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Report to the Chairman, Committee on Veterans' Affairs, U.S. Senate

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VA HEALTH CARE

Issues Affecting Eligibility Reform Efforts

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Health, Education, and
Human Services Division

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September 11, 1996

The Honorable Alan K. Simpson
Chairman, Committee on Veterans' Affairs
United States Senate

Dear Mr. Chairman:

This report, prepared at your request, discusses and evaluates proposals to simplify and expand eligibility for veterans' health care benefits. The report identifies the major issues that the Congress will face in considering approaches to eligibility reform.

As agreed with your office, we are also sending this report to the Secretary of Veterans Affairs, relevant congressional committees, and other interested parties. Copies also will be available to others on request.

GAO contacts and staff acknowledgments are listed in appendix VIII. If you have any questions about this report, please call me on (202) 512-7101.

Sincerely yours,

David P. Baine

David P. Baine
Director, Veterans' Affairs and
Military Health Care Issues

Executive Summary

Purpose

The evolution of the Department of Veterans Affairs (VA) health care over the past 60 years has created a myriad of complex eligibility rules. These rules frustrate veterans, who cannot understand what services they can get from VA, and VA physicians and administrative staff, who have to interpret the eligibility provisions. Proposals to simplify and expand eligibility for veterans' health care benefits have been developed by the Congress, the administration, and the major veterans service organizations.

The Chairman of the Senate Committee on Veterans' Affairs asked GAO to identify major issues that the Congress will face in considering these and other approaches to eligibility reform. In doing so, GAO studied

- the evolution of the VA health care system and VA eligibility;
- the problems that VA's current eligibility and health services contracting provisions create for veterans and providers;
- the extent to which VA provides veterans with health care services for which they are not eligible;
- legislative proposals to reform VA eligibility and contracting rules and their potential effect on ease of administration, equity to veterans, costs to VA, and clarity of eligibility for veterans' health benefits; and
- approaches that could be used to limit the budgetary effects of eligibility reforms.

Background

For fiscal year 1996, VA received an appropriation of about $16.6 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. Although VA expects to receive a slight increase in its fiscal year 1997 appropriation to compensate for medical care inflation, both the administration and the Congress expect VA budgets to decline over the ensuing 6 years.

The VA health care system consists of (1) a health benefits program and (2) a health care delivery program. In administering the veterans' health benefits program, 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, and (3) 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). VA is also

responsible for ensuring that the health benefits provided to its beneficiaries—veterans—are (1) medically necessary and (2) provided in the most appropriate care setting (such as a hospital, nursing home, or outpatient clinic).

Similarly, in operating a health care delivery program, VA strives to ensure that its facilities (1) provide care of high quality, (2) are used to their optimum capacity, (3) are located where they are accessible to veterans, and (4) provide good customer service.

Results in Brief

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 those veterans with service-connected disabilities rated at 50 percent or higher (about 465,000 of the nation's 26.4 million veterans). 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 care for veterans with limited access to health care through other public and private programs (about 9 out of 10 veterans now have public or private insurance that meets their basic health care needs).

As the eligibility requirements for VA health care have evolved over the years, they have become increasingly complex and a source of frustration to veterans who are often uncertain about which services they are eligible to receive and to VA physicians and administrators who find them difficult to administer. Unlike private health insurance, VA health care does not have a defined, uniform benefit package and cannot guarantee the availability of covered services. Similarly, unlike private sector providers, VA is limited to providing only those services covered by an individual veteran's VA benefits. A VA facility is not permitted under current law to provide a noncovered service even if it has the resources to provide the service and the veteran is willing to pay for it. This often places VA physicians in the difficult position of having to either (1) ignore the 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. As a result, VA facilities appear to provide hundreds of millions of dollars in ineligible treatments.

GAO recognizes the need for eligibility reform, which, for most veterans, might result in additional health care services not covered under their public or private insurance. For the approximately 10 percent of veterans who do not have other public or private insurance to meet their health care needs, however, eligibility reform is more important. It could result in access to comprehensive health care services, including preventive care.

Four legislative proposals have been introduced in the 104th Congress to simplify and expand veterans' eligibility for VA care. A fifth proposal, by the American Legion, has not yet been introduced as a legislative proposal. Each of the proposals has significant implications regarding the number of veterans who would be eligible for care as well as the cost of providing that care.

- Four of the proposals, which retain the discretionary funding of VA health care, could more than double demand for VA outpatient services, forcing VA to either ration care to many veterans or seek larger appropriations. Adequate resources might not be available to preserve VA's safety net mission.
- The American Legion proposal, which would create an entitlement, would likely require significantly increased appropriations because 9 million to 11 million veterans would become entitled to VA health care. Other issues in the proposal that would need to be addressed include provisions to exempt VA from most federal contracting laws and to deem VA as a Medicare provider.

GAO's work suggests that eligibility reforms could be developed that would both strengthen VA's safety net mission and preserve its ability to provide specialized services. Among the approaches that could be pursued are 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.

The American Legion proposal, which uses all of these approaches, provides a good starting point for developing future reform proposals. Changes would need to be made, however, to reduce the number of veterans covered by the entitlement if significant increases in VA appropriations are to be avoided. One approach for reducing the number of veterans who would be entitled to free care would be to limit the entitlement to VA benefits for veterans with no service-connected disabilities, in order to ensure entitlement for those veterans who have low incomes and lack private or public insurance.

On July 30, 1996, the House of Representatives unanimously approved eligibility reform legislation (H.R. 3118). The Senate Committee on Veterans' Affairs drafted eligibility reform legislation on July 24, 1996. As of September 1, 1996, the resulting bill had not been introduced in the Senate.

Principal Findings

Veterans' Health Care Needs Have Changed Over Time

Since colonial times, the nation has pledged its continued support for those who serve in the military. Historically, demand for VA care would surge during and soon after periods of war, then taper off as returning casualties recovered from their injuries. The Congress expanded eligibility for hospital care to include certain veterans with no service-connected disabilities. First, beginning in 1924, eligibility for hospital care was gradually extended to wartime veterans with low incomes; then, in 1973, to peacetime veterans with low incomes; and finally, in 1986, to higher-income veterans.

While eligibility for hospital care steadily expanded, eligibility for outpatient care grew more slowly. It was not until 1960 that VA was first authorized to treat nonservice-connected conditions on an outpatient basis. Initially, eligibility was limited to services needed in preparation for, or as a follow-up to, hospital care. Thirteen years later, eligibility for outpatient treatment of nonservice-connected conditions was expanded to include services that would obviate the need for hospitalization. Finally, in 1986, the Congress established a means test and extended eligibility for hospital-related outpatient care to higher-income veterans with no service-connected disabilities.

Changes have also occurred in veterans' health care options. When VA was established in 1930, there was no public or private insurance program to help low-income veterans pay for needed health care services. With the subsequent growth of private and public health insurance, over 90 percent of veterans now have other health care coverage in addition to their VA benefits.

The third major change affecting the future direction of veterans' health benefits is the aging of the veteran population. Although the veteran population is declining, the number of veterans aged 65 and older is

increasing. The number of veterans aged 85 and over is projected to increase from 154,000 to 1.3 million between 1990 and 2010. This is important because about 50 percent of people aged 85 and older are expected to need nursing home care.

The result of VA's long history of eligibility expansions is a myriad of complex rules governing eligibility for VA health care. In considering changes to those rules, the Congress faces many difficult questions concerning the future mission of the veterans' health care system. For example, what is and what should be the nation's commitment to its veterans? Similarly, what, if any, effect should changes in other public and private health insurance coverage have on VA's role as a safety net provider? Finally, with an aging veteran population, are changes needed in VA's role in meeting the long-term care needs of veterans?

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

The complex eligibility provisions that have developed over many decades are often ill-defined and confusing—which ultimately creates frustration for veterans and VA staff. Veterans are often uncertain about which services they are eligible to receive and what right they have to require VA to provide them. VA physicians are likewise frustrated by requirements that they determine, before treatment can be provided, whether a condition is related to a service-connected disability or whether, if left untreated, the condition would require immediate hospitalization.

Unlike public and private health insurance, VA cannot offer well-defined benefits or guarantee the availability of covered services. Further, because provision of VA care is contingent upon available resources, whether a veteran receives care can depend on where and when the veteran seeks care. To add to veterans' confusion, VA medical centers use different methods to ration care when funds are not sufficient to meet demand. Because of these problems, veterans may be unable to obtain needed health care services from VA facilities.

Designing solutions to these problems will require both administrative and legislative actions. Among the difficult choices to be made are whether to guarantee the availability of services to one or more groups of veterans and whether to develop one or more defined benefit packages.

VA Provides Extensive Noncovered Services

VA may be spending billions of dollars providing services to veterans not eligible for the services provided. VA officials estimate that 20 percent of

the patients treated in their hospitals do not need hospital care but are not eligible to receive the services they are provided on an outpatient basis. In addition, VA's Office of Inspector General (OIG) estimated on the basis of its review at one medical center that if the percentage of ineligible treatment found at the medical center reviewed is representative of other VA facilities, then VA spent between $323 million and $831 million on ineligible outpatient treatments in fiscal year 1992. The medical center reviewed by the OIG was selected as a typical tertiary care facility with the assistance of officials from the Veterans Health Administration.

VA cites a series of studies to support its view that 20 percent of VA hospital patients are admitted to circumvent restrictions on their eligibility to receive needed services on an outpatient basis. GAO's review of the cited studies, however, found little basis for linking most inappropriate hospitalizations to VA eligibility provisions. The studies did not ascertain veterans' eligibility status and, therefore, did not contain the types of data that would be needed to show a potential link between eligibility restrictions and nonacute admissions. Studies by VA's Inspector General, however, often found that patients were admitted for surgeries that could have been performed on an outpatient basis because VA facilities had not developed ambulatory surgery capabilities.

Because nonacute admissions appear to be caused more by inefficiencies than by eligibility restrictions, changes in the law to expand eligibility would not appear likely to significantly reduce nonacute admissions to VA hospitals. However, VA's announced plans to implement a preadmission certification program could, if effectively implemented, essentially eliminate nonacute admissions with or without eligibility reform. As a result, the preadmission certification program has important implications for VA's ability to meet veterans' health care needs.

Increased Demand Could Cause Extensive Rationing or Higher Budgets

Each of the major eligibility reform proposals developed during the past year would make VA benefits easier to understand and administer. The four proposals that have been introduced would retain the discretionary funding of veterans' health benefits but expand the number of veterans eligible for comprehensive VA outpatient services from about 465,000 to over 26 million. Such expansions are likely to generate significant new demand for VA care. For example, a 1992 VA eligibility reform task force estimated that making all veterans eligible for comprehensive benefits could increase demand for outpatient visits by almost 28 million visits, more than doubling the fiscal year 1995 level.

Under the proposals that would retain discretionary funding of VA health care, if appropriations did not keep pace with increased demand, VA would face the prospect of extensive rationing. In order to provide a broader range of benefits to veterans in the highest priority categories, other veterans, including many current users, would likely lose benefits. On the other hand, increasing appropriations to avoid extensive rationing could potentially add billions of dollars to VA's budget. VA's 1992 eligibility reform task force estimated that, without new sources of revenues, expanding eligibility for comprehensive care to all veterans could add about $38 billion a year to the cost of VA services.

Although VA developed a new formula to estimate the cost of its eligibility reform proposal, the formula does not consider the increased demand for outpatient care by veterans that would likely result from expanded benefits, and it is based on a series of questionable assumptions. In its current form, the formula is independent of the particulars of eligibility reform. In other words, changes in benefits covered, the number of veterans in the mandatory and discretionary care categories, and cost sharing do not have any bearing on the savings estimate.

The eligibility reform proposal developed by the American Legion would make more fundamental changes in the veterans' health care program. It would avert the potential for increased rationing by converting veterans' health benefits into a true entitlement for about 9 million to 11 million veterans. In addition, it would establish comprehensive, basic, and supplemental benefit packages, with most of these veterans provided the basic benefit package at no cost, with an option to buy an upgraded package. VA would no longer receive appropriations to cover the cost of services provided to other veterans, primarily those in the current discretionary care category for hospital care. Such veterans, and veterans' dependents, would be allowed to buy into VA managed care plans.

GAO considers many of the features contained in the American Legion proposal worthwhile, such as defined and guaranteed benefits and the ability to purchase noncovered services, but observes that the large number of veterans who would be covered by the entitlement could add billions of dollars to VA appropriations. In addition, the proposal to exempt VA from most federal contracting rules and to deem VA facilities Medicare providers without requiring these facilities to meet Medicare requirements would create significant risks.

Although discussion of eligibility reform proposals centers primarily around increased demand for outpatient care, additional work is needed to assess the potential effects of reforms on demand for hospital and long-term care services. This is because veterans attracted to the system by expanded outpatient benefits may increase their use of other VA services. Similarly, further efforts are needed to assess the potential effects of VA's attempts to improve accessibility of services on the demand for VA services. Accessibility of services is key to estimating demand because veterans living within 5 miles of a VA clinic are more likely to use VA services, and to use them more often, than veterans living more than 5 miles from a VA clinic.

Approaches for Limiting the Budgetary Effect of Eligibility Reforms

The cost of eligibility reform could vary greatly, depending 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 four eligibility reform proposals that would retain the discretionary nature of VA's medical care budget 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 or in the methods used to establish VA's appropriation.

Five basic approaches could be used, individually or in combination, to limit the budgetary effect of eligibility reforms. These are (1) set limits on covered benefits, (2) limit the number of veterans eligible for health care benefits, (3) generate increased revenues to pay for expanded benefits, (4) allow VA to "reinvest" savings achieved through efficiency improvements in expanded benefits, and (5) provide a methodology in the law for setting a limit on VA's medical care appropriation.

Both the eligibility reform legislation approved by the House of Representatives on July 30, 1996, and the legislation being developed by the Senate Committee on Veterans' Affairs would set limits on the growth in VA medical care authorizations. In addition, the House bill would require the Secretary of Veterans Affairs to establish information systems to assess the effects of the legislation and to report to the Committees on Veterans' Affairs on those effects by March 1, 1998.

Recommendations

Although GAO is not making recommendations in this report, the report discusses major issues identified through GAO's work that would affect eligibility reform decisions.

Agency Comments

VA said that GAO's report, in presenting a summation of many years of discussion concerning eligibility reform issues, shows how confusing, convoluted, and difficult even debate on the issues can be. VA noted that unanimous passage of H.R. 3118 by the House of Representatives and the recent reporting of a bill by the Senate Committee on Veterans' Affairs support the need for change. See appendix VII for the full text of VA's comments.

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Abbreviations

AEP	appropriateness evaluation protocol
AIDS	acquired immunodeficiency syndrome
BIRLS	Beneficiary Identification and Records Locator System
CBO	Congressional Budget Office
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
DOD	Department of Defense
GPO	U.S. Government Printing Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
ISD	intensity, severity, discharge
MSA	medical savings account
OIG	Office of Inspector General
PHS	Public Health Service
RPM	Resource Planning and Management
VA	Department of Veterans Affairs/Veterans Administration
VHA	Veterans Health Administration
VISN	veterans integrated service network
VSO	veterans service organization

Introduction

The Department of Veterans Affairs (VA) operates one of the nation's largest health care systems, including

- a health benefits program for over 26 million eligible veterans and
- a health care delivery program consisting of 173 hospitals, 376 outpatient clinics, 136 nursing homes, and 39 domiciliaries in fiscal year 1996.

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 a particular veteran's health care benefits and (2) the clinics are not permitted under the law to sell noncovered services to veterans.

In administering the veterans' health benefits program authorized under title 38 of the U.S. Code, some of VA's responsibilities are similar to those of the Health Care Financing Administration (HCFA) in administering Medicare benefits and to those of private insurance companies in administering health insurance policies. For example, VA is responsible for determining under the statute (1) which benefits veterans are eligible to receive, (2) whether and how much veterans must contribute toward the cost of their care, and (3) where veterans can obtain covered services (in other words, 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 beneficiaries—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/HCA and Kaiser Permanente. For example, VA strives to ensure that its facilities (1) provide high quality care, (2) are used to optimum capacity, (3) are located where they are accessible to their 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.

For fiscal year 1996, VA received an appropriation of about $16.6 billion to maintain and operate its facilities, which 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.

Eligibility for Veterans' Health 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 eligible for some VA health care benefits. The amount of required active duty service varies depending on when the person entered the military, and an eligible veteran's health care benefits depend on factors such as the presence and extent of a service-connected disability, income, and period or conditions of military service.[1]

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

Although all veterans meeting the 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.

Generally, veterans can obtain health services only in VA-operated health care facilities. There are three primary exceptions:

- 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.

[1]A service-connected disability is one that results from an injury or disease or other physical or mental impairment incurred or aggravated during active 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.

- VA pays private sector physicians and other health care providers to extend care 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). VA has limited the use of fee-basis physicians primarily to veterans with service-connected disabilities.
- Veterans can obtain emergency hospitalization from any hospital and then be transferred to a VA hospital when their conditions stabilize.

In addition, veterans being treated in VA facilities can be provided specific scarce medical resources from other public and private providers through sharing agreements and contracts between VA and non-VA providers.

Hospital and Nursing Home Care

All veterans' health care benefits include medically necessary hospital and nursing home care, but certain veterans, referred to as Category A, or mandatory care category, veterans, have the highest priority for receiving 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 certain toxic substances or ionizing radiation,
- served during the Mexican Border Period or World War I,
- receive disability compensation,
- receive nonservice-connected disability pension benefits, or
- have incomes below the means test threshold (as of January 1996, $21,001 for a single veteran or $25,204 for a veteran with one dependent, plus $1,404 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, known as Category C, or discretionary care category, veterans, must pay a part of the cost of the care they receive.

Outpatient Care

VA 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 care categories apply to outpatient care. Only veterans who have service-connected disabilities rated at 50 percent or more (about 465,000 veterans) are in the mandatory care category for comprehensive outpatient care. VA may provide comprehensive outpatient care to veterans who (1) are former prisoners of war, (2) served during the Mexican Border Period or World War I, or (3) are housebound or in need of aid and attendance. In other words, all medically necessary outpatient care is covered for these groups of veterans, subject to the availability of space and resources.

All veterans with service-connected disabilities are in the mandatory care category for treatment related to their disabilities. Veterans seeking outpatient services needed to treat medical conditions related to injuries suffered as a result of VA hospitalization or while participating in a VA rehabilitation program are also in the mandatory care category for such services. Other medically necessary care is noncovered unless the veteran also qualifies for comprehensive care or meets the conditions for hospital-related care.

Veterans (1) with service-connected disabilities rated at 30 or 40 percent and (2) whose annual incomes do not exceed VA's pension rate for veterans in need of regular aid and attendance are in the mandatory care category for hospital-related outpatient care. VA may, to the extent resources permit, furnish limited hospital-related outpatient care to veterans not otherwise eligible for outpatient care, providing they agree to pay a part of the cost of care. For veterans qualifying for outpatient care only under the hospital-related care provisions, all other medically necessary outpatient care is noncovered.

Figure 1.1 summarizes VA eligibility provisions.

Figure 1.1: 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	■	■	●
Service-Connected Disabilities Rated 0-40%, for a Service-Connected Condition	■	■	●
Discharged for Disability	■	■	●
Service-Connected Disabilities Rated 30-40%, for a Nonservice-Connected Condition	■	▲	●
Pensioner or Has Income Under $13,190	■	▲	●
Injured in VA	■	▲	●
Prisoner of War	■	●	●
World War I or Mexican Border Period Veteran	■	●	●
Pensioner Receiving Aid and Attendance Payments	■	●	●
Service-Connected Disabilities Rated 0-20%, for a Nonservice-Connected Condition	■	◆	●
Nonservice-Connected Disabilities, With an Income of $13,190-$21,001 (No Dependents)	■	◆	●
Exposed to Agent Orange or Radiation, or Medicaid-Eligible	■	◆	●
Nonservice-Connected Disabilities With Income Over $21,001 (No Dependents)	▼	▼◆	▼

■ Mandatory ▲ Mandatory, Limited to Hospital-Related Care ▼ Discretionary, With Copayment
● Discretionary ◆ Discretionary, Limited to Hospital-Related Care

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

VA Facilities Generally Restricted to Providing Covered Services to Veterans

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. In addition, VA can sell health care services in only a few situations. Specifically, statutes authorize VA hospitals and outpatient clinics to enter into agreements to sell

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

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

To allow VA's resources to be more effectively used and avoid unnecessary duplication and overlap of activities, VA has been authorized for over 60 years to sell or share its resources with other federal agencies. For example, all VA medical centers within 50 miles of a DOD hospital currently have sharing agreements to provide one or more services to DOD beneficiaries.[2] In 1989, the Congress enacted legislation specifically authorizing the use of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) funds to reimburse VA for care provided to CHAMPUS beneficiaries under sharing agreements. As of April 1996, three VA medical centers were providing services to CHAMPUS beneficiaries. Finally, in June 1995, VA and DOD completed work on an agreement that will allow VA facilities to compete with private sector facilities to serve as providers under DOD's new TRICARE program.[3]

Since 1966, VA facilities have also had limited authority to share health care resources with federal and nonfederal hospitals, clinics, and medical schools. This authority, however, is limited to sharing of "specialized medical resources," medical techniques, and education. Such resources include equipment, space, or personnel, which, because of their cost, limited availability, or unusual nature, are either unique in the medical community or can be fully used only through mutual use. VA facilities cannot provide routine patient care services to veterans' dependents or

[2]Neither VA nor DOD reports on the sharing program provide data on the volume of services actually shared.

[3]DOD is restructuring the military health care system into a managed care program known as TRICARE. Under TRICARE, a managed care support contractor establishes an integrated network of military and civilian health care providers and offers CHAMPUS beneficiaries a triple-option health care benefit. For more information, see VA Health Care: Efforts to Increase Sharing With DOD and the Private Sector (GAO/T-HEHS-96-41, Oct. 18, 1995).

other nonveterans,[4] even if they have the capacity to do so and the patients are willing to pay for the services.

Similarly, VA facilities cannot sell noncovered services to veterans. This restriction primarily affects outpatient care because hospital care is a covered service for all veterans. However, routine outpatient care is not a covered service for most veterans, and VA cannot sell routine outpatient care to most veterans even if they are willing to pay for the care.

Objectives, Scope, and Methodology

In July 1995 and March 1996, respectively, we testified before the House and Senate Committees on Veterans' Affairs on major issues affecting reform of VA health care eligibility. At the request of the Chairman, Senate Committee on Veterans' Affairs, this report expands on the information presented at those hearings. Specifically, it discusses

- the evolution of the VA health care system and VA eligibility;
- the problems that VA's current eligibility and health care contracting provisions create for veterans and providers;
- the extent to which VA provides veterans with health care services for which they are not eligible;
- legislative proposals to reform VA eligibility and contracting rules and their potential effect on the ease of administration, equity to veterans, costs to VA, and clarity of eligibility for veterans' health benefits; and
- approaches that could be used to limit the budgetary effects of eligibility reforms.

In addressing these objectives, we relied primarily on the results of reviews that we conducted over the last 5 years that detailed problems in administering VA's outpatient eligibility provisions, compared VA benefits and eligibility with those of other public and private health benefits programs and with the veterans' health benefits programs in other countries, and assessed VA's role in a changing health care marketplace. A list of related GAO products is at the end of this report.

In addition, in developing information on the evolution of the VA health care system and veterans' health benefits, we relied on the legislative

[4]VA does, however, administer a health benefits program called CHAMPVA—Civilian Health and Medical Program of the Department of Veterans Affairs—for dependents of veterans who are permanently and totally disabled because of a disease, injury, or other physical or mental impairment incurred or aggravated during military service. CHAMPVA, authorized by the Veterans Health Care Expansion Act of 1973 (P.L. 93-82), is patterned after CHAMPUS and functions much like a health insurance plan using private sector physicians, hospitals, and other providers. The program is administered by the CHAMPVA Center, which processes and pays claims for covered services.

history of the veterans' health care provisions of title 38 of the U.S. Code and articles and reports prepared by or for the Brookings Institution (1934),[5] the House Committee on Veterans' Affairs (1967),[6] the National Academy of Sciences (1977),[7] VA's Commission on the Future Structure of Veterans Health Care,[8] the Congressional Research Service,[9] the Twentieth Century Fund (1974),[10] and VA.[11]

In assessing the extent to which VA hospitals and clinics provide inappropriate and noncovered services, we relied primarily on studies prepared by VA researchers and VA's Office of Inspector General (OIG). In reviewing these studies, we paid particular attention to the underlying causes for the problems identified to determine the extent to which the problems were attributed to VA eligibility provisions.

In evaluating eligibility reform proposals, we focused on those proposed by members of the Senate or House Veterans' Affairs Committees, VA, and the major veterans service organizations (VSO). We focused on the extent to which the proposals would (1) change VA health care funding from discretionary to mandatory, (2) expand eligibility for VA health care services, (3) create a uniform benefit package(s), (4) guarantee availability of covered services, and (5) provide new sources of funding for expanded benefits.

On the basis of this work and discussions with officials from VA and the major VSOs, we identified a series of issues that could be considered in future debate on eligibility reform.

We did our work between March 1995 and June 1996 in accordance with generally accepted government auditing standards.

[5]Gustavus A. Weber and Laurence F. Schmeckebier, The Veterans' Administration: Its History, Activities and Organization (Washington, D.C.: The Brookings Institution, 1934).

[6]Medical Care of Veterans, House Committee Print No. 4, 90th Congress, 1st Session (Washington, D.C.: U.S. Government Printing Office (GPO), Apr. 17, 1967).

[7]National Academy of Sciences, National Research Council, Study of Health Care for American Veterans, pursuant to Section 201(c) of Public Law 93-82 (Washington, D.C.: GPO, June 7, 1977).

[8]Report of the Commission on the Future Structure of Veterans Health Care (Washington, D.C.: VA, Nov. 1991).

[9]Memorandum dated July 18, 1995, from Dennis W. Snook, specialist in Social Legislation, Education and Public Welfare Division, to the House Committee on Veterans' Affairs.

[10]Michael K. Taussig, Those Who Served: Report of the Twentieth Century Fund Task Force on Policies Toward Veterans (Millwood, N.Y.: Draus Reprint Co., 1975).

[11]VA History in Brief: What It Is, Was, and Does (Washington, D.C.: VA, undated pamphlet, approximately 1986).

Evolution of Veterans' Health Care Coverage

The United States has a long tradition of providing benefits to those injured in military service, but the role of the federal government in providing for the health care needs of other veterans has evolved and expanded over time. The federal role, initially limited to a program of financial assistance for those injured in combat, has expanded to include a combination of financial assistance and direct provision of health care services to a wide range of combat and noncombat veterans.

Just as VA's role in meeting veterans' health care needs has broadened over time, the role of public and private health insurance in meeting the health care needs of veterans (and other Americans) has also grown. About 90 percent of veterans now have public or private health insurance or both in addition to their VA health care benefits. As a result, many veterans now have multiple options for paying for basic hospital and physician services.

Changes in the veteran population have also contributed to the evolution of VA from a system focused on treatment of war injuries to a system increasingly focused on treatment of veterans with no service-connected disabilities and on treatment of disabilities associated with aging. For example, the number of veterans is declining, fewer in the veteran population served during wartime, and a growing proportion of veterans are over age 65.

Our work identified many difficult questions facing the Congress as it considers future changes in the mission of the veterans' health care system. For example, what do veterans perceive as the nation's obligation to meet their health care needs and how does that perception differ from the commitment made by the Congress and the administration? Similarly, with the growth of public and private health insurance, are changes needed in VA's role as a safety net provider? Finally, with an aging veteran population, are changes needed in VA's role in meeting the long-term care needs of veterans?

Federal Role in Veterans' Health Care

In the nation's early years, the federal role was limited to direct financial payments to veterans injured during combat; direct medical and hospital care was provided by the individual colonies, states, and communities. The first colonial law establishing veterans' benefits, enacted by the Pilgrims of Plymouth Colony in 1636, provided that any soldier injured in the war with the Pequot Indians would be maintained by the colony for the rest of his life. Other colonies enacted similar provisions.

The Continental Congress, seeking to encourage enlistments during the Revolutionary War, provided federal compensation for veterans injured during the war and their dependents. Similarly, the first U.S. Congress passed a veterans' compensation law.[12]

The federal role began to expand in 1833 with the opening of the first domiciliary and medical facility for veterans—the U.S. Naval Home. A second federal home for disabled and invalid soldiers—the Old Soldiers and Sailors Home—authorized in 1851, is still in operation in Washington, D.C. Although the federal role was no longer limited to financial support for war-disabled veterans, medical care was only an incidental part of the homes, which were primarily residential facilities.

Direct Medical Care Expanded During and Following the Civil War

The federal role in veterans' health care significantly expanded during and following the Civil War. During the war, the government operated temporary hospitals and domiciliaries in various parts of the country for disabled soldiers until they were physically able to return to their homes. Following the war, the number of disabled veterans, and veterans unable to cope with the economic struggle of civilian life, became so great that the government built a number of "homes" to provide domiciliary care.[13] Incidental medical and hospital care was provided to residents for all diseases and injuries, whether or not they were service related.

In addition to indigent and disabled veterans of the Civil War, eligibility for admission to the homes was subsequently extended to veterans of the Indian Wars, Spanish-American War, Mexican Border Period, and discharged regular members of the armed forces.

Onset of World War I Ushered in New Veterans' Benefits

The modern era of the veterans' health care system began with the onset of World War I. During World War I a series of new veterans benefits were added: voluntary life insurance, allotments to take care of the family during service, reeducation of those disabled, disability compensation, and medical and hospital care for those suffering from wounds or diseases incurred in the service.

[12]Since 1946, VA has used the term "compensation" rather than "pension" to refer to payments for disabilities or death related to military service. "Pension" is paid on the basis of financial need for totally disabled veterans or certain survivors for disabilities or death not related to military service.

[13]In 1865, the Congress established the National Asylum for Disabled Volunteer Soldiers. The Asylum operated individual homes, known as branches, which provided domiciliary, hospital, and medical care. The term "home" was substituted for "asylum" in 1873. Such homes are now referred to as "domiciliaries."

Throughout the 1800s, the federal role had been limited to the provision of (1) compensation to war-disabled veterans and (2) domiciliary care and incidental medical care to veterans with injuries incurred during wartime service or to veterans who are incapable of earning a living because of a permanent disability, tuberculosis, or neuropsychiatric disability suffered after their wartime service.

During World War I, however, Public Health Service (PHS) hospitals treated returning veterans and at the end of the war, several military hospitals were transferred to PHS to enable it to continue serving the growing veteran population. In 1921, those PHS hospitals primarily serving veterans were transferred to the newly established Veterans' Bureau.

Casualties returning from World War I soon overwhelmed the capacity of veterans' hospitals to treat injured soldiers. The Congress responded by increasing the number of veterans' hospitals with an emphasis on treatment of veterans' disabling conditions. In 1921, eligibility for hospital care was expanded to include treatment for all service-connected conditions.

Eligibility Expanded When Supply Exceeded Demand for Care

After most of the immediate, postwar, service-connected medical problems of veterans were met, VA hospitals began to experience excess capacity instead of a shortage of beds. Proposals were made to close underutilized hospitals. The VSOs lobbied for free hospital care for medically indigent veterans without service-connected disabilities. The Congress, in 1924, gave wartime veterans with nonservice-connected conditions access to Veterans' Bureau hospitals, provided space was available and the veterans signed an oath indicating they were unable to pay for their care.

VA Established to Better Coordinate Veterans' Programs

During the 1920s, three federal agencies—the Veterans Bureau, the Bureau of Pensions in the Interior Department, and the National Home for Disabled Volunteer Soldiers—administered various benefits for the nation's veterans. With the establishment of the Veterans Administration (VA)[14] in 1930, previously fragmented care for veterans was consolidated under one agency.

[14]We use the VA acronym to represent both the Veterans Administration and, when it became a cabinet-level department in 1989, the Department of Veterans Affairs.

During the Great Depression, demand for VA hospital care was unprecedented. As part of efforts to curtail federal spending, President Roosevelt, in 1933, issued regulations making veterans ineligible for hospital treatment of nonservice-connected conditions. The following year, however, the Congress restored eligibility for treatment of nonservice-connected conditions. Subsequently, in 1937, President Roosevelt authorized construction of additional VA hospital beds to (1) meet the increased demand for neuropsychiatric care and treatment of tuberculosis and other respiratory illnesses and (2) provide more equitable geographic access to care.

Care During and Following World War II Led to Further Eligibility Expansions

Rapidly rising demand for hospital care brought on by the onset of U.S. involvement in World War II led to construction and expansion of VA hospitals. Because of the heavy demand for care, World War II veterans were initially eligible only for treatment of service-connected disabilities. In 1943, however, new eligibility requirements were established for World War II veterans identical to those for World War I veterans.

Demand for care was so great, however, that in March 1946 VA had a waiting list of over 26,000 veterans seeking care for nonservice-connected conditions. As had occurred following the end of World War I, the initial high demand for medical services for returning casualties soon declined and VA once again had excess hospital capacity. In 1947, the Congress created a presumption that a diagnosis of a chronic psychiatric condition within 2 years of discharge would be regarded as service-connected.

The next significant expansion of hospital eligibility occurred in 1962, when legislation was enacted that defined as a service-connected disability any condition traceable to a period of military service, regardless of the cause or circumstances of its occurrence. Before that time, care for service-connected conditions was not assured unless they were incurred or aggravated during wartime service.

In 1973, eligibility for hospital care was extended to treatment of nonservice-connected disabilities of peacetime veterans unable to defray the cost of care. Previously, treatment of nonservice-connected disabilities was limited to wartime veterans.

Finally, in 1986, the Congress extended eligibility to higher-income veterans with no service-connected disabilities. Previously, only those veterans with nonservice-connected disabilities who signed a poverty oath

were eligible for VA hospital care. To be eligible for VA hospital care, higher-income veterans must agree to contribute toward the cost of their care.

Eligibility for Outpatient Care Expanded More Slowly

Eligibility for outpatient care was initially limited to treatment of service-connected disabilities. It was not until 1960 that VA was first authorized to treat nonservice-connected disabilities on an outpatient basis. In that year, Public Law 86-639 authorized outpatient treatment for a nonservice-connected disability in preparation for or to complete treatment of hospital care. So concerned was the 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 expanded eligibility for outpatient care. The act (1) made veterans with service-connected disabilities rated at 80 percent or higher eligible for free comprehensive outpatient care and (2) authorized outpatient treatment for any nonservice-connected disability to "obviate the need of hospital admission." Three years later, in 1976, the mandatory care category for free comprehensive outpatient services was extended to include veterans with service-connected disabilities rated at 50 percent or higher.

In 1986, the Congress expanded eligibility for outpatient care to include higher-income veterans agreeing to contribute toward the cost of their care. Previously, only those veterans with nonservice-connected disabilities who signed a poverty oath were eligible for outpatient care.

The last major expansion of outpatient eligibility occurred in 1988 when veterans with (1) service-connected disabilities rated at 30 or 40 percent or (2) with incomes below the maximum pension rate were placed in the mandatory care category for outpatient treatment for prehospital and posthospital care and for care that would obviate the need for hospital care.

Veterans' Other Health Care Options Have Improved Since 1930

When the VA health care system was established, there was no public or private health insurance program to assist veterans in paying for needed health care services. Private health insurance, which typically pays for services provided by physicians and health care facilities on a fee-for-service basis,[15] began to emerge in the 1930s with the establishment of Blue Cross and Blue Shield and commercial plans. The industry expanded rapidly during the 1950s, and in 1959, the Federal Employees Health Benefits Act authorized the federal government to provide health care benefits to millions of federal employees and retirees and their dependents through private health insurance. By 1993, over 182 million Americans were covered by private health insurance.

In 1965, the Congress enacted legislation establishing the two largest public health insurance programs—Medicare, serving elderly and disabled Americans, and Medicaid, a jointly funded federal-state program serving low-income Americans.[16] The following year, the Congress established CHAMPUS to enable military retirees and the dependents of active duty and retired military personnel to obtain health care in the private sector when services are not available or not accessible in DOD facilities.[17]

Although each of the major public and private programs has a different target population, overlaps between target populations result in many veterans having coverage under multiple programs. Table 2.1 describes potential overlaps in populations served by the VA health care system and other health care programs.

[15]Fee for service refers to an arrangement in which providers render services and are paid for each medically necessary service rendered to a covered beneficiary.

[16]Medicare and Medicaid are administered at the federal level by HCFA within HHS. Medicaid programs are primarily state-administered, and there is considerable variation in the benefits covered.

[17]The Dependents' Medical Care Act, effective December 7, 1956, previously authorized care from civilian sources for spouses and children of active duty military members. Coverage was extended to retired members and their dependents and to dependents of deceased servicemembers through the Military Medical Benefits Amendments of 1966. The program became known as CHAMPUS at that time.

Table 2.1: Overlapping Populations Served by VA and Other Major Health Programs, 1991

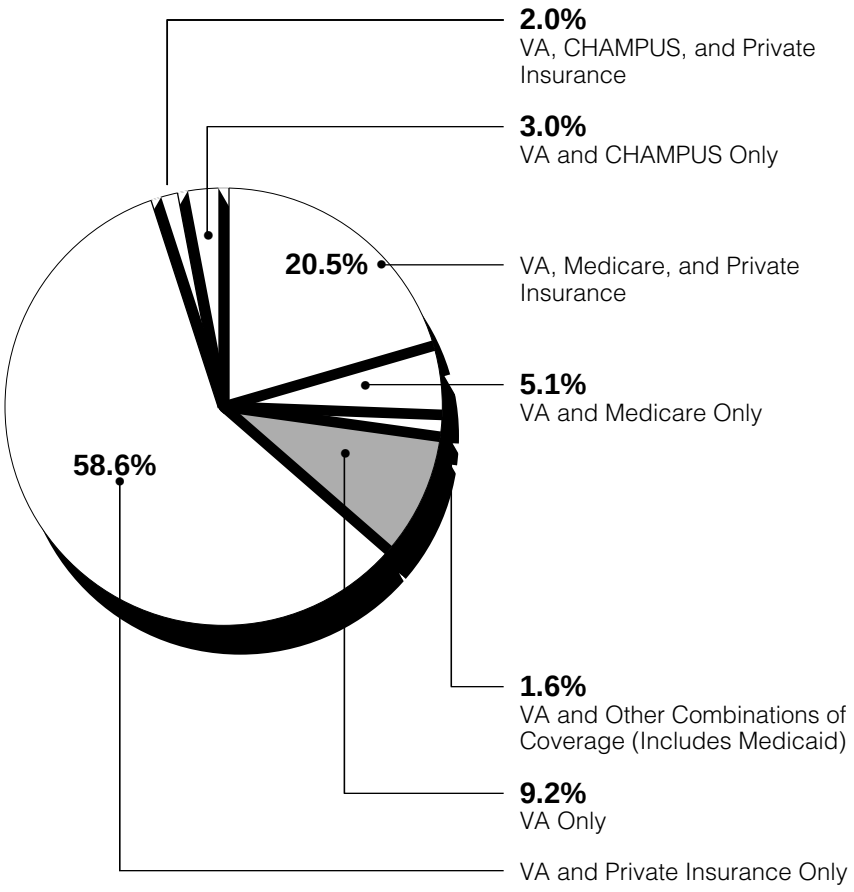
Target population		Major overlaps with VA
Description	**Size**	
VA		
Veterans	26,600,000	Not applicable
DOD direct care		
Active duty military personnel	2,000,000	None
Military retirees	1,700,000	1,700,000 military retirees
Dependents of active duty and retired military personnel	5,300,000	None
DOD-CHAMPUS		
Military retirees under age 65	1,200,000	1,200,000 military retirees
Dependents of active and retired military personnel	4,800,000	None
Medicare		
Elderly, disabled, and persons with end-stage renal disease	34,900,000	7,400,000 Medicare-eligible veterans[a]
Medicaid		
Low-income veterans	32,300,000	400,000 Medicaid-eligible veterans[a]
Federal Employees Health Benefits Program		
Active federal employees	2,400,000	745,000 active federal employees
Retired federal employees	1,700,000	754,000 retired federal employees
Dependents of active and retired federal employees	5,300,000	None
Private insurance		
General public	185,000,000[a]	22,900,000 veterans[a]

[a]Estimate based on Bureau of the Census' "Survey of Income and Program Participation," using 1990 data.

Veterans' Utilization of VA Health Care

With the growth of public and private health insurance, more than 9 out of 10 veterans now have alternate health insurance coverage, decreasing the importance of VA's safety net mission. (See fig. 2.1.)

Figure 2.1: Veterans' Health Care Coverage



Note: Veterans covered by CHAMPUS are also eligible for care in DOD health care facilities on a space-available basis. Veterans losing CHAMPUS coverage upon becoming Medicare-eligible can still use DOD facilities on a space-available basis.

Veterans with higher incomes, alternate health insurance coverage, and no service-connected disabilities are significantly less likely to seek care from VA health care facilities than are veterans with service-connected disabilities, low incomes, and no health insurance. The following data illustrate:

- Over 82 percent of veterans with health insurance had never used VA, compared with about 56 percent of veterans with no health insurance.[18]
- Over 88 percent of veterans with incomes of $40,000 or more had never used VA, compared with over 63 percent of veterans with incomes under $10,000.
- Over 70 percent of veterans with no service-connected disabilities had never used VA health care services, compared with 30 percent of those with service-connected disabilities.

Significant Changes Are Occurring in the Veteran Population

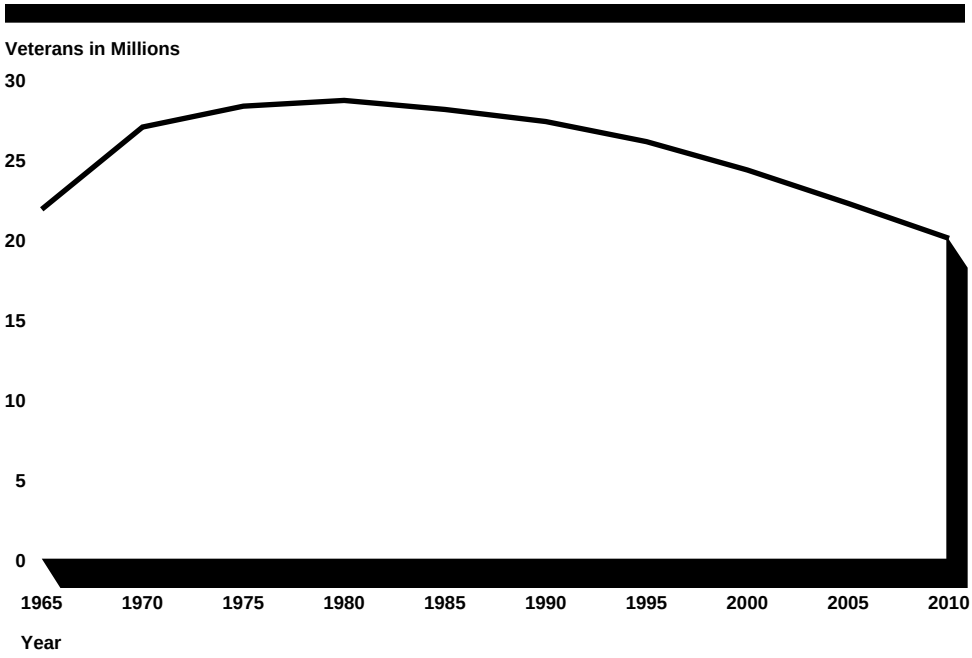
Changes in the size and composition of the veteran population also contribute to the evolution of the VA health care system from one primarily treating war-related injuries to one increasingly focused on veterans with no service-connected disabilities. As the nation's large World War II and Korean War veteran populations age, their needs for nursing home and other long-term care services are increasing.

The veteran population, which totaled about 26.4 million in 1995, is both declining and aging. The number of veterans has steadily declined since 1980 and is expected to decline at an accelerated rate through 2010. Between 1990 and 2010, VA projects the veteran population will decline 26 percent.[19] (See fig. 2.2.)

[18]In 1990, about 25.6 million of the nation's estimated 28.2 million veterans (almost 91 percent) had public or private health care coverage or both in addition to their VA coverage. Over 81 percent of veterans (22.9 million) had private health insurance; 26 percent (7.4 million) had Medicare coverage; 5.1 percent (1.4 million) had coverage under CHAMPUS; and 1.6 percent (0.4 million) had Medicaid coverage. (See Veterans' Health Care: Most Care Provided Through Non-VA Programs (GAO/HEHS-94-104BR, Apr. 25, 1994).)

[19]VA's projections are based on a relatively stable number of new veterans entering the system following military discharge. War or other military buildup would likely increase the number of veterans. Conversely, further downsizing of the military would accelerate the decline in the veteran population.

Figure 2.2: Estimated Number of Veterans, 1965-2010

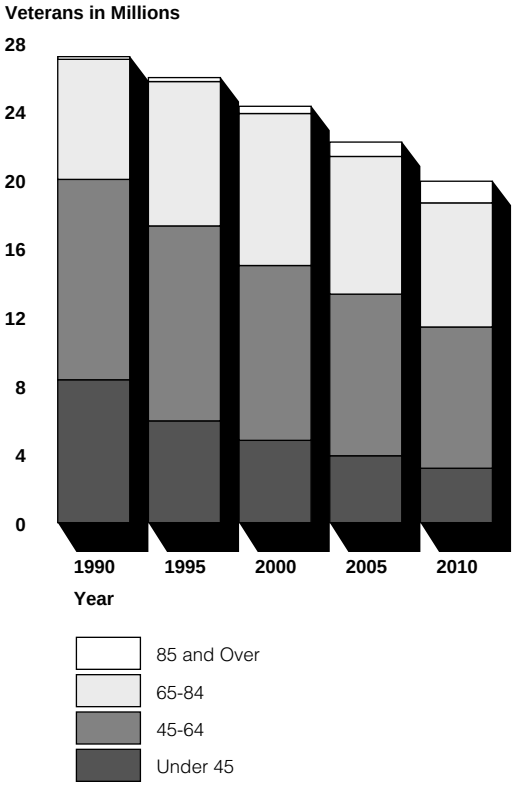


Source: VA National Center for Veteran Analysis and Statistics.

Veterans Increasingly Need Nursing Home and Other Long-Term Care Services

As the veteran population continues to age, the decrease will not be evenly distributed among age groups. The decline will be most notable among veterans under 65 years of age—from about 20.0 million to 11.5 million (42 percent). The number of veterans aged 65 to 84 will increase from 7.0 million to 8.9 million in the year 2000, then will drop to about 7.2 million by 2010. In contrast, the number of veterans aged 85 and older will increase more than eight-fold, from 154,000 to 1.3 million by 2010. At that time, veterans aged 85 and older will constitute about 6.3 percent of the veteran population. (See fig. 2.3.)

Figure 2.3: Estimated Veteran Population, by Age, 1990-2010



Source: VA National Center for Veteran Analysis and Statistics.

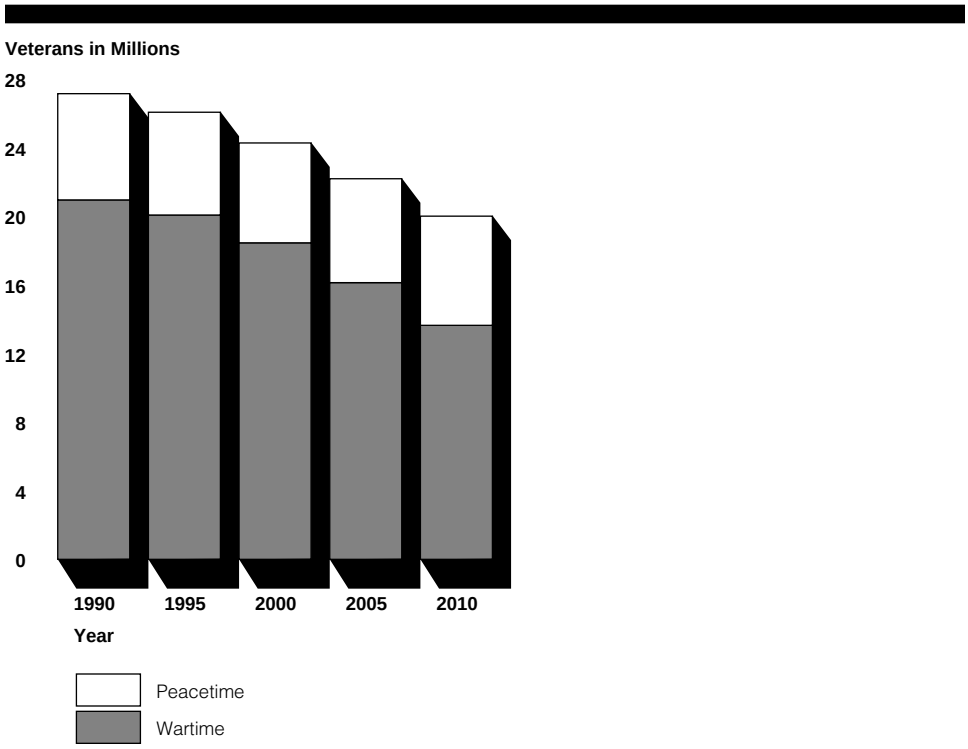
Old age is often accompanied by the development of chronic health problems, such as heart disease, arthritis, and other ailments. These problems, important causes of disability among the elderly population, often result in the need for nursing home care or other long-term care services. With the veteran population continuing to age rapidly, VA faces a significant challenge in trying to meet increasing demand for nursing home care. Over 50 percent of veterans over 85 years old are expected to need nursing home care compared with 13 percent of those 65 to 69 years old.

Declining Numbers of Veterans Have Wartime and Combat Duty

Coinciding with the overall decline in the number of veterans is a decline in the percentage of the veteran population that served during wartime. Because of the higher death rate of veterans who served in World War II

(they currently account for almost three of every four veteran deaths), the population of veterans who served during wartime will decrease faster than the total veteran population—35 percent verses 26 percent. VA projects the number of total wartime veterans will decline from 21.0 million in 1990 to 13.6 million in 2010. (See fig. 2.4.)

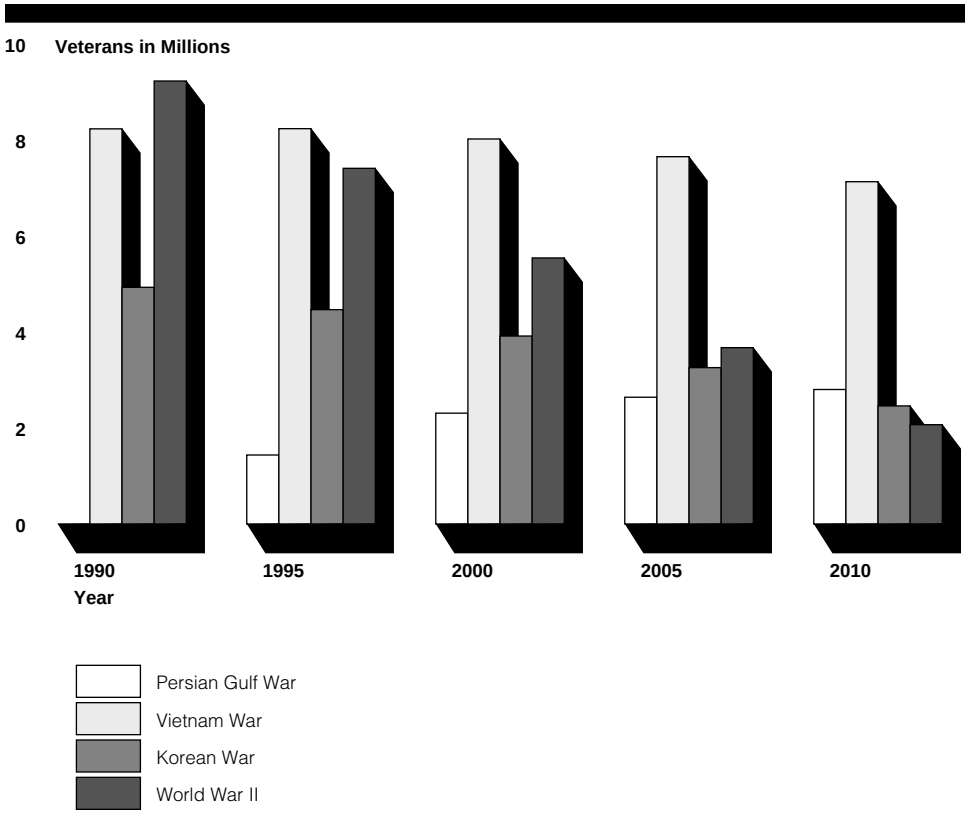
Figure 2.4: Estimated Veteran Population, by Wartime and Peacetime Service, 1990-2010



Source: VA National Center for Veteran Analysis and Statistics.

Even more dramatic is the shift in the number of wartime veterans by period of service. In 1990, the largest group of wartime veterans were World War II veterans, followed by Vietnam and Korean War veterans, respectively. By 1995, however, deaths of World War II veterans had reached the point where Vietnam-era veterans outnumbered surviving World War II veterans by about 826,000. By 2010, Persian Gulf War veterans are expected to outnumber both Korean War and World War II veterans. (See fig. 2.5.)

Figure 2.5: Estimated Wartime Veterans, by Period of Service, 1990-2010



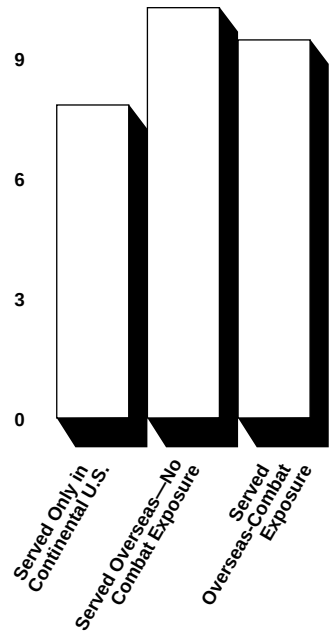
Notes: Excludes World War I and Mexican Border Period veterans. In 1990, there were an estimated 62,000 World War I veterans. This number was expected to drop to 13,000 in 1995, 2,000 by the year 2000, and to less than 500 by 2005. VA estimated that there were 164 Mexican Border Period veterans in 1994.

Veterans who served during more than one wartime period are counted in each period.

Source: VA National Center for Veteran Analysis and Statistics.

Most veterans who served during wartime saw no combat exposure. As a result, about 35 percent of U.S. veterans were actually exposed to combat. (See fig. 2.6.)

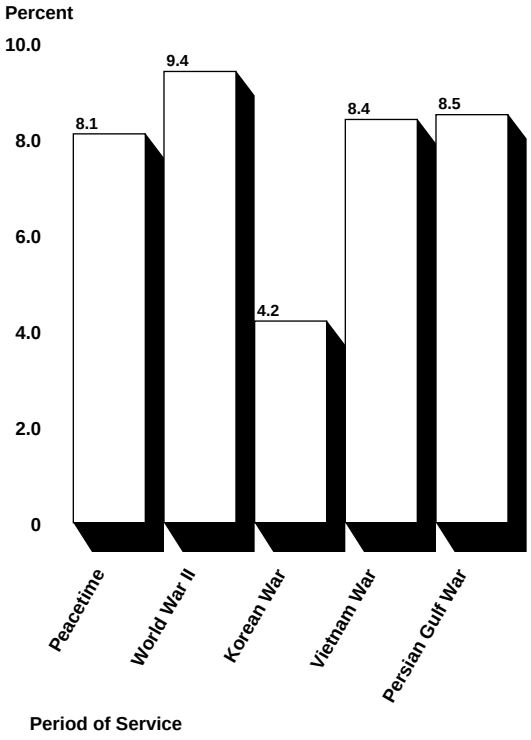
Figure 2.6: Combat Exposure of the Veteran Population, 1992



Source: Based on VA's 1992 National Survey of Veterans.

About 8.3 percent of veterans have compensable service-connected disabilities. 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 and Persian Gulf War veterans. Most likely to have service-connected disabilities are World War II veterans. (See fig. 2.7.)

Figure 2.7: Percentage of Veterans With Service-Connected Disabilities, by Period of Service, 1995

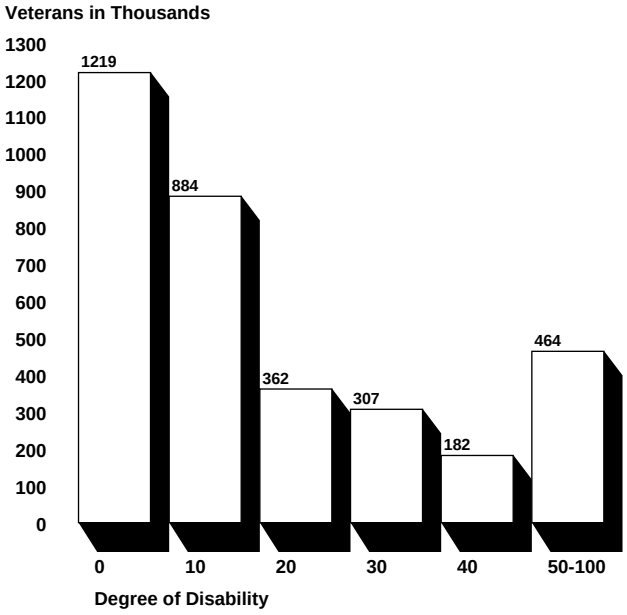


Source: Data are from the Annual Report of the Secretary of Veterans Affairs, Fiscal Year 1995 (Washington, D.C.: VA, 1996).

Of the over 2.2 million veterans with compensable service-connected disabilities, over half have disability ratings of 10 or 20 percent.[20] Of the remaining veterans with service-connected disabilities, about 464,000 had disabilities rated at 50 percent or higher and 488,000 had disabilities rated at 30 or 40 percent. (See fig. 2.8.)

[20]VA reported 2,217,908 veterans with service-connected disabilities as of September 30, 1994. However, VA does not maintain records on most veterans with noncompensable service-connected disabilities rated "0." VA estimates that there are about 1.2 million such veterans.

Figure 2.8: Veterans With Service-Connected Disabilities, by Degree of Disability, 1994



Note: The number of veterans with "0" percent service-connected disabilities includes 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 (Washington, D.C.: VA, 1995) and discussions with VA officials.

Multiple Issues Face VA and the Congress in Planning Changes in VA's Health Care Mission

Many of the health care benefits for which veterans are now eligible were added after they were discharged from the military. For example, most World War II and Korean War veterans were discharged before nursing home benefits were added to the VA system in 1964. Similarly, higher-income veterans were not eligible for VA health care until 1986, when the means test was added. More importantly, outpatient benefits, other than for treatment of service-connected disabilities, were not available even for pre- and posthospital care until 1960. And broader outpatient benefits to cover services needed to obviate the need for hospital care were not added until after the Vietnam War. In other words, not one of the three largest groups of veterans—World War II, Korean War, or Vietnam War—was discharged with a promise of comprehensive health care for both service-connected and nonservice-connected conditions.

Although many of the health benefits for which veterans are now eligible were not covered at the time they were discharged, were servicemembers

led to believe, either as an inducement to enlist or as a promise upon discharge, that the government would provide for their health care needs for the remainder of their lives?

The first, and perhaps most important, issue to be addressed in considering changes in veterans' health care eligibility is the nation's commitment to its veterans. But what is and what should that commitment be? Since colonial times, there has been little doubt that servicemembers injured in combat are entitled to compensation for their injuries. There is less agreement, however, on the role and responsibility of the federal government in meeting the other health care needs of veterans.

Decisions made with regard to what the nation's commitment is to its veterans will largely drive decisions on whether eligibility distinctions should continue to be based on factors such as degree of service-connected disability and income. If a decision is made that all veterans should be eligible for the same comprehensive health benefits, then eligibility distinctions will, in the future, be used only to determine veterans' relative priorities for care. If, however, a decision is made that certain veterans should be given more extensive benefits than others, then such distinctions will continue to be used to define the differences in benefits. For example, certain categories of veterans might be eligible for a broader range of services or lower cost sharing. The question then would become whether to keep the same distinctions as in the current law or base the distinctions on other factors.

In three other countries that operated direct delivery systems for veterans (United Kingdom, Australia, and Canada), declining use of veterans' hospitals prompted actions to open them to nonveterans. It was hoped that caring for community patients would allow the hospitals and staff to maintain their medical expertise and expand services. Should our veterans' health care system similarly be opened to nonveterans? Among the options that could be considered would be extending veterans' benefits to more dependents. If a veteran is uninsured and lacks health care options, his or her family is also likely to be uninsured and without adequate health care.

Once a benefit has been established, it can be difficult to change the cost-sharing requirements. As new benefits are added, however, an opportunity exists to determine to what extent the government and the veteran will share the cost of the added benefits.

Because of the limitations on coverage of routine outpatient services, VA's health care safety net is structured more like a catastrophic health insurance plan than comprehensive health insurance. Most veterans are responsible for paying for routine health care services not needed to obviate the need for hospital care. For veterans with other public or private insurance, this limitation likely has a minimal effect on their use of health care services. But low-income veterans without public or private insurance must either use their own funds to obtain routine health care services or forgo needed care. An important issue, then, in considering eligibility reform is whether changes need to be made in VA's safety net mission.

Veterans frequently have unmet needs for nursing home and other long-term care services. Medicare and most private health insurance cover only short-term, post-acute nursing home, and home health care. Although private long-term care insurance is a growing market, the high cost of policies places such coverage out of the reach of many veterans. As a result, most veterans must pay for long-term nursing home and home care services out of pocket until they spend down most of their income and assets on health care and qualify for Medicaid. Although VA has a nursing home benefit, it is a discretionary benefit for all veterans. Should changes be made in the nursing home benefit to enable VA to meet the long-term care needs of more veterans?

Because of the overlapping populations, changes in one health care program can have a significant effect on demand for care under other programs. For example, expanded availability of private health insurance would likely decrease demand for VA health care.[21] Similarly, changes in the Medicare program, such as those proposed by some in the Congress, could affect future demand for VA health care services, although it is unclear whether they would increase or decrease demand for VA care. To what extent should changes in other health care programs affect the design of VA eligibility reforms?

These issues are discussed in more detail in appendix I.

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

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 services or guarantee that services are covered. 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:

- Veterans are often uncertain about which 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 difficult 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.

Designing solutions to these problems will require both administrative and legislative actions. VA and the Congress will face many difficult choices. For example, in designing legislative solutions, decisions will need to be made on whether the availability of services should be guaranteed for one or more groups of veterans and whether a defined benefit package should be developed.

Veterans Uncertain About Which Services Are Covered

Because public and private insurance policies generally have a defined benefit package, both policyholders and providers generally know in advance which services are covered and what limitations apply to the availability of services. Defined benefit packages also preserve insurers' flexibility by permitting them to trade benefits against program costs. For example, by eliminating certain benefits (such as dental care or prescription drugs), an insurer can restrain the growth in premiums. An insurer can also offer multiple policies with varying benefits, but individuals with the same policy have the same benefits.

Like private insurance, VA essentially offers multiple health benefits "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 veterans with service-connected disabilities rated at 50 percent or higher—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 because there is no apparent need for hospital-related care.

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

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. The VA system limits veterans' access to covered services (that is, it rations care to certain veterans), rather than narrowing the scope of services offered to all veterans in the same coverage group.

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 only the types of medical services that cannot be provided on an outpatient basis. Except for service-connected disabilities, VA outpatient clinics generally cannot provide, for example,

- 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 treatment started while in a VA hospital; and

- routine prenatal care and delivery services.

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 on a daily basis—VA physicians and administrative staff—express similar frustration in attempting to interpret the provisions. Although the criterion limiting outpatient services to those needed 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 provided limited guidance to its facilities on how to interpret 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.[22] 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 depends greatly on which medical center he or she 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

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

". . . 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 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 eligibility rules apply to care for service-connected and nonservice-connected disabilities;
- 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;
- 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; and
- determine whether the veteran's medical condition may have been related to exposure to toxic substances or environmental hazards during service in Desert Storm or Vietnam, in which case care may be provided without regard to other eligibility provisions.

Availability of VA Health Care Is Uncertain

Under private health insurance, Medicare, and Medicaid, the coverage of 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. Medicare is authorized to spend as much as necessary to pay for covered services, creating guaranteed access to covered services. Under private health insurance, policyholders are essentially guaranteed coverage of medically necessary services under their benefit package. In other words, under both Medicare and private insurance, the insurer—either the government in the case of Medicare or an insurance

company in the case of private health insurance—assumes the financial risk for paying for covered services.

Under the VA health care system, however, the government does not assume the same degree of financial risk for providing covered services. Being in the mandatory care category for VA health care services does not entitle veterans to, or guarantee coverage 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 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 up to the amount the Congress has authorized to be spent. 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 as well as most of those in the discretionary care categories. Rationing of health care has occurred when individual facilities or programs run short of funds because of unanticipated demand, inefficient operations, or inequitable resource allocation.

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.[23]

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 treated similarly. 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.

A recent VA survey of its medical centers found that 6 of 162 facilities had either turned away or provided only a single limited treatment to category A (mandatory care) veterans who needed hospital care. The survey also found that 22 VA outpatient clinics had denied treatment or provided only a single treatment to category A veterans.

Restrictions on VA's Authority to Sell Noncovered Services Makes Eligibility Decisions More Difficult

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 patients 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.

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

Although VA health care facilities are in general restricted to use by veterans, VA actually has greater authority to sell health care services to, for example, medical school hospitals serving nonveterans through sharing agreements than it does to sell the same services directly 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 the veterans (1) have public or private health insurance that would pay for the care or (2) agree to pay for the services out of their own funds.

By contrast, VA hospitals and clinics can share or sell any available health care service to (1) other federal health care facilities and (2) CHAMPUS beneficiaries. VA facilities can also share with federal and nonfederal hospitals, clinics, and medical schools, but such sharing is limited primarily to sharing of specialized medical resources. VA has no authority to sell these or other health care services directly to nonveterans.

VA's inability to sell noncovered health care services to veterans makes eligibility decisions more difficult. For private sector providers, a determination of eligibility under public or private health insurance is essentially a determination of the source of payment; if the service is not covered under the patient's insurance, the physician can still provide the service and bill the patient. But for VA physicians, a determination that a service is not covered under a veteran's health benefits means that the patient must be denied care. Even if the patient has private health insurance that would pay for the care or is willing to purchase the service, VA physicians are not allowed to provide noncovered services. This puts the physician in the difficult position of examining veterans to identify their need for health care but then turning them away without providing needed health care services if the service is not one the veteran is eligible to receive from VA.

Some Veterans Forgo Care When Turned Away From VA Facilities

In a 1993 review, we examined veterans' efforts to obtain care from alternative sources when VA medical centers did not provide it.[24] 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.

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

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.

Solving Problems Will Require a Combination of Administrative and Legislative Actions

Developing solutions to the problems discussed in this chapter will require both administrative and legislative actions. Several approaches could be used to improve veterans' equity of access to VA health care services without legislation. First, VA could better define the conditions under which the provision of outpatient care would obviate the need for hospitalization. Such action would help promote consistent application of eligibility restrictions, but VA physicians would still be placed in the difficult position of having to deny needed health care services to veterans when treatment of their conditions would not obviate the need for hospitalization. This part of the problem can be addressed only through legislative action to (1) make veterans eligible for the full range of outpatient services or (2) authorize VA to sell noncovered services to veterans.

A second approach VA could take to reduce inconsistencies in veterans' access to care would be to better match veterans integrated service networks' (VISN),[25] and individual medical centers', resources with the volume and demographic makeup of eligible veterans requesting services at each center. A third approach to improving equity of access would be to place greater emphasis on use of the fee-basis program to equalize access for those veterans with service-connected disabilities who do not live near a VA facility or who live near a facility offering limited services.

Solutions to some of the eligibility-related problems would, however, require changes in law. For example, legislation would be needed before VA could (1) sell noncovered services to veterans, (2) provide prostheses and equipment to most veterans on an outpatient basis, (3) admit veterans with no service-connected disabilities directly to community nursing homes, (4) develop uniform benefit packages, or (5) provide routine prenatal and maternity care.

An important part of the decision about the nation's commitment to its veterans is the extent to which VA health care benefits are "earned"

[25]VISNs are groups of medical centers serving a particular geographic area.

benefits, which the government should have a legal obligation to provide. Currently, the provision of VA health care services, even for treatment of service-connected disabilities, is discretionary.

Guaranteed benefits would have important advantages for veterans. For example, veterans with guaranteed benefits would no longer face the uncertainty about whether health care services will be available when they need them. Guaranteed funding, however, could significantly increase government spending unless limits are placed on the number of veterans covered by the entitlement.

One way to control the increase in workload likely to be generated by eligibility expansions is to develop a defined benefit package patterned after public and private health insurance. This could be used to trade off services veterans obtain from VA against the level of funding available. VA could adjust the benefit package periodically on the basis of the availability of resources.

The significance of VA eligibility restrictions could be lessened if legislation was enacted authorizing VA to sell to veterans those health care services not covered under their veterans' health benefits. With enactment of such legislation, VA physicians would no longer be placed in the difficult position of having to deny needed health care services to veterans when not covered under their health benefits package. Instead, physicians, or administrative staff, would decide whether the veteran would be expected to pay for the service.

Eligibility reform would address some but not most veterans' unmet health care needs. This is because many of the problems veterans face in obtaining health care services appear to relate to distance from a VA facility or the availability of the specialized services they need rather than to their eligibility to receive those services from VA. Legislation to expand VA's authority to purchase care from private sector providers would be needed to address unmet needs created by geographic inaccessibility.

These issues, including advantages and disadvantages of alternate approaches where appropriate, are addressed in more detail in appendix II.

VA Provides Services That Veterans May Not Be Eligible to Receive

VA may be spending billions of dollars providing health care services to veterans not eligible for the services provided. VA officials estimate that 20 percent of the patients treated in their hospitals do not need hospital care but would not be eligible to receive the services they are provided on an outpatient basis. In addition, VA's OIG estimated that from $321 million to $831 million of the money VA spent on outpatient care in fiscal year 1992 was used to provide veterans outpatient services that they were not eligible to receive.

VA cites a series of studies to support its view that 20 percent of VA hospital patients were admitted to circumvent restrictions on their eligibility to receive needed health care services on an outpatient basis. Our review of the studies, however, revealed that they do not contain the types of data needed to link nonacute admissions (meaning the patients did not need to be admitted to the hospital) to eligibility restrictions. The studies, and reviews conducted by the OIG, suggest that most of the nonacute admissions were the result of inefficiencies in VA facilities and conservative physician practice patterns.

If most nonacute admissions are caused by inefficiencies rather than ineligible treatments, then changes in the law to expand eligibility would probably not significantly reduce nonacute admissions to VA hospitals. VA's announced plans to implement a preadmission certification program, if the program is effectively implemented, could essentially eliminate nonacute admissions with or without eligibility reform. As a result, it has important implications for veterans. If 20 percent of VA's hospital patients would not be eligible to receive needed health care services on an outpatient basis, then a preadmission certification program that denies admission of patients not needing a hospital level of care could result in significant unmet health care needs. On the other hand, if treatment of most of the patients on an outpatient basis would obviate the need for hospital care, then the certification program would reduce costs without creating unmet needs.

Veterans Admitted to VA Hospitals Do Not Circumvent Restrictions on Outpatient Eligibility

VA studies issued in 1991 and 1993 found that over 40 percent of the admissions to VA acute care hospitals could have been avoided if the patients had been treated on an outpatient basis. VA officials contend that these studies show that remaining restrictions on veterans' eligibility for outpatient care are causing inappropriate hospitalizations. In addition, VA officials cite anecdotes to suggest that its hospitals are admitting patients who do not need hospital care in order to give them crutches and

eyeglasses they are not eligible to receive on an outpatient basis. They estimate that 20 percent of all VA hospitalizations could be avoided if eligibility were expanded to give all veterans coverage of comprehensive outpatient care. Our review, however, found little basis for linking most inappropriate hospitalizations to VA eligibility provisions.

A 1991 VA-funded study of admissions to VA acute medical and surgical bed sections estimated that 43 percent (+/- 3 percent) of admissions were nonacute. Nonacute admissions in the 50 randomly selected VA hospitals ranged from 25 to 72 percent. 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.

VA officials believe that 20 percent of veterans admitted to VA hospitals are admitted to provide them services that they are not eligible to receive on an outpatient basis. In addition, they believe that veterans admitted to VA hospitals to circumvent outpatient eligibility restrictions are kept in the hospital an average of 7 days. In other words, VA estimates that it is spending over $750 million dollars a year to provide noncovered outpatient services to veterans on an inpatient basis.

We believe that VA overestimates the extent to which it provides noncovered services to veterans on an inpatient basis to circumvent the law. Linking the problems identified in the studies to eligibility restrictions is problematic because the studies did not contain the types of data needed to make such a link. Specifically, the studies did not ascertain the eligibility category of the veterans. For example, the studies did not determine whether the patients inappropriately admitted to VA hospitals had service-connected or nonservice-connected disabilities, the degree of any service-connected disability, 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 eligible for only hospital-related outpatient services than for those eligible for comprehensive outpatient services.[26]

[26]This is a limitation in how the studies can be used, not a deficiency in how the studies were conducted.

The studies point more toward inefficiency, conservative physician practice patterns, and the slow development of ambulatory care alternatives as the primary causes of nonacute admissions. Our evaluation of the studies and VA's efforts to link their findings to the need for eligibility reform are discussed in more detail in appendix V.

Similarly, while the anecdotes VA cites, such as one about a veteran admitted to a VA hospital in order to get a pair of crutches, 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.

In a May 10, 1996, letter to the Ranking Minority Member of the Senate Committee on Veterans' Affairs, the Veterans Health Administration (VHA) said that all nonacute admissions are not the result of eligibility limitations but that such limitations have been the precursor explanation influencing many of the more specific clinical reasons documented in the medical records. VHA said that VHA has very conservatively estimated that less than half of the totally nonacute admissions can be attributed to the need for eligibility reforms and thus could be shifted to alternative levels of care.

VHA's estimate of nonacute admissions attributable to eligibility restrictions is not conservative because VHA assumed that 20 percent of all admissions would be shifted to outpatient settings, including admissions

- to long-term psychiatric and intermediate care units, when the studies address only acute medical and surgical care; and
- for veterans currently eligible for comprehensive outpatient services (veterans with service-connected disabilities rated at 50 percent or higher, former prisoners of war, World War I veterans, and veterans receiving a pension with aid and attendance).

To shift the number of patients VA assumed would be shifted to outpatient settings from only acute medical and surgical wards, and from only veterans not already eligible for comprehensive outpatient care, would require that VA shift over 30 percent of acute medical and surgical admissions.

Studies Show Continuing Problems in Enforcement of Outpatient Eligibility

Studies by the VA OIG show problems in VA's enforcement of eligibility provisions for outpatient care that have continued for over 12 years. VA has yet to initiate action to strengthen enforcement of its eligibility requirements, stating that rather than enforce current requirements, it would seek eligibility reforms that would make the provision of the services legal.

In a 1983 review at nine VA medical centers, the OIG found treatment of ineligible veterans ranging from 7.2 percent to 26.8 percent of outpatient visits.[27] The study evaluated only determinations of whether outpatient care provided to veterans with nonservice-connected disabilities was necessary to obviate the need for hospital care or reasonably necessary to complete hospital care for which the veteran was eligible. Although medical center directors generally agreed with the findings and promised corrective actions, the OIG, in subsequent reviews completed in 1991 through 1992, identified a continued and possibly growing problem. For example, the OIG found the following:

- About 24 percent of the outpatient visits reviewed at the Muskogee, Oklahoma, medical center were provided to veterans not eligible for the care provided. The OIG reviewed a random sample of visits provided to veterans with service-connected disabilities rated at 20 percent or lower and veterans with no service-connected disabilities who were not receiving VA pension benefits.[28]
- About 37 percent of the outpatient visits reviewed at the Fort Lyon, Colorado, medical center were determined to be ineligible for the outpatient services provided. The OIG found that the medical center did not have an effective system to ensure that eligibility certifications were complete and current.[29]
- About 38 percent of the outpatient visits reviewed at the Denver medical center were for treatments for which the veteran was not eligible. The OIG found veterans with nonservice-connected disabilities whose outpatient treatment (1) was not discontinued after their conditions became stable, (2) was for conditions unrelated to the condition for which they were

[27]Audit of Outpatient Eligibility for Treatment, VA OIG, Report No. 3AR-A02-140 (Washington, D.C.: VA, Sept. 28, 1983).

[28]Audit of Selected Activities, Department of Veterans Affairs Medical Center, Muskogee, Oklahoma, Report No. 3R6-A99-053 (Washington, D.C.: VA, Feb. 19, 1993).

[29]Audit of VA Medical Center, Fort Lyon, Colorado, VA OIG, Report No. 1R5-F03-026 (Washington, D.C.: VA, Jan. 23, 1991).

hospitalized, and (3) was not needed to obviate the need for immediate hospitalization.[30]

In a review of the Allen Park, Michigan, medical center, the OIG found that the outpatient clinic was incorrectly reporting discretionary care patients as mandatory care patients.[31] The OIG estimated that about one-half of the patients and one-third of outpatient visits were provided to veterans in the discretionary care category. Further, the OIG estimated that more than 50 percent of the visits provided to veterans in the discretionary care category were provided for ineligible conditions. The OIG estimated that from $321 million to $831 million of the $1 billion to $1.5 billion VA spent on discretionary outpatient care in fiscal year 1992 may have been for ineligible outpatient treatments.

As of April 1996, VHA had not issued guidelines to ensure that outpatient visits are properly reported in accordance with outpatient eligibility criteria.

In a March 1992 report, the OIG concluded that the VHA had not effectively disseminated criteria to physicians or other clinicians addressing when outpatient treatment is needed to obviate the need for hospitalization.[32] The report noted that

". . . VHA has never requested a legal opinion of the meaning or intent of the language. Also, we are unaware of any attempt by VHA to define the term in its own program guides or other instructions to clinical staff. Instead, VHA's practice has been to allow each clinician to interpret its meaning and application for each individual patient. In practice, we found the concept is either ignored or perfunctorily applied to every treatment provided to every patient."

The OIG recommended that VHA develop regulations that address the conditions and circumstances under which outpatient treatment may be provided to obviate the need for hospitalization. VHA did not concur with the recommendation and stated that

"The phrase 'obviate the need for hospital care' is, however, a very difficult, if not impossible concept to define and to apply at the clinical level. It is one of the major

[30]Audit of VA Medical Center, Denver, Colorado, VA OIG, Report No. 1R5-F03-050 (Washington, D.C.: VA, Apr. 5, 1991).

[31]Audit of the Outpatient Provisions of Public Law 100-322, VA OIG, Report No. 2AB-A02-059 (Washington, D.C.: VA, Mar. 31, 1992).

[32]VA OIG, Report No. 2AB-A02-059 (Washington, D.C.: VA, Mar. 31, 1992).

problems clinicians face in attempting to determine eligibility for treatment. Often, conditions which appear stable and chronic, will deteriorate and result in hospitalization if treatment is discontinued. The decision to obviate the need for hospital care is made on individual cases by the clinician caring for the patient . . . ."

The OIG report did not find the VHA arguments convincing, stating

"We do not believe there is a basis to conclude it is an 'impossible concept to define,' rather the absence of a definition creates a significant weakness in controls over VA's outpatient programs. Without a policy definition or other instructions to clinical staff, inconsistent application of criteria among facilities and clinicians is certain."

VHA officials said that they have no plans to further define the concept of obviating the need for hospital care. They said that the practice of medicine does not determine whether to treat patients on the basis of whether they would otherwise be hospitalized. VHA is focusing its efforts on legislation to expand outpatient eligibility rules to eliminate the obviate-the-need provisions and permit VA facilities to provide comprehensive health care services to all veterans. VA submitted such a legislative proposal to the Congress in September 1995.

In its May 10, 1996, letter, VHA said that VA's General Counsel found that VHA had defined the concept of obviating the need for hospitalization reasonably well in its guidance. VHA said that what GAO does not recognize, and has not assessed, is that applying the guidance at the clinical level does not automatically result in the type of consistency of application GAO seeks because of the complexities presented by each patient and the decisions of the clinicians providing the care.

We do recognize, and have assessed, the inconsistencies that result from application of the VA guidance at the clinical level. As discussed in chapter 3, we asked clinicians at 19 VA medical centers to make eligibility determinations of six veterans based on medical profiles developed from actual medical records. The interpretations ranged from permissive (care for any condition) to restrictive (care only for certain medical conditions). We agree with VHA that because of differences among patients and differences in the way doctors view patients, there will always be inconsistencies in how patients are treated. Clearer guidance, however, should help reduce the level of inconsistency.

VHA also said that while documentation may have been lacking to demonstrate that the care provided was consistent with the guidance, it

should not be assumed on the basis of the OIG study that the care is neither appropriate nor advisable, nor that it was not necessary to obviate the need for hospitalization. The results of the OIG's study of one facility should not, VHA said, be extrapolated to the system.

The OIG's report actually discussed problems at two facilities—the Allen Park medical center and the Columbus, Ohio, outpatient clinic. The Allen Park facility was, the OIG report notes,

"selected as the review site in consultation with VHA program officials because it was considered to be a typical outpatient environment in an urban tertiary care facility."

In addition, the report found lax enforcement of eligibility provisions at many other medical centers as described previously. One of the recommendations in the report was that VHA conduct reviews of each facility's outpatient workload in order to identify the proportion of visits properly classified as mandatory, discretionary, and ineligible using the definitions relevant to current law. VHA, however, was apparently unwilling to conduct such reviews, which might potentially have disproved the OIG's findings or shown the problems to be isolated to a few facilities. As of June 1996, VHA had not conducted the reviews.

Issues Need to Be Addressed Concerning Enforcement of VA Eligibility

Many issues need to be addressed in strengthening enforcement of VA eligibility provisions. Strict enforcement of VA eligibility requirements, or VA's planned implementation of a preadmission certification program, could increase veterans' unmet health care needs. Enforcement of existing eligibility rules, with VHA's interpretation of the obviate-the-need criterion, would force many veterans to seek routine outpatient care outside the VA system or forgo needed health care. Similarly, to the extent that VA hospitals admit veterans in order to provide health care services the veterans are not eligible to receive as outpatients, then preadmission certification procedures to prevent admission of patients who do not need a hospital level of care could increase unmet needs.

The VA health care benefit was not designed to meet all of the health care needs of most veterans. Under current law, VA is intended to provide comprehensive health care services primarily to veterans with service-connected disabilities rated at 50 percent or higher. Other veterans must find health care services from other sources when the needed services exceed the limits of their VA eligibility or if VA lacks the resources to provide covered services.

Unlike private sector providers, VA facilities are not financially at risk for inappropriate admissions, unnecessary days of care, and treatment of ineligible beneficiaries. Private sector health care providers are facing increasing pressures both from private health insurers and public health benefits programs such as Medicare and Medicaid to eliminate inappropriate hospitalizations and reduce hospital lengths of stay. For example, private health insurers increasingly use preadmission screening to ensure the medical necessity of hospital admissions and set limits on approved lengths of stay for their policyholders. While private sector hospitals are not prevented from admitting patients without an insurer's authorization, the hospital and the patient, rather than the insurer, become financially responsible for the care.

Significant savings can accrue from shifting a sizable portion of VA's inpatient workload to other settings if entire wards or facilities are closed. Current eligibility provisions do not, however, appear to prevent VA from shifting much of its current workload to ambulatory care settings through administrative actions. Twice before, in 1960 and 1973, the Congress expanded VA outpatient eligibility for the express purpose of reducing inappropriate admissions to and unnecessary days of care in VA hospitals.

In 1960, the Congress enacted Public Law 86-639 authorizing provision of outpatient care to veterans with nonservice-connected conditions if such care was needed in preparation for or as a follow-up to hospital care. VA hospitals are still not effectively using this authority more than 30 years after the enactment of this law. Among the primary reasons for nonacute days of care identified in the studies discussed in this chapter are premature admission of patients and delayed discharge of patients who could have been treated as outpatients.

Issues related to the enforcement of VA eligibility requirements and the potential effects of eligibility expansions on nonacute admissions to VA hospitals are discussed in more detail in appendix III.

Increased Demand Generated by Eligibility Reform Could Cause Extensive Rationing Unless VA Appropriations Are Increased

Each of the eligibility reform proposals developed during the past year would make VA benefits easier to understand and administer.[33] Four of the proposals would retain the discretionary funding of VA health care but would expand the number of veterans eligible for comprehensive VA outpatient services from about 465,000 to over 26 million. Such expansions are likely to generate significant new demand for VA care. If appropriations are not increased to satisfy the increased demand, VA faces the prospect of extensive rationing, including turning away many current users. The fifth proposal, developed by the American Legion, would avert the potential for increased rationing by converting veterans' health benefits into a true entitlement for about 9 million to 11 million veterans, potentially adding billions of dollars to VA appropriations. Other veterans, and veterans' dependents, would be allowed to buy into VA managed care plans.

Our work identified a number of issues concerning the potential effect of the eligibility reform proposals on demand for VA health care services. For example, to what extent would increased demand for outpatient services result in corresponding increases in demand for hospital and nursing home care? Similarly, would VA efforts to improve customer service and make VA care more accessible to veterans further increase demand?

House Veterans' Affairs Committee Bill Would Provide Most Modest Eligibility Expansion

Although each of the five eligibility reform proposals would significantly expand eligibility for VA health care, the House Veterans' Affairs Committee bill would provide the most modest expansion. Table 5.1 compares the key provisions of the five proposals.

[33]A sixth proposal, being developed by the Senate Committee on Veterans' Affairs, would eliminate the current distinction between "hospital care" and "outpatient care." Under the proposal, which the Committee expects to introduce in September 1996, VA would be authorized to provide eligible veterans with "health care." In addition, the proposal, drafted by the Committee on July 24, 1996, would (1) regulate access to care through an enrollment system limiting the number of veterans enrolled to those who can be treated with available resources; (2) establish priorities for enrollment; and (3) limit the increase in the VA medical care authorization to the percentage change in the cost of living for each year.

Table 5.1: Key Provisions of Proposals to Reform VA Eligibility

	Proposal (sponsor)				
Key provisions	**S. 1345 (VA)**	**S. 1563 (VSO)**	**H.R. 1385 (Montgomery/ Edwards)**	**H.R. 3118 (House Veterans' Affairs)**	**American Legion**
Expands the number of veterans in the mandatory care category	X	X	X	X	X
Creates an entitlement to VA care; guarantees availability of care					X
Creates a uniform benefit package					X
Eliminates obviate-the-need provision	X	X	X	X	X
Reforms health care contracting provisions	X			X	X

Following are other major provisions of eligibility reform proposals:

- **S. 1345 (VA)** (1) expands the definition of covered services to include virtually any necessary inpatient or outpatient care, drugs, supplies, or appliances and (2) allows VA to retain a portion of third-party recoveries.
- **S. 1563 (VSO)** (1) includes nursing home care as mandatory service; (2) provides that the mandatory care category would include catastrophically disabled veterans; (3) allows adult dependents to become eligible for VA care, provided they reimburse VA; and (4) allows VA to bill and retain collections from Medicare.
- **H.R. 1385 (Montgomery/Edwards)** (1) requires VA to provide veterans similar access regardless of their home state, (2) allows VA to use a system of enrollment and priorities for care, and (3) allows VA to retain a portion of third-party recoveries to expand outpatient care.
- **H.R. 3118 (House Veterans' Affairs)** (1) requires VA to establish a system of annual enrollment based on priorities for care, and (2) creates a new category of priority for catastrophically disabled veterans.
- **American Legion proposal** (1) funds VA appropriations on a capitated basis; (2) establishes separate benefit packages for basic, supplemental, and specialized services; (3) allows VA to bill and retain payments from Medicare, Medicaid, the Federal Employees' Health Benefits Program, and private insurers; (4) allows dependents to enroll in VA health plans; (5) exempts VA from federal procurement laws; (6) deems VA to be a qualified provider under federal and state health programs; and (7) allows

VA to preempt state and local regulations relating to health insurance or plans.

Appendix VI contains a more detailed summary of each proposal.

H.R. 3118 would, like the other proposals, expand eligibility for comprehensive outpatient services to all veterans. It contains provisions, however, intended to make it easier for VA and the Congress to ration care. Specifically, the bill does the following:

- Expressly states that the availability of health care services for veterans in the mandatory care category is limited by the amounts appropriated in advance by the Congress (S. 1345 also contains this provision). Although services for mandatory care category veterans are currently subject to the availability of resources, such services are frequently viewed as an entitlement. The language of H.R. 3118 and S. 1345 would make it clear that mandatory care category veterans do not have an entitlement to VA care.
- Removes about 1.2 million veterans with noncompensable service-connected disabilities from the mandatory care category. H.R. 1385 would also shift such veterans from the mandatory to discretionary care category. By contrast, S. 1345 would move veterans with noncompensable service-connected disabilities to a higher priority within the mandatory care category than most low-income veterans with no service-connected disabilities.
- Requires VA to establish an enrollment process as a means for managing demand within available resources. Veterans with disabilities rated at 30 percent or higher would have the highest priority for enrollment. A similar enrollment process would be optional under H.R. 1385.
- Allows VA to determine the extent to which eyeglasses and hearing aids would be covered and limits the provision of prosthetics to veterans under VA care. Other than the American Legion proposal, which would require enrollment, the other bills would essentially remove all restrictions on provision of prosthetics on an outpatient basis, allowing veterans to come to VA for the sole purpose of having a prescription for eyeglasses or hearing aids filled.

Proposals Would Make Benefits Easier to Administer and Understand, but Other Problems Would Continue

Each of the five proposals would make VA health care benefits easier to administer and understand by eliminating the obviate-the-need criterion for accessing outpatient care. The proposals generally do not, however, address the other provisions in current law that contribute to inappropriate use of VA health care resources and uneven access to health care services.

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.

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

- Four of the proposals would retain the discretionary funding of VA health care. The American Legion proposal would create new funding mechanisms resulting in guaranteed benefits.
- Under the four bills that would retain the discretionary funding of VA health care services, VA would continue to be unable to provide noncovered services directly to veterans. Because all veterans would become eligible for comprehensive outpatient services, there would, however, be fewer noncovered services. If adequate funds are not appropriated to allow VA facilities to serve all veterans seeking care, veterans turned away could not use their insurance or other resources to buy care from VA.
- Current restrictions on provision of dental care would not be changed under any of the proposals. Restrictions on the provision of prenatal and maternity care would be removed only under the American Legion proposal.
- S. 1345 and the American Legion proposal would remove the restriction on direct admission of veterans with no service-connected disabilities to community nursing homes. The other bills would not, however, remove this restriction.
- Of the four proposals that would retain discretionary funding of VA health care, 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. These problems could, however, be addressed through the expanded contracting authority VA would be given under S. 1345 and H.R. 3118. The American Legion proposal contains specific provisions intended to make the availability of services more equitable. In addition, the American Legion proposal would force VA to address the uneven availability of services through the use of contracting because benefits would be guaranteed.

Exempting VA From Contracting and Personnel Laws and Regulations Would Create Significant Risks

The American Legion proposal to grant VA exemptions to most federal contracting and personnel laws and regulations and deem VA facilities to be qualified providers under both federal and state health programs could create significant risks. Specifically, the American Legion proposal would

- deem a VA health plan or facility to be a qualified provider or carrier under a federally administered health care program, including Medicare, Medicaid, CHAMPUS, the Indian Health Service, and the Federal Employees Health Benefits Program;
- authorize VA to plan and implement administrative reorganization, consolidation, elimination, or redistribution of offices, facilities, functions, or activities notwithstanding any other provision of law;
- allow VA to enter into agreements with non-VA health care plans, insurers, health care providers, health care professionals, health care facilities, medical equipment suppliers, and related entities notwithstanding any law or regulation pertaining to competitive procedures, acquisition procedures or policies, source preferences or priorities, or bid protests;
- preempt and supersede any state or local law or regulation that relates to health insurance or health plans to the extent such law or regulation is inconsistent with provisions of the VA law; and
- require that a VA plan be considered a qualified provider or carrier under any state health care reform plan, law, or regulation.

Reducing contracting requirements heightens the potential for fraud and abuse. VA has a long history of problems in administering contracts and sharing agreements. Because VA medical centers' senior managers often receive part-time employment incomes from medical schools that receive millions of dollars through VA contracts, conflicts of interest could arise.

The expanded contracting envisioned under the American Legion proposal would greatly increase the potential for conflicts of interest.

In addition to exemptions from general contracting requirements, VA health plans would be exempt from specific requirements relating to risk contracting, such as those that apply to Medicare health maintenance organizations (HMO). Because VA has little experience in risk contracting, such exemptions might heighten the potential for fraud and abuse and could affect veterans' access to needed medical services.

VA facilities and health plans would also not be accountable to Medicare or other federal, state, or local health plans because of their deemed status. Other programs would have little recourse against VA health plans and facilities if they failed to enforce program safeguards.

Eligibility Expansions Likely to Generate Increased Demand

The five reform proposals 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.

Under the four bills that would retain the discretionary nature of VA funding, 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. Similarly, under the American Legion proposal, about 9 million to 11 million veterans with service-connected disabilities would become entitled to free VA health care services.[34] The American Legion proposal would make veterans with service-connected disabilities rated at 50 percent or higher entitled to any needed health care service included in the comprehensive and supplemental care packages; other veterans currently in the mandatory care group for hospital care, with the exception of those with noncompensable service-connected disabilities, would be entitled to the basic benefit package for free. Two additional groups of veterans would become entitled to the basic benefit package: veterans with catastrophic illnesses that render them destitute and veterans proven uninsurable in the private market.

Increased demand would likely come from both increased use of VA services by current users unable to obtain all of the health care services

[34]Under the American Legion proposal, veterans other than those with service-connected disabilities and veterans' dependents would also be eligible to purchase care from VA health plans, but appropriated funds would no longer be used to pay for their care.

they need from VA and from veterans seeking VA services for the first time. 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 most 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.[35] 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 five proposals would also eliminate the restriction on provision of other prosthetic devices, such as eyeglasses, contact lenses, and hearing aids. H.R. 3118 would, however, give the Secretary of Veterans Affairs the authority to restrict the provision of eyeglasses, contact lenses, and hearing aids.

A 1992 VA eligibility reform task force developed estimates of the changes in demand likely to be generated through several alternative approaches to eligibility reform. VA's task force estimated that if eligibility was reformed to make all current VA users (defined by the task force as veterans who had used VA in the past 2 years) eligible for the full continuum of VA health care services, then demand for outpatient care would increase by about 8.4 million visits annually. Similarly, expanding eligibility to all veterans would increase demand for outpatient care by about 32.8 million visits annually. The task force further estimated that demand for inpatient care would increase by 1.8 million patients treated, primarily because of demand generated by new users.

The methods VA used to develop its projections were reviewed by the Congressional Budget Office (CBO). CBO found VA's methods reasonable.

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 effect of eligibility reforms on demand for VA care will likely be heightened. As it

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

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.

VA's recent efforts to improve access by establishing separate access point clinics have attracted many new users.[36] As we reported in April 1996, 12 new access points operate in a variety of locations, including three areas that are more than 100 miles from a VA facility; six areas between 50 and 100 miles from a VA facility; and three areas less than 50 miles from a VA facility (including 1 access point located 8 miles from a VA medical center in a large urban area). Four clinics are operated by VA; the remaining eight are operated via contracts with county and private clinics. The clinics have been successful in attracting veterans who have not used VA health care for several years as well as veterans who have never used VA health care. Forty percent of the 5,000 veterans enrolled at the 12 clinics had not received VA care in the past 3 years—1 clinic served only new users.

Three proposals, S. 1345, H.R. 3118, and the American Legion proposal, would facilitate the expansion of access points by giving VA broader 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. More importantly, they would no longer be required to meet the cost-sharing requirements of Medicare and private health insurance.

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. These improvements also heighten the potential for increased demand to be generated through eligibility expansions.

[36]VA Health Care: Efforts to Improve Veterans' Access to Primary Care Services (GAO/T-HEHS-96-134, Apr. 24, 1996).

Expanding Eligibility While Constraining Budgetary Increases Could Result in Extensive Rationing

Expanding eligibility without providing adequate funds to pay for the expected increase in demand could significantly increase the number of veterans turned away from VA facilities. The four bills that would retain the discretionary funding of VA health care services would, however, provide little or no new revenue to offset the costs of increased demand. Expanding eligibility with a fixed or declining budget could give veterans false expectations of what services they can obtain from VA. In addition, many current users might be shut out of the VA system as veterans with higher priority increase their use of VA services.

Both the President and the House of Representatives propose declining VA medical care budgets after fiscal year 1997, although these budgets would increase slightly after the turn of the century. (See table 5.2.)

Table 5.2: Proposed VA Medical Care Budget Authority, 1996-2002

Proposal	1996	1997	1998	1999	2000	2001	2002
Administration	$16.9	$17.2	$16.2	$14.4	$13.0	$14.4	$16.5
House	16.9	17.3	16.8	15.4	15.2	15.3	16.7

Because low-income veterans would be the third or fourth highest priority for care, and the law does not differentiate between low-income veterans with and without other health care coverage, 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, uninsured veterans. For example, under the new definition of health care in VA's reform proposal (S. 1345), veterans in the top three priority categories would be in the mandatory care category for virtually any service other than nursing home care offered by VA. 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 for comprehensive outpatient services.[37]

Increased demand for routine health care services generated by these expansions could leave fewer resources available to pay for essential health care services for uninsured veterans. Only after the increased demand for nonservice-connected care generated by the 3 million veterans

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

VA proposes to add to the mandatory care category for free comprehensive outpatient services was met could VA use its resources to provide essential hospital and other services to low-income, uninsured veterans without service-connected disabilities. With steady or declining budgets it could be increasingly difficult for VA to fulfill its safety net mission after meeting the increased demand for care generated through eligibility expansions.

Although two bills (H.R. 3118 and H.R. 1385) propose establishing an enrollment process to help VA ration care if adequate funds are not appropriated to meet the increased demand likely to be generated by eligibility expansions, such a process would not protect VA's safety net mission. Only after veterans in the top three priority categories were enrolled for comprehensive health care services could low-income veterans with no public or private health insurance enroll. One VA official told us that she did not think VA would enroll veterans below the highest priority category under H.R. 3118—veterans with service-connected disabilities rated at 30 percent or higher. As a result, veterans with no health care options might no longer be able to use VA health care services, including the hospital-related services they now receive.

The four bills that retain discretionary funding of VA health care contain few new sources of revenues to offset the costs of eligibility expansions. The bills essentially assume that eligibility reform will not require new sources of revenue because the savings generated by shifting patients from inpatient to outpatient care would offset the costs of increased demand for outpatient care. Although we agree that savings can occur by shifting nonacute hospital admissions to outpatient settings, it is not clear that sufficient savings will occur to offset the potential increase in demand, especially if hospital beds emptied by shifts to outpatient care are filled with new users enticed to use VA by the eligibility expansion.

As discussed in chapter 3, problems in VA's methods for allocating resources to its facilities result in unequal access to VA health care services. Some facilities have adequate resources to treat veterans in both the mandatory and discretionary care categories while others are forced to ration care to veterans in the discretionary care category. Because most of the reform proposals do not address the uneven availability of VA services, the increased demand for care generated by eligibility expansions could heighten the problems VA already faces in trying to equitably distribute available resources.

Prospects of Extensive Rationing Would Create Pressure to Increase Appropriations

In the past, VA has been unable to provide the Congress the types of data on VA users that the Congress would need to make informed decisions on appropriate funding levels. The increased demands for care generated by the eligibility expansion proposals would put pressure on the Congress to appropriate the additional funds needed to avoid extensive rationing.

A 1992 VA eligibility reform task force estimated that, without resource constraints, expanding eligibility for comprehensive VA care could increase VA spending by about $38 billion per year. Although VA and CBO arrived at strikingly different conclusions about the budgetary effects of the current reform proposals, we find CBO's arguments about the potential costs of eligibility expansions more compelling because they incorporate the costs of meeting the potential increased demand predicted by VA's 1992 eligibility reform task force.

Controlling Budgetary Increases Would Be Difficult

Historically, the Congress has fully funded both VA's anticipated mandatory and discretionary workload. VA does not, however, provide the Congress data on the extent to which its resources are used to provide services to veterans in the mandatory and discretionary care categories for hospital and outpatient care in justifying its budget request. 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 difficult for the Congress to appropriate funds for the care of only a portion of the veterans in the mandatory care category. As a result, the Congress has little basis for determining which portion of VA's discretionary workload to fund.

Our work shows that a significant portion of appropriated funds are used to serve veterans in the discretionary care category. We matched VA's fiscal year 1990 treatment records against federal income tax records and found that about 15 percent of the veterans with no service-connected disabilities who used VA medical centers had incomes that placed them in the discretionary care category for both inpatient and outpatient care.[38] In a May 10, 1996, letter to the Ranking Minority Member, Senate Committee on Veterans' Affairs, VHA said that our estimate was either inaccurate or a very old estimate. According to VHA, only 4 percent of all veterans treated in 1994 were in the discretionary care category.

[38]VA Health Care: Verifying Veterans' Reported Income Could Generate Millions in Copayment Revenues (GAO/HRD-92-159, Sept. 15, 1992).

Our estimate more accurately reflects the extent to which care is provided to veterans in the discretionary care category. VHA's estimate is apparently based on unverified data provided by veterans when they apply for care; such data underestimate veterans' incomes. We developed our estimate through a match of VA treatment records and income tax data. Our match showed that VA may have incorrectly placed as many as 109,230 veterans in the mandatory care category in 1990. Tax records for these veterans showed they had incomes that should have placed them in the discretionary care category. We estimated that VA could have billed as much as $27 million for care provided to these veterans.

Although data from our study are now 6 years old, data from VA's own tax matches are yielding similar results. VA has now established its own income verification program. Its initial match found that about 18 percent of veterans with no service-connected conditions underreported their income. VA's matching agreement with the Internal Revenue Service indicates that VA expects its match of fiscal year 1996 treatment records against tax data to generate about $30.5 million in copayment collections for care provided to veterans who were incorrectly classified as mandatory care category veterans. Accordingly, our estimate—and VA's own data—show that about 15 percent of veterans with nonservice-connected disabilities using VA medical centers are in the discretionary care category for both inpatient and outpatient care.

VHA recently advised us that it cannot provide the Congress with information on the extent to which VA services are provided to veterans in the mandatory and discretionary care categories for inpatient and outpatient care. VHA advised us that VA does not have accounting systems in place that would allow VA to differentiate between mandatory and discretionary care. VHA said that developing the accounting systems capable of differentiating between the categories would be extremely difficult and may not be cost-effective.

Without such information, the Congress could find it difficult to set limits on VA appropriations. For example, it would not know whether the funds appropriated were adequate to meet the health care needs of all veterans with service-connected disabilities likely to seek VA care.

1992 VA Task Force Estimates Costs of Eligibility Reform

In March 1992, the Acting Secretary of Veterans Affairs established a task force to develop alternative proposals for reforming eligibility for VA health care. The task force developed four proposals, which ranged from

retaining current eligibility provisions to expanding eligibility to make all veterans eligible for a full continuum of services. Specifically, the four proposals were as follows:

- Alternative 1: Limit the system to current users with no eligibility reform.
- Alternative 2: Limit the system to current users with no eligibility reform, but implement managed care.
- Alternative 3: Limit the system to current users, but expand eligibility to cover the full continuum of services without budgetary constraints.
- Alternative 4: Expand eligibility to cover the full continuum of care for all veterans with no resource constraints.

The task force also developed cost estimates for each alternative, assuming both no budget offsets and different combinations of veteran cost sharing[39] and third-party recoveries from private insurers, Medicare, and Medicaid. The cost estimates ranged from $11.0 billion (alternative 3 with offsets) to $53.6 billion (alternative 4 with no offsets).[40] (See table 5.3.)

Table 5.3: VA Cost Estimates of Alternative Approaches to Eligibility Reform

	Estimated costs (in billions)	
Alternative	Without budget offset	With budget offset
1	$16.0	[a]
2	14.3	[a]
3	21.0	$11.0
4	53.6	27.5

[a]The task force did not consider offsets under approaches 1 and 2.

Source: VA Eligibility Reform Task Force draft report, Nov. 1992.

The task force noted that the cost increases would result more from the number of new users attracted to the VA health care system than from providing existing users the full continuum of care. Much of the cost increases, the task force notes, are for inpatient and outpatient care for new users.

[39]Veterans would be responsible for a copayment of 25 percent for all services except 50 percent for nursing home services and no copayment on social services.

[40]The task force reported to the Acting Secretary but never issued a final report.

VA's Current Estimate Is Based on Questionable Assumptions

Although its eligibility reform task force had developed detailed estimates of the increased demand and costs of reform options, VA developed a new formula for estimating the effects of eligibility reform as part of its National Performance Review efforts. Neither the original formula, nor the recent revision to it, adequately considered the increased demand for outpatient care likely to be generated by the proposed eligibility expansions. In addition, if VA had accurately applied its original formula and assumptions, it would have predicted an increase rather than a decrease in costs resulting from eligibility reform. VA made a number of other questionable assumptions in its calculations.

VHA originally developed what appears to be a complex formula for estimating the cost effects of eligibility reform on the basis of the overall assumption that eligibility reform would enable VA to divert 20 percent of its hospital patients to outpatient care.[41] The results from applying VHA's original formula were 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; how the average costs of treating patients remaining in VA hospitals after eligibility reform would be affected; and how eligibility reform would affect demand for outpatient care. The original formula could show either a decrease or increase in costs depending on the assumptions made.

VA did not include a key portion of the original formula—a 10-percent increase in the costs of treating those patients remaining in VA hospitals after eligibility reform—in its calculations and, therefore, reported that its analysis showed that eligibility reform would result in savings of about $268 million. Including that portion of the formula in the calculation results in the claimed savings becoming a cost increase of $51 million.

VA subsequently revised its formula to delete the adjustment for the costs of treating those patients remaining in the hospital. As a result of this change, whatever assumptions are made about the percentage of care shifted and the average days of hospital care avoided, the formula will result in net savings. Even under the assumption that no inpatients are transferred to outpatient care, the formula shows that expanding eligibility would result in savings of about $39 million. What appeared on the surface to be a formula taking many factors into account is, in its current form, actually a simple calculation—eligibility reform will save 30 percent of the

[41]VA assumed that 5 percent of admissions would be shifted to the outpatient setting during the first year after eligibility reforms were implemented and an additional 15 percent would be shifted the following year.

costs of inpatient care shifted to outpatient settings plus 10 percent of the total costs of fee-basis and travel reimbursements. The formula includes no adjustments for increased demand for outpatient care by veterans other than those shifted from inpatient to outpatient care.

VA's revised formula for estimating the cost effects of eligibility reform is also independent of the provisions of eligibility reform. In other words, it would yield the same result when applied to any of the five reform proposals or if changes were made in the proposals to increase or reduce the number of veterans in the mandatory care category. Specifically, it would yield the same savings estimate regardless of

- which benefits are included,
- whether and to what extent veterans are required to contribute toward the costs of the expanded benefits,
- the number of veterans placed in the mandatory and discretionary care categories, and
- whether veterans' health benefits remain discretionary or are made an entitlement.

Our specific concerns about VA's analysis are discussed in the following sections.

Formula Does Not Adequately Account for Increased Demand

The formula assumes that an increase in demand for outpatient care would not occur 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. 3118 were designed to give VA added flexibility by eliminating the obviate-the-need-for-hospitalization criterion, not to attract new users. VA's 1992 task force, however, estimated that most new demand would be generated through new users. Although headquarters officials anticipate few new users, some medical centers are already aggressively pursuing new users. As discussed earlier, about 40 percent of the veterans using VA access points had not used VA health care within the 3 years preceding their enrollment at the access point.

Adjustment for Higher Costs of Treating Remaining Patients Not Included in VA Calculations

Because the less sick patients would theoretically be shifted to outpatient care under eligibility reform, the costs of treating patients remaining in the hospital should increase. This is what happened when Medicare beneficiaries increased their use of outpatient surgery. When we initially met with VHA officials to discuss our concerns about their cost estimate, we were told that the formula included an adjustment for sicker inpatients

to account for these higher costs. The "Briefing Book on Eligibility Reform Proposals for Veterans Health Administration," provided to us by VA officials, included such an adjustment in the reinvestment formula and the stated assumption

> "[b]ecause less sick patients will be shifted to outpatient care, the remaining in-patients will be sicker and will have a 10% higher cost per admission . . . ."

VHA, however, did not include the calculation in its savings estimates. VHA officials indicated that they would provide an explanation for why the adjustment was not included in the calculations, but in later discussions, the VHA economist who applied the formula declined to provide an explanation for why the adjustment was not made. Including this adjustment in the original formula would have turned VHA's projected savings of $268 million into a cost increase of $51 million.

In a May 10, 1996, letter to the Ranking Minority Member of the Senate Committee on Veterans' Affairs, VHA said that GAO has consistently misunderstood that no change is taking place with the actual length of stay of the admissions not shifted. The patients with longer lengths of stay would remain as inpatients, but, according to VHA, neither their lengths of stay nor the costs of their care would increase.

Research has consistently shown that moving the least costly patients out of hospitals increases the average cost of caring for the patients who remain even though there is no change in an individual patient's length of stay or cost of care. This phenomenon occurs because removing a group of patients with shorter lengths of stay and fewer care needs (none of the patients VA envisions shifting needed hospital-related care) raises a hospital's average length of stay and average cost per discharge. The following example illustrates this.

A VA hospital treats two inpatients. Patient A has congestive heart failure and spends 7 days in the hospital. Treatment for this patient costs the hospital $10,000. Patient B is treated on an outpatient basis for a broken leg and then admitted to the hospital and provided a pair of crutches. Patient B stays in the hospital 1 day, and the cost of providing the care is $1,000. The average length of stay for the two patients was 4 days [(7 days + 1 day)/2 patients], and the average cost per day of care provided to the two patients was $1,375 [($10,000 + $1,000)/8 days].

If, following eligibility reform, patient B is provided crutches on an outpatient basis rather than being admitted to the hospital, the average length of stay and cost per day for the remaining patient(s) would increase. The hospital's average length of stay for the remaining patient would be 7 days (7 days/1 patient), and the average cost of treating the patient would be $1,429 a day ($10,000/7 days).

Other Concerns About VA's Assumptions and Calculations

Our review identified a number of other concerns about the reasonableness of VA's assumptions and calculations. The following paragraphs illustrate some of these concerns:

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.

It is possible to achieve savings by shifting inappropriate inpatient services to other settings. But, as discussed earlier in this report, current eligibility provisions are not a major contributor to inappropriate admissions, nor do those provisions prevent VA from shifting a significant portion of inappropriate inpatient services to ambulatory care settings. Actions such as the preadmission certification program previously discussed could, however, generate savings that could be used to offset some of the costs of eligibility reform.

VA applied the assumed 20-percent reduction in hospital admissions across all inpatient care, not just acute medical and surgical admissions. Although the studies VA cites as supporting its assumption that 20 percent of admissions could be shifted to outpatient care addressed only acute medical and surgical admissions, VA applied the 20-percent reduction to all inpatient care, including intermediate care and both acute and long-term psychiatric admissions. Such admissions account for over 25 percent of VA admissions. Applying the 20-percent reduction only to acute medical and surgical admissions would reduce projected savings. To maintain the total number of shifted admissions, VA would have to assume that more than 27 percent of acute medical and surgical admissions would be shifted under eligibility reform.

VA assumed a 10-percent savings in fee-basis costs. The fee-basis program is used to pay for outpatient care veterans obtain from private

sector providers when VA care is either not available or not convenient. Therefore, shifting veterans from VA hospital beds to outpatient settings should have no effect on current fee-basis use or costs.

VA claims the savings in fee-basis costs will result from establishment of access points. As of April 1996, VA operated 12 access points on a pilot basis, and it is too early to tell whether they will affect fee-basis costs. Moreover, because access points are attracting new users, they may increase rather than decrease VA's fee-basis costs. VA provides no other basis for estimating that eligibility reform will reduce fee-basis costs.

VA assumes that travel reimbursements will decline by 10 percent as a result of eligibility reform. VA indicates that travel reimbursements will decline because of the creation of access points. While travel reimbursements might decline for those veterans living near an access point, any such reduction would not result from eligibility reform. Under VA's assumption that veterans shifted from hospital care to outpatient care will receive an average of 17 additional outpatient visits, beneficiary travel could significantly increase rather than decrease. Rather than receiving travel reimbursement for one trip to the hospital, veterans qualifying for beneficiary travel would, under VA's assumptions, receive travel reimbursement for 17 outpatient visits.

Beneficiary travel includes (1) medically necessary ambulance travel; (2) medically necessary travel by wheelchair van, stretcher, or other means of special travel; (3) intrafacility travel; (4) travel for compensation and pension examinations; and (5) all other travel, which includes transportation by common carrier, bus, taxi, or privately owned vehicle.

Beneficiary travel is provided at the discretion of the Secretary of Veterans Affairs to certain types of veterans: (1) veterans with service-connected disabilities rated at 30 percent or higher; (2) veterans with service-connected disabilities of 20 percent or less for travel related to treatment of their service-connected disabilities; (3) veterans receiving a VA pension; (4) veterans traveling in connection with an examination for compensation or pension, or both; and (5) veterans whose income is less than or equal to the maximum VA pension rate with aid and attendance.

Most of the veterans eligible to receive beneficiary travel are already eligible to receive, on an outpatient basis, the care that qualifies them for travel reimbursement. For example, veterans with service-connected disabilities rated at 20 percent or less are in the mandatory care category

for outpatient treatments related to their service-connected disabilities, the only care for which they are eligible to receive travel reimbursement.

An average of 7 days of hospital care would be saved for every patient diverted to outpatient care. This assumption may not be 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. It appears that 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.[42]

In providing comments to the Ranking Minority Member, Senate Committee on Veterans' Affairs, on our March 20, 1996, testimony, VHA said that it has a sound basis for its assumption that the average length of stay for shifted admissions would be 7 days. VHA said that the same research that initiated the estimates of VA nonacute days of hospital stays also provided VA information on the average length of stay of the totally nonacute admissions included in the study. According to VHA, the research showed the average length of stay to be a little longer, not less, than 7 days. VHA said that VA's estimate of 7 days was also confirmed by preliminary current VA utilization management information.

However, the average length of stay for the totally nonacute admissions in the study cited was 5.5 days, not over 7 days. In addition, the average length of VA acute medical/surgical admissions in fiscal year 1986—the year studied—was slightly over 16 days. By fiscal year 1995, however, the average length of stay of VA acute medical/surgical patients had declined to 11.6 days, a 28-percent decline. VA's progress in reducing its average length of stay should also be considered in its assumptions. Finally, VA's 1992 eligibility reform task force estimated that 1- and 2-day admissions would be shifted to outpatient settings following eligibility reform.

Changing the assumption about average length of stay alters VA's savings estimates. Substituting 3 days for VA's assumption of a 7-day average

[42]VA's 1992 eligibility reform task force reached a similar conclusion. The task force assumed that short episodes of care (1 or 2 days) would be shifted to outpatient care.

length of stay would decrease VA's projected savings of $268 million from eligibility reform to about $137 million.[43]

CBO's Conclusions on Costs of Eligibility Reform

Last year, CBO estimated that the eligibility reform provisions contained in H.R. 3118 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.[44] 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 assumed 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.

On July 15, 1996, CBO provided the House Veterans' Affairs Committee a revised cost estimate for H.R. 3118, as reported by the Committee on May 8, 1996. Expanding eligibility for outpatient services would, CBO estimated, ultimately increase the cost of veterans' medical care by $3 billion a year, assuming appropriation of the necessary amounts. CBO

[43]VA correctly noted in its May 10, 1996, comments on our March 20, 1996, testimony that we had misinterpreted its formula in estimating the costs of outpatient care for shifted patients. We had assumed that the cost of treating a nonacute admission on an outpatient basis would be the same regardless of what assumption was made concerning how long, on average, the shifted admissions remained in the hospital. VA's formula assumes that the cost of treating a shifted admission on an outpatient basis is 70 percent of the inpatient costs for the average length of stay that is used. While this assumption appears questionable, we have adjusted the figures used in this report to apply the formula as VA intended. The formula tends to understate potential savings from shifting patients to outpatient settings as assumed lengths of stay increase.

[44]Washington, D.C.: VA, National Center for Veterans Analysis and Statistics, 1992.

noted that the bill would affect direct spending and is subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

In its July 18, 1996, report on H.R. 3118, the House Committee on Veterans' Affairs disagreed with CBO's cost estimate and estimated that the bill would be budget neutral for annual outlays in fiscal year 1996 and in each of the 5 following fiscal years.[45]

Further Evaluation of Potential Effects of Eligibility Reforms on Demand Are Needed

Eligibility reforms that would increase the number of veterans eligible for comprehensive outpatient services would likely generate new demand for outpatient care in three primary ways. First, current VA users are likely to seek previously noncovered services, such as preventative health care. Second, veterans who previously had not used VA because of its eligibility restrictions might begin using VA, particularly for those services not covered under their public or private health insurance. Third, some care might be shifted from inpatient to outpatient settings as patients admitted to circumvent eligibility restrictions are treated on an outpatient basis.

VA's 1992 Eligibility Reform Task Force conducted the most comprehensive study of the potential effects of eligibility reform, but it was not based on any of the current proposals. The current VA evaluation assesses only one of three ways eligibility reforms are likely to increase demand for outpatient care and is based on questionable assumptions.

Among the issues that could be considered in future analyses are the following:

- Increased demand could be lower than anticipated if VA facilities are currently circumventing the eligibility restrictions and providing noncovered services. As discussed in chapter 4, studies by VA's OIG found that VA outpatient clinics are providing significant numbers of noncovered services. This suggests that at least some current VA users may already receive comprehensive health care services from VA and, therefore, their use of VA services might not significantly increase under eligibility reforms that essentially make legal what is already happening in practice.
- Expanded outpatient eligibility could result in a corresponding increase in demand for hospital care. After removing 1- and 2-day hospital stays (assumed to be shifted to outpatient care), VA's 1992 eligibility reform task

[45]H.R. 104-690, 104th Cong., 2nd Sess. (1996).

force estimated that demand for inpatient care could nearly triple from 987,000 to about 2.8 million patients treated.

- Eligibility reform that would authorize direct admission of veterans with nonservice-connected disabilities to contract community nursing homes could increase demand. As VA moves patients from costly inpatient care to less intensive settings, demand for nursing home care is likely to increase. The increased demand for nursing home care could, however, be offset to some degree by greater use of home care and residential care for patients requiring less intensive treatment.
- Concurrent changes to make VA health care services more accessible to veterans could increase the potential effect of eligibility reform on outpatient, and, indirectly, on inpatient workload. 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 even without eligibility reform.
- Giving VA broader authority to contract for health care services with private hospitals and providers might give veterans greater freedom to choose health care providers closer to their homes. If this happens, then increased demand for VA-supported health care is likely with or without eligibility reform.

In addition to further assessing the potential effects of eligibility and other reforms on demand for outpatient care, further assessments appear warranted to determine how reforms would affect the availability of specialized services. Provisions in the major VA eligibility reform proposals could have both positive and negative effects on VA's specialized services. Reforms that increase VA's efficiency could free resources that could be reprogrammed to increase specialty services. Unanticipated new demand for routine outpatient services could, however, outstrip VA's capacity to provide specialized services such as treatment of spinal cord injuries, substance abuse, and the blind.

These issues are discussed in more detail in appendix IV.

Approaches for Limiting the Budgetary Impact of 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 four proposals that would retain the discretionary funding of the VA health care system 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 or in the methods used to establish VA's appropriation.

Our work identified five basic approaches that could be used, individually or in combination, to limit the budgetary impact of eligibility reforms. These are (1) setting limits on covered benefits, (2) limiting the number of veterans eligible for health care benefits, (3) generating increased revenues to pay for expanded benefits, (4) allowing VA to "reinvest" savings achieved through efficiency improvements in expanded benefits, and (5) providing a methodology in the law for setting a limit on VA's medical care appropriation.

The American Legion proposal, which as of July 1, 1996, had not been introduced, combines some of the above approaches that could be used to constrain the growth of the VA budget. It would make significant changes in VA funding streams and would turn VA health benefits into an entitlement for certain veterans. In addition, it would authorize VA to sell health benefit plans to other veterans and veterans' dependents. The number of veterans to be covered under the entitlement—9 million to 11 million—would likely result in the proposal, in its current form, adding billions of dollars to the budget deficit.

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 reductions from the eliminated services to offset the workload from increased demand for other services. Like private health insurers, VA could adjust the benefit package periodically 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 the redistribution of benefits issue is to establish separate benefit packages for each type of veterans. For example, veterans with disabilities rated at 50 percent or higher might continue to be eligible for 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.

Of the five major reform proposals, only the American Legion proposal would require VA to develop defined benefit packages. The American Legion proposal would require VA to establish both comprehensive and basic packages as well as a supplemental benefit package to cover specialized services.

Limit the Number of Veterans Eligible for VA Health Care

Another way to limit the budgetary effects of 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 military service, and income. In practical application, however, these priorities have little effect on the VA health care system. In the 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.

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 military service that should be available regardless of alternate coverage or (2) a safety net available only to those veterans 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 veterans with no service-connected disabilities who use VA health care services 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 would limit the potential for nonusers to be enticed by improved benefits into becoming users 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 of these 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.

The American Legion proposal is the only major proposal that would specifically limit the number of veterans, and the number of services, covered under VA's medical care appropriation. The expanded benefits to be provided for veterans covered under the entitlement would, however, likely result in a significant increase in VA's medical care appropriation.

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 better 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.

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. Resulting funds 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, most such proposals would not

require VA to offset the recoveries against its appropriation. As a result, they would not affect VA's budget request and would increase overall federal expenditures for health care. Authorizing VA recoveries from Medicare would, however, further jeopardize the solvency of the Medicare trust fund. 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 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 was 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 private health insurance to do so.

The American Legion proposal would allow VA to recover and retain funds from Medicare. The proposal is not clear, however, on whether recoveries would be limited to those services not covered by VA's medical care appropriation.[46] American Legion officials agreed that the proposal is unclear, but said that they intended for VA to recover and retain funds from Medicare only for those veterans not covered under VA's appropriation. Assuming that VA receives payments from Medicare at rates no higher than private sector providers, it would be appropriate for VA to retain recoveries under this scenario. One limitation to this approach, however, is that VA does not have accounting and information systems adequate to keep funds appropriated for patient care separate from funds generated through such third-party recoveries.

Another limitation is that the American Legion proposal would deem VA facilities to be Medicare providers without requiring them to meet Medicare quality, utilization, and reporting requirements.

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 also represent a form of double payment. For the same reasons already discussed related

[46]The proposal would also allow VA to retain recoveries from Medicaid, the Federal Employees Health Benefits Program, the Indian Health Service, and CHAMPUS.

to Medicare, unless recoveries from private insurance 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, we, VA's OIG, VHA, and others have 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, assuming that facilities that are made excess by this are eliminated. 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.

Provide a Methodology in the Law for Limiting VA Appropriations

One way to control increases in VA appropriations in response to the increased demand likely to be generated through eligibility expansions would be to state in the law which portion of the demand would be funded. For example, the law would state which groups of veterans, such as those with service-connected disabilities rated at 30 percent or higher, would be covered by the appropriation. Other groups that might be included in the appropriation could be veterans already eligible for comprehensive care, such as former prisoners of war and veterans of World War I and the Mexican Border Period. To preserve VA's safety net

mission, funds might also be appropriated to cover veterans with no public or private health insurance who have incomes below the means test threshold or some other level.[47]

Such an approach would make it easier to limit appropriation increases, but they would result in significant rationing (see ch. 5) unless revenues from other sources were available to VA. This approach could be combined with other approaches that increase VA revenues to enable VA to provide any available health care service to any veteran. For example, VA might be authorized to sell available health care services to veterans in eligibility categories not covered by the appropriation. (Such an approach would be used under the American Legion's eligibility reform proposal.) Because VA would have received no appropriation to serve these veterans, VA might be authorized to bill and retain recoveries from private health insurers, Medicare, Medicaid, and CHAMPUS.[48] Veterans' copayments and deductibles could be administered in accordance with the provisions of their insurance coverage. In effect, care for veterans not covered by the appropriation would be fully funded through insurance recoveries and veterans' cost sharing.

Such an approach would help control budgetary increases without forcing VA to ration care. All veterans would have the opportunity to choose VA as their health care provider. VA would, however, for those veterans not covered by the appropriation, be competing with private sector providers on a more level playing field.

By limiting VA's appropriation to specified categories of veterans, VA would be given an incentive to focus outreach efforts on those veterans with the highest priority and greatest need for VA services in order to maximize its appropriation. In addition, VA facilities would have a stronger incentive to provide cost-effective care because they would be more dependent on recoveries from public and private insurance to offset their operating costs. In becoming more dependent on outside payers, VA would be subject to many of the cost-containment pressures exerted on private sector hospitals over the past decade. For example, VA facilities could no longer count on appropriations to cover the costs of care denied by private insurers as not medically necessary or not requiring hospitalization.

[47]Provisions could also be made to appropriate funds to cover the costs of (1) treating the service-connected disabilities of veterans with disabilities rated at 0 to 20 percent; (2) veterans treated for conditions related to exposure to Agent Orange, ionizing radiation, or environmental hazards in the Persian Gulf; (3) long-term care; and (4) specialized services.

[48]VA would continue to collect from private health insurers for those covered by the appropriation, but could not retain recoveries beyond the costs of operating the recovery program.

H.R. 3118, as passed by the House of Representatives, would set a limit on the growth of VA medical care appropriations. It would authorize medical care appropriations not to exceed $17,250,000 for fiscal year 1997 and $17,900,000 for fiscal year 1998.[49] If funds are appropriated at the authorized levels, H.R. 3118 would allow essentially no increase in VA medical care spending for fiscal year 1997 over the levels contained in the administration's 7-year balanced budget plan and the House budget resolution. For fiscal year 1998, H.R. 3118 would limit the increase in budget authority to $1.7 billion over the administration's budget plan and $1.1 billion over the House budget resolution.

The final House bill also contains provisions requiring VA to assess the effects of the bill on demand for VA health care. For example, VA would be required to include in a report to the Veterans' Affairs committees detailed information on the numbers of and costs of providing care to veterans who had not received care from VA within the preceding 3 fiscal years.

[49]H.R. 3118 would not set limits on authorizations beyond fiscal year 1998. The proposal being developed by the Senate Committee on Veterans' Affairs would authorize an appropriation not to exceed $17.1 billion in fiscal year 1997 with the authorization for subsequent years increasing by the percentage change in the cost of living for each year.

Conclusions and Agency Comments

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, relatively 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 competitive price 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, VA's mandatory and discretionary care workload has been fully funded. The four eligibility reform bills that would retain the discretionary nature of funding of veterans' health benefits could

significantly increase demand for VA health care services by expanding all veterans' benefits to include comprehensive inpatient and outpatient care services. This could result in increased 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.

However, by not fully funding VA's anticipated increase in 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 readily available through other providers.

If eligibility reforms 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 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. The American Legion proposal contains a framework for accomplishing such changes, but is unrealistic in the number of veterans who would be covered under the entitlement it would create. A significant reduction in the number of veterans covered by the entitlement would be needed if the proposal was to be budget neutral. For example, the entitlement for low-income veterans might be restricted to those who lack other public or private insurance coverage, or the income cutoff might be lowered to reduce the number of veterans covered by the new entitlement.

Agency Comments

VA said that GAO's report, in presenting a summation of many years of discussion concerning eligibility reform issues, shows how confusing, convoluted, and difficult even debate on the issues can be. VA noted that unanimous passage of H.R. 3118 by the House of Representatives and the recent reporting of a bill by the Senate Committee on Veterans' Affairs support the need for change. See appendix VII for VA's comments.

Issues That Need to Be Addressed in Planning Changes to VA's Health Care Mission

This appendix discusses issues identified during our work that should be considered in planning changes to VA's health care mission:

- What is and what should be the nation's commitment to its veterans?
- What do veterans perceive as the nation's commitment to its veterans?
- Should eligibility distinctions continue to be based on factors such as degree of service-connected disability or income?
- Should dependents and other nonveterans be given greater access to VA's health care system?
- To what extent should veterans be expected to contribute toward the cost of expanded benefits?
- Are changes needed in VA's role as a safety net provider?
- What effect would changes in Medicare and Medicaid have on the need for VA eligibility reform?

What Is and What Should Be the Nation's Commitment to Its Veterans?

The first, and perhaps most important, issue to be addressed in considering changes in veterans' health care eligibility is the nation's commitment to its veterans. But what is that commitment and what should it be? Since colonial times, there has been little doubt that service members injured in combat are entitled to compensation for their injuries. There is less agreement, however, on the role and responsibility of the federal government in meeting the other health care needs of veterans.

Most would agree that veterans injured "in the line of duty" should receive care for their disabilities. But what does "in the line of duty" mean? Currently, any injury or illness that manifests itself during a servicemember's period of service is considered service-related unless it is caused by willful misconduct. Current eligibility for VA health care varies on the basis of the severity but not the cause of service-connected disabilities. Should eligibility vary on this basis? For example, should a veteran who was injured in an automobile accident while on leave or in an accident around the home be eligible for the same compensation and veterans health care benefits as a veteran injured in combat? For many, such as VA and the major veterans service organizations, the answer is yes. They point out that military personnel are on duty 24 hours a day, particularly when stationed overseas or living on military bases. Others, however, argue that many military personnel, such as most of those stationed in Washington, D.C., work regular hours and are "off duty" and "off base" at their private homes at other times.

A similar debate centers around the extent to which the government should have an obligation to provide health care to veterans suffering from diseases that become evident during a veteran's period of service but are not caused by that service. For example, about 19 percent of veterans receiving VA disability compensation, and therefore in the mandatory care category for VA hospital care, have disabilities resulting from diseases contracted during military service that were neither caused nor aggravated by military service. Many of these diseases are hereditary or related to lifestyle rather than to military service.[50]

Under current eligibility provisions, all veterans with service-connected conditions, regardless of the cause of the condition, are in the mandatory care category for treatments related to that disability. But only those with disabilities rated at 50 percent or over are in the mandatory care category for free comprehensive outpatient care for conditions not related to their service-connected disability. To what extent should other veterans with service-connected disabilities be eligible for care for conditions not related to their service-connected disabilities? Should the commitment to provide nonservice-connected care to veterans with service-connected disabilities vary on the basis of such factors as the degree and cause of the service-connected disability?

For veterans with no service-connected disabilities, VA currently serves primarily as a safety net, providing hospital-related care to those with low incomes and limited health care options. Certain veterans with nonservice-connected disabilities, such as World War I veterans, have, however, been placed in the mandatory care category for hospital care and are eligible for comprehensive outpatient care regardless of their incomes. Should the priorities for care for nonservice-connected veterans be changed? Among the factors that have been suggested for consideration in deciding whether to change the priorities for care are (1) how long the veteran served, (2) whether the veteran was drafted or volunteered, (3) whether the veteran served during wartime or peacetime, (4) whether the veteran was exposed to combat, and (5) whether the veteran has other health care options (income and/or insurance to pay for health care services). For most veterams with nonservice-connected disabilities, the only factor currently considered is income. For example, a combat veteran with no service-connected disabilities may have a lower priority for VA health care than a veteran with 2 years of peacetime service.

[50]VA Benefits: Law Allows Compensation for Disabilities Unrelated to Military Service (GAO/HRD-89-60, July 31, 1989).

What Do Veterans Perceive as the Nation's Commitment to Its Veterans?

Is there a gap between what veterans expect from VA and what the current veterans' health care law covers? VSO's generally maintain that the government made certain promises to servicemembers when they were drafted or volunteered for military service. Although many of the health benefits for which veterans are now eligible were not covered at the time they were discharged, were servicemembers led to believe, either as an inducement to enlist or as a promise upon discharge, that the government would provide for their health care needs for the remainder of their lives?

Comments made by veterans participating in a series of focus group meetings we held in 1994 suggest that they did not necessarily leave the service with an expectation that the government would provide for their health care needs for the rest of their lives.[51] For example, veterans made the following comments:

"I was in the military but I don't know whether I would be covered. I don't have any disabilities or anything from the military. I don't know whether I'd be eligible for anything through the VA or not."

"The first problem is that when you are coming out of the service . . . when you are going through the discharge processing, they don't tell you what the VA will do for you."

"My son . . . just got out of the Navy not too long ago . . . looked at the packet of papers and phfftt and he tossed them. He wasn't going to go until I insisted that he go up to the VA and get examined . . . . He really didn't know what he was entitled to because the VA doesn't advertise a whole lot of what you're entitled to . . . ."

VA's 1992 National Survey of Veterans provides further indications that many veterans expect little from the VA system and are not aware that they are eligible for VA health care services. Although all veterans are eligible for VA hospital care, about 34 percent of veterans using non-VA hospitals in 1992 cited as a reason for not using a VA hospital that they did not know that they were eligible for VA care. Similarly, under VA's 1987 Survey of Veterans, about 18 percent of veterans who had never used VA health care services said that they were not aware that they were eligible for them.

The limited awareness of VA health care benefits may, however, also reflect the important expansions of VA health care eligibility that have occurred since most veterans were discharged from the service. Many of the health care benefits for which veterans are now eligible were added after they were discharged from the military. For example, most World

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

War II and Korean War veterans were discharged before nursing home benefits were added to the VA system in 1964. Similarly, higher-income veterans without service-connected disabilities were not eligible for VA health care until 1986, when the means test was added. More importantly, outpatient benefits, other than for treatment of service-connected disabilities, were not available even for pre- and posthospital care until 1960. And broader outpatient benefits to cover services needed to obviate the need for hospital care were not added until after the Vietnam War. In other words, not one of the three largest groups of veterans—World War II, Korean War, and Vietnam-era—was discharged with a promise of comprehensive health care for both service-connected and nonservice-connected conditions.

Veterans with service-connected conditions who participated in our focus group meetings generally seemed to feel more strongly that they are entitled to health care from the government than did veterans with nonservice-connected disabilities. Still, not all veterans or even all veterans with service-connected disabilities saw themselves as entitled to care from VA. For example, focus group participants made the following comments:

"Every veteran in the United States feels that because we did our share, we did what we did, we should receive the treatment."

"It's the VA's responsibility to take care of those injuries that you received in the war, not your insurance company's."

"Anybody that has had problems in the service, they need to be taken care of. I think it should only be service-connected disabilities."

Veterans participating in our focus groups, however, generally did not suggest that they believed they have a lifetime entitlement to comprehensive health care services. Many of the veterans with service-connected disabilities, for example, said that they use VA only for treatment of their service-connected conditions.

Should Eligibility Distinctions Continue to Be Based on Factors Such as Degree of Service-Connected Disability or Income?

Decisions made with regard to what the nation's commitment to its veterans should be will largely drive decisions on whether eligibility distinctions should continue to be based on factors such as degree of service-connected disability and income. If a decision is made that all veterans should be eligible for the same comprehensive health benefits, then eligibility distinctions will, in the future, be used only to determine veterans' relative priorities for care. If, however, the decision is that certain veterans should be given better benefits than others, then such distinctions will continue to be used to define the differences in benefits. For example, certain categories of veterans might be eligible for a broader range of services or lower cost sharing. The question then would become whether to keep the same distinctions as in the current law or base the distinctions on other factors.

Eligibility distinctions are seldom used to set priorities for care under the current law. For example, the distinction between which services veterans "shall" and "may" (mandatory and discretionary care) be provided has little real meaning in practice. This is because VA's budget requests have historically been based on the resources needed to provide inpatient and outpatient services sought by all veterans, both those in the mandatory and those in the discretionary care categories. Only when an individual facility, program, or service runs short of resources does a facility have to apply the priorities. The priorities could take on new importance, however, if increased demand generated by eligibility reform forces increased rationing of VA health care services.

Should Dependents and Other Nonveterans Be Given Greater Access to VA's Health Care System?

Historically, eligibility for VA health care has been expanded when VA hospitals develop excess capacity because of declining demand. In three other countries that operated direct delivery systems for veterans (United Kingdom, Australia, and Canada), declining use of veterans hospitals prompted actions to open these hospitals to nonveterans. For example, Australia, in 1973, authorized its veterans' hospitals to use their excess capacity to treat community patients. The action was taken, in part, because of concern that the aging veteran population was transforming the veterans' hospitals into geriatric facilities, resulting in poorer quality of care and fewer services available to veterans. It was hoped that caring for community patients would allow the hospitals and staff to maintain their medical expertise and expand services. In addition, the medical education mission of the veterans' hospitals was being challenged because the hospitals were increasingly focusing on geriatric care.

If eligibility reforms are enacted in the United States that limit the benefits provided to veterans either directly through limits on covered services or indirectly through resource limits, then it would be questionable to allow the sale of services to nonveterans without first giving veterans the chance to buy noncovered services. Veterans should have the first right to use any excess capacity.

Allowing VA to sell excess services to veterans or nonveterans could help contain VA health care costs by making better use of medical resources. For example, if VA uses an expensive piece of equipment only 4 hours a day, but it is staffed to operate the equipment for 8 hours, it could generate additional revenues by selling its excess capacity. Selling excess resources to nonveterans could offer several other advantages, including broadening the mix of patients seen by VA facilities. This might enable facilities to offer a broader range of services than they could support solely through veteran demand. In addition, the broader case mix of patients could strengthen VA's education mission.

However, treating dependents or other nonveterans would place VA in direct competition with private providers. Essentially, every nonveteran treated in a VA hospital means one less patient treated in a non-VA hospital. Because many private sector hospitals are facing dwindling numbers of patients, placing government hospitals in direct competition with private sector hospitals could result in additional closures of private sector hospitals. On the other hand, to the extent that VA hospitals and clinics are located in medically underserved areas, opening VA hospitals to dependents or other nonveterans might improve access to health care in the entire community without putting the government in competition with the private sector.

Among the options that could be considered with respect to treatment of nonveterans would be extending veterans' benefits to more dependents. If a veteran is uninsured and lacks health care options, his or her family is also likely to be uninsured and without adequate health care. Currently, VA coverage of dependents is limited primarily to the survivors of veterans killed in action and to the dependents of veterans with service-connected disabilities rated at 100 percent. The same basic factors used in evaluating the nation's commitment to its veterans could be considered in determining whether changes are needed in the commitment to their families. In addition, dependents are covered through a separate health financing program rather than through VA facilities.

The topic of VA offering dependent care elicited a range of responses in our focus group meetings. Some of the participating veterans were strongly opposed to VA offering dependent care. For many veterans, VA hospitals are special because they are reserved almost exclusively for use by veterans. In contrast, other veterans believed that VA would have to offer dependent care to attract veterans with families. Some of those veterans, however, believed that VA would be unable to meet the needs of the family or that dependents would be uncomfortable seeking care at VA. One alternative that elicited a favorable response from these veterans was for VA to provide care for veterans in its own facilities and offer contract care for veterans' dependents similar to what is currently done under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) program.

To What Extent Should Veterans Be Expected to Contribute Toward the Cost of Expanded Benefits?

VA has traditionally provided virtually free care to most veterans. Only higher-income veterans without service-connected disabilities, such as single veterans with incomes above $21,001, are required to contribute toward the cost of their care. Compared to private sector and other public programs, VA has relatively little cost sharing.

Increased veteran cost sharing could help to (1) offset the costs of increased demand, (2) discourage inappropriate use of VA health care services, and (3) reduce the financial incentive for veterans with adequate private or public health insurance to shift from private providers to VA.

Once a benefit has been established, it can be difficult to change the cost-sharing requirements. As new benefits are added, however, an opportunity exists to determine to what extent the government and the veteran will be expected to pay for the benefits. For example, decisions could be made to create cost-sharing requirements for veterans with 0 to 20 percent service-connected disabilities that apply to the expanded benefits.

Increased cost sharing could, however, put VA health care out of reach for some veterans. Some veterans who qualify for VA health care under VA's safety net mission may be unable to afford increased cost-sharing requirements; if cost-sharing requirements are set too high, veterans may forgo needed care. Symptoms that could have been treated at an earlier stage at less cost could develop into more serious conditions requiring hospitalization.

Under current law, veterans' insurance coverage is not considered in determining their copayment status. When seeking care from private providers, a veteran with a $15,000 income but no health insurance is liable for all of his or her health care out of pocket. By contrast, a veteran with the same income who has Medicare or private health insurance coverage can obtain services from private providers with significantly lower out-of-pocket costs; he or she is responsible for paying only the copayments and deductibles required by the policy. Basing requirements that veterans make copayments, in part, on whether they have private insurance might increase the number of veterans making copayments without placing an unreasonable burden on low-income veterans.

While increased cost sharing would place an added burden on some veterans, it could also yield several benefits. For example, collections from copayments and deductibles could be used to provide a broader range of services within available resources, reduce incentives to overuse services, or reduce VA expenditures. Cost sharing could also be used to provide an incentive for veterans to use VA facilities instead of contract providers—for example, deductibles could be lowered or waived if a veteran uses a VA hospital. As VA increasingly competes with the private sector for patients, a question arises about whether free VA care and low cost sharing gives VA an unfair advantage, particularly for the higher-income veterans with no service-connected disabilities that VA hopes to attract.

To reduce the effect of increased cost sharing, eligibility reform could (1) adopt a sliding scale of cost sharing based on the veteran's ability to contribute, (2) apply cost sharing only to nonservice-connected conditions, (3) give VA broader authority to bill third-party insurers, or (4) include a combination of these three.

Under most private health insurance, policyholders pay a portion of the cost of their health care coverage through premiums. While charging veterans premiums for enrolling in VA health care benefits would help offset the cost of expanded benefits, the premiums would not be fair unless the benefits covered by the premiums were guaranteed. In addition, VA's health care appropriation would need to be adjusted so that funds are appropriated only to cover that portion of the cost of the benefit package not covered by the veterans' premiums.

Are Changes Needed in VA's Role as a Safety Net Provider?

From its beginnings, VA has given special consideration to veterans who are unable to pay for their health care. VA's role in meeting the health care needs of low-income veterans has grown steadily in recent years. VA reported that about one-half of the veterans who used VA health care in 1994 were low-income veterans with no service-connected disabilities.

Currently, VA serves as a safety net for low-income and unemployed veterans who have no health insurance and for other veterans who have catastrophic illnesses, such as acquired immunodeficiency syndrome (AIDS) or cancer, or catastrophic injuries, such as injuries to the spinal cord or eyes, that deplete their resources and ability to earn a living. Many veterans participating in our focus groups saw VA's safety net mission as among its most critical. For example one veteran noted that

"[VA is] a safety net for me [and] that's just what it's supposed to be. I don't think that if I'm working, I should abuse it by going there and getting in line when there are others who don't have money [and] really need it. If I am insured, I don't believe that I should abuse what's given to me."

Another focus group participant said that

"I have always thought of the VA as providing medical care at the last resort [when] . . . a veteran couldn't afford private care, and [he or she] would go into the Veterans Administration."

For most veterans, VA health care benefits resemble Medicare part A benefits and private sector catastrophic health insurance policies rather than comprehensive private health insurance. The government's role is primarily limited to paying for costly inpatient care, including hospital care and treatment in such specialized programs as spinal cord injury and blind rehabilitation. Veterans are generally expected to obtain their routine day-to-day medical care from non-VA sources and either pay for the services themselves or use their health insurance to pay for the services.

VA benefits resemble Medicare part A benefits in that both focus on hospital-related care. Under part A, Medicare beneficiaries do not pay premiums and are covered for medically necessary hospital care and certain other hospital-related care such as nursing home and home health care. Medicare beneficiaries are not, however, covered for routine outpatient services unless they enroll in and pay premiums for optional part B benefits. The cost of these optional benefits is shared by the beneficiary and the government. Similarly, all veterans are eligible for

hospital care and certain other hospital-related services, including nursing home care. Only hospital-related outpatient care is covered for most veterans. Unlike Medicare, however, VA health benefits do not include an optional health benefits package to cover routine outpatient services.

VA health care benefits are also similar to private sector catastrophic health insurance coverage in that they function as a safety net.[52] Some health insurers sell policies with high deductibles, such as $2,000, that essentially guarantee policyholders full coverage once they have met the deductible. Because of the high deductible, premiums for catastrophic insurance policies are significantly lower than for comprehensive health insurance. People who purchase catastrophic insurance are essentially betting that their health care expenses will be lower than the difference in premiums between purchasing catastrophic and comprehensive health insurance. Moreover, by holding a catastrophic insurance policy they set a limit on their risk if they incur the higher costs of a catastrophic illness.

Veterans' health care benefits are similar to a private sector catastrophic insurance policy in that most veterans are eligible for VA care only if they have a medical condition normally requiring hospital care. Like private sector catastrophic insurance, veterans are responsible for paying for routine health care services not needed to obviate the need for hospital care. Unlike private sector catastrophic insurance, however, there is no direct link between veterans' out-of-pocket expenses and eligibility for VA benefits. Nor is there a limit on veterans' out-of-pocket expenses above which the government assumes responsibility for further expenses.

Broadening veterans' benefits within existing resources could jeopardize VA's safety net mission. Reforms that broaden benefits without increasing resources essentially take benefits away from some veterans in order to give expanded benefits to others. With limited resources, available funds might be consumed in providing free routine health care services to veterans with higher priorities for care, leaving less money available for VA's safety net mission.

The primary limitation in VA's safety net mission today is the geographic inaccessibility of VA facilities for many veterans. By expanding its use of private providers, VA might be able to better meet the needs of low-income veterans living in communities without VA hospitals. One option for strengthening VA's safety net mission would be to expand the use of

[52]Catastrophic health care expenses can be defined in terms of out-of-pocket expenses relative to income or of an absolute dollar amount (such as $2,000).

fee-basis care. Another option is to expand the number of "access points." Access points include both VA-operated clinics and contractual or sharing agreement arrangements with non-VA providers to provide primary care services to veterans. The access points that have been established, however, have not been targeted toward low-income veterans. Rather, they have focused on attracting veterans without regard to their service-connected status or incomes.

What Effect Would Changes in Medicare and Medicaid Have on the Need for VA Eligibility Reform?

VA believes that proposed Medicare and Medicaid reforms could increase demand for VA medical services. Medicaid proposals generally would permit states more latitude in setting eligibility and service coverage rules. Thus, their effect on VA would depend on actions taken by the states, and we are not in a position to predict such changes. We agree that proposed changes in Medicare could affect demand for VA care, but it is unclear whether they would increase or decrease demand for VA services. To the extent that reforms result in more Medicare-eligible veterans enrolling in health maintenance organizations or other managed care plans with little or no beneficiary cost sharing, the use of VA services might decrease. On the other hand, if reforms result in higher Medicare deductibles and copayments under the existing fee-for-service system, more veterans might move to the VA system to avoid high out-of-pocket costs.

One area where proposed Medicare reforms could have an unintended effect on government health care costs is the medical savings account (MSA) provision. This provision would enable Medicare beneficiaries to opt out of the traditional Medicare program in exchange for a fixed yearly government payment to be placed in an MSA. The beneficiary is expected to use the funds in the MSA to pay for needed health care services and purchase a catastrophic health insurance policy. Funds left in the savings account at the end of the year become the beneficiary's property.

These provisions might encourage Medicare-eligible veterans to choose the MSA option but seek needed health care from VA at no cost rather than use funds in their MSA to pay for health care services. Two options that could address this potential interaction between the two health benefits programs would be to (1) allow VA to charge those Medicare-eligible veterans choosing the MSA option for services provided or (2) require Medicare beneficiaries choosing the MSA option to relinquish their benefits under other federal health care programs.

A similar interaction could occur between veterans' benefits and Medicare and Medicaid for those enrolling in prepaid managed care plans. To the extent VA provides services to dually eligible veterans enrolled in a managed care plan under Medicare or Medicaid, the government could essentially end up paying twice for the same services. This is because the capitation payment the government makes to the managed care plan covers all medically necessary care included under the benefit plan. However, VA is generally unable to collect the costs of services it provides to veterans enrolled in managed care plans because VA facilities are not participating providers.

Representatives from several VSOs said that many Medicare managed care plans are encouraging their veteran enrollees to obtain needed health care services from VA facilities. If a veteran enrolled in such a managed care plan obtains care from VA for a service included under their Medicare benefits, the government ends up paying twice for the same benefit. The managed care plan would be the primary beneficiary of the government's double payment.

Two potential ways to prevent such problems would be to (1) require dually eligible beneficiaries enrolling in managed care plans to obtain covered services from their health plan or (2) require that such health plans include VA in their provider networks and reimburse VA for the care provided.

Even if Medicaid reforms resulted in veterans losing their eligibility for Medicaid, these reforms would be unlikely to affect the need for eligibility reform. First, those with incomes low enough to have qualified them for the Medicaid program would also qualify for comprehensive VA health care services. This is because the income levels to qualify for Medicaid are well below the VA pension level. In addition, veterans potentially losing Medicaid coverage of nursing home care would already be eligible for VA nursing home care, although space and resource limits might prevent them from obtaining care.

Issues Relating to the Design of Eligibility Reforms

This appendix discusses issues relating to the design of veterans' health care benefits identified during our work. Specifically, it addresses the following questions:

- How can the availability of veterans' health care benefits be made more equitable within existing legislative authority?
- Which eligibility-related problems would require a legislative solution?
- Should the availability of services be guaranteed for one or more of the coverage groups?
- Should a defined benefit package be developed for one or more coverage groups? Which benefits should be included in such packages?
- To what extent would eligibility reform address the unmet health care needs of veterans?
- To what extent would changes in VA's role as a health care provider alter the need for eligibility reform?

How Can the Availability of Veterans' Health Care Benefits Be Made More Equitable Within Existing Legislative Authority?

Several approaches could be used to improve veterans' equity of access to VA health care services within existing legislative authority. First, better defining the conditions under which the provision of outpatient care would obviate the need for hospitalization might lead to greater consistency and equity in coverage decisions. Such action would help promote consistent application of eligibility restrictions, but VA physicians would still be placed in the difficult position of having to deny needed health care services to veterans when treatment of their conditions would not obviate the need for hospitalization. This problem can be addressed through legislation to (1) make veterans eligible for the full range of outpatient services or (2) authorize VA to sell noncovered services to veterans.

Second, VA could reduce inconsistencies in veterans' access to care by better matching VISNs, and individual medical centers' resources to the volume and demographic makeup of eligible veterans requesting services at each center. In effect, VA would be shifting some resources from medical centers that have sufficient resources and therefore do not ration care. Such resource shifts could mean, for example, that some higher-income veterans at those medical centers might not obtain care in the future. But the shift would also mean that some veterans with lower incomes who had not received care at the other medical centers might receive care in the future.

From a veteran's perspective, VA's development of a strategy to deal with resource shortfalls on a more equitable basis systemwide seems preferable. We recommended in 1993 and again in 1996 that VA modify its system for allocating resources to its medical centers so that veterans with similar economic status or medical conditions would, to the extent practical, be provided more consistent access to outpatient care.

Although VA created a new resource allocation system, the Resource Planning and Management (RPM) system, in part to improve the equity of resource allocation, RPM, like its predecessor, allocates resources without consideration of the incomes or service-connected status of the veterans obtaining care. VA officials told us that they will consider including data on veteran demographics in the system at some point in the future. In the meantime, VA is planning to use RPM to shift resources between VISNs on the basis of differences in efficiency and workload.

The increased demand for VA health care services that could be generated through eligibility reforms could heighten the problems caused by the unequal distribution of resources among VA facilities. Those facilities that historically have had more resources would be in a better position to respond to increased demand generated by eligibility expansions. They may have adequate resources to treat veterans in lower-priority categories, while other facilities are forced to turn away veterans in higher categories. Because VA does not differentiate between care categories in RPM, the use of RPM will not result in reallocation of resources that will facilitate equal access by similarly situated veterans in accordance with the priorities established in title 38.

A third approach to improving equity of access would be to place greater emphasis on use of the fee-basis program to equalize access for those veterans who do not live near a VA facility or who live near a facility offering limited services. VA has specific statutory authority to contract for medical care when its facilities cannot provide necessary services because they are geographically inaccessible. While this approach would help some veterans, current law severely restricts the use of fee-basis care by veterans with no service-connected disabilities. Such veterans are eligible only for limited diagnostic services and follow-up care after hospitalization.

VA's recent efforts to establish access points[53] will improve accessibility for some veterans, but VA has not applied the priorities for care in enrolling patients. As a result, access points actually divert funds that could be used to provide access to VA-supported care for high-priority veterans to pay for services for discretionary care veterans. Although the concept of access points appears sound—to increase competition and therefore reduce costs of contract care—to be equitable, enrollment in access points should be subject to the same limitations that apply to issuance of fee-basis cards for other veterans. Equity could be further enhanced by applying the same restrictions to care in VA facilities that apply to the fee-basis program. This would likely result in shifts in resources away from VA facilities and into the fee-basis program. With a fixed budget, lower-priority veterans currently obtaining care in VA facilities would likely be denied VA-supported care, while higher priority veterans currently unable to obtain VA-supported care because of restrictions on the use of fee-basis care would gain access to VA-supported care.

Such a change is not, however, without risks. The capacity of VA's direct delivery system serves as a control over growth in VA appropriations. Without changes in the methods used to set VA appropriations, removing the restrictions on use of fee-basis care could create significant pressure to increase VA appropriations. In other words, the priorities for care covered under the fee-basis program might be expanded to match the priorities currently covered at VA facilities rather than be reordered within available resources. This can result because VA's budget request does not differentiate between the priorities for care.

Finally, VA could ensure that its facilities use consistent methods to ration care when demand exceeds capacity. This would be particularly important if eligibility is expanded but VA budgets do not increase.

Which Eligibility-Related Problems Would Require a Legislative Solution?

Solutions to some of the eligibility-related problems would require changes in law. For example, legislation would be needed before VA could do the following:

- Sell noncovered services to veterans. Authorizing VA to sell noncovered services directly to veterans would help reduce the administrative burden on VA physicians. This is because they would no longer have to decide whether to provide specific services depending on whether the veteran is

[53]VA access points can be either VA-owned and -operated facilities or local providers under contract with VA to serve veterans.

eligible for that service. Instead, administrative staff would decide who pays for the care, the government or the veteran.

- Provide prostheses and equipment on an outpatient basis. Current rules prohibit VA from providing prostheses to veterans who obtain VA outpatient care under the obviate-the-need-for-hospitalization criterion. Because of this provision, according to VA, patients with broken legs must be hospitalized in order for VA to provide them crutches. Under title 38, the term "prosthesis" includes such items as crutches, wheelchairs, eyeglasses, contact lenses, and hearing aids in addition to artificial limbs. Because some of these items are not widely covered under other public or private insurance, removing the restriction on providing all types of prostheses could generate significant demand for items such as eyeglasses and hearing aids.
- Admit veterans with no service-connected disabilities directly to community nursing homes. Current eligibility provisions do not allow VA to admit such veterans directly. Veterans with no service-connected disabilities can only be transferred to community nursing homes after an inpatient stay in a VA hospital. As a result, veterans are sometimes admitted to VA hospitals just so they can be placed in a community nursing home. Legislation that would give VA greater flexibility to admit patients directly to community nursing homes could help reduce unnecessary admissions to VA hospitals. It could, however, make it more difficult for VA to limit growth of the nursing home program.
- Develop uniform benefit packages. VA has limited authority to define or limit covered benefits. For example, it cannot set a limit on the number of days of psychiatric care or prescriptions covered. Nor can it establish separate benefits by category of veteran. Legislation authorizing VA to establish and adjust benefit packages would allow VA to develop packages that would enable it to provide a narrower range of services to a wider range of veterans within available resources.
- Provide routine prenatal and maternity care. Section 106 of Public Law 102-585 specifically prohibits VA from providing routine prenatal and maternity care either through its own facilities or through contractors.

Should the Availability of Services Be Guaranteed for One or More of the Coverage Groups?

An important part of the decision about the nation's commitment to its veterans is the extent to which VA health care benefits are "earned" benefits that the government has a legal obligation to provide. Currently, the provision of VA health care services, even for treatment of service-connected disabilities, is discretionary.

Guaranteed benefits would have important advantages for veterans. For example, veterans with guaranteed benefits would no longer face the uncertainty about whether health care services would be available when they need them. They could essentially forgo private sector coverage. Guaranteed funding would also shift the financial risk of veterans' health care from the veteran, or private insurance, to the government. In other words, veterans with guaranteed benefits would no longer need to maintain separate coverage as a backup to VA in the event that the VA system lacked resources to provide needed care. VA facilities could no longer deny care to veterans if they run out of funds, because the government would have to devise a fall-back funding mechanism. Guaranteed funding could also create stronger incentives for VA facilities to become efficient to avoid having to use the fall-back mechanism.

Guaranteed funding, however, would also force the Congress to relinquish control over the VA budget and could significantly increase government spending unless limits were placed on the number of veterans covered by the entitlement. For example, creating an entitlement to VA health care for veterans with service-connected disabilities rated at 50 percent or higher would limit the entitlement to about 465,000 veterans.

Guaranteeing benefits for some veterans could, however, limit the availability of benefits to others. Essentially, any increased demand generated by the newly entitled veterans could decrease funds available to provide care to other veterans unless VA's appropriation were increased to maintain service levels to veterans in the discretionary care categories.

Guaranteed funding of comprehensive health care services would also put VA in more direct competition with other public and private providers and insurers. Because veterans with guaranteed benefits would be assured of the availability of needed care through VA, they would have less incentive to maintain private health insurance. The effect on insurance coverage would be limited, however, because most veterans would likely continue to maintain private insurance for their families. Medicare-eligible veterans, however, might drop their part B coverage and supplemental private health insurance coverage if they had guaranteed, free benefits from VA.

Secondarily, guaranteeing benefits could also encourage veterans to leave their private providers and seek care from VA, thus resulting in a cost shift to the government and loss of revenues to private providers. The significance of this competition would depend on many factors, including the number of veterans offered guaranteed benefits, the benefits covered,

and actions to improve the accessibility to and customer service provided by VA facilities.

Operating the VA health care system as both an entitlement and a discretionary program would, however, create significant challenges. VA would need to establish accounting systems adequate to ensure that funds appropriated for the entitlement program are not used to pay for other health care services. In addition, VA would need to ensure that funds appropriated to pay for discretionary care are not used to "bail out" VA facilities that are unable to meet their commitment to veterans with guaranteed benefits within appropriated funds. Finally, because the benefits would be an entitlement, the Congress would be forced to appropriate additional funds to "bail out" VA facilities if they run out of funds or if demand for contract care exceeds VA's ability to pay for it.

Should a Defined Benefit Package Be Developed for One or More Coverage Groups? Which Benefits Should Be Included in Such Packages?

One way to control the increase in workload likely to be generated by eligibility expansions would be to develop a defined benefit package patterned after public and private health insurance. This could be used to trade off services veterans could obtain from VA against the level of funding available. VA could adjust the benefit package yearly on the basis of the availability of resources.

Creating a uniform benefit package could result in some veterans receiving a narrower range of services than they receive now while others would receive additional benefits. Depending on the benefits included, this approach could essentially take 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 nonservice-connected disabilities.

One option for addressing this problem would be to establish separate benefit packages for different types of veterans. For example, veterans with disabilities rated at 50 percent or higher might continue to be placed in the mandatory care category for any needed outpatient service, while a narrower range of outpatient benefits—perhaps excluding such items as eyeglasses, hearing aids, and prescription drugs—could be provided to higher-income veterans with nonservice-connected disabilities. In essence, benefit packages could be developed to reflect the extent of the nation's commitment to different categories of veterans.

Similarly, benefit packages could set limits on the number or duration of covered services. For example, mental health benefits might be limited to a defined number of days or admissions during a year or be subject to a lifetime limit as they are under Medicare. Such limits might enable available resources to be used to provide some mental health services to a larger number of veterans, but they might deny needed services to those veterans with the greatest need—those who have exhausted their coverage under Medicare or other health insurance.

Many Medicaid programs limit the number of prescriptions covered per month under recipients' health benefits. Such limits on veterans' health benefits could enable available resources to be used to provide services to more veterans. Again, however, such limits might prevent veterans with the greatest need for care, such as those with AIDS, from getting all of the prescriptions they need unless provisions are enacted giving VA the discretion to exceed the limit on a case-by-case basis.

Any limitations placed on covered benefits would, however, place veterans in a situation similar to the problems created by the current obviate-the-need criterion. That is, if a veteran needs a service not covered by his or her benefit package, VA would be unable to provide the service even if VA had the resources to provide it and the veteran was willing to pay for it. This problem could, however, be addressed through legislation to allow VA to sell excess capacity to veterans.

Benefit packages could also be tailored to supplement, or wrap around, veterans' other health care coverage. Because 9 out of 10 veterans have other public or private health insurance, offering them comprehensive health care benefits will largely duplicate their existing coverage. By using VA benefits to supplement their existing coverage, VA would be able to target its coverage to those veterans lacking other health insurance and to those services, such as long-term psychiatric care and substance abuse treatment, not well covered under other programs.

Defining covered services or establishing uniform benefit packages would clarify covered services, provide more equity in benefits for similarly situated veterans, and ease administration of VA health programs. Similar to Medicare or any number of private health plans, veterans would know in advance which services they can expect from their health care provider.

Unless the establishment of defined benefit packages is coupled with guaranteed services, veterans still would not have a clear sense of what

they can expect to receive from VA. Veterans' uncertainty and frustration about which services they can expect to obtain from VA could increase under reform proposals that would expand benefits without guaranteeing them, and guaranteeing services could easily result in a need for additional VA funding.

To What Extent Would Eligibility Reform Address the Unmet Health Care Needs of Veterans?

Eligibility reform would address some, but not most, veterans' unmet health care needs. This is because many of the problems veterans face in obtaining health care services appear to relate to distance from a VA facility or the availability of the specialized services they need rather than their eligibility to receive those services from VA.

VA's 1992 National Survey of Veterans reported that less than 1 percent of veterans said they could not get needed hospital care in 1992. By far the most common reason cited for not obtaining needed care was that they could not afford to pay for the needed care (cited by 54.9 percent of those reporting the problem).[54]

While the cost of care may have prevented some veterans from obtaining care from private sector providers, it is not a likely reason for not seeking care from VA. All veterans are currently eligible for hospital care, and about 11 million are in the mandatory care category for free hospital care. Other veterans are required to make only nominal copayments.

Our analysis of the 1992 National Survey of Veterans data found that most of the estimated 159,000 veterans who did not obtain needed hospital care in 1992 did not live near a VA hospital. Of the 159,000,

- 44 percent estimated that they lived within 25 miles of the nearest VA hospital,
- 37 percent estimated that they lived between 26 and 100 miles of the nearest VA hospital, and
- 15 percent estimated that they lived more than 100 miles from the nearest VA hospital.

About 4 percent indicated that they did not know where the nearest VA hospital was.

[54]Veterans cited a variety of other reasons, but none was cited by more than 10 percent of the veterans unable to obtain needed hospital care.

By comparison, 92 percent of the 159,000 veterans indicated that a private sector hospital was within 25 miles of their homes. VA currently has statutory authority (38 U.S.C. 1703) to contract for medical care when its facilities cannot provide necessary services because they are geographically inaccessible. Therefore, VA could address veterans' unmet needs for hospital care through existing authority, assuming sufficient funds are available.

The 1992 National Survey of Veterans also estimated that 288,401 veterans were diagnosed at some time during 1992 as needing outpatient care that they were unable to get. Almost 75 percent of these veterans indicated that they did not obtain the needed care because they could not afford it. About 7 percent said that they had been turned down for care at a VA facility.[55]

Of those reporting that they were unable to obtain needed outpatient care, 68 percent reported that they lived within 5 miles of a non-VA doctor's office or outpatient facility. By contrast, only 13 percent reported that they lived within 5 miles of a VA facility; 25 percent indicated that they lived between 6 and 25 miles from a VA clinic; 52 percent reported living more than 25 miles from the nearest VA facility. The remaining 10 percent indicated that they did not know where the nearest VA outpatient clinic was.

The likelihood of using VA outpatient care declined significantly for veterans living more than 5 miles from a VA outpatient clinic. Among veterans living within 5 miles of a VA outpatient clinic, there were 131 users for every 1,000 veterans, compared with fewer than 80 users per 1,000 veterans living at distances of over 5 miles from a VA outpatient clinic.

Unmet needs—other than those of veterans who live too far from VA to use it as a safety net provider—appear to be largely centered around services that veterans are already eligible to receive, such as rehabilitation for the blind, substance abuse treatment, and programs for the homeless. Expanding coverage of routine health care services could decrease funds available for those services not widely available through other health care programs.

[55]Veterans cited a variety of other reasons, but none was cited by more than 5 percent of the veterans unable to obtain needed outpatient care.

To What Extent Would Changes in VA's Role as a Health Care Provider Alter the Need for Eligibility Reform?

Under current law, VA physicians are often placed in the difficult position of having to turn veterans away from their outpatient clinics even if the veteran needs health care and the outpatient clinic has available space and resources to provide the service. VA can sell its excess space and resources to the Department of Defense or its medical school affiliates, but it cannot sell those same excess resources to veterans. If legislation was enacted authorizing VA to sell to veterans those health care services not covered under their veterans' health benefits, physicians would no longer be placed in this position because the service is not covered under the veterans' health benefits. While the physicians would still need to decide whether the care provided was covered by the veteran's benefits, the decision would determine whether the veteran would be expected to pay for the service, not whether the physician should provide the service.

Because most veterans have other insurance, decisions to charge veterans for noncovered services would largely allow them to use their private or public insurance to purchase care from VA. Changes would need to be made in the law, however, before veterans could use their Medicare coverage to buy health care services from VA facilities.

One important consideration in deciding whether to allow VA to sell services to veterans would be what to do with the funds recovered from Medicare or private health insurance that pay for services not covered under veterans' VA benefits. Allowing the facility to keep revenues generated through the sale of noncovered services could provide a strong incentive for VA facilities to provide services in outpatient clinics rather than hospitals whenever appropriate. Before such an approach would be practicable, however, budgeting and accounting systems would have to be developed that would enable VA to segregate funds appropriated for provision of covered services from funds received from sale of noncovered services.

Changes would also need to be made to ensure that VA did not receive an appropriation to cover the cost of noncovered services provided to veterans. Currently, VA's methods of preparing its budget submission result in VA's basing its budget request on the total number of services it provides, not just on the number of covered services provided to veterans.

Issues Concerning the Enforcement of VA Health Care Eligibility Requirements

This appendix discusses issues identified during our work relating to the enforcement of VA eligibility requirements. Specifically, it addresses the following questions:

- To what extent would eligibility reform reduce inappropriate use of VA hospitals?
- Can VA effectively enforce eligibility provisions?
- To what extent would strict enforcement of VA eligibility requirements increase unmet needs?
- To what extent can VA reduce nonacute admissions through administrative actions?

To What Extent Would Eligibility Reform Reduce Inappropriate Use of VA Hospitals?

One argument frequently used to promote the need for eligibility reform is that the obviate-the-need criterion 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.

Significant savings can accrue from shifting a sizable portion of VA's inpatient workload to other settings if entire wards or facilities are closed. Current eligibility provisions do not, however, appear to prevent VA from shifting much of its current workload to ambulatory care settings.

The same obviate-the-need criterion that makes 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 the need for hospital admission. The eligibility provisions, for example, allow VA to perform cataract surgery on an outpatient basis to obviate the need for inpatient care. VA officials, however, suggest that VA continues to perform cataract surgery on an inpatient basis because VA can provide veterans eyeglasses following inpatient cataract surgery but not following outpatient surgery. VA does not, however, maintain statistics on how many patients were admitted in order to provide them eyeglasses.

The management inefficiencies that prevented VA from effectively implementing the obviate-the-need provision and shifting care to outpatient settings for over 20 years and from avoiding unnecessary days of hospital care by providing prehospital and posthospital outpatient care for over 35 years will not be eliminated by expanding eligibility.

Twice before, in 1960 and 1973, the Congress expanded VA outpatient eligibility to reduce inappropriate admissions to and unnecessary days of care in VA hospitals. First, in 1960, the Congress enacted Public Law 86-639 authorizing provision of outpatient care to veterans with nonservice-connected conditions if such care was needed in preparation for or as a follow-up to hospital care. The 1960 Senate report accompanying the bill stated that

"The purpose of the bill is to accelerate the rate of patient turnover in Veterans' Administration hospitals. Presently the rate of patient turnover in VA hospitals does not compare favorably with the turnover rate in private hospitals. Generally private hospitals conduct preadmission procedures before a patient actually occupies a bed. Similarly, at the terminal part of the care, the patient is usually discharged from the hospital as soon as medically feasible, leaving various terminal procedures to be conducted on an outpatient basis. In contrast, the Veterans' Administration has the authority to offer such preadmission and posthospital care only with respect to veterans with service-connected disabilities....

"A direct approach to this problem is provided by this bill which authorizes a complete workup on a prehospital outpatient basis for those cases which are found to be eligible and in need of hospital care and which have been actually scheduled for admission. This procedure, of course, would shorten the time of the patient in the hospital in many instances and it is essentially similar to the procedure now followed in private practice."[56]

VA hospitals are still not effectively using this authority more than 30 years after the enactment of Public Law 86-639. Among the primary reasons identified in VA studies for nonacute days of care are premature admission of patients and delayed discharge of patients who could have been treated on an outpatient basis.

Similarly, in 1973, the House Committee on Veterans' Affairs stated that the basic purpose of the bill that became Public Law 93-82 was to improve the ability of VA to deliver quality medical care to its beneficiaries by removing certain legislative restrictions on the scope of treatment. Specifically, the law permits the furnishing of medical services on an outpatient basis to any veteran eligible for hospital care where such care is reasonably necessary to obviate the need for hospital admission. The House report accompanying the bill notes that these services include, in addition to medical examination and treatment, certain optometry, dental, and surgical services.[57]

[56]Senate Report 1662, June 22, 1960.

[57]H.R. 93-368, 93rd Cong., 1st Sess. (1973).

But the VA OIG found that many medical centers were still performing too many surgeries on an inpatient basis because the medical centers had not developed the capability for conducting outpatient surgery.

Can VA Effectively Enforce Eligibility Provisions?

VA facilities must enforce a myriad of eligibility requirements in deciding whether to provide health care to each individual veteran. First, VA must determine whether the individual meets the basic eligibility requirement—that he or she is a veteran or CHAMPVA beneficiary—but VA's databases do not include enough information to make this an easy task. The Beneficiary Identification and Records Locator System (BIRLS), VA's most complete database of information on living veterans, contains Social Security numbers on only about 18 million of the more than 26 million veterans. In addition, BIRLS is not promptly updated to delete records of deceased veterans. Finally, BIRLS contains no data on veterans' incomes and incomplete data on service-connected disabilities. As a result, its usefulness in establishing a veteran's basic eligibility for care is limited.

The second problem VA faces in enforcing its eligibility requirements is the absence of an adequate system for determining which care group—mandatory or discretionary—a veteran is in. VHA does not currently have information systems in place that will allow VA to differentiate between mandatory and discretionary care.

VA can quickly tell whether a veteran has a compensable service-connected disability through a check against its computerized Compensation and Pension File, but has no way of quickly verifying the core group status of most other veterans. For example, the Compensation and Pension File does not contain records of most veterans with "0" percent service-connected disabilities because these veterans do not receive cash payments. VA estimates, however, that about 1.2 million veterans have "0" percent noncompensable disabilities.

Third, VA cannot quickly verify the incomes of veterans with nonservice-connected disabilities to determine which eligibility category to place them in. Preliminary results from VA's first income verification match against tax records, in December 1993, showed that about 18 percent of veterans with nonservice-connected disabilities underreported their incomes when applying for VA health care. VA began routinely using tax data to verify veterans' incomes in 1994 and is working to develop the ability to do real-time income verification.

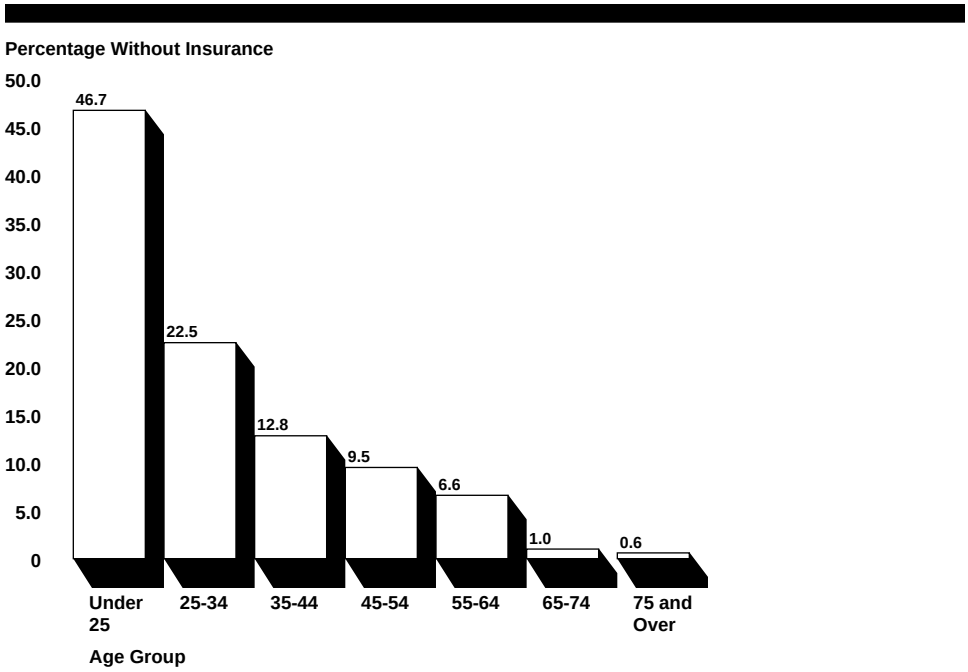
To What Extent Would Strict Enforcement of VA Eligibility Requirements Increase Unmet Needs?

Strict enforcement of VA eligibility requirements could increase veterans' unmet health care needs. VA's OIG found that veterans were not eligible for much of the outpatient care they received from VA. The OIG determined that the services provided were medically necessary but were not covered under the veterans' eligibility status. As a result, strict enforcement of existing eligibility rules would force many veterans to seek routine outpatient care outside the VA system or forgo needed health care. Similarly, to the extent that VA hospitals admit veterans in order to provide health care services they are not eligible to receive as outpatients, preadmission certification procedures to prevent admission of patients who do not need a hospital level of care could increase unmet needs.

The VA health care benefit was not designed to meet all of the health care needs of most veterans. Under current law, VA is intended to provide comprehensive health care services primarily to veterans with service-connected disabilities rated at 50 percent or higher. Other veterans must find health care services from other sources when the needed services exceed the limits of their VA eligibility or if VA lacks the resources to provide covered services.

Most veterans have alternate insurance coverage to pay for health care services not available through VA. According to VA's 1992 National Survey of Veterans, more than one-half of the veterans in every age group reported having public, private, or a combination of non-VA health insurance. Most striking is the increased coverage as veterans age. Nearly all veterans aged 65 and older reported having alternate insurance—primarily Medicare. Over 90 percent of veterans aged 45 to 64 reported having public or private insurance. Figure III.1 illustrates the increased availability of alternate insurance among older veterans.

Figure III.1: Percentage of Veterans Without Alternate Insurance, by Age Group



Source: 1992 National Survey of Veterans.

While most veterans have alternate insurance coverage, those veterans who use VA care are less likely to have health care options. About 40 percent of veterans using VA health care facilities have neither public nor private insurance to supplement their VA benefits. This increases the likelihood that actions to strictly interpret the obviate-the-need-for-hospital-care criterion and reduce the number of nonacute admissions to VA hospitals would increase unmet needs for health care services among veterans.

Strict interpretations of VA eligibility provisions could also increase unmet needs among veterans with other health care coverage. This is because veterans often use VA coverage to supplement their private or public health insurance coverage. For example, in an October 1994 study[58] we reported that Medicare-eligible veterans make substantial use of VA services not covered, or covered with limitations, under Medicare. Our analysis suggested that many Medicare-eligible veterans turn to VA specifically to

[58](GAO/HEHS-95-13, Oct. 24, 1994).

obtain several of these services, particularly prescription drugs. Because Medicare-eligible veterans who use VA health care facilities generally have lower incomes and less private insurance than those who rely solely on Medicare, strict interpretations of VA eligibility could increase Medicare-eligible veterans' unmet needs for prescription drugs, mental health care, and dental services.

To What Extent Can VA Reduce Nonacute Admissions Through Administrative Actions?

Unlike private sector providers, VA facilities are not financially at risk for inappropriate admissions, unnecessary days of care, and treatment of ineligible beneficiaries. Private sector health care providers are facing increasing pressures both from private health insurers and public health benefits programs such as Medicare and Medicaid to eliminate inappropriate hospitalizations and reduce hospital lengths of stay. For example, private health insurers increasingly use preadmission screening to ensure the medical necessity of hospital admissions and set limits on approved lengths of stay for their policyholders. While private sector hospitals are not prevented from admitting patients without an insurer's authorization, the hospital and the patient, rather than the insurer, become financially responsible for the care.

Similarly, the Medicare prospective payment system and utilization reviews provide financial incentives for hospitals to provide services in the most appropriate care setting and to discharge patients as soon as their medical conditions allow. The financial incentive is particularly strong for hospital care financed under Medicare because the hospital is, in general, not allowed to charge beneficiaries for services determined to be medically unnecessary or inappropriate.

VA hospitals and veteran patients do not face these same risks. VA hospitals are not subject to the same payment limitations and external utilization reviews that private sector hospitals face. And, although VA hospitals can recover funds from veterans' private health insurance, failure to comply with private health insurers' preadmission screening and length-of-stay requirements has little direct financial impact on the hospital. This is because (1) before 1994, VA facilities were funded primarily on the basis of their inpatient workload and (2) medical care cost recoveries are returned to the Department of the Treasury, not retained by the providing facility. In other words, in past years, providing medically unnecessary care could actually benefit VA facilities through larger resource allocations.[59]

[59]In 1994, VA implemented a new method for allocating resources to its medical centers that should help alleviate the incentive to provide inappropriate care. The new method, the RPM system, measures workload on the basis of numbers of unique veterans served rather than on hospital workload.

Similarly, veterans assume no financial responsibility for unnecessary care furnished by VA hospitals other than any applicable copayments for veterans in the discretionary care category.

VA has initiated several actions to reduce inappropriate hospital admissions and days of care. For example,

- RPM creates a stronger financial incentive to shift care to the most cost-efficient setting;
- VHA set performance expectations for its VISN directors that call for establishing ambulatory surgery capabilities at all VA medical centers by October 1, 1996, and set goals for the percentage of surgeries to be performed on an outpatient basis; and
- VHA plans to establish a preadmission certification program for hospital admissions.

These actions, if effectively implemented, should help prevent nonacute admissions. Unless changes are made to shift financial risk from veterans to the VA, however, facilities that do not effectively implement such changes could compensate for their continued inefficiency by rationing care to veterans.

Issues Concerning the Potential Effects of Eligibility Reform Proposals on Demand for and Availability of VA Services

This appendix discusses the potential effects of eligibility reform on demand for and availability of VA services. Specifically, it addresses the following questions:

- How would eligibility reform proposals affect demand for VA outpatient services?
- How would eligibility reform affect demand for hospital care?
- How would eligibility reform affect demand for nursing home care?
- What effect would changes to make VA health care more accessible to veterans have on demand for care under eligibility reform?
- How would eligibility reform affect the availability of specialized services?

How Would Eligibility Reform Proposals Affect Demand for VA Outpatient Services?

Eligibility reforms that would make all veterans eligible for comprehensive outpatient services would likely generate new demand for outpatient care in three primary ways. First, current VA users are likely to seek previously noncovered services, such as preventative health care. Second, veterans who previously had not used VA because of its eligibility restrictions might begin using VA, particularly for those services not covered under their public or private health insurance. Third, some care might be shifted from inpatient to outpatient settings as patients admitted to circumvent eligibility restrictions are treated on an outpatient basis.

Veterans currently eligible for comprehensive health care services make significantly more use of VA health care services than do veterans with more limited outpatient eligibility. For example, among service-connected veterans living within 5 miles of a VA outpatient clinic, those with service-connected disabilities rated at 50 percent or higher and, therefore, in the mandatory care category for comprehensive outpatient care, obtained an average of 20 visits per user. By contrast, those veterans with service-connected disabilities rated at less than 50 percent and eligible only for outpatient care related to their service-connected disabilities and hospital-related outpatient care, obtained an average of only 11 visits per user.[60]

Although many factors, such as income and the availability of private health insurance coverage, also contribute to differences in the rates at which veterans use VA services, the differences in the richness of the benefits available to these groups of veterans likely contribute to the greater use of VA benefits among those eligible for comprehensive

[60]VA Health Care: How Distance From VA Facilities Affects Veterans' Use of VA Services (GAO/HEHS-96-31, Dec. 20, 1995).

outpatient services. Similarly, VA's 1992 eligibility reform task force recognized the greater use of outpatient care by veterans with service-connected disabilities rated 50 percent or greater—those eligible for comprehensive outpatient care. The task force evaluated usage rates for veterans with full and limited access to VA outpatient care, then adjusted its workload projections upward to reflect the anticipated demand from veterans who would have greater access to VA outpatient care.

VA's Management Sciences Group also predicted that eligibility reform would generate significant increases in outpatient use by current users. As part of the 1992 eligibility reform task force, the Management Sciences Group developed a multivariate model to predict the effect of eligibility reform on outpatient demand.

The model measures how various characteristics, such as (1) how far veterans live from the nearest VA facility, (2) degree of service-connected disability, (3) income, (4) availability of alternate insurance coverage, (5) health status, and (6) age, combine to determine whether, and how often, veterans seek VA outpatient care. For example, the model predicted that veterans with no service-connected disabilities and those with service-connected disabilities rated "0" who currently use VA care would increase their use of VA outpatient care by 35 percent if they were authorized comprehensive outpatient care.

Eligibility reforms that would expand VA's contracting authority could also provide veterans access to VA-sponsored care closer to home. The added convenience of using local providers might even increase the use of VA care by even those veterans with service-connected disabilities rated 50 percent or higher. Although such veterans are currently eligible for comprehensive outpatient services, improved access would likely lead to greater use.

Eligibility reform that would clarify and expand veterans' access to VA health care services would likely generate demand for care from veterans who had not previously used VA health care. Each of the eligibility reform proposals would significantly expand eligibility for a wide range of outpatient services, making it feasible for many veterans, for the first time, to rely on VA as their sole or primary source of health care coverage. Currently, only those approximately 465,000 veterans with service-connected disabilities rated at 50 percent or higher are in the mandatory care category for free comprehensive outpatient services.

VA's 1992 task force found that most of the increased demand resulting from eligibility expansion would come from new users attracted to the VA health care system, not from increased usage by current users. Likewise, projected cost increases will result more from new users than from providing current users a full continuum of care. Further, with a full continuum of care, new users will significantly increase VA costs of providing outpatient services.

Veterans participating in a series of focus group meetings held in early 1994 often cited being ineligible for VA health care or being uncertain about their eligibility as impediments to use of VA. For example, several veterans were reluctant to use VA because they did not know whether they were eligible. In other instances, veterans who thought that they might be eligible only clarified their status when they needed VA services. Such comments suggest that eligibility reform that would simplify eligibility might be expected to generate additional demand.

VA's belief that eligibility reform would enable it to attract higher-income Medicare-eligible veterans suggests that VA expects to be able to attract new users through eligibility reform. If higher-income beneficiaries, who generally have other health care options and can obtain care from any source, are likely to seek care from VA in increasing numbers, then lower-income Medicare beneficiaries who lack other coverage are also likely to increasingly seek care from VA. VA's suggestion that proposed changes to Medicare such as increasing deductibles and copayments could increase demand for VA health care services by up to 400,000 users (an increase of 16 percent) even with VA's current eligibility restrictions also suggests that changes in VA health care benefits could generate new users.

The effect of eligibility reform on demand for outpatient care will also depend on the extent to which VA facilities are currently circumventing the eligibility restrictions and providing noncovered services. As discussed in chapter 4, studies by VA's OIG found that VA outpatient clinics are providing significant numbers of noncovered services. This suggests that at least some current VA users may already receive comprehensive health care services from VA, and therefore their use of VA services might not significantly increase under eligibility reforms that essentially make legal what is already happening in practice.

How Would Eligibility Reform Affect Demand for Hospital Care?

Reforms that attract new users to the VA health care system will create an increase in demand for hospital care. After removing 1- and 2-day hospital stays (assumed to be shifted to outpatient care), VA's 1992 eligibility reform task force estimated that demand for inpatient care could nearly triple from 987,000 to about 2.8 million patients treated.

Veterans would have even greater access to VA-sponsored hospital care if, in addition to eligibility reform, contracting reforms allow them to use nearby non-VA providers under contract to VA. Under such a scenario, new users attracted to VA outpatient or long-term care would generate additional inpatient demand. The extent to which this new demand is served in VA hospitals or non-VA hospitals would depend on the proximity of new users to VA hospitals and the flexibility established in the contracting reform. Preliminary results from our study of VA's access point pilot program found 40 percent of the 5,000 veterans enrolled at VA's 12 access points were new users to the VA system. Access point physicians are directed to refer any veterans needing specialized services or inpatient care to a VA medical center. The high percentage of new users suggests that demand for care in VA hospitals would increase under eligibility expansions. CBO, in its analysis, noted that eligibility expansions could increase costs by billions of dollars if the induced demand for outpatient care resulted in corresponding increases in demand for hospital care.

Other eligibility reform provisions, as well as federal and state health reform efforts, could affect the demand for VA-supported hospital care. The following items illustrate such reform efforts:

- Contracting reforms that give veterans greater access to community providers could reduce demand for care in VA facilities but increase overall demand for VA-supported hospital care. Because veterans, like most patients, prefer to receive their care close to home, they would likely seek care from nearby providers. These providers may be reluctant to refer patients to distant VA hospitals if closer alternatives exist.
- Reforms that give dependents and other nonveterans greater access to VA care could increase demand for VA hospital care. For example, the two VSO proposals would allow VA to furnish hospital and nursing home care to certain dependents of veterans if they agree to pay for their treatment.
- Proposed changes in Medicare and Medicaid could either increase or decrease demand for VA hospital care. Changes that reduce program benefits, deny coverage to some current recipients, or increase cost-sharing requirements could cause more veterans to seek VA care. But

changes that result in more Medicare-eligible veterans enrolling in managed care plans could reduce demand for care in VA hospitals.

How Would Eligibility Reform Affect Demand for Nursing Home Care?

As VA moves patients from costly inpatient care to less intensive settings, demand for nursing home care is likely to increase. Eligibility reform that would authorize direct admission of veterans with nonservice-connected disabilities to contract community nursing homes could significantly increase demand. The increased demand for nursing home care could, however, be offset to some degree by greater use of home care and residential care for patients requiring less intensive care.

Three eligibility reform proposals would change nursing home care from a discretionary to a mandatory care benefit for certain veterans. The other two proposals would retain nursing home care as a discretionary care benefit for all veterans. S. 1563 would make nursing home care a mandatory benefit for about 9 million to 11 million core group veterans. S. 1345 would include nursing home care, respite care, home care, and domiciliary care in the definition of health care services that VA is to provide in accordance with established priorities. Although the wording of S. 1345 indicates that nursing home care would be shifted from a discretionary to a mandatory benefit for core group veterans, VA officials told us their intention was to keep nursing home care a discretionary benefit for all veterans.

The American Legion proposal would create an entitlement to extended care services for veterans with service-connected disabilities rated at 50 percent or higher, but would eliminate the government-funded nursing home benefit for all veterans.[61] VA would, however, be authorized to sell supplemental health care plans providing nursing home coverage to other veterans.

A mandatory nursing home benefit would likely generate significant new workload, particularly if guaranteed funding is also included in the reform legislation. At a cost of $1.5 billion in fiscal year 1994, VA planned to provide services to less than 16 percent of veterans needing nursing home care. Any significant expansion of VA nursing home benefits is likely to cost hundreds of millions of dollars.

[61]The proposal would create an entitlement to "extended care services," which an American Legion official said was not intended to include nursing home care.

To the extent that eligibility reform would draw new users to the VA system, an increase in demand for nursing home care would be likely. Increased availability of VA nursing home care could attract veterans who otherwise would have to spend their resources on nursing home care before they could qualify for Medicaid coverage. Even a relatively small increase in demand could cost hundreds of millions of dollars given the high cost of nursing home care—an average of $32,371 per patient in a VA nursing home in fiscal year 1994.

Eligibility reform could make additional nursing home space available if VA is successful in shifting hospital patients to outpatient care. VA could then convert unneeded inpatient wards to intermediate and long-term care. VA has already successfully made such conversions in some facilities that had declining inpatient populations. Further conversions could provide additional nursing home beds needed by the aging veteran population.

VA's 1992 eligibility reform task force also examined several reform scenarios and their effect on demand for VA long-term care. Their projections ranged from a twofold increase (assuming that current users receive a full continuum of care) to an eightfold increase (assuming a full continuum of care to all veterans who seek VA care). The cost of the full continuum for all veterans, which includes community-based care, home care, and support services, was estimated to exceed $11.3 billion.

What Effect Would Changes to Make VA Health Care More Accessible to Veterans Have on Demand for Care Under Eligibility Reform?

Concurrent changes to make VA health care services more accessible to veterans could significantly increase the potential effect of eligibility reform on outpatient and, indirectly, inpatient workload. 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 even without eligibility reform.

Living within 5 miles of a VA hospital or outpatient clinic significantly increases the likelihood that a veteran will use VA health care services. Although most veterans live within 25 miles of an outpatient clinic and about half of all veterans live within 25 miles of a VA hospital, use of VA facilities, both in terms of the likelihood of VA use and the frequency of use, declines significantly among veterans living more than 5 miles from a

VA facility. Only about 11 percent of veterans live within 5 miles of a VA hospital providing acute medical and surgical care and about 17 percent live within 5 miles of a VA outpatient clinic.

VA plans to improve veterans' access to outpatient care by establishing "access points"—either VA-owned and -operated clinics or primary care physicians in private practice who contract with VA on a capitation basis to provide primary care services to veterans. As of April 1996, 12 clinics were operational—4 are owned and operated by VA and the remaining 8 were established through contracts with county and private clinics. Forty percent of the 5,000 veterans enrolled at the 12 access point clinics were new users—1 clinic, with 208 enrollees, served only new users.[62]

Similarly, if VA's authority to contract for health care services with private hospitals and providers is broadened and VA uses such authority to allow veterans greater freedom to choose health care providers closer to their homes, then increased demand for VA-supported health care is likely with or without eligibility reform.

Many veterans, given a choice between care in non-VA facilities close to their homes and more distant VA facilities, with no difference in out-of-pocket costs, would likely choose non-VA care. Our prior work suggested that VA facilities might lose as much as 47 percent of their acute inpatient workload and 41 percent of its outpatient workload if veterans obtained better access to community providers through a universal health care program. Expanding services to veterans through contracts with community providers might have a similar downward effect on demand for care from VA facilities, but at the same time significantly increase overall demand for VA-supported care. Through contracting, veterans might be able to see the same physicians and use the same hospitals they could through Medicare or private insurance, but without the higher out-of-pocket costs.

Currently, over 40 percent of veterans using VA acute medical and surgical hospitals live more than 25 miles from the VA hospital and over 30 percent live more than 25 miles from the nearest VA outpatient clinic. While an expansion in the number of providers is essential if VA is to improve accessibility of VA-supported health care, actions to allow veterans to obtain VA-funded health care closer to their homes could result in decreased demand for care from VA facilities.

[62](GAO/T-HEHS-96-134, Apr. 24, 1996).

If veterans currently using VA facilities choose to get care from community providers through access point clinics or other forms of contract care, VA would need to attract new users or increase the volume of services provided to the remaining veterans if it is to maintain the workload at its existing facilities. Essentially, VA cannot improve accessibility of outpatient care without either increasing overall outpatient workload to compensate for veterans who shift to community providers, or reducing the capacity of its current facilities.

Contracting reforms that give veterans greater access to non-VA outpatient care but retain limits on referrals to non-VA hospitals could increase demand for VA inpatient care. As VA attracts new outpatient users, either through additional access point clinics or eligibility reform, these new patients would likely generate concomitant demand for VA hospital care.

Unless VA increases its market share of the veteran population or veterans are replaced by other patients, overall use of VA health care facilities will continue to fall. In other words, if VA continues to support about 930,000 hospital admissions and 25 million outpatient visits, but supports them through a network of VA and community providers, then those veterans' use of VA facilities will decline.

How Would Eligibility Reform Affect the Availability of Specialized Services?

Provisions in the major VA eligibility reform proposals could have both positive and negative effects on VA's specialized services. Reforms to increase VA's efficiency could free resources that could be reprogrammed to increase specialty services. Unanticipated new demand for routine outpatient services could, however, outstrip VA's capacity to provide specialized services such as spinal cord injury rehabilitation, substance abuse treatment, and care for homeless veterans.

Because of space and resource limitations, VA is currently unable to meet the specialized care needed by some veterans. Specific data on unmet needs are not generated by VA, but there are indications that space and resource restrictions are limiting VA's ability to meet veterans' needs. The following examples illustrate this point:

- Specialized VA post-traumatic stress disorder programs are operating at or beyond capacity, and waiting lists exist particularly for inpatient treatment. Treatment waiting lists have hovered between 900 and 1,000 veterans for the past 3 years. While VA has been able to reduce the waiting

lists, the number of veterans seeking post-traumatic stress disorder care continues to increase even though the Vietnam War ended 20 years ago.

- Limited resources make it difficult for VA to care for homeless veterans. VA's current programs constitute a small portion of what is likely needed to fully address the needs of the homeless veteran population. For example, in the San Francisco area, the Homeless Chronically Mentally Ill program, established to locate and provide clinical care to mentally ill homeless veterans, had only 11 beds available to meet the needs of an estimated 2,000 to 3,300 homeless veterans in the area at the time of our review. Similarly, those veterans who apply may wait up to 2 months before being admitted to a residential program.
- A similar situation regarding homeless veterans exists in Washington, D.C. Its Homeless Chronically Mentally Ill program had an average of 11 contract beds to serve an estimated 3,300 to 6,700 homeless veterans at the time of our review. Eligible veterans who applied had to wait up to 6 weeks for admission to the program.
- In April 1994, VA reported that its substance abuse programs were providing services near their capacity as of January 1, 1992. Extended care programs for substance abuse were more restrictive in their admissions and maintained longer waiting lists.

The availability of specialized services would improve under the American Legion proposal because benefits would be guaranteed. Under the other proposals, however, the availability of specialized care would not be guaranteed. Because VA would be required to meet the comprehensive health care needs of veterans in the highest-priority groups before using resources to provide specialized services to veterans in lower-priority groups, the availability of such care might deteriorate in an environment of budget constraints.

For example, H.R. 3118 would require VA to establish a system of enrollment. Enrollment would give VA a better basis for creating benefit packages, planning for potential demand, and allocating resources. However, veterans who fail to enroll might be locked out of needed specialty care. Similarly, if VA does not have sufficient capacity to enroll all veterans who seek to enroll, some veterans may not receive needed specialty care.

Some reform proposals, such as H.R. 1385, would attempt to counteract incentives to reduce specialty care by requiring VA to maintain current capacity in these programs. As veterans age, however, their needs for specialty care services targeted toward older veterans will increase. Thus,

maintaining current capacity in some specialty care programs may not be sufficient to meet increasing demand. Conversely, if demand decreases (as it has for spinal cord injury rehabilitation), requiring VA to maintain a minimum capacity would consume resources better used elsewhere. One option suggested by the Paralyzed Veterans of America would be to allow VA facilities to use the excess capacity in its spinal cord programs to treat nonveterans as long as veterans continued to have the highest priority for care.

Studies Do Not Support VA Contention That Eligibility Restrictions Are a Major Cause of Nonacute Admissions

In 1985, we reported that about 43 percent of the medical and surgical days of care in the VA hospitals reviewed could have been avoided.[63] Since then, a number of studies by VA researchers and VA's OIG have found similar problems. VA, the Vice President's National Performance Review, and VSOs frequently claim that these studies show that restrictions on VA outpatient eligibility force VA to admit patients to VA hospitals in order to provide them necessary health care services. Our review of the studies does not support this contention.

A 1991 VA-funded study of admissions to VA acute medical and surgical bed sections estimated that 43 percent (+/- 3 percent) of admissions were nonacute.[64,65] Nonacute admissions in the 50 randomly selected VA hospitals studied ranged from 25 to 72 percent. The study found that the most frequent reason (about 60 percent of cases) for nonacute medical admission was that care could have been performed on an outpatient basis. Another 17 percent of admissions were determined to need a lower level of institutional care.[66] All of the surgical admissions determined to be nonacute were found to (1) be procedures that VA had determined could be done on an outpatient basis and (2) lack documented risk factors indicating a need for inpatient care. The study concluded that, based on medical necessity, a large proportion of acute medical/surgical care in VA medical centers could potentially be shifted to outpatient and long-term care settings.

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

[64]Brenda Booth, Robert L. Ludke, Douglas S. Wakefield, and others, "Nonacute Inpatient Admissions to Department of Veterans Affairs Medical Centers," Medical Care, Vol. 29, No. 8, Supplement (Aug. 1991), pp. AS40-50.

[65]In conducting the study, registered nurses did retrospective medical record reviews of fiscal year 1986 medical and surgical hospitalizations from 50 randomly selected VA medical centers. A total of over 6,000 admissions were reviewed using the appropriateness evaluation protocol (AEP). A medical admission was considered nonacute if none of the AEP clinically based criteria indicating the need for inpatient hospital care on the day of admission were documented in the medical record. A surgical admission was considered nonacute if it was on the VA list of procedures approved for outpatient surgery and none of the AEP outpatient surgery risk factors were documented in the medical record. The study was conducted under the assumption that the care was medically necessary regardless of where it was provided.

[66]Other reasons cited were admission for detoxification, admission as a transfer from another institution, premature admission, admission for placement in a nursing home, admission of patients too frail for outpatient care, admission for transfer to another acute care facility, and admission because the patient was a high risk for outpatient therapy or the patient was unlikely to comply with prescribed treatment.

The study suggests several reasons why there is a higher rate of nonacute admissions to VA hospitals than has been found using the same methodology in studies of private sector facilities:

- VA is required to maintain a minimum number of beds.
- 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, such as mandatory preadmission review, to control nonacute admissions.
- VA, unlike the private sector, has a significant social mission that may influence use of inpatient resources.[67]

With respect to VA's social mission, however, the study noted that reasons such as travel distance or presence of an insufficient social/home support system to maintain the patient outside the hospital were infrequent reasons for nonacute admissions.

The authors, in a separate article, also estimated that 48 percent (+/- 2 percent) of the days of care at the 136 VA medical centers providing acute medical and surgical care were nonacute, ranging from 38 to 72 percent.[68] They estimated that the entire stay was completely acute for only 25 percent of VA acute medical or surgical hospitalizations; for 31 percent of hospitalizations the stay was determined to be completely nonacute. The remaining 44 percent of hospitalizations were a mix of acute and nonacute days, with a greater proportion of the nonacute days falling in the final third of the hospital stay. The study identified a number of reasons for the nonacute days of care, but most frequently cited was conservative patient management. Not frequently cited, the study noted, were reasons associated with VA's social mission, such as VA eligibility or social/economic considerations delaying discharge. The study also noted, however, that the extent to which such reasons are documented in medical records is unknown.

The authors concluded that

"The results of this study suggest that changes in admitting and continued stay practices may be needed to reduce the level of nonacute hospital level care. In particular, the finding

[67]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.

[68]Booth, Ludke, Wakefield, and others, "Nonacute Days of Care Within Department of Veterans Affairs Medical Centers."

that 31% of the hospitalizations were completely nonacute suggests that stringent reviews of the need for hospitalization should be undertaken either before admission through mechanisms such as preadmission review and certification or soon after admission through explicit concurrent review practices."

In a May 10, 1996, letter following our March 20, 1996, testimony on eligibility reform, VHA stated that it believes we misinterpreted the research findings.[69] According to VHA, in determining whether an admission was nonacute, the study (1) assumed that the patient needed the care given (2) assumed that all levels of care were potentially available at the medical center, and (3) considered only clinical and social factors documented in the medical record. VHA said that VA believes that eligibility reform would allow VA to shift 20 percent of hospital admissions to outpatient settings. VHA also said that it is not surprising that "lack of eligibility" was not cited as a reason for the nonacute admissions when the research study "assumed outpatient settings were available for all (i.e., there were no eligibility problems)."

Both our March 20 testimony and this report state that the study does not support VA's contention that eligibility restrictions were the cause of the nonacute admissions. It is inconsistent for VHA to cite the study as evidence that eligibility restrictions are the cause of 20 percent of nonacute admissions and then maintain that the study assumed there were no eligibility problems.

In a 1993 pilot study to test the validity and reliability of the InterQual ISD (intensity, severity, discharge) system for assessing the appropriateness of admissions and days of care on VA acute medical, surgical, and psychiatric services, researchers found that

- 47 percent of admissions and 45 percent of days of care in medical wards were nonacute and
- 64 percent of surgical admissions and 34 percent of days of care in surgical wards were nonacute.

High rates of nonacute admissions and days of care were found in all 24 hospitals studied.[70,71] Reasons cited for nonacute admissions and days of

[69]Letter to the Honorable John D. Rockefeller IV, Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate, dated May 10, 1996.

[70]Charles B. Smith, Pilot Study of the ISD* Measurement of Appropriateness of Bed Utilization, Health Services Research and Development Project, SDR #91-010 (Washington, D.C.: June 16, 1993).

[71]The study did not validate the ISD criteria for acute psychiatric services.

care included nonavailability of outpatient care, conservative physician practices, delays in discharge planning and factors such as homelessness and long travel distances from home to the hospital. (See table V.1.) The authors suggested that VA establish a systemwide utilization review program.[72]

Table V.1: Reasons for Nonacute Admissions and Days of Care

Numbers in percent

	Medical		Surgical		Psychiatric	
Type of reason	**Admissions**	**Days of care**	**Admissions**	**Days of care**	**Admissions**	**Days of care**
Practitioner	32.2	42.6	21.1	41.4	50.7	58.4
Administrative	17.9	3.1	6.8	11.9	9.5	6.6
Service availability	17.7	12.9	36.1	4.7	3.3	10.4
Social[a]	11.3	11.9	4.8	12.8	24.8	11.7
Environmental[b]	8.4	9.2	7.8	10.2	2.2	5.1
Scheduling	8.2	10.2	16.5	13.9	0.0	1.0
Communication[c]	2.0	3.3	2.0	1.7	1.6	1.8
None given	2.5	6.4	3.0	1.8	6.8	4.6

[a]Social reasons, such as "no support," "no family," and "homeless," were the second most common cause for nonacute admissions in psychiatric service (24.8 percent), fourth most common for medical services (11.3 percent), and a less frequent reason for nonacute admissions to surgical services (4.8 percent).

[b]Environmental reasons for nonacute admissions include living more than 75 miles from the hospital and lacking a housing alternative. Scheduling reasons meant that the admission was premature because the necessary procedure, surgery, or test was not performed by the day after admission.

[c]Communication reasons meant either that the hospital received the wrong information about the patient's need for care or that the inability to communicate with family resulted in the nonacute admission.

Source: Pilot Study of the ISD* Measurement of Appropriateness of Bed Utilization.

Practitioner-related reasons were most frequently identified as the reason for nonacute admissions to psychiatric and medical services (50.7 percent and 32.2 percent, respectively) and were the second most common reason for nonacute admissions to surgical services (21.1 percent). These admissions were generally attributed to "conservative practice," meaning that no other social, VA system, or regulatory reason for the acute admission of the patient was found. A VHA economist told us that reasons citing conservative physician practices were an indication that veterans

[72]VA expects its VISN directors to establish a VISN-wide utilization review program by the end of fiscal year 1996.

were admitted to provide them services that they were not eligible to receive on an outpatient basis. When we followed up with the economist to determine the basis for this assertion, she was unable to provide any explanation.

Administrative reasons were the second most common category for nonacute admissions to medical services (17.9 percent) and were often cited for surgical and psychiatric admissions (6.8 percent and 9.5 percent, respectively). These reasons included transfers from another medical center, admissions for transfer to a nursing home, and a variety of other reasons.

The nonavailability of outpatient services was the most common category for nonacute admissions to surgical beds (36.1 percent) and was frequently cited as a reason for nonacute admissions to medical bed sections (17.7 percent). The specific reason cited was generally lack of an ambulatory surgery alternative or nonavailability of an ambulatory care alternative for medical admissions.

The study noted that laws and regulations governing eligibility for VA health care also contribute to inappropriate admissions and days of care. Specifically, the study notes that

- the requirement that veterans with nonservice-connected disabilities be admitted to a VA hospital before they are eligible for nursing home care accounted for over 5,000 admissions to VA hospitals in 1992;
- regulations that prevent veterans from receiving travel reimbursements when visiting clinics lead to inappropriate admissions because such reimbursements can be made when veterans are hospitalized; and
- requirements that certain services, such as prosthetic devices, be provided only to inpatients also lead to nonacute admissions.

According to VHA, two of the three broad recommendations contained in the study are related to limited outpatient eligibility and its impact on the development and availability of outpatient care. The recommendations, as stated in the study's executive summary, were as follows:

"A. VA should establish a system-wide program for using the ISD* criteria for utilization review with emphasis on identifying the local and systemic reasons for nonacute admissions and days of care and for monitoring the effectiveness of changes in policy.

"B. VA physicians need to be encouraged to make greater use of ambulatory care alternatives and to be more effective and timely in planning for patient discharges.

"C. VA needs to facilitate the shift of care from inpatient to the outpatient setting. This should include incentives in the reimbursement methodology for providing ambulatory care, changes in eligibility regulations that promote rather than prohibit ambulatory care, prioritization of construction funds and seed funds for new programs to support the shift to ambulatory care."

Our work suggests that VA does not need eligibility reform to begin implementing the first two recommendations. VA recently announced plans to establish a preadmission authorization program to reduce inappropriate admissions to VA hospitals. In addition, VA has, through its emphasis on primary care, encouraged the shift to ambulatory care. Nor does VA need eligibility reform to change its reimbursement methodology to promote ambulatory care (such a change is under way through RPM) or to prioritize construction funds to facilitate the shift toward ambulatory care (VA continues to seek funds for construction of new hospitals).

With respect to the recommendation to change eligibility "regulations," the detailed section of the study report recommended that legislation be enacted 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) remove limitations on eligibility for outpatient care compared with inpatient services such as dental services and provision of needed prosthetic devices. The eligibility reform proposal developed by VA and submitted to the Congress in September 1995 would allow direct admission of veterans with nonservice-connected disabilities to community nursing homes and the provision of prosthetic devices on an outpatient basis for treatment of nonservice-connected conditions. The VA proposal would not remove the limitations on provision of dental services on an outpatient basis.

VA Inspector General Studies Identify Lack of Ambulatory Surgery as Cause of Inappropriate Surgical Admissions

A series of audits by VA's OIG in 1991 and 1992 identified the nonavailability of ambulatory surgery or other outpatient capabilities as the primary cause of unnecessary admissions and days of care in VA surgical wards. For example, the OIG estimated the following:

- 931 of the 2,921 days of surgical care at the New Orleans VA medical center could have been avoided had the medical center established an ambulatory surgery program.[73]
- About 32 percent of the Denver VA medical center's 1- to 4-day surgical admissions were for medical care that could have been provided on an outpatient basis without jeopardizing the welfare of the patient. In addition, the report noted that patients scheduled for surgery were unnecessarily admitted the day before surgery because Medical Administration Service personnel were not, according to the Chief of Surgical Services, available early enough in the morning to do the paperwork necessary to admit the patient the day of the surgery.[74]
- About $400,000 was spent by the Ft. Lyon VA medical center on patients who did not need to be admitted to a hospital or could have been outplaced earlier. The OIG attributed the problems primarily to physicians' failure to (1) follow the medical center's admission criteria and (2) promptly identify and transfer eligible patients to nursing homes.[75]
- About 45 percent of the 2-day surgical admissions at the Togus, Maine, VA medical center could have been avoided by treating the patients on an outpatient basis. The medical center agreed with the finding and attributed the inappropriate admissions to the perception that VA's resource allocation method did not cover the cost of ambulatory surgery.[76,77]
- About $766,000 in unnecessary expenses were incurred at the Dallas VA medical center because physicians admitted patients who did not require inpatient care and hospitalized veterans longer than medically necessary. The lack of facilities dedicated to outpatient surgery was the sole reason cited for the inappropriate admissions. Poor scheduling of surgical procedures and inadequate coordination of testing and consultations were cited as causing unnecessary days of care. Medical center officials agreed with the findings and indicated that corrective actions were under way.[78]

[73]Audit of VA Medical Center, New Orleans, Louisiana, VA OIG, Report No. 2R6-F03-121 (Washington, D.C.: VA, Apr. 17, 1992).

[74]VA OIG, Report No. 1R5-F03-050 (Washington D.C.: Apr. 5, 1991).

[75]VA OIG, Report No. 1R5-F03-026 (Washington, D.C.: VA, Jan. 23, 1991)).

[76]Audit of Medical Center Operations at Department of Veterans Affairs Medical and Regional Office Center, Togus, Maine, VA OIG, Report No. 1R1-F03-027 (Washington, D.C.: VA, Jan. 25, 1991).

[77]VA's resource allocation method was replaced by the RPM system.

[78]Audit of VA Medical Center, Dallas, Texas, VA OIG, Report No. 2R6-F03-151 (Washington, D.C.: VA, June 10, 1992).

- About 72 percent of inpatient cataract surgeries and 29 percent of other short-term minor surgical admissions reviewed at the West Los Angeles medical center could have been done on an outpatient basis.[79]

VHA's recently established performance measures for VISN directors (1) include measures to encourage those facilities that lack ambulatory surgery programs to establish them and (2) set expectations for what portion of surgeries should be done on an outpatient basis.

[79]Audit of VA Medical Center, West Los Angeles, California, VA OIG, Report No. 2R7-F02-022 (Washington, D.C.: VA, Oct. 30, 1991).

Key Provisions of Proposals to Reform Eligibility for VA Health Care

Each of the five leading reform proposals contains unique provisions that would affect both which veterans are eligible for care and how VA delivers health care. The following sections describe these provisions.

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 health care eligibility reform provisions would do the following:

- Previous provisions covering hospital care, outpatient care, respite care, pharmaceuticals, supplies, equipment, appliances, and other items 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.

Senate Bill 1563

S. 1563 was introduced at the request of the VSOs 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;[80]
- 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

[80]"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.

- switch VA health care funding from a discretionary to a mandatory spending account,
- authorize VA to provide pre- and postnatal care for women veterans,
- 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' Health Care Eligibility Reform Act of 1996

On March 20, 1996, the Chairman of the House Veterans' Affairs Committee introduced the Veterans' Health Care Eligibility Reform Act of 1996 (H.R. 3118). The bill is similar to a proposal that was approved by the House in its budget reconciliation package (H.R. 2491) but was deleted in

conference with the Senate. The Committee's proposal would, among other provisions, reform eligibility for VA health care to

- specifically state that provision of care for both mandatory and discretionary care category veterans is subject to the amounts provided in advance in appropriations, thus clearly stating that VA health care services are not an entitlement for veterans in the mandatory care category;
- 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 (about 1.2 million veterans);
- 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 (veterans with service-connected disabilities rated at 30 percent or higher would have the highest priority for enrollment);
- create a new category of priority for veterans who are catastrophically disabled; and
- expand VA contracting and sharing authority.

Veterans' Health Care Security Act

This eligibility reform proposal, developed by the American Legion, would make more fundamental changes to the VA health care system than any of the other reform proposals. Under the Veterans' Health Care Security Act, VA would adopt characteristics typical of a private sector health insurer, including guaranteed benefits, annual enrollment, and dependent coverage. As of July 1, 1996, the proposal has not been introduced in the Congress.

Unlike the other bills, the Veterans' Health Care Security Act would guarantee the availability of covered services by creating an entitlement to care. VA appropriations would be based on a capitated method covering the cost of care for veterans entitled to free or discounted VA care. Veterans would be entitled to free or discounted care on the basis of the degree of their service-connected disabilities or if they are special category veterans, which is similar to today's mandatory care category.

The bill would also

- reorganize the VA health system into regional Veterans Health Plans;
- replace current restrictions on outpatient care with several benefit packages that offer wider coverage including hospital, outpatient, emergency, and preventive services;
- establish three enrollment options: basic, comprehensive, and specialized services;
- entitle veterans with service-connected disabilities at 50 percent or greater to all medically necessary services, including extended care services, at no cost to the veteran;
- entitle other veterans currently in the mandatory care category for hospital care (other than veterans with noncompensable service-connected disabilities) to a basic benefit package at no cost, or to a premium discount on the purchase of the comprehensive benefit package;
- entitle veterans who (1) suffer catastrophic illnesses that render them destitute or (2) are proven uninsurable in the private market to the basic benefit package at no cost;
- allow higher-income veterans with no service-connected disabilities and veterans with noncompensable service-connected disabilities to purchase the basic, comprehensive, or supplemental benefit packages;
- allow dependents of enrolled veterans to enroll in the basic or comprehensive plans upon payment of a premium intended to cover the costs of their care;
- deem VA as a qualified provider, authorized to retain reimbursement from the Medicare, Medicaid, Federal Employees Health Benefits, CHAMPUS, and Indian Health Service programs for those veterans not covered under the entitlement;
- expand VA's authority to contract with private sector facilities, providers, health plans, insurers, suppliers, or related entities; and
- exempt VA from federal procurement regulations.

Comments From the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

AUG 8 1996

Mr. David P. Baine
Director, Health Care Delivery
and Quality Issues
United States General Accounting Office
Washington, D. C. 20548

In Reply Refer To: 10/105E

Dear Mr. Baine:

Thank you for the opportunity to review your draft report, ***VA HEALTH CARE: Issues Affecting Eligibility Reform Efforts***, Report No. GAO/HEHS-96-160. The Deputy Under Secretary for Health, in a conversation with you on August 5, 1996, provided you with our oral comments on the report. He also stated that we would provide written comments to you. We are taking this opportunity to provide those comments.

We are pleased with the statement in the report that GAO recognizes the need for eligibility reform. The current system, with its different rules for hospital care, outpatient care and long term care, results in disjointed, fragmented and discontinuous care which leads to both inefficiencies and suboptimal conditions. Your report, in presenting a summation of many years of discussion on these issues, shows how confusing, convoluted and difficult even debate on the issues can be. It is fairly apparent from the information presented that there is no certain spreadsheet analysis, econometric model of demand, or other quantitative analysis that will provide the much desired guidance with which to address all of the issues.

What is clear is that the system is ineffective and inefficient and needs to be changed. The unanimous passage of H. R. 3118 by the House of Representatives and the recent reporting of a bill by the Senate Committee on Veterans Affairs indicates to us that having heard the debate, Congress agrees with the need for change. We are encouraged by these recent actions and look forward to final passage of the legislation. As Congress is already taking action on eligibility reform, we believe any further discussion of this report would be moot.

Sincerely,

Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

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Related GAO Products

VA Health Care: Efforts to Improve Veterans' Access to Primary Care Services (GAO/T-HEHS-96-134, Apr. 24, 1996).

VA Health Care: Approaches for Developing Budget-Neutral Eligibility Reform (GAO/T-HEHS-96-107, Mar. 20, 1996).

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).

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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 Care 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).

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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).

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Washington, D.C. 20548-0001

Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested