it to divert 20 percent of its hospital patients to outpatient care. The results, however, are sensitive to a series of assumptions about such things as how many veterans are inappropriately admitted to VA hospitals because of restrictions on outpatient eligibility; how long, on average, those veterans stay in the hospital; and how eligibility reform would affect demand for outpatient care. We have the following concerns

about VA's assumptions or how they were used in VA's calculations of savings to be realized from eligibility reforms:

Eligibility reform would enable VA to eliminate 20 percent of hospital admissions. 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 services to other settings. But we do not believe that current eligibility provisions prevent VA from shifting much of its current inpatient services to ambulatory care settings.

The same obviate-the-need provision discussed earlier as making it difficult for VA physicians to determine whether to provide outpatient care for certain conditions makes 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 provision and shifting care to outpatient settings for over 20 years would be eliminated and the planned savings actually realized.

Actions such as the preadmission certification program previously discussed could, however, generate savings that could be used to offset the costs of eligibility reform.

An average of 7 days of hospital care would be saved for every patient diverted to outpatient care. This assumption is not sound given VA's argument that the patients it would be diverting were admitted in order to provide them routine outpatient care. Because the inpatients VA expects to shift to outpatient care are essentially self-care patients with no acute medical need, VA would most likely be drawing from patients with the shortest lengths of stay—such as veterans admitted to provide them crutches or as a prerequisite to placement in a community nursing home. In fiscal year 1994, about 37 percent of VA medical and surgical patients had 1- to 3-day stays. We believe it would be more reasonable to assume

the average length of stay of patients to be diverted to outpatient care to be 1 to 3 days.

Changing the assumption about average length of stay dramatically alters VA's savings estimates. Substituting 3 days for VA's assumption of a 7-day average length of stay would change VA's projected savings of $268 million from eligibility reform into an overall increase in VA costs of almost $167 million.

Because the less sick patients would be shifted to outpatient care, the costs of treating patients remaining in the hospital would increase by 10 percent per admission. Although VA's formula originally included this adjustment, VA did not include the calculation in its savings estimates. Including this adjustment would turn VA's projected savings of $268 million into a cost increase of $51 million.

An increase in demand would not occur for outpatient care other than demand generated by veterans shifted from inpatient to outpatient care. VA anticipates limited new demand because, according to headquarters officials, the administration proposal and H.R. 2491 were designed to give VA added flexibility, not to attract new users. Although headquarters officials anticipate few new users, medical centers are already aggressively pursuing new users.

CBO's Conclusions Appear Sound

CBO estimated that the eligibility reform provisions of H.R. 2491 could increase the deficit by $3 billion or more annually if the Congress fully funds the increased demand for outpatient care that the eligibility expansions would likely generate. CBO's estimates were based in part on tables contained in what at the time was VA's newly released 1992 National Survey of Veterans. VA claimed that CBO misinterpreted one of the tables in the survey—which VA acknowledged was confusing—and raised concerns about CBO's methodology and the accuracy of its projections.

After reviewing VA's concerns, CBO determined that any problem in interpreting the survey data did not affect its overall conclusion that the bill would not be budget neutral because the expanded eligibility would generate significant new demand. CBO assumes in conducting budgetary impact analyses that if demand increases under a discretionary program, funds will be appropriated to meet that demand. CBO estimated that the cost of providing outpatient care to the 10.5 million veterans who are currently eligible only for hospital-related outpatient care would far outweigh the savings from shifting inpatients to outpatient care. Further,

CBO concluded that VA could incur significant costs under provisions that expand VA's authority to provide prosthetic devices on an outpatient basis. Finally, CBO noted that the bill could increase costs by billions more if the induced demand for outpatient care resulted in corresponding increases in demand for hospital care.

Approaches for Developing Budget-Neutral Eligibility Reforms

The cost of eligibility reform depends on a number of factors, including the benefits covered, the number of veterans offered the benefits, and the extent to which veterans are expected to pay for or contribute toward the cost of their health care benefits. The current reform proposals would essentially make all 26 million veterans eligible for comprehensive inpatient and outpatient care with little or no change in the system's sources of revenue. Three basic approaches could be used, individually or in combination, to develop budget-neutral eligibility reform. These are (1) set limits on covered benefits, (2) limit the number of veterans eligible for health care benefits, and (3) generate increased revenues to pay for expanded benefits. Another approach would be to allow VA to "reinvest" savings achieved through efficiency improvements in expanded benefits.

Set Limits on Covered Benefits

One way to control the increase in workload likely to result from eligibility expansions would be to develop one or more defined benefit packages patterned after public and private health insurance. This would narrow the range of services veterans could obtain from VA, allowing workload to be reduced by the eliminated services to offset the workload from increased demand for other services. Like private health insurers, VA could adjust the benefit package annually on the basis of the availability of resources.

Creating a defined 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 veterans with the greatest service-connected disabilities and give additional benefits to veterans with lesser service-connected disabilities and to veterans with no service-connected disabilities.

One option for addressing this problem is 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 veterans with no service-connected disabilities.

Limit the Number of Veterans Eligible for VA Health Care

Another way to develop budget-neutral eligibility reform would be to pay for expanded eligibility for some veterans by restricting or eliminating eligibility for others. Under current law, all veterans are eligible for VA hospital and nursing home care and at least some outpatient care, but there is a complex set of priorities for care based on such factors as presence and degree of service-connected disability, period of service, and income. In practical application, however, these priorities have little effect on the VA health care system. In preparation of VA budget justifications, no distinction is made between veterans in the mandatory and discretionary care categories, let alone those in different priority groups within the mandatory and discretionary care categories. Two of the reform bills (H.R. 1385 and H.R. 2491) would authorize VA to control demand for VA services through the use of priorities for care and an enrollment process.

Among the approaches that could be used to limit the number of veterans taking advantage of expanded benefits is to limit VA eligibility to those veterans who lack other public or private insurance. Exceptions could be made for treatment of service-connected disabilities and for services not covered under veterans' public or private insurance. Such an approach might help target available funds toward those veterans most in need.

The Congress would face a difficult choice, however, in determining whether VA health care is (1) a benefit of service that should be available regardless of alternate coverage or (2) a safety net available only to those who lack health care options.

Limiting eligibility of veterans with nonservice-connected disabilities to those whose income is below the current, or some new, means test limit would allow VA to retarget some resources currently used to provide services to higher-income veterans. Because about 15 percent of VA users have incomes above the means test threshold, eliminating their eligibility would make additional resources available to offset increased demand for outpatient services by veterans in higher-priority categories. Such veterans could be allowed to purchase services from VA facilities on a space-available basis.

Another way to limit the number of veterans eligible for expanded VA benefits is to restrict enrollment in VA health care to current VA users. This

approach could limit the potential "woodwork" effect and thereby reduce the costs of eligibility reforms. While current users might increase their use of VA health care in response to expanded benefits, most such veterans already obtain those services they are unable to get from VA from private sector providers through their public and private insurance. As a result, this approach might enable those higher-income veterans with nonservice-connected disabilities already using VA services to shift all of their care to VA, while veterans who had not previously used VA services but would like to start using them would essentially be shut out of the system. This would include veterans with higher priorities for care, such as those with service-connected disabilities and low incomes. Similarly, restricting enrollment to current users might prevent VA from fulfilling its safety net mission by denying care to veterans whose economic circumstances change.

Generate Increased Revenues

Several approaches could be used to generate additional revenues to pay for expanded benefits. These include increased cost sharing, authorizing recoveries from Medicare, and allowing VA to retain funds from third-party recoveries.

Increase Veteran Cost Sharing

Increased veteran cost sharing could help offset the costs of increased demand. For example, through contracting reform, VA might be authorized to sell veterans any available health care service not covered under their current veterans' benefits without changing existing eligibility provisions. In other words, veterans could purchase, or use their private health insurance to purchase, additional health care services from VA.

Such an approach would not eliminate the problems VA physicians have in interpreting the obviate-the-need provision. But it would lessen the importance of the decision. Physicians would no longer be forced to turn away veterans needing health care services. Instead, obviate-the-need decisions would determine who would pay for needed health care services, the government or the veteran. In addition, VA could issue regulations interpreting the obviate-the-need provision. Because uninsured veterans may be unable to pay for many additional health care services, an exception could be made to help such veterans pay for additional health care services.

A second approach for offsetting the costs of eligibility expansions through cost sharing could be to impose new cost-sharing requirements for existing services. For example, 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. Similarly, copayments and deductibles for hospital and outpatient care could be adjusted to be more comparable with other public and private sector programs.

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 service-connected disabilities of 0 to 20 percent.

Authorize Recoveries From Medicare

Proposals have been made in the past few years to authorize VA recoveries from Medicare either for all Medicare-eligible veterans or for those with higher incomes. For example, S. 1563 would allow VA to bill and retain recoveries from Medicare. Such proposals, though, 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, the proposals would not require VA to offset the recoveries against its appropriation. As a result, it would not affect VA's budget request. Authorizing VA recoveries from Medicare could, however, further jeopardize the solvency of the Medicare trust fund and increase overall federal health care costs. Such an action would essentially transfer funds between federal agencies while adding administrative costs.

Allowing VA to bill and retain recoveries from Medicare 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. For example, if VA were authorized to sell noncovered services to veterans and did not receive an appropriation for such services, then veterans should be allowed to use their Medicare benefits to help pay for the services just as they would use their private health insurance.

Allow VA to Retain a Portion of Third-Party Recoveries

Proposals, such as the ones contained in S. 1345 and H.R. 1385, that would allow VA to retain a portion of recoveries from private health insurance beyond what it needs to finance its recovery program would not reduce VA's budget request and therefore would not generate the revenues needed

to offset the costs of expanded benefits. Just as allowing VA to retain Medicare recoveries would essentially result in duplicate payments unless they were earmarked for some purpose other than to pay for care covered by an appropriation, proposals to allow VA to retain a portion of its third-party recoveries would essentially result in duplicate payments.

Reinvest Savings From Efficiency Improvements

During the past 5 to 10 years, GAO, VA's IG, the Veterans Health Administration, and others identified numerous opportunities to improve the efficiency of the VA health care system and enhance revenues from sales of services to nonveterans and care provided to veterans. Savings from such initiatives could be "reinvested" in the VA health care system to help pay for eligibility expansions.

VA has historically used savings from efficiency improvements to fund new programs. For example, VA is allowing its facilities to reinvest savings achieved by consolidating administrative and clinical management of nearby facilities into providing more clinical programs. Similarly, VA allows medical centers to use savings from efficiency improvements to fund access points.

Through establishment of a preadmission certification requirement similar to those used by many private health insurers, VA could reduce nonacute admissions and days of care in VA hospitals and save hundreds of millions of dollars. While such inappropriate admissions and days of care to a large extent are unrelated to problems with VA eligibility provisions, savings resulting from administrative actions to address the problem could nonetheless be targeted to pay for expanded benefits.

Actions to reinvest savings from efficiency improvements would, however, limit VA's ability to contribute to deficit reduction.

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. In other words, its primary mission is to meet the comprehensive health care needs of veterans with service-connected disabilities rated at 50 percent or more.

For other veterans, the system is primarily intended to provide treatment for their service-connected disabilities and to serve as a safety net to provide health care to veterans with limited access to health care through other public and private programs.

Because 9 out of 10 veterans now have other public or private health insurance that meets their basic health care needs, few veterans today need to rely on VA as a safety net. Rather, most of them turn to private sector providers for all or most of their care, using VA either not at all or to supplement their use of private sector health care.

Reforms of VA eligibility that would significantly expand veterans' eligibility for comprehensive care in VA facilities would significantly alter VA's health care mission and place VA in more direct competition with the private sector. To the extent veterans are given expanded benefits that are either free or have lower cost sharing than other public and private health insurance, the VA system will gain a clear competitive advantage over its private sector competitors. Coupling eligibility reform with other changes, such as improved accessibility and customer service, could heighten the increased demand for VA services. Because most veterans currently use private sector providers, any increased demand generated by eligibility expansions would come largely at the expense of those providers.

For most 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 public or private health insurance, however, eligibility reform is more important. It could improve their access to comprehensive health care services, including preventive health care services.

Historically, the Congress has fully funded VA's mandatory and discretionary care workload. The four eligibility reform bills that have been introduced could significantly increase demand for VA health care services, putting pressure on the Congress to increase VA appropriations to fully fund at least the demand generated by the 9 million to 11 million veterans added to the mandatory care category for comprehensive free outpatient services.

If the Congress decides not to fully fund VA's anticipated workload, VA would be faced with developing rationing policies that would ensure the funds appropriated are directed toward those veterans with the highest priorities for care. This would likely entail turning away many of the

veterans currently using VA health care. Depending on the level of funding, those turned away could include low-income uninsured veterans. The funds needed to meet the increased demand for routine health care services could also jeopardize VA's ability to provide specialized services, such as treatment of spinal cord injuries, not available through other programs.

Eligibility reforms should focus on strengthening VA's safety net mission while preserving its ability to provide specialized services veterans may be unable to obtain through their public and private insurance. Several approaches could be pursued to develop budget-neutral reforms that would also limit the extent to which the government competes with the private sector. These approaches generally involve placing limits on the number of veterans given expanded benefits, narrowing the range of benefits added, or increasing cost sharing to offset the costs of added benefits.

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.

Contributors

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Key Provisions of Selected Proposals to Reform Eligibility for VA Health Care

This appendix contains a synopsis of the key provisions in the four major eligibility reform bills introduced during the past year.

The Department of Veterans Affairs Improvement and Reinvention Act of 1995

The Department of Veterans Affairs Improvement and Reinvention Act of 1995 (S. 1345) was introduced at the administration's request on October 19, 1995. In addition to reforming VA health care eligibility, S. 1345 would expand VA contracting authority and amend VA housing and education benefits. The eligibility reform provisions would do the following:

- Previous provisions covering hospital care, outpatient care, respite care, pharmaceuticals, supplies, equipment, appliances, and other material and services would be combined into a new "health care" provision. Health care would be defined as "the most appropriate care and treatment for the patient furnished in the most appropriate setting."
- All veterans would be eligible for the expanded benefits offered under the new definition of health care.
- The current fixed categories of eligibility would be replaced by a priority system.
- The highest-priority groups of veterans in the mandatory category for comprehensive care would be expanded to include veterans (1) with any compensable service-connected disability, (2) who are former prisoners of war, (3) whose discharge or release was for disabilities incurred or aggravated in the line of duty, and (4) who are receiving disability compensation.
- VA would be allowed to provide, subject to available funding, comprehensive health care services to lower-priority veterans.
- The obviate-the-need-for-hospitalization criterion for outpatient care would be eliminated.
- The discretionary nature of VA funding would be retained by making the availability of services subject to annual appropriations.

The administration's proposal would also expand VA contracting authority. It would allow VA to share (purchase or sell) health care resources with health plans, insurers, organizations, institutions, or any other entity or individual who furnishes any health care resource. Under current law, such sharing agreements are limited to medical schools, health care facilities, and research centers.

Finally, S. 1345 would allow VA to retain a greater portion of its third-party collections. Currently, VA must return all third-party collections, less the

administrative costs of collection activities, to the Treasury. Under the administration's proposal, VA would be allowed to retain an additional 25 percent of recoveries to be distributed to its health care facilities.

S. 1563

S. 1563 was introduced at the request of the veterans' service organizations (VSO) on February 7, 1996. The VSOs' highest priority, according to VSO representatives, is eligibility reform that authorizes a full range of medical services for veterans currently in the mandatory category for hospital care, and funding to ensure the availability of those services. As a practical matter, the VSOs did not attempt to include all of the eligibility reforms recommended in their 1996 Independent Budget in this year's proposal. In the scaled-back version, S. 1563 would

- add catastrophically disabled veterans to the mandatory category for comprehensive health care;[15]
- expand the mandatory care category (Category A) for hospital care to apply to outpatient, nursing home, domiciliary, and long-term care;
- allow VA to treat adult dependents of veterans, provided they reimburse VA for the cost of their care;
- broaden VA's authority to provide primary and preventive health care services;
- require VA to provide prosthetic appliances and aids for veterans in the mandatory care category who are blind or hearing-impaired;
- authorize VA facilities to participate as Medicare providers and retain reimbursements from Medicare;
- require VA to maintain current capacity in specialized services for mandatory care category veterans, including those with spinal cord dysfunction, blindness, and mental illness; and
- eliminate the obviate-the-need provision, making all veterans eligible for comprehensive outpatient care.

Some reforms described in their 1996 Independent Budget for VA were not included in S. 1563. VSO representatives said these initiatives will be retained for future consideration. For example, the VSOs also recommended that the Congress

- switch VA health care funding from a discretionary to a mandatory spending account,
- authorize VA to provide pre- and postnatal care for women veterans,

[15]"Catastrophically disabled" is defined in S. 1563 as any veteran whose expenditures for hospital and nursing home care exceed 7.5 percent of his or her gross adjusted income for federal income tax purposes during the preceding year.

- provide investment funds to improve VA's infrastructure, and
- allow VA medical centers to conduct marketing activities.

The Veterans Health Care Reform Act of 1995

Introduced April 4, 1995, by Congressmen Edwards and Montgomery, the Veterans Health Care Reform Act of 1995 (H.R. 1385) would, on a temporary basis for the period ending September 30, 1999,

- expand the mandatory care category for comprehensive outpatient medical treatment to include all veterans in the mandatory care category for hospital care (core group) other than those with noncompensable service-connected disabilities (nursing home and dental services would remain discretionary);
- require VA to expand its capacity to provide outpatient care and allocate resources to its facilities in a way that would give veterans access to care that is reasonably similar regardless of where they live;
- include preventive health services and prosthetic appliances in the definition of services that are provided to core group veterans;
- include home health services in the definition of services that may be provided to core group veterans;
- authorize the Secretary of Veterans Affairs to use systems of patient prioritization and to set up a system of enrollment of eligible veterans;
- allow VA to retain a portion of third-party recoveries to expand outpatient care; and
- require VA to ensure that any veteran with a service-connected disability is provided all benefits to which he or she is entitled.

Like the administration's proposal, H.R. 1385 would not shift VA funding from a discretionary to a mandatory account. That is, availability of benefits would still be dependent upon available funding—benefits would not be guaranteed. In addition, VA would be required to ensure that its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans is not reduced.

The Veterans Reconciliation Act of 1995

In October 1995, the House approved a budget reconciliation package (H.R. 2491) that contained a Veterans' Affairs Committee proposal—the Veterans Reconciliation Act of 1995. The bill would, among other provisions, reform eligibility for VA health care to

- subject provision of care to amounts provided in advance in appropriations, thus retaining VA's discretionary funding;

- expand the mandatory care category for comprehensive outpatient care to include all veterans in the mandatory category for hospital care except those with noncompensable service-connected disabilities;
- remove the obviate-the-need criterion and other limitations on the provision of outpatient care, making all veterans eligible for comprehensive outpatient care;
- retain nursing home care as a discretionary benefit for all veterans;
- require VA to establish a system of annual patient enrollment based on priorities for enrollment contained in the bill;
- create a new category of priority for veterans who are catastrophically disabled; and
- expand VA contracting and sharing authority.

Related GAO Products

VA Health Care: Opportunities to Increase Efficiency and Reduce Resource Needs (GAO/T-HEHS-96-99, Mar. 8, 1996).

VA Health Care: Issues Affecting Eligibility Reform (GAO/T-HEHS-95-213, July 19, 1995).

VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-147, 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).

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).

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

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