

VETERANS' MILLENNIUM HEALTH CARE ACT

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
ONE HUNDRED SIXTH CONGRESS
FIRST SESSION

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MAY 19, 1999
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WEDNESDAY, MAY 19, 1999

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., in room 334, Cannon House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Smith, Gutierrez, Doyle, Peterson and Shows.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning. The Health Subcommittee will come to order.

Three years ago this subcommittee developed and held hearings on legislation to reform VA rules governing eligibility for care. That, quote, eligibility reform, end quote, legislation paved the way for a major shift from primary reliance on VA hospital care to less costly outpatient care. It also resulted in vastly improved access for veterans. That legislation was described as a first step on a path to reform, but it was an important first step.

Today, we take another very significant step in hearing testimony on draft legislation which tries to tackle some of the major challenges facing the VA. This legislation offers a blueprint to help position VA for the future; and I think it is appropriately titled the Veterans' Millennium Health Care Act.

Foremost among VA's challenges are the long-term care needs of aging veterans. For many among the World War II population, long-term care has become as important as acute care. However, the long-term care challenge has gone unanswered for too long. It is important, therefore, that just last month this committee held a hearing on VA long-term care. The bill we discuss today will squarely address this issue and would adopt some of the key recommendations of a blue ribbon advisory committee, but our bill goes further than that in providing VA important new tools to improve veterans' access to long-term care.

Similarly, the bill tackles another challenging issue, namely GAO's findings that VA may spend billions of dollars in the next 5 years to operate unneeded buildings. GAO has testified that one of every four VA medical care dollars is spent in maintaining buildings, rather than caring for patients.

These are just not abstract concerns. It is no secret that VA's discussing closing hospitals. In some locations, that may be appro-

priate. The point is that VA has closure authority and has already used it. In fact, we could expect closure of needed facilities under the disastrous budget submitted by the President this year.

This bill, instead, calls for a process to be sure that decisions on closing hospitals can only be made based upon comprehensive planning with veterans' participation. The bill sets numerous safeguards in place and would specifically provide that VA cannot simply stop operating a hospital and walk away from its responsibilities to veterans. It must reinvest savings in a new, improved treatment facility or improved services in the area.

I am pleased that many of those testifying on this bill recognize that its key provisions are interdependent. The bill responds to pressing veterans' needs. Thus, it opens the door to an expansion of long-term care, to greater access to outpatient care, and to improve benefits, including emergency care coverage. In turn, it provides for reforms that would help advance these goals.

I commend those organizations which have been willing to look at the bill as a whole and recognize that it would strengthen the VA health care system. I believe this is a most important step forward.

And I particularly want to commend Lane Evans for his work in shaping this legislation and for his support of this measure.

I also want to recognize the contribution of Chris Smith, my colleague from New Jersey, in introducing H.R. 1762, a bill to expand the scope of VA respite care. The language of his bill has been incorporated into the draft bill and is an important element of the long-term care improvements the bill provides.

I want to recognize my colleagues that are here if they wish to have an opening statement; and I will start with my colleague from New Jersey, Mr. Smith.

OPENING STATEMENT OF HON. CHRISTOPHER H. SMITH

Mr. SMITH. Thank you very much, Mr. Chairman, for convening this very important hearing on the future of VA health care as we go into the 21st century.

The legislative package which you are unveiling today is an ambitious and very necessary undertaking. It compels the VA and the Congress to step up to the challenges posed by the graying of America. It also will help ensure that the VA's long-term care services reflect the progressive reforms already under way in the private sector as well as expand eligibility within the VA health care system.

The Millennium Health Care Act which we will be discussing today includes the following key components:

It requires the VA to provide long-term care to veterans who are either 50 percent service connected or in need of such care for a service-connected condition. It requires the VA to operate and maintain long-term care programs, including geriatric evaluation, nursing care, domiciliary care, adult day health care and respite care; and it restores the ability of Purple Heart recipients to automatically use VA health care facilities.

One component, as you pointed out, Mr. Chairman, that is especially important to me is respite care. I recently introduced H.R. 1762, legislation which expands the definition of respite care within

the VA health care system. This legislation allows the VA to contract with skilled health care professionals to provide care for our aging veteran population as well as to provide care services through non-VA facilities when appropriate.

H.R. 1762 has been endorsed by the American legion, VFW, and a host of other important groups; and I would ask that my full statement be made part of the record on that, Mr. Chairman.

Mr. STEARNS. Without objection, so ordered.

[The prepared statement of Congressman Smith appears on p. 39.]

Mr. SMITH. If I could just make a point, according to the Care Giver Assistance Network, family and volunteer care givers provide 85 percent of all home care given in the United States. These husbands and wives, sons and daughters are willing to make the sacrifices necessary to ensure that their loved ones who have served our Nation and our Armed Forces are able to remain at home in their time of need.

I would just point out parenthetically, both my father and mother had long, debilitating diseases, cancer in both cases.

My father ended up—he was a combat veteran in New Guinea during the Second World War. He didn't require home health care, although we made provision for it. He never did come home from the hospital, after more than 50 days in the hospital.

My mother, when she went through her ordeal, was cared for by my wife. And I can tell you, having had my mom live with us day in and day out and all the—she was on oxygen—and all the other requirements that were part of the regimen of taking care of her, my wife, as the primary care giver, needed time and needed health care professionals; and we often found that there was a lack of it. And I think this—having lived through that ordeal, I really think that respite care is an important part of your package.

Maybe perhaps a freestanding bill has to pass this Congress, because there are many, many of the World War II aged veterans who will have a son or daughter, and it is usually a daughter take care of them, and they are going to be needing this kind of help.

So I want to commend you for your great work on this, and this is a bipartisan effort, and I think we need to get this down to the President as soon as possible.

Mr. STEARNS. I thank the gentleman for his example and support.

The gentleman from Pennsylvania, Mr. Doyle.

OPENING STATEMENT OF HON. MICHAEL F. DOYLE

Mr. DOYLE. Thank you, Chairman Stearns. I appreciate having the opportunity to add my voice to the discussion on the Veterans' Millennium Health Care Act and its treatment of a wide range of interdependent VA health care programs and issues. The scope and potential magnitude of this comprehensive initiative should not be underestimated, and it is my hope that members will carefully measure the short-term and long-term effects of each provision. It is also my hope that legitimate concerns with the draft legislation will be considered in a productive manner.

We all want to take steps that are necessary to remedy problems that exist within the VA health care system and to ensure its lon-

gevity. Given the growing demands placed upon the VA and its diminishing funding levels, it is quite understandable that these necessary steps demand immediate and innovative adjustments to budgeting, planning and decision-making throughout the entire VA system. Indeed, I would be the first to agree that many of the changes should be implemented on a system-wide basis and followed in a standardized manner in an effort to establish continuity and minimize randomness. The challenge is to demonstrate that a specific change is directly reflective of a system-wide problem, and/or need for that matter, and that the standardized approaches being forwarded are inclusive of all pertinent factors and variables. Ultimately, we should be weary of condoning practices that have not been proven to be beneficial to the VA or to veterans.

In terms of the bill's subject matter, it touches on every significant VA health-care-related issue that demands the committee's attention and that holds great influence in shaping the VA's mission and place in our communities. I am pleased that the bill includes many forward-thinking directives that address the inevitable, such as mandating the Secretary operate and maintain a national program of extended care services. I do think that many improving adjustments could be made in terms of the planning requirements, cost-benefit analysis, and level of VA employee partnership and participation in decision making. Sections 10, 11, and 13 are of particular concern to me in terms of the potential effects they may have on the three VA hospitals in my area and the access to and delivery of health care services to the many veterans who live in western Pennsylvania.

In closing, Mr. Chairman, I want to recognize your efforts in dealing with the many difficult issues that share so many common problems. It is virtually impossible to talk about one aspect of the bill without directly commenting upon another. Indeed, it is this interwoven dynamic that serves to reinforce the need for a comprehensive health care measure. It is my sincere interest that our discussions will lead to a final product that is thoughtful and reasoned in its approach and provide for the betterment of the VA health care system.

Let me just say in closing, Mr. Chairman, I see we have a distinguished panel here, people from the DVA and VSOs, and I think that is good, but I think we have forgotten an important element that needs to be looked at, too, and that is the men and women who serve our veterans every day on the frontlines in the VA hospitals. I would hope at future hearings that we could hear from them, too. The actual employees of the VA health care system should be invited to this committee to testify so we hear what they have to say about health care delivery, and I ask that maybe we can consider that in future hearings.

Thank you, Mr. Chairman.

Mr. STEARNS. I thank the gentleman. I think that is an excellent idea. I think we certainly concur on this side.

And, of course, we welcome any ideas you have dealing with planning requirements; and you mentioned sections 10, 11, 12, and 13 so we appreciate any input, help in that area.

The gentleman from Mississippi, Mr. Shows.

OPENING STATEMENT OF HON. RONNIE SHOWS

Mr. SHOWS. Thank you, Mr. Chairman.

I think everything has been said, but I am really encouraged about the direction of your legislation. It really is something we need to be looking at a long time.

Another thing that really I think we need to look at is the smoking-related illnesses that veterans of World War II—cigarettes were offered in their C-rations. My dad was a World War II vet, just like Mr. Smith's, and I know how that is and how they got addicted on cigarettes back there in war when they didn't have anything else to do but sit in the trenches and smoke. These are growing concerns, and I am very proud and glad that you are leading the fight on this.

And I have got a prepared statement here that I would like to enter into the record if that is okay.

Mr. STEARNS. By unanimous consent, so ordered. I thank the gentleman.

[The prepared statement of Congressman Shows appears on p. 41.]

Mr. STEARNS. Now we will start with Panel 1: John R. Vitikacs, Assistant Director, Veterans Affairs and Rehabilitation Commission, The American Legion; Dennis M. Cullinan, National Legislative Director, Veterans of Foreign Wars; Richard A. Wannemacher, Associate National Legislative Director, Disabled American veterans; and Larry D. Rhea, Deputy Director of Legislative Affairs, Non Commissioned Officers Association.

Gentlemen, good morning. I appreciate your coming here, and I know how valuable your time is.

I would like to announce a little bit different format. Out of deference to you, of course, we wanted to have you up first, but also Dr. Kizer has indicated he has a very tight schedule this morning. And Dr. Kizer is on the Hill frequently; and considering everything, I thought what I would do is allow you folks to make your opening statement; and then if Dr. Kizer would come up and give his opening statement, we would address questions to all of you. This should allow Dr. Kizer to meet his other obligations. And I appreciate Dr. Kizer frequently coming on the Hill on short notice and helping us out with his testimony.

STATEMENTS OF JOHN R. VITIKACS, ASSISTANT DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; DENNIS M. CULLINAN, NATIONAL LEGISLATIVE DIRECTOR, VETERANS OF FOREIGN WARS; RICHARD A. WANNEMACHER, JR., ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; LARRY D. RHEA, DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS, NON COMMISSIONED OFFICERS ASSOCIATION; AND KENNETH W. KIZER, M.D., M.P.H., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Mr. STEARNS. So if you will start now. Why don't we just start with Mr. Vitikacs? Your opening statement, please.

STATEMENT OF JOHN R. VITIKACS

Mr. VITIKACS. Mr. Chairman, members of the subcommittee, good morning.

Mr. STEARNS. Good morning.

Mr. VITIKACS. The American Legion welcomes the opportunity to comment on important draft legislation related to the Veterans' Health Administration. We greatly appreciate the chairman's sponsorship of both of the draft bills. Today we will address the sections on long-term care facility realignments and the pilot program for care of certain dependents of eligible veterans. We ask that our full statement be included in today's hearing record.

Mr. STEARNS. With unanimous consent, so ordered.

Mr. VITIKACS. Mr. Chairman, a successful strategic plan for VHA over the next decade includes many of the provisions in the bills under consideration. We are here today to discuss present and future issues that must be successfully negotiated and attained.

The American Legion commends the effort to revise VA's long-term care eligibility criteria. The draft bill on long-term care would, for the first time, statutorily obligate VA to provide long-term care to certain veterans rated greater than 50 percent disabled and to other veterans for service-connected disabilities rated below 50 percent.

Additionally, the proposal would require VA to establish an extended care program for all other veterans using the State Veterans' Home System of monthly co-payments as a model.

Mr. Chairman, the proposal incorporates some important recommendations made in the 1998 report of the Federal Advisory Committee on the Future of VA Long-Term Care. Recently, Dr. Ken Kizer suggested that Congress mandate and clarify eligibility for long-term care as an essential service, develop new revenue sources for long-term care, form flexible partnerships with State and local entities and that Congress appropriately fund VA long-term care services and programs.

The views of the Under Secretary for Health on VA long-term care are consistent with the views of The American Legion as set forth in the GI bill of health.

Any revision of long-term care eligibility must grandfather veterans currently receiving long-term care into any co-payment program and provide realistic access to long-term care for low-income, non-service-connected veterans.

The American Legion commends the subcommittee for taking the necessary first steps in developing a draft bill on the future of VA's long-term care programs. The American Legion supports the draft bill and looks forward to working with the committee to develop the best possible proposal.

Mr. Chairman, section 10 of the draft bill sets forth an important set of standards for future medical center realignments and the potential closure of certain VA medical centers. These standards will go together with the authority already vested in the Secretary on realigning the functions and missions of VA medical centers.

The American Legion does not support closing VA medical centers without compelling reasons. Targeting a medical center for closure primarily due to underutilization is not an acceptable reason. If a medical center has a low patient census, it is preferable to seek

ways to increase the workload rather than close a facility. Nevertheless, the proposed enhanced service program sets forth important standards to provide future guidance to the department.

The American Legion questions whether all of the funding saved as a result of any future facility closures should remain within the affected VISN. There should be a protected transition period of a few years. However, in time, those savings should be used for the overall needs of the department.

Mr. Chairman, it is important for VHA to answer to somebody on how many operating beds need to be maintained throughout the system. Currently, bed availability is critically low. An example of this is an 80 percent service disabled veteran recently who required heart bypass surgery for a service-connected condition. The VA medical center providing treatment had to delay surgery three times even after the veteran had a heart attack due to a lack of available ICU beds.

Eventually, the bypass surgery was performed at the affiliated university medical center; and the patient is now doing fine. However, the university billed Medicare for the patient's treatment and also billed his Medicare supplemental insurance policy. This billing took place despite the fact that this was a VA patient, 80 percent service disabled, receiving care for a service-connected condition. If VA had available bed space in the ICU, none of this mistreatment and abuse of medical care funding would have occurred.

The American Legion wonders how many of these situations take place daily and weekly throughout VA and whether this is symptomatic of the funding stress being placed on the system.

The American Legion further questions whether DOD or VA has sufficient beds available to handle military emergencies. The crisis in Kosovo is a good example of why VA cannot reduce FTE and operating beds below a critical level.

The American Legion supports the draft proposal to establish a pilot program for the provision of medical care to certain dependents of veterans. The test pilot would be an expansion of existing but limited CHAMPVA program authority. The American Legion's GI bill of health seeks to provide permanent access to VA health care for all veterans and their eligible dependents.

The future of VA health care rests on stabilized funding. At a time when VHA seeks new sources of income, it makes sense to experiment with new, innovative concepts and ideas.

We agree with others that the dependents pilot program should in no way delay or impede health care for veterans. While The American Legion prefers that Congress take immediate steps in implementing the GI bill of health, the proposed pilot program by providing primary care of certain dependents is a good beginning.

In summary, The American Legion believes the draft bills under consideration will help VA and veterans in the 21st century. Nevertheless, there is still a need to address VHA's fundamental problems. That is, how to stabilize system-wide funding, permanently increase access to care for all veterans, and improve the timeliness of care. The American Legion believes the answer to all of these concerns can be addressed in the provisions set forth in the GI bill of health.

Mr. Chairman, that completes my statement.

[The prepared statement of Mr. Vitikacs appears on p. 50.]
Mr. STEARNS. Thank you, John. Mr. Cullinan. Welcome.

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you very much.

Mr. Chairman, members of the subcommittee, on behalf of the almost two million men and women of the Veterans of Foreign Wars, I thank you for inviting our participation in today's most important hearing. As an organization comprised of combat theater veterans, we are committed to the proposition that VA must be fully enabled to serve as the health care provider of choice for all of America's veterans. Toward this end, it is essential that VA should provide for the long-term care needs of veterans.

Under discussion today is a draft of a major legislative initiative known as the Veterans' Millennium Health Care Act that addresses this and other veterans' health care issues.

Before briefly discussing its individual provisions I would extend the VFW's heartfelt appreciation for this forward-thinking, proactive and politically courageous bill to ensure that this Nation may properly meet its obligation to our former defenders in their time of need.

Section one of this bill represents a comprehensive long-term care reform package. The VFW applauds requiring the Secretary to operate and maintain a national program of extended care services as well as mandating that VA maintain its in-house capability.

We also support the requirement that VA develop a plan for carrying out the recommendations of the Federal Advisory Committee on Long-Term Care.

Also vital is that VA expands available community-based care options.

The VFW would voice strong support for the proposed requirement that VA provide such services on an ongoing basis to all 50 percent service-connected or higher veterans as well as to veterans requiring such due to a service-connected disability.

Further, the VFW supports the establishment of priorities for access for VA extended care for non-service-connected veterans. We are especially supportive of the establishment of monthly co-payment limits on extended care services as well as removing the 6-month limitation on provision of VA health care. The VFW applauds authorizing VA to provide respite care services under contract and expanding the scope of the State Home program to encompass extended care services.

Mr. Smith, we would extend our special thanks for your contribution on this issue.

The VFW will next address the sections of the bill addressing improved access through facility realignment. Without attempting to comment on all the particulars of this highly complex issue, the VFW offers support for the establishment of an enhanced service program to improve the quality, accessibility, and timeliness of VA care for veterans. For a number of years, the VFW has maintained that we are not married to bricks and mortar with respect to the provision of VA care, and our support for this legislative initiative is grounded in this view. We would only add that such a course

may only be pursued for the sake of providing all veterans desiring such with mandated access to the full continuum of VA care.

Next under discussion is the eligibility reform language contained in this draft bill. VFW has no objection to the language providing enhanced eligibility to recipients of the Purple Heart and to certain TRICARE-eligible veterans. We are highly supportive of requiring DOD to reimburse VA for the cost of care provided to military retirees under the TRICARE initiative.

Again, with the goal providing more and better VA care to all veterans desiring such, the VFW is in support of this bill's provisions providing for enhanced revenues. Given VA's current strained funding situation, it only makes sense to establish an expanded and more reasonable co-payment schedule for VA care, products and services. We insist, however, that all existing statutory exemptions as well as those additional exemptions enumerated in this bill be strictly applied. Further, all benefits derived from such action must be exclusively applied to veterans care.

The VFW supports the language addressing other program improvements in this bill.

With respect to the other draft bill under discussion today providing for a pilot project for the provision of care to certain dependents, the VFW would only note that such may be only provided based on the availability of resources as outlined in this bill. Given the current constrained funding situation and the very real prospect of deterioration of VA health care funding in fiscal year 2000, we question whether such will be available.

It bears mentioning that under VERA, which is, in truth, a mechanism for distributing budget pain equally throughout the system, it would appear that the resources to provide for dependent care will be inadequate throughout VA.

Mr. Chairman, this concludes my statement. I will be happy to respond to any questions you may have.

[The prepared statement of Mr. Cullinan appears on p. 66.]

Mr. STEARNS. Thank you, Dennis. Mr. Wannemacher, your opening statement.

STATEMENT OF RICHARD A. WANNEMACHER, JR.

Mr. WANNEMACHER. Thank you and good morning.

On behalf of the more than one million members of the Disabled American Veterans and our women's auxiliary, I thank you for the opportunity to express our views relative to the legislation currently pending before this committee affecting our Nation's service-connected disabled veterans and their families. And I, too, ask that my full statement be entered into the record.

Mr. STEARNS. With unanimous consent, so ordered.

Mr. WANNEMACHER. At the outset, Mr. Chairman, I wish to thank you and all members of the subcommittee for the chance to give consideration to the issues contained in today's agenda. Clearly, actions taken will materially affect the lives of those Americans who gave themselves in defense of the freedoms we all enjoy.

Mr. Chairman, before I discuss the legislation pending before the committee, I note with grave concern that the Department of Veterans Affairs is facing a serious dilemma with respect to full funding for fiscal year 2000. As you are aware, the administration's pro-

posed budget flatline for the fourth consecutive year includes a number of new initiatives without providing any additional appropriated funding. The proposed budget flatline budget instead relies on an inflated estimate of VA's ability to obtain third party payments.

In fact, we understand that the appropriators will provide for a token increase in VA's funding for fiscal year 2000, at the low end, \$200 million; at the high end, \$900 million. Either way, it is a blueprint for disaster.

Next Friday, May 28, marks the beginning of Memorial Day weekend when we gather to remember and honor America's patriots who gave, as President Lincoln called it, the last full measure of devotion. Their ultimate sacrifice serves as a constant reminder of the high cost of freedom and hope for safer and more peaceful world. In honor of the dead and serving the living, the DAV and others will be holding rallies around the country at VA medical centers and other locations to garner support for increased funding for the VA health care system.

As members of the Veterans' Affairs Committee, you are the principal advocates here in Congress for our Nation's veterans' population and are called upon to provide critical leadership necessary to ensure that America honors its moral obligation to the men and women who served in our armed services. I thank you in advance for your effort to assist us in resolving the crisis in VA health care. America's sick and disabled veterans want to thank you for your efforts on their behalf.

In the discussion draft of the veterans' millennium bill, it has long been a standing position of the DAV that veterans should be afforded quality and timely services by VA for their honorable service to this Nation. There continues to be a critical need to clearly define eligibility for VA long-term care that ensures necessary services will be provided and the system will be sufficiently funded.

The DAV very much appreciates the provisions in the draft to ensure that VA provides extended care services. We are especially pleased to see that the same mandates as provided in section 1710(a)(1)(B) are carried forward in addressing extended care entitlement.

While fully aware of the need for additional revenue streams to support VA's inadequate budget, we do not understand why the co-payment program for long-term care could not have an expiration or sunset for 3 to 5 years following enactment. By enactment of this expiration, adequate time will have passed to assess the state of the Nation's economy and the utilization and costs of the program. Co-payments for VA health care were instituted as a means for deficit reduction. As our Nation moves closer to budget surplus, the need for additional co-payments for VA health care should diminish.

The DAV fully supports the provision of the draft legislation mandating the Secretary operate and maintain a national program for extended care.

The VA's maintenance of capacity is especially critical and addressed in this draft legislation under section 2, and the DAV appreciates your intuitiveness.

Representative Smith, we thank you for your legislation H.R. 1762. As we just heard earlier, the subcommittee is going to take your provisions for respite care and roll them into the millennium bill, and for that we are thankful. The DAV fully supports you and your initiatives on this subject.

The DAV fully supports sections 3 and 4 of the draft legislation which provides specific authority for the VA, to provide increased priority health care to veterans who have been awarded the Purple Heart in defense of America's freedoms, as well as providing special authority to provide health care for the men and women who have dedicated their adult lives in making the military their career and now entitled to TRICARE.

Mr. Chairman, the DAV is and will remain adamantly opposed to any effort to increase co-payments for medical care to this Nation's sick and disabled veterans. Co-payments were put in effect to reduce the budget deficit by reducing the cost of VA health care. As our Nation now moves to a budget surplus, the need for co-payments is diminished.

Veterans have a higher incidence of smoking and smoking-related illness. As you properly noted in section 8 and in subsection 8 of section 7, quote, it is in the public interest for Congress to enact legislation requiring that a portion of any amounts received from manufacturers of tobacco products be used to meet the cost of, A, treatment for diseases and adverse health effects and, B, medical care services.

The DAV requests the repeal of the prohibition against service-connected smoking-related illnesses and urges the support of Congressman Frank and Senator Snowe's bills as well as, Mr. Chairman, we commend you for your bill H.R. 691 for the recovery of smoking-related illness proceeds.

The DAV supports sections 8 and 9 of this draft legislation.

Under section 10, the DAV and others are very concerned that VA's unique contribution to the Nation's health care delivery system has fallen victim of a budget-cutting craze that will ultimately destroy the fabric of the system. VA is at an important crossroad in regard to its long-term funding commitments from the administration and Congress, and the VA health care system must be maintained.

The VA has been able to provide greater access to VA health care professionals with the creation of the CBOCs.

All of these changes have occurred in a flatline budget.

While most integrating systems in VHA seek to maximize the efficiency of their resources, all VHA systems also seek to improve patient care and customer service by strengthening the continuum of care using a single standard across locations.

Clinical integration is the key to improvement of patient care, and the men and women who rely on VA for their health care currently are forced to wait long periods of time for primary and specialty care and for their medications.

Under section 11, expansion of enhanced-use lease, the DAV has consistently supported that provision.

We also support 12, 13, and 14.

We commend you on section 15 to bring veterans equal to non-veterans for emergency services, and the DAV is pleased to see

that you share our concern with respect to the changes in bed sections and conversions of such beds. We are hopeful that you would share our concerns. The dollars expended for their care should not be accepted as a justification for closure of any bed section.

We support chiropractic medicine; and, with regard to the pilot program for the provision of dependents, until the VA has a billing system and accounting system fully in place and with verifiable data systems, we cannot support the pilot program proposal to expand treatment to non-veterans.

And I would be glad to answer any questions that you might have. Thank you.

[The prepared statement of Mr. Wannemacher appears on p. 68.]

Mr. STEARNS. Thank you, Richard. Mr. Rhea, for your opening statement.

STATEMENT OF LARRY D. RHEA

Mr. RHEA. Thank you, Mr. Chairman. Good morning to you and the ranking member and the distinguished members of the subcommittee.

The Non Commissioned Officers Association thanks you for your invitation to appear today and comment on the draft legislation under consideration. We thank you for that, Mr. Chairman, and also for the substantial work that the members of this subcommittee have undertaken to improve the access and quality of health care for deserving veterans.

It is important to begin my oral comments with a brief description of the Association's membership.

NCOA is a total force organization, Mr. Chairman. By that I mean our members come from the ranks of those still serving in the military, from military retirees and veterans, and from the spouses and dependents of those current and former military members.

Our diverse membership base allows NCOA to view the issue of health care provided by the Federal Government in a global perspective. From that perspective, NCOA is particularly sensitive to Federal-provided health benefits that create anomalies among military members, military retirees, and veterans. With that description, Mr. Chairman, NCOA is pleased that the subcommittee has prepared a proposal to improve access and quality of VA health care in what we believe is a fair and equitable manner.

The Association reaffirms our support this morning for the Veterans' Millennium Health Care Act. As NCOA has stated countless times, this Association believes VA health care must remain forever focused on the service-connected disabled veteran. For that reason, NCOA fully endorses the long-term care provisions of the act for service-connected disabled veterans.

The provisions of the act relating to long-term care for non-service-connected veterans are meritorious, but we believe the focus must remain on the service-connected veteran. In NCOA's opinion, priority for maintaining nationally the level of in-house extended care services should also be to the service-connected disabled veteran.

NCOA supports provisions to improve access and quality of care through facility realignment. In our view, these provisions have the

potential to improve the access and quality of care for more veterans. The Association urges the subcommittee to retain in any final legislation that you choose to advance the requirement for VA to submit proposals with justification to Congress for review.

NCOA is particularly pleased with the eligibility reform measures in the draft act. The provisions relating to veterans awarded the Purple Heart decoration and the one related to retired military veterans are issues that this Association has supported for quite some time. We urge that these provisions be retained in any final legislation the subcommittee advances.

The fact that this subcommittee is now considering legislation that would recognize military retired veterans as veterans in the VA is a major step forward, in our opinion. While NCOA supports this initiative, the Association must also honestly express our belief that military retired veterans have earned and deserve a higher priority than what is proposed in the draft act. NCOA believes military retired veterans have earned and deserve a priority immediately below service-connected disabled veterans, and we would therefore ask that you consider such a change.

Having made that request, Mr. Chairman, let me restate the Association's great appreciation for what you have proposed for this category of long-serving veterans who have been almost universally forgotten by the Federal Government they served.

NCOA supports the enhanced revenues and other program improvement measures contained in the draft.

For the reasons stated in our prepared testimony, Mr. Chairman, the Association is not inclined to support the pilot health care program for certain dependents of veterans.

In conclusion, NCOA salutes the subcommittee and the dedicated staff of this subcommittee for the diligent work you have done and continue to do to advance the cause of improving veteran health care. The Millennium Health Care Act is a fair, reasonable, and prudent proposal, given the stubborn reality that VA health care appropriations are not limitless.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Rhea appears on p. 77.]

Mr. STEARNS. Thank you, Larry.

We will now have Dr. Kizer come up and give his opening statement. Dr. Kizer, do you mind? We can let these gentlemen stay here. We have a chair for you.

While Dr. Kizer is coming up, I will just make a few comments.

Yesterday, we voted an emergency supplemental for the military of almost \$15 million. The staff, including the chairman and others, have spoken to Mr. Walsh, who is head of the VA-HUD appropriations, about increasing the spending for veterans. He seems very supportive.

We have to make the argument here on the veterans subcommittee and the full committee how important it is to increase funding for veterans. When you look in the overall budget of almost \$2 trillion and then you look at veterans, it seems to us on the committee—I am sure the ranking member, Mr. Gutierrez, would confirm it—it is not unreasonable for us to ask for additional funding no matter what the circumstances. So we are here today to say we are

an advocate for the veterans, and we appreciate the compliments on this bill.

This bill is an attempt to be proactive, as you pointed out, proactive and to be bold in its step forward. I hope all the members on the subcommittee realize that we have an opportunity before the new millennium to come up with legislation that would make the veterans' health care system more efficient, and in the end provide a better service for all veterans and to try and project into the future where VA is going, which includes looking at VA's hospitals. In some cases, it may be better to have only outpatient clinics in areas where VA now operates hospitals which may no longer be needed.

Mr. STEARNS. With that in mind, let me have Dr. Kizer with his opening statement. Dr. Kizer, I appreciate your coming forward.

STATEMENT OF KENNETH W. KIZER, M.D., M.P.H.

Dr. KIZER. Thank you, good morning.

Mr. Chairman, members of the committee, I appreciate the opportunity to comment this morning on the two bills that, if enacted, would generally enhance VA health care.

VA supports most of the provisions of the two draft bills, although in my opinion section 16 is a fatal flaw. I also have concerns about section 17 as far as its inhibiting our ability to provide care that may be needed.

My formal statement provides an analysis of each of the proposals and discusses potential problems and, in some cases, some suggested modifications.

I am pleased the committee is addressing challenges that confront VA health care, particularly clarifying congressional intent with regard to long-term care and addressing the need to restructure VA's infrastructure to more effectively support current needs of the system.

Regarding long-term care, your proposal addresses a number of the proposals of the Federal Advisory Committee on the Future of VA Long-Term Care. This report and the development of VA strategy in this regard were discussed extensively during the committee hearing on April 22. In the interest of time, I am not going to repeat that presentation except to say that it is critical that VA be able to integrate long-term care treatment modalities into the continuum of services that are employed to provide health care for our patients. I believe your proposal defines these services. It sets appropriate priorities for access, and it provides a first step towards funding these services.

Notwithstanding your remarks immediately prior to my making these comments, I should note, though, that any new mandated service would be especially troubling if, in fact, it is true that the congressional mark on VA's budget will be 8 to 12 percent below the President's proposed budget.

Other aspects of the draft bill provide additional funding mechanisms that will assist VA in providing more services to veterans. The proposed enhanced services program and improvements to enhanced leasing authority will help VA manage its infrastructure, to generate increased revenues, and to make changes that will mean more funds are available for direct patient care.

Mr. Chairman, your draft bill addresses numerous other issues and we appreciate your support of our efforts to restructure and improve VA health care.

And, with that, I will stop and be happy to address any of your questions or comments.

[The prepared statement of Dr. Kizer appears on p. 83.]

Mr. STEARNS. Thank you, Dr. Kizer.

At this point I thought—we have all five of you here, and I have questions, and I am sure the ranking member does, too, for all of you. I know that staff has been discussing our millennium bill with the veterans and military organizations.

I mentioned earlier I appreciate your support and, of course, several of you have pointed out provisions that you are a little concerned with. And so our hope today is to listen and to work with you.

And, Dr. Kizer, when you say section 16 is fatally flawed, I hope you'll work with us to see what we can do. I assure you that I am fairly well convinced that the Appropriations Committee is not going to provide VA funding below the administration's budget. I feel pretty confident about that.

The first question is for any one of you on the first panel. The GAO states that our bill would, one, enhance long-term care services for aging veterans' populations, two, enhance services at underused facilities and, three, eventually enable us to serve more veterans. Do you agree that the bill would achieve those three goals?

I know from your opening statements you touched on several of these points.

Mr. WANNEMACHER. I agree with that. I agree with the statement that, by using underutilized services and by conversion—there is a place within the current VA health system for long-term care. The conversion of beds and facilities, though, has been a concern over the lack of funding for construction in both minor and major construction. I do believe that the vacant buildings can be readily turned into long-term facilities and it was the lack of funding that and have concern with as far as how the conversions can take place.

Mr. STEARNS. Mr. Cullinan.

Mr. CULLINAN. The VFW would basically agree with that. Given adequate funding, that certainly should be a likely outcome, that these facilities which are now used for something else would be better applied to long-term care services.

Mr. STEARNS. Yes, good.

Mr. VITIKACS.

Mr. VITIKACS. Thank you, Mr. Chairman.

I think there is—definitely, the long-term care provisions will tend to increase the utilization of those services. I think our concern would be that VA would be able to meet whatever increase in long-term care demand that is generated from this bill. So, yes, there will definitely be anticipated increase in long-term care utilization.

As of the end of last fiscal year, VA was operating roughly 14,200 nursing care beds. Now that figure may not be sufficient for the future demand.

Mr. STEARNS. Mr. Rhea, anything you would like to add?

Mr. RHEA. Certainly it has the potential to do those three things, Mr. Chairman. Yes, we believe that exists.

Mr. STEARNS. Mr. Wannemacher, you mentioned in your opening statement about the \$2 co-payment on drugs for treating non-service-connected conditions. This has been in place since 1990 without an increase, without a change. Yet, at the same time, VA drug prices have doubled. I don't mean to put you on the spot, but isn't a reasonable increase in this co-payment warranted?

Mr. WANNEMACHER. As I said in my statement—

Mr. STEARNS. It is almost 10 years.

Mr. WANNEMACHER. As I said in my statement, when the co-payments were enacted, it was for deficit reduction. We don't have a deficit now. And the men and women who rely on VA health care, some on fixed incomes, others not, have paid in blood and sacrifice and shouldn't be expected to pay co-payments for medical conditions; and that is why we are opposed to it.

Mr. STEARNS. Dr. Kizer, I understand VA's drug costs have doubled since Congress established a \$2 co-payment requirement. How does a \$2 payment compare with cost-sharing under private and other government health plans?

Dr. KIZER. The private sector co-pays typically start at \$5 and then go up to 20 percent of the cost of the drug. It is not uncommon that a month's supply of a single drug might cost close to \$200, so the co-pay under, say, a Blue Shield plan might be 20 percent of that or \$40. And you have everything in between depending on the plan and how robust is its pharmacy benefit. But I don't know of any that are less than \$5. Indeed, I am not sure there are many of those left. Most of them are \$10.

Mr. STEARNS. Do you have any indication whether Medicare-eligible veterans are turning to VA prescription for drugs? In other words, they can go to the VA instead of the Medicare? Do you have any statistics or anything that would confirm that?

Dr. KIZER. I can't quantify it in precise dollars, but it is a generally recognized phenomena that is occurring across the country and for very understandable reasons. It is a heck of a deal to go to the VA for your drugs.

Mr. STEARNS. Dr. Kizer, I wrote you some time ago about the impact on VA of a bill that would tie Medicare drug prices to the lowest prices paid by the Federal Government. Doesn't recent history suggest that such legislation would create sharp increases in VA drug prices?

Dr. KIZER. I think it is an issue that has been debated for some time. From the perspective of VA, and I think I can also say for the Department of Defense, this provision would result in higher expenditures for these two health plans.

Mr. STEARNS. There is, of course, some concern about the closure of VA hospitals. We are not advocating wholesale closure of hospitals but a rational process, some rational process. We had the base closure procedure for military bases, but I think we need a rational procedure for looking at the issue so that we can better deploy the dollars for veterans' health care when funds are not being well utilized.

And my closing question is, if, briefly, we would start with Mr. Vitikacs, if you could just comment on the issue of closure of VA hospitals. I think if you could give a brief response regarding the question of closing inefficient hospitals and redeploying funds to establish more efficient facilities and provide more care under the veterans budget.

Mr. VITIKACS. I think it is the GAO report that states that one out of every four medical care dollars are used to maintain bricks and mortars, is a very frightening statistic. And let's assume that that is accurate, one of every four. If we are talking about closing hospitals or closing unused buildings on multi-building campuses or just the actual vertical closure of facilities, I am not certain, you know, what definitions here are being used.

The vertical closure of hospitals, we do not support that as a general principle unless there are compelling reasons to do so; for example, maybe safety concerns or the antiquated condition of a facility and the cost of refurbishing that facility versus looking at alternatives to that.

I don't think there is a problem with accessing underutilized buildings on multi-building campuses but, in general, if the issue is that we want to look at a facility to close simply because of underutilization, I think that, conversely, we need to consider how to better increase the utilization of that facility.

Mr. CULLINAN. We would adamantly oppose closing any VA facility due to lack of staffing or funding. On the other hand, we well understand that there are those facilities whose resources could be better applied elsewhere. Our main objective is to provide the best health care that could possibly be provided to veterans through the VA system, not maintaining bricks and mortar.

Mr. STEARNS. Mr. Wannemacher?

Mr. WANNEMACHER. If the clinical needs are met in the area, and veterans no longer need that facility and that facility isn't prepared to deliver health care and data shows that—like I meant to say, the demand isn't there then there wouldn't be a need to maintain a bricks and mortar infrastructure. But if there still remains a clinical need for either long-term or acute care, then veterans need to have an identifiable health care system in place in order to meet their needs.

As I mentioned before, the CBOCs that are going out for primary health care, are tremendously well received in the veterans community. But there has to be a facility in the area that is able to treat their inpatient needs. If that facility isn't there we would oppose a blanket closure, but if it is looked at and the clinical needs are met, bed sizing is met, everything like that, then we are not opposed.

Mr. STEARNS. We try to do that in the bill.

Mr. RHEA. NCOA believes this is inevitable, Mr. Chairman, these are the tough questions the VA system must face; I suspect today we would be further along if we would have been a little more receptive to what one of your predecessor chairman proposed. Mr. Hutchinson proposed, something similar, but he tied it too closely to BRAC. And I noticed you mentioned the word BRAC, Base Realignment and Closure Commission. BRAC was very heavy on closure and very light on realignment, and I think when we—when

you put the words BRAC in the connotation of what we are talking about here, you scare people.

Mr. STEARNS. Good point.

Mr. RHEA. I don't think there is any objection—certainly for NCOA there is no objection to the process that you are proposing to establish. In this legislation that process involves veterans' organizations. It requires the gentleman sitting next to me to submit those proposals to you before he can act upon them. I think that gives ample time for review and input on anything that comes out of it before actions are taken.

Mr. STEARNS. Dr. Kizer, would you like to comment?

Dr. KIZER. I just want to underscore what was just said. The analogy to the BRAC is a flawed analogy. It is one that contaminates the thinking of the whole process. BRAC is about taking something away. And despite what the words of BRAC may mean, what it has meant is taking something away from a community. When we talk about realignment of VA facilities, what we are talking about is how we can get the best health care return on investment for the limited dollars that we have. It is not about taking health care away.

We all know that our budget is constrained. We have limited dollars. We can either put them into supporting bricks and mortar or we can put them into taking care of people.

There are situations around the country where we could do a lot better job of providing health care if we relooked at where we are putting some of our dollars, recognizing 40 percent of our facilities are more than 50 years of age. The average age of our facilities is 38 years.

The example that was cited earlier today, I bet if you went back and actually explored it, you would find that it goes to the heart of the problem that we are dealing with. Health care today and health care in the 21st century will require hospitals to be basically large intensive care units. So what we need is to be able to have facilities that are designed and fashioned to provide health care in the 21st century, not health care in the middle 20th century.

Mr. STEARNS. I thank my colleagues for their indulgence. My ranking member, Mr. Gutierrez, has various questions.

Mr. GUTIERREZ. Thank you very much, Mr. Chairman.

Let me just ask about the co-payments, DAV. In your statement you addressed a millennium plan that puts additional co-payments into a fund meant to be used for veterans' long-term care, not deficit reduction. If it is used for a long-term care fund, what would be the position of the DAV?

Mr. WANNEMACHER. We don't have a problem with long-term co-payments similar to the State veterans' homes. It is the medication—increase of the medication co-payment and the co-payment for acute care.

Mr. GUTIERREZ. If we lumped all of the co-payment into one fund for long-term care, even the ones for medicine?

Mr. WANNEMACHER. You can't lump acute and long-term care together.

Mr. GUTIERREZ. I am simply saying if that is where the money was all directed to go, if all co-payment dollars were directed to go to long-term care.

Mr. WANNEMACHER. And do away with the acute care medication co-payment?

Mr. GUTIERREZ. Well, we would use all of the funds, any co-payment. Right now, it is \$2 for prescription medication, and I understand why—I understand your point about it was supposed to be used for deficit reduction.

Mr. WANNEMACHER. That is on the acute care side. We don't have any objection to the long-term care proposal that is in the millennium plan. We don't have any opposition to that.

Mr. GUTIERREZ. Could the members of the different veterans' organizations here before us talk a little bit about your experience specifically vis-a-vis your membership or your outreach in terms of long-term care and what is going on in different VISN, if you have any information about that?

Mr. VITIKACS. There has been a major concern over the past several years about the direction of VA long-term care. Many individuals who have received VA long-term care for a considerable period of time have been—have had their care discontinued, oftentimes on very short notice. And in terms of even access into this system today for new veterans seeking long-term care, it is very problematic. It may be better in one VISN than it is in another VISN. So there is an unevenness throughout the country on being able to access those services so The American Legion certainly applauds these provisions that are in this bill today, with the aforesaid reservations that we believe the low-income category A veteran, their access to long-term care certainly needs to be better addressed before we move forward with this bill.

Mr. GUTIERREZ. Dr. Kizer, each one of the VISN has flexibility to do as they wish with their long-term care dollars or how they appropriate them or prioritize them?

Dr. KIZER. In essence, that is correct. You understand, and we have had some of this discussion before, that, in essence, we have been put in an untenable situation where the Congress has mandated certain things be provided. Some networks are able to provide that and still have funds left over to provide discretionary long-term care. Networks provide as much of it as they can. Those that are more financially strapped are going to focus on providing those things that the Congress has mandated as opposed to those things that the Congress has said you don't have to provide unless there is money for it.

Mr. GUTIERREZ. I follow up with the question, as you look at this bill that is before us, do you see the VA, should this bill become law, continue to do that as you are mandated to open up access for long-term care?

Dr. KIZER. I think there would be more uniformity if it is adequately funded.

Mr. GUTIERREZ. If this bill is adequately funded?

Dr. KIZER. If this bill and if the service you are asking to be provided is adequately funded.

Mr. GUTIERREZ. So that, in the absence of a mandate from Congress, this mandate from Congress proposed in this bill without additional funding, we would simply continue to see different VISNs say this is what we have to do and cut elsewhere?

Dr. KIZER. Well, let me ask you, would you rather they not do what you have said they have to do and do something else?

Mr. GUTIERREZ. Would I rather they do—

Dr. KIZER. In other words, you have said certain services are mandatory. Certainly acute care services are mandatory, and if we are having a hard time providing those because of financial strain and then there is long-term care which is discretionary, which you have said provide if you have the funds, would you rather us put the things in the latter category or the former?

Mr. GUTIERREZ. I can answer that question very, very easily. I would have obviously funded it if we had an opportunity and given the DVA and all of the independent budget group, the \$3.5 billion that they asked for, but I never got a chance to propose that. So that is my answer. The record is pretty clear, and there is a hole right here where the chairman gaveled me out of order.

So my position is very clear. I am simply asking you questions because I want to make sure that we all understand, and so you have answered my question rhetorically by asking a question. I hope you don't become so defensive because, in reality, I am on your side, even though it may not appear to be so.

So my question is—you have answered it. If we pass this and there isn't any additional funding, other areas of the veterans' administration are going to suffer because Congress does mandate things that they do not properly fund which we have done in the past and could continue to do in the future. That is my only point. So we are both on the same side today, anyway. I don't want you to think that this is going to—this is limited. It is a limited one, but I understand what you are saying.

Of course, I heard you say very clearly that, under the congressional mark—since this is a bipartisan committee, we won't suggest that it is the Republican's mark because it is—we are all responsible as Members of Congress. You say it is 10 to 12 percent under what the President proposed?

Dr. KIZER. The word that we understand or what has been floating around is that the congressional mark will be 8 to 12 percent below the President's proposal.

Mr. GUTIERREZ. Below the President's mark.

Dr. KIZER. I see people on the other side of the table shaking their head yes. It is part of the milieu of what is going on.

Mr. GUTIERREZ. I am sorry, Mr. Chairman, that they were—I am sure everybody will get a chance to ask even more questions. The red light is on. That ends my time.

Mr. STEARNS. The gentleman's time has expired.

The gentleman from New Jersey, Mr. Smith, is recognized for 5 minutes.

Mr. SMITH. Thank you very much, Mr. Chairman.

I first will agree with Dr. Kizer in his statement regarding to BRAC having gone through two very difficult BRACs in my central part of New Jersey, losing one base and saving another that was actually on the radically realigned, which is very hard to do, but we did win Navy Lakers.

The whole idea behind BRAC, as we all know and I think it needs to be repeated over and over, was with a reduced military, a significantly reduced military and an infrastructure that far ex-

ceeded it, we had to tone down and bring down the number of assets; and that is not the case with the VA where we are trying to provide more service. There it is a matter of realignment, with the emphasis on realignment rather than on closure. The former BRAC definitely focused on closure.

So I thank you, Dr. Kizer, because I think—because that sends shivers down my back whenever I hear BRAC.

Let me ask a couple of questions, first of all, in talking about the co-payments. As we all know, in 1986, the Congress authorized the VA to require higher-income veterans without service-connected conditions to pay a co-payment for inpatient-outpatient care; and, according to GAO, in 1998, \$143 million was realized during that year. I am concerned about the term of art "higher income". I was wondering, Dr. Kizer, if you might speak to that.

The number for a veteran who has no dependents is now \$22,064, which doesn't, to me, strike me as being somebody with a higher income. Is there a way—and perhaps this is something the subcommittee should consider—of ratcheting up that number so that we really—if we are going to have a co-payment enhancement and if the flexibility again inures to the VA that the threshold be raised so that we don't inadvertently catch people who really are struggling at the lower end? And 22,000 doesn't strike me as higher income.

Dr. KIZER. I think it is certainly something that warrants consideration and exploration insofar as what it would mean and who would be affected.

It is clear and I am glad, actually, that we have progressed to the point now where we use the term higher income. I remember when I first came here, these veterans were referred to as high income. They certainly don't qualify for that description.

Mr. SMITH. Hopefully, we can work together and with the VSOs as well.

Mr. CULLINAN. I would just offer we have strong support for that approach. In discussion earlier this morning with a colleague, we agreed there are certain veterans who shouldn't have any co-payment, medically indigent. On the other end, there are certain veterans who are higher income, who are solid middle class who can afford a higher co-payment; and I would just add to that there are certain services and goods like medicine that VA might want to provide also if there was a sufficient co-payment—more products, more veterans.

Mr. VITKACS. Congressman Smith, one of the problems with all of the additional co-payments that VA receives is that, instead of those funds being used as a supplement to congressional appropriations, they are used as a substitute for additional congressional appropriations. So the more they will collect in co-payments then the less the appropriation amount becomes. So there is a—these co-payments are not used as what they—as they were originally intended.

Mr. SMITH. It is an excellent point because we have seen that with the attempts to garner third-party reimbursement where it then makes the case that this place is the appropriations. I think that is a very good point.

Let me ask, Dr. Kizer, with regards to the—allowing those military retirees who are eligible for DOD's TRICARE, you seem to have punted. Because it seems like the information has not been adequately reviewed by the administration yet, according to your testimony, but do you have a personal view as to whether or not that would be an advisable provision to enact?

Dr. KIZER. Is one allowed personal views here?

Mr. SMITH. Without a doubt.

Dr. KIZER. I think the issue is DOD has not actually been able to work through this and what it might mean for their program. I personally think it is a good thing. It would be good for the VA.

Mr. SMITH. Do you have any sense as to how many retirees might avail themselves?

Dr. KIZER. We have done no formal study like that. I think the experience that I have had is similar to the experience that probably many of you have had as well. At different meetings in the community, dedications and other such events, I find that at every one of these that I go to now, there is a group of retirees that meet me after the event is over and say, "how can we access the VA," "we are not happy with TRICARE," and "we would like to get service in the VA, and we can't do it." I hear that over and over again.

Mr. SMITH. I appreciate that. I do hear from some of those same veterans in the Fort Dix, Fort McGuire area who make that same case. Hopefully, the administration's full view and analysis will be available before markup, but we are very happy to have your support for that.

Thank you, Mr. Chairman.

Mr. GUTIERREZ. Would the gentleman yield?

Mr. SMITH. I would be happy to yield.

Mr. GUTIERREZ. I just thought if Dr. Kizer could tell us—why is section 16 fatally flawed? If you could just share. Fatal is pretty extreme. Why is it fatally flawed?

Dr. KIZER. It is unnecessary, regressive, and I guarantee would result in perverse behavior.

Mr. GUTIERREZ. I am sorry, what kind of behavior?

Dr. KIZER. Perverse behavior.

Mr. GUTIERREZ. Perverse behavior. Okay.

Mr. STEARNS. The gentleman's time has expired.

The gentleman from Pennsylvania is recognized for 5 minutes.

Mr. DOYLE. Thank you, Mr. Chairman.

Dr. Kizer, in our VISN, it is estimated that approximately 17 percent of all veterans are being provided care through the VA. What efforts are we making proactively to increase the amount of veterans that—patients that we serve in our VA hospitals before we jump to the conclusion that the beds aren't needed? What are we doing proactively to increase?

Dr. KIZER. Of course, your area is one of the lowest in the country; and if we look at the population which at least in recent history have been able to access the VA, the former category A's, the service-connected-disabled and low-income, in most parts of the country it runs in the high 30 percent range up to the low 40s, 35 to 45 percent roughly. There are a couple of areas where it is particularly low; and we aren't entirely clear why that is, although we

believe it has to do with the availability of other insurance and job markets and other such things in those particular communities.

A number of efforts have been under way to increase the number of users insofar as we can provide that care with the funds that we have.

I know in your area, there were a number of efforts, going out to health fairs, going out to a variety of other forums with veteran service organizations and others to advise people about the availability of VA health care; and, indeed, the number of users of the system is up 22 percent in 1998 compared to 1994, which equates to over half a million more people actually getting serviced than 4 years ago. So we have made, I think, some significant progress in that regard.

The last thing I would say is that was one of the strong reasons behind opening up the system to all priority levels last year or in the current year. The decision was made to enroll Priority 7 veterans because, in part, we wanted to find out what was the demand among those higher income veterans which historically have been shut out of the system.

Mr. DOYLE. Let me ask you another question, too. Given Secretary West has indicated that there is going to be facilities closed in 2001 and you, yourself, have made statements indicating that maybe as many as 8,000 employee positions will be eliminated largely because of inadequate funding levels, how will this legislation we are discussing today help to minimize these trends or will this legislation do anything to impact that?

Dr. KIZER. I think it depends entirely on what else happens as well. If you impose some additional mandates and the congressional mark actually is 10 percent below what the President has proposed—

Mr. DOYLE. There will be World War III. Believe me, if that mark isn't increased, they are not going—there is going to be fist-fights on the floor of the house.

Dr. KIZER. I hope we can count on that. But all I am saying is those are the sorts of realities that we have to look at as we try to plan for what we are going to do in the year 2000. So it really would depend on the composite of budget and mandates and other things that happen.

Mr. DOYLE. Let me ask you another thing. In our VISN again it is projected by the year 2005 that the overall number of veterans age 75 and over is actually going to increase by 37 percent, from about 244,000 to 334,000. In your opinion, does the criteria regarding long-term care reform in the bill provide the necessary flexibility for networks to tailor delivery of care to meet the needs of veterans in their particular areas, my area, Allegheny County, being one of the oldest areas in the country?

Dr. KIZER. My first comment, I am surprised, actually, that the increase is only 37 percent. I would have expected it would be much larger than that since it will be much larger than that in most parts of the country.

Having a combination of options available to us, such as, increasing home care, increasing adult day health care, increasing other non-institutional care settings for long-term care and being able to provide long-term care in VA nursing homes and State homes and

in community nursing homes, should in the aggregate provide us with the ability to provide what is needed if there is funding to support those services.

Mr. DOYLE. And, finally, just one last question. In general, when beds are eliminated, what efforts are going to be made to reallocate both the resources and staff to address health care needs within the context of an outpatient structure?

Dr. KIZER. Well, clearly, those efforts are being made. We have established almost 300 new community-based outpatient clinics and received no additional funding, i.e. the funding for all those clinics came from redirected savings. Alas, many of the conversions at hospitals from former inpatient bed wards to outpatient facilities, is being done through those redirected savings. None of this is such that you could say, you know, directly that dollars from this bed unit funded that particular outpatient clinic because there is a composite of dollars that were spent one way and now they are being spent in a different way. But, clearly, the funds are being re-invested, the infrastructure is changing, and we are taking care of more patients.

Again, I go back to what I said a few minutes ago. We are taking care of more than 20 percent more people today than 4 years ago.

Mr. DOYLE. I see the light is on, Mr. Chairman. Thank you.

Mr. STEARNS. I thank my colleague.

The gentleman from Minnesota, Mr. Peterson.

Mr. PETERSON. Thank you, Mr. Chairman.

Maybe the question I have can't be answered by Dr. Kizer or the staff. Do we have a figure on the cost of this bill yet? Do we know how much it would cost?

Mr. STEARNS. I can attempt to answer that. The bill is not subject to availability of funds. It works within the structure to save money and use the savings to implement the bill. So we work off of GAO audit, and we try to say the savings that they recommend we are going to make those available to implement the bill.

So I think, as a first start, that is our thinking anyway.

Mr. PETERSON. But it looks to me like what you are doing in here is going to cost money, a lot, by mandating that they provide these services. I don't think it is realistic to think that that is just going to come out of thin air. That is part of why we have gotten into this problem that we are in now.

Mr. STEARNS. I think the mandating is subject to the availability of resources and let the administration work through, I think would be a polite answer to that question.

Mr. PETERSON. Dr. Kizer, don't you think if this bill passed that it would put even greater pressure on your budget?

Dr. KIZER. There is no question. As I testified on April 22, that while we feel that it is essential to provide long-term care, it is going to cost money. But it is money that should be spent.

Mr. PETERSON. My question is, do you know how much it would cost?

Dr. KIZER. No. This bill has been in evolution by the committee, and we have not done a cost analysis. I would have to defer to the committee on that or we may try to make some efforts at costing it out.

Throughout my written testimony, as well as my oral comments, I have emphasized that these things should be done. This is an appropriate bill. These are measures that are needed, but if you mandate them and don't provide the resources, you are going to create chaos in the system and you are going to have effects that you really don't want.

Mr. PETERSON. That is my concern. Do you have any idea of—

Mr. STEARNS. If the gentleman would just let me interrupt. We asked the CBO to give us a cost estimate by the first of June on this bill. We will have that, obviously, before we mark up, just for the member's information.

Mr. PETERSON. Do you, Dr. Kizer, have any kind of number on what it would cost if we provided long-term care, extended care to all of the service-connected-eligible veterans?

Dr. KIZER. I don't have that. You are talking about all the way down to the zero percent?

Mr. PETERSON. Yes.

Dr. KIZER. I don't have that number. I don't have degradations for, you know, 50 percent or above. And we can try to produce a number for you, but I would caveat it up-front that it would depend on their receiving long-term care in the most appropriate settings and other specifics, and one will have to make a number of assumptions about future need and costs in generating that.

The other thing I would tell you up front is that depending on the proposal costs could be substantial.

Mr. PETERSON. I understand that. For my own information I would like to have some idea what we are talking about here before we start down this road. I mean, I think it is pretty clear how tough it is going to be for us to get budget money. I don't think we should kid ourselves. From what that process looks like, they are going to backload these spending caps and have this—the bill with your money be one of the last bills when they are out of money. That is what is going to happen. And how that is going to work is beyond me, but it is—

Dr. KIZER. That is reassuring.

Mr. PETERSON (continuing). It is going to be interesting. At least you are not in the Labor-HHS bill. It is going to be interesting to see what happens when we get to that point. But I don't think anybody ought to think that there is going to be a lot of money floating around here, from what I can see. But I would like—if you could get us some estimate just so I have some idea what—you know, what kind of costs we are talking about projected out.

Yesterday I was in a meeting where we talked about the Social Security Fund and in looking at the next 75 years and what is coming in and how much that costs. I think we need to have some kind of similar estimates on what kind of—as this population ages, what kind of money are we looking at if we, in fact, provide these services. And it may be way beyond what is possible for us to put together, but I guess I would like to know what the universe is.

Dr. KIZER. We will provide the committee some best-estimates scenarios under some different circumstances.

Mr. PETERSON. I would appreciate that.

Thank you, Mr. Chairman.

Mr. STEARNS. I thank the gentleman.

I think we have finished with Panels 1 and 2, unless you have additional questions. Yes, Mr. Gutierrez.

Mr. GUTIERREZ. Just going back, Dr. Kizer, one moment, to section 16. I read it again. It doesn't require the VA to leave unnecessary beds open. It requires the VA to have a plan for the care that would have been provided in those beds should you decide to eliminate them. Are we in disagreement with what section 16 does?

Dr. KIZER. I read it that same way, but I also know that—first of all, it is not clear what the problem is that is being addressed. If it were more clear what the problem was, then maybe we can look at other ways of addressing it.

For example, it has been rumored that there is some concern about mental health beds. We have in process actually a directive that will be coming out which will require, in essence, the same thing that I think is being dealt with here, that before any mental health beds would be closed, that the facility will have to provide a plan for what will be done and how will the VISN assure community-based care and a number of other things. So if it is that type of problem, there is a far easier way to deal with it.

I also know from prior experience that when you say 45 days in session, that is not what it equates to. For example, I remember when we were going to implement the transformation of the VA, the VISN network plan, and on the 89th day, which was 6 months after it had been submitted but the 89th day it was in session, Congress went on recess; and we were advised in no uncertain terms that even though there was no opposition to that plan that we could do nothing to implement it until 6 weeks later when Congress came back from their recess.

So those types of things I just see as creating all kinds of problems and fundamentally don't address the problem, and I would much rather try to address whatever the perceived or real problem is by a more effective mechanism.

Mr. GUTIERREZ. I think the reason it would be in here—and I could be wrong—one of the reasons I thought it was a good idea, although it is perverse—I think of pervert when I think of perverse—

Dr. KIZER. I won't get into that.

Mr. GUTIERREZ. I know. So I said to myself; in Chicago, for example, at Hines, they have a directive that, right now, for every thousand veterans that they serve, they want to make sure that there aren't any more than 1,800 stays, bed stays for every thousand. They say that is too high and that you sent them a directive saying that it should be 1,500 so that it could—

Dr. KIZER. That is not so.

Mr. GUTIERREZ. Then you know what they told them. You sent them a directive it shouldn't be 1,800 per thousand. It should be more like 1,500 per thousand, which everybody thought, which at least all of the medical staff thought, could be accomplished. But lo and behold, the VISN director sent out a directive that it should be 950 nights per thousand.

This is information that I got from the heads of each one of the departments. I met with about 38 of them on Saturday morning, and they all came together—director of surgery, chief surgeon—all of them came. These are their directives.

So you can understand how someone like me, anyway, would say, well, before we take any further steps, maybe we should be informed. Because at least what was told to me, was that there was one level that is what is universally accepted in medical fields, whether you use Medicaid or Medicare, as how many bed stays per thousand patients; and then there were—that is where VA is at, specifically Hines, and that is where you would like them to be at. But then there is the VISN director who really wants to do well and show and champion the world that she can do better than that.

So that is the information that I received, not happenstance but from pretty good sources that that is what is going on. So there isn't a directive.

Dr. KIZER. Your example is a good example of how it doesn't address the problem. Because bed days of care refers to the number of nights or days in the hospital, not the number of beds that are on the ward.

Mr. GUTIERREZ. But you see—you are right. You are absolutely right, Dr. Kizer. But you see what happens is, as you try to reach those goals, you may unwittingly reduce the number of beds. Because as you go down—if I go from 1,800 to 1,500 to 1,400 to 1,200, guess what happens? I begin to eliminate those beds. Because I say, guess what? We are at 1,200 per thousand. We don't need those extra beds. We eliminate those beds. So it is kind of a fait accompli in that if we reach our goals we are eliminating the beds because we don't need them any more because we have met those goals.

I know this for a fact. People at Hines show up, and the folks at Hines have to send them to Loyola or to other medical centers because they cannot give them emergency care at Hines because there are no beds for them, literally no beds. I have e-mail sent from one department to another department at Hines saying, we have no beds, and so people there are sent to more expensive care outside.

The same thing happens with radiology and with other services which are privatized and then sent out because the capacity at Hines keeps reducing, reducing, reducing.

This is one example. I imagine it happens at other settings. So that in the end what will—I mean, in my mind, if I continue to do this ad infinitum, there will be no VA medical health care because the VA at one point can say nobody is showing up and we don't have beds and we have met our goals.

So that is why I think it is important that we have at least some linkage between your actions, the actions of the VA and giving us a plan so that we know that it just doesn't eliminate the service completely.

Mr. STEARNS. I think the gentleman's point is well taken. I think you have a plane to catch so we certainly wanted to accommodate you on that. If the gentleman—did you expect an answer?

Mr. GUTIERREZ. If he could. I just looked up the word perverse, and it says corrupting, and I don't see anything corrupting about making sure that there are proper health care facilities for—I think it is corrupting that you take away something and then not answer to anybody about what is going on. So I just wanted to

make sure, because I am a college graduate, but I just wanted to make sure what perverse meant.

I don't think it is perverse at all. I think it is pretty good policy, because it is the function of Congress to make sure to do oversight on the executive branch of government, and it would be perverse of us not to watch what you are doing.

Dr. KIZER. And you watch us very closely.

Mr. GUTIERREZ. We try to. You can take the dictionary back. I learned an important lesson.

Dr. KIZER. Let me give you an example of how it might be perverse behavior. Instead of having 20-bed units we will suddenly have an abundance of 18-bed units. That doesn't address the issue.

Mr. GUTIERREZ. We will work on it together.

Dr. KIZER. I think I would much rather deal with the fundamental problem, whatever it is, that you are trying to address than putting in law something that really won't work.

Mr. STEARNS. I thank the gentleman.

Mr. Vitikacs, you worked with the staff, and we appreciate your efforts. Our understanding is that you support the bill while you do recommend certain provisions. Is that a fair statement of what The American Legion's position is?

Mr. VITIKACS. That is accurate.

Mr. STEARNS. All right. I want to thank the first and second panels for your patience and your time. Now we will call up the third panel. Thank you, Dr. Kizer.

The third panel, we have Harley Thomas, Associate National Legislative Director of Paralyzed Veterans of America; Colonel Robert Norton, USA, Retired, Deputy Director of Relations, the Retired Officers Association; John J. Daly, Legislative Assistant, the Retired Enlisted Association; Rick Weidman, Legislative Director, Vietnam Veterans of America.

STATEMENTS OF HARLEY THOMAS, ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; COLONEL ROBERT F. NORTON, USA (RET.), DEPUTY DIRECTOR OF GOVERNMENT RELATIONS, THE RETIRED OFFICERS ASSOCIATION; JOHN J. DALY, LEGISLATIVE ASSISTANT, THE RETIRED ENLISTED ASSOCIATION; AND RICK WEIDMAN, LEGISLATIVE DIRECTOR, VIETNAM VETERANS OF AMERICA

Mr. STEARNS. Mr. Thomas, you are recognized for 5 minutes for your opening statement, please.

STATEMENT OF HARLEY THOMAS

Mr. THOMAS. Good morning, Mr. Chairman and members of the subcommittee. It is a pleasure to be here to express our views on the proposed draft legislation.

In general, PVA believes the provisions contained in the proposed Millennium Health Care Act are commendable, and we would like to thank the authors for this legislation. We do, however, have some concerns and would like to suggest that the committee proceed with great caution in several areas.

My written statement covers all of our concerns in detail. Therefore, I would like to limit my remarks to the area of greatest con-

cern to our members. Therefore, I would like to make sure that the entire written statement is included in the record.

Mr. STEARNS. With unanimous consent, so ordered.

Mr. THOMAS. Under extended care services, the provision, for the first time, would mandate that VA operate and maintain a broad range of extended services. The provision, if enacted, would underscore and clearly identify by statute the importance of VA's long-term care mission.

Eligibility reform, enacted 4 years ago, left long-term care outside the umbrella of mandated services. Extreme budget pressures on the provision of acute care services have allowed local managers to seriously degrade their long-term care programs in order to shift resources to maintain services that fall under the mandated benefits package. At the time that our aging veteran population is looking to VA for long-term care support, veterans find local hospital directors and VISN planners divesting themselves of their long-term care capability.

The provision also clearly identifies the full spectrum of long-term care services within the VA service delivery system. Long-term care is far more than just a nursing home bed. The only addition to this list we would make would be to include assisted living in the same long-term care "tool chest".

The United States, unlike most western developed nations, has no generalized long-term care policy. Long-term care has been left out of the discussions over Medicare reform. The combination of public services, private programs, and long-term care insurance initiatives have left major gaps in long-term care coverage for most Americans and their families who face, or could face, catastrophic illness.

As PVA members with spinal cord dysfunction age, deterioration in physical condition and health status make the eventual need for specialized long-term care services an ever-present threat. In many instances, the veteran's spouse or caregiver is also aging and faces their own inability to provide the same level of services and assistance they have provided for a lifetime. For these veterans and their families, long-term care options are often quite grim.

Anyone who uses a wheelchair is precluded from purchasing long-term care insurance. Medicaid, perhaps the only safety net option, requires the indignity of impoverishment and, in most cases, institutionalization, unsuited for the veteran's need for specialized care.

Preferred home care options are limited and expensive. Medicare home care programs have come under-increasing costs and eligibility scrutiny. State Medicaid waivers for home and community-based care are sporadic and not implemented with every State. For many veterans, particularly PVA members, the VA has been the only option for their specialized health care needs as well as for their present and future needs for specialized long-term care.

Sadly, the erosion in VA long-term care capability that has taken place over the past several years has seriously threatened the specialized VA long-term care option that PVA members have thought they could count on.

The draft bill for the first time attempts to address the unclear reality of exactly which veterans are eligible for nursing home and

other long-term care—health care services. The bill would spell out eligibility for veterans requiring care for service-connected disability and for veterans rated 50 percent disabled or more for service-connected disability.

For other veterans, it would require the Secretary to prescribe regulations governing the priorities for provisions of in-house nursing home care, indicating that priority would be given for, A, patient rehabilitation; B, for clinically complex patient population; and, C, for patients whom there are no other suitable placement options. This language applies clearly to veterans in need of long-term specialized care, particularly those such as veterans with spinal cord dysfunction who rely on existing specialized designated SCD long-term care beds not available or suitable in the private sector.

We believe if this language is enacted the committee should ensure that statutory or report language clearly acknowledges access to special patient populations such as SCD veterans who, because of the clinically complex nature of their disabilities, require long-term care. The provision should also acknowledge that this care is an essential component of the entire range of specialized SCD care that VA has developed. The capacity and availability of these services must be maintained and made available to any veteran in need.

The provision for long-term care fees allow the Secretary to establish a fee schedule for veterans receiving VA long-term care services who are not service-connected, rated 50 percent or more, or who are receiving services for their service-connected disability. PVA considers fees charged for these veterans to be a basic retrenchment of existing eligibility.

Despite certain guidelines and protections included in the legislation, it is not clear exactly how the Secretary would designate this fee schedule. The provision would establish the Department of Veterans Affairs Extended Care Fund that would be a repository of the collections in the attempt to protect these funds from budget or appropriations offsets. The goal is well intended but, based on previous experience from the authorization of other fees or collections, what was once intended to benefit and enhance one VA program in reality was offset from future appropriations by OMB.

The requirement to increase extended care services calls on the VA to develop a plan to implement the recommendations of the Federal Advisory Committee on the Future of Long Term Care. PVA fully supports this initiative.

On Medicare collections, PVA opposes increasing prescription drug fees, and for both medical equipment and supplies.

Reimbursement for emergency treatment. PVA believes that all enrolled veterans should be eligible for reimbursement for emergency services.

In the review of proposed changes to operation of medical facilities, this provision would require congressional notification and approval in any situation where a facility intended to close more than 50 percent of the beds within a bed section of 20 or more beds. Current law requires VA to maintain its capacity to provide spinal cord dysfunction medicine. SCD medicine is primarily a hospital-based specialty. In our opinion, the capacity to provide these services does

not allow for reduction in the number of beds at all. If VA were to close 40 percent of the beds in one SCI center, the provision would not require notification to the Committees on Veterans' Affairs. If the hospital closed 50 percent of the beds, they would be notified. In either case, such closures would violate the statutory mandate to maintain the capacity of specialized SCD care.

I thank you, and I will answer any questions you may have.

[The prepared statement of Mr. Thomas appears on p. 105.]

Mr. STEARNS. Colonel Norton, for your opening statement, 5 minutes.

STATEMENT OF COLONEL ROBERT F. NORTON, USA (RET.)

Colonel NORTON. Thank you, Mr. Chairman. It is a pleasure for me, sir, to have the opportunity to appear before your subcommittee on behalf of the 400,000 members of The Retired Officers Association, TROA. TROA appreciates your leadership, Mr. Chairman, and the subcommittee's commitment to veterans, especially in regard to health care eligibility reform and the additional reforms proposed in the Veterans' Millennium Health Care Act. TROA supports all the provisions contained in the bill.

I would like to take a moment, Mr. Chairman, and just review a couple of the sections of the bill that are of particular interest to military retirees and to our members.

TROA endorses the provisions of the draft legislation that would incorporate long-term care into the policy framework of eligibility reform. As Dr. Kizer said earlier this morning, long-term care should be considered an essential element in the continuum of health care services and not an add-on or supplemental service.

TROA is actively supporting legislation to permit military retirees to purchase long-term care insurance under the Federal Employees Health Benefits Program. But, frankly, many military retirees would not be able to afford such insurance premiums; and, of course, a number of military retirees have significant service-connected disabilities that would make them eligible for long-term care if it were made a mandatory benefit.

A significant proportion of the 1.7 million military retired veterans are eligible for VA health care as Category A veterans. The rest have only potential access to VA health care under Enrollment Priority Group 7. The draft bill before the subcommittee would create a new enrollment category authorizing them to VA health care as Category A or mandatory veterans. We support this provision. It would open another option to military retirees who are increasingly being shut out of military hospitals as a result of the post-Cold War downsizing.

But this is no panacea. The problem is resources as well as statutory authority. Last week, for example, the VA, after months of foot dragging, announced that it was about to release what it is calling enrollment welcoming letters to Priority 7 veterans, some 500,000 veterans waiting in the queue for months to be notified under the VA's so-called open enrollment policy. A significant number of those waiting in line are military retired veterans. Once they finally get their letters, they will be assured of care only for the last 4 months of this fiscal year. Then the process begins all over.

Along the same lines, Mr. Chairman, TROA is concerned that if a new category is established for military retirees, even if it is a mandatory one, the VA might use it to spike enrollment numbers but in the end care will not be made readily available to many military retired veterans.

One other point on the new category. The average age of all military retirees is 61. That means that non-service-connected retired veterans who enroll in the new category could only be seen in a VA facility for a few short years until they lose TRICARE eligibility at age 65.

We urge you, therefore, Mr. Chairman and members of the subcommittee, to continue to work with Mr. Thomas' Subcommittee on Health of the House Ways and Means Committee to bring VA subvention to passage as soon as possible so that the real potential of the new category can be exploited in the near future.

TROA also supports the provision authorizing broader authority for reimbursement of emergency care; and we support the need to realign and, if necessary, close facilities within the guidelines laid out in the bill and provided that the primary objective is to enhance medical care services to more veterans.

A brief comment about dependant care. We support a demonstration allowing certain dependents of veterans to get VA care provided they agree to pay co-payments and meet the other stated requirements. And as a matter of fact, as you know, Mr. Chairman, a number of VA facilities are already participating as TRICARE partners; and I guess there are limited demonstrations already happening in certain parts of the country. But here again, however, we are concerned about the capacity of the system to handle the increased demand in the face of stagnant budgets. However this comes out, Congress must be willing to provide the necessary resources to guarantee care to those who have earned it by their sacrifice.

Once again, Mr. Chairman, I would like to thank you for the opportunity to represent The Retired Officers Association before your subcommittee, and I look forward to answering any questions you may have. Thank you.

[The prepared statement of Colonel Norton appears on p. 114.]

Mr. STEARNS. Thank you, Colonel Norton. Mr. Daly, your opening statement for 5 minutes.

STATEMENT OF JOHN J. DALY

Mr. DALY. Good morning, Mr. Chairman. I come before you today on behalf of the 100,000 members and auxiliary of The Retired Enlisted Association, representing all branches of the armed forces, retired, active, guard and reserve, to discuss the single most important issue to our members, health care.

Perhaps more than any other member of the military family, military retirees have suffered at the hands of cost-cutting measures. For example, as Colonel Norton previously stated, at the age of 65, they are no longer eligible for their health insurance, the only class of Federal employees this happens to. Others have seen the military treatment facility they relied on for their health care needs either downsized or closed, leaving them with few, if any, options for care.

Over the past several years, our primary goal has been to increase a retiree's options for health care. Access to the Department of Veterans Affairs facilities is one of those options.

In preparing for today's hearing, we were presented with a draft copy of the Veterans' Millennium Health Care Act. This draft legislation addresses several issues of direct impact to retirees. I would like to briefly address three at this time.

The concept of eligibility reform is one of particular interest to the members of this organization. Such reforms will help the government maintain its promise to retirees by providing retirees with the possibility of having increased access to VA health care. We believe that the creation of a separate enrollment category is a justifiable benefit for those who have served 20 or more years in our Nation's armed forces.

Today, there are military retirees who live in areas where bases have closed and have no service-connected disability and are considered higher income veterans. The VA may be the best option they have for health care, but they will fall under Priority 7 at the VA and in all likelihood be told there is no space available, no space available for those who dedicated the prime of their life to the military. The government of the United States has no space available for those who move their families all over the world out of a sense of duty.

Mr. Chairman, does it not seem like the fair and decent thing to offer these retirees a separate category, one that will place them between the existing Priority 6 and 7 as outlined in the millennium plan? This organization believes so and urges this subcommittee to enact such legislation.

Secondly, as we urge the subcommittee to provide retirees improved access to the VA, we also urge this subcommittee to guarantee the VA provides a complete benefits package. Specifically, we request the VA be granted reimbursement authority for emergency treatment. This is an essential benefit if we are to tell our members and all military retirees that the VA will provide them with a full health care benefit.

The program outlined in the millennium plan is a cost-conscious plan which would help protect those veterans who have no alternative when it comes to paying for emergency medical treatment. Many military retirees will certainly benefit from this legislation.

Surely many members of this subcommittee are aware of military retiree struggles regarding Medicare Part B. Many retirees are not enrolled in Medicare Part B because they believe that their local military treatment facility will provide the necessary health coverage at no cost. Now thousands of retirees live who in BRAC areas will have to pay tremendous fines to be eligible to enroll in Medicare Part B. The recommendation in the millennium plan will give the retirees not just the option but the financial ability to receive the necessary emergency care.

Lastly, I would like to address the issue of long-term care. The veterans' population, as stated by Dr. Kizer before this subcommittee, is aging. In fact, Dr. Kizer stated that the percent of veterans over the age of 85 will increase by a remarkable 333 percent over the next 2 decades.

As these veterans age, they will need an increasing amount of long-term care resources. In light of this, the proposals included in the millennium plan should be the foundation for a fully funded, VA-managed, long-term care program. The proposals include the maintaining of fiscal year 1998 levels of in-house extended care, mandating that the VA provide near extended care services on an ongoing basis in the case of 50 percent service-connected veterans or veterans in need of such care for service-connected disabilities and require the VA to develop and implement a plan to carry out the recommendations of the Federal Advisory Committee on the Future of Long Term Care, which recommended that the VA should increase both home-based and community-based care options.

In closing, Mr. Chairman, the members of TREA realize that this great debate will come down to dollars and cents. However, our members hope that Congress will realize that this is not, as far as military retirees and their dependents are concerned, a Department of Defense responsibility or a Department of Veterans Affairs responsibility. It is the responsibility of the Federal Government as a whole.

Military retirees were promised health care by the United States. Diffusing the resources of the VA will help provide that option for more retirees, and it should be pursued.

Mr. Chairman, thank you for your time; and I would be pleased to answer any questions you may have.

[The prepared statement of Mr. Daly appears on p. 123.]

Mr. STEARNS. Thank you. Mr. Weidman, your opening statement for 5 minutes.

STATEMENT OF RICK WEIDMAN

Mr. WEIDMAN. Thank you very much, Mr. Chairman, for inviting us here today to present our views. We are very much in favor of this legislation, and grateful to you for your leadership in introducing the "Veterans' Millennium Plan." VVA believes that it is a necessary step in light of the great reduction of resources that we have experienced, not just this year, but over the course of the past decade.

Much discussion has taken place in this room about that diminishment of resources over this time and, while this may be "hard medicine," we believe that it is a sensible way to approach and make orderly the process for accountability for closures and reductions of capacity.

There are two things that VVA has questions about. The first has to do with the implementation actually more and what is reasonable for veterans to "co-pay." While Vietnam Veterans of America does not conceptually disagree with the need for co-payments, reasonable co-payments, for non-service-connected veterans, we would point out that often the veterans' benefits side of the VA house is such a mess—I could get technical and fancy—but it is a mess, and I think we all know that, and it is often very unfair, and so veterans are seeking care from VA. If they are non-service connected and their claim has been hung up for many years, then to charge that individual a relatively high rate for a prosthesis, as an example, or other kinds of expensive medical equipment that is

needed seems to us to be grossly unfair. So the sensitivity with which this higher co-payment is implemented then would become key from this point on.

Secondly, the problem that—I will just note in the written statement, Mr. Chairman, that we noted other reservations, but they are relatively minor in comparison to this one. What underpins this whole discussion this morning and what underpins the veterans' millennium plan is the question of resources, as has been pointed out by virtually every witness here this morning.

But there is a flip side to that and perhaps even more important part of it as we move to try and bring on-line additional funding streams. What is crucial is the question of organizational capacity, to be able to serve those additional people no matter what additional resources from whatever source that they bring with them.

That organizational capacity has been dramatically diminished over the course of the last several years. It seems to VVA that if there isn't a plan that we can build into place working, all of us, both those of you in the Congress as well as the folks within the Administration and the veterans' service community, to develop that organizational capacity to restore it, it doesn't matter whether it is a third party payer that is a private insurance company, whether it is the individual, him or herself, whether it is Medicare or anybody else. If there is X number of staff that can serve Y number of veterans and we are adding in addition to Y number of veterans Z number of veterans, who will serve those individuals with quality health care?

That gets into the rationing question, which is really what all of this debate on priorities is about, is "Who shall VA serve?" My organization has been clear from the outset about what our priorities are, and we believe that they should be for the Veterans Administration. It is for the "he or she who hath borne the battle," first and foremost, the service-connected disabled vets, and particularly those who fall into the category of the specialized services as defined in Title 38, U.S. Code, which is really at the core of the mission of VA.

Whatever we can start to do beyond that, then by all means we should do. However, we have not made those hard choices in terms of who, in fact, gets access to care. Once again, that is directly connected to the question of "organizational capacity" to serve X number of people for whatever type of care you are trying to provide.

There are other things that we believe that need to be done in tandem with the possible closing of medical facilities, which is really what we believe that this is all about. The "realignment" is all too much like a euphemism.

I believe that Dr. Kizer portrayed where he believes we are going and need to go this morning when he said that in 20 years VA hospitals will be there to provide intensive care only. The question is, if that is the case, where is other long-term and acute care going to take place that is not in an intensive care ward? Where is it from whence goes that? Where will be that organizational capacity developed?

If there is a plan, it certainly has not been shared with those of us in the veterans' service organizations, and I expect not with the Congress either.

I would just touch on one other thing that we mention in our statement before closing, Mr. Chairman. That is, a future investment in alcohol and drug prevention programs—and I very much commend you for setting up the trust fund and a move toward “holistic” and a “wellness” model of care within the VA—would make a great deal of difference in the resources available even within the same fiscal year if VA would rigorously implement it.

Again, thank you very much, Mr. Chairman, for your leadership.

[The prepared statement of Mr. Weidman appears on p. 128.]

Mr. STEARNS. Thank you very much, Mr. Weidman, for your comments. I think they are thoughtful and will help us a little bit here.

Mr. Thomas, let me go back to this question. The PVA has favored expanding benefits but opposes cost sharing for non-service-connected care that might help fund those expansions. I guess the question is, are there any circumstances under which the PVA might support cost sharing tied to expanding benefits or improving services?

Mr. THOMAS. I think that would depend upon the income level of the individuals and the circumstances. I don't think we are prepared to make a definitive statement in that area at this time.

Mr. STEARNS. Do you think you will make a definitive statement at a later time?

Mr. THOMAS. Probably.

Mr. STEARNS. When might that be?

Mr. THOMAS. I would be happy to submit something to you in writing, sir.

Mr. STEARNS. Do you mind doing that for me?

Mr. THOMAS. We can do that.

Mr. STEARNS. We are sort of proposing a modest proposal for veterans' dependents here, and this is just a mere test that might benefit your own members' dependents. It will still provide VA reimbursement, but you seem pretty strong against it. You are adamantly opposed to a mere test?

Mr. THOMAS. I think the primary reason is, in past examples of cost sharing, what has happened, rather than to supplement the VA, the money has been an offset in the appropriation cycle, and we are opposed to that concept.

Mr. STEARNS. Would the rest of you care to comment, Colonel Norton or Mr. Daly or Mr. Weidman? You don't have to, but if you feel incumbent to do so.

Colonel NORTON. The only thing I would offer, Mr. Chairman, is that we think it is probably inevitable in the manner of co-payments, but we do believe that dependents should have access to VA health care, again within the priority framework that has already been established in eligibility reform. I mean, service-connected disabled veterans must now and always be assured of care. If there is remaining capacity for dependents, then we would support it.

Mr. STEARNS. Mr. Daly.

Mr. DALY. I would just like to add that, as the VA hospitals continue to become TRICARE-designated providers, the dependents of our members will be receiving care at the VA, and we support the concept of the test. We support the test itself to see how it would work for others.

Mr. WEIDMAN. VVA is very committed to treating the whole family, if you will, for many reasons. We believe it is part and parcel of the wellness model. We do not object to it, but it comes back to the question that I talked about before which is perhaps the central question. It is decisions about organizational capacity. Where they say they have excess organizational capacity now is really where they deliberately emptied out hospitals in certain areas in order to draw down the census in order to meet other kinds of goals that really have nothing to do with the quality of health care delivered to the people in that area.

So our real question has to do with, really, two things. One is the ability of VA to be able to successfully build and collect appropriate third party payments from anybody. We have heard questions about that in this room. VA admits that they don't know how to do it yet. Secondly, is there in fact really excess organizational capacity to do so, to provide that care to dependents without taking away from veterans, particularly service-connected? VVA questions that there is much "excess" at most facilities.

Mr. STEARNS. Mr. Weidman, you mentioned in your opening testimony, the written testimony, about the VA health care system being overtaxed and increasingly brittle. Now, I would submit to you is it possible that part of that is due to the high cost of maintaining and operating a number of antiquated hospitals in areas that perhaps no longer need it and they still have this continuing cost when we could use that cost to help the overtaxed system that you mentioned? Is that a legitimate proposition in your opinion or not?

Mr. WEIDMAN. I think it is a legitimate proposition. The question has to do with the faith that one can have in the system now, from the point of view of the veterans in the community. Let me give you an example if I may, Mr. Chairman.

Inpatient PTSD units were decimated in the course of the last 5 years all across this country; and the inpatient capability of neuropsychiatry in general, including the ability to treat substance abuse, which is the number one underlying problem in VA health care that doesn't often get discussed, were also dramatically reduced on an inpatient basis. What was told to the veterans at the local level and at the VISN level as well as at the national level is that "we (VHA) will shift those FTEE and those resources into outpatient," but they did not.

So the question is, what the heck happened to the resources that were ostensibly being shifted into a different modality of behavior? And that is a question—why, I believe, Mr. Chairman, that people are so nervous about closing a hospital, is that it may, in fact, be a Maginot Line that is antiquated and is not helpful and merely a drain on the system. In other words, a Maginot Line, as soon as the blitzkrieg got invented and with modern medicine moving the way it is, it may in fact be a detriment.

The real question is, how can we reestablish a trust factor in order to be able to close that hospital and have confidence that they will deliver services to the veterans in that area, particularly in areas where it is the only VA Hospital?

Mr. STEARNS. Well, you know, we outline in our legislation that they have to show us where they are going—their plans, and it has

to have the involvement of the veterans' organization. Staff has indicated that some examples you use are specialized services which VA is charged to maintain under current law and, of course, in this bill. I think it is helpful to talk about this, though. I mean, let's be honest.

Colonel Norton, the PVA expressed concern that our bill may raise false expectations for military retirees because of funding issues. But the bill would require the Department of Defense to reimburse VA. If the DOD agrees to do this, isn't that resolving the question of funding issues?

Colonel NORTON. Well, it should in general, Mr. Chairman, but I would point out that, as you know, the TRICARE system encourages—there are a couple of levels of TRICARE participation. Many military retirees pay an enrollment premium in order to join what is called TRICARE Prime. That gives them assured access to appointments and military treatment facilities and so forth. We would, along those lines, have great concerns about military retired veterans being required to pay an enrollment premium for TRICARE in order to get access to the VA simply to offset the costs that may be required for their care.

But, in general, I would agree that if DOD were willing to pay for military retirees that could offset some of the cost.

I would also if I may, Mr. Chairman, just make an additional point along those lines that, in creating this new category and if DOD were willing to transfer funds to the VA for military retired care, the commitment of the DOD system to military retirees should not be decimated. I know that is not a problem or a concern directly of your committee, but we would not want to see the Department of Defense renege or walk away from its commitment to military retirees having their primary source of care available from military treatment facilities. In other words, we would not want to see any kind of a trade-off.

Mr. STEARNS. That would not be the intent of the bill, but I understand your point.

Mr. Daly, did you want to comment on that at all?

Mr. DALY. I really think that I couldn't say it much better than Colonel Norton has.

Mr. STEARNS. Well, I think I have finished the questions that I have, gentlemen, and we have no other additional questions, so I will conclude the third panel and conclude the Health Subcommittee hearing here.

I would say, in conclusion, that we are trying to move forward with a proactive bill, as mentioned by The American Legion earlier; and I think we have established with the witnesses today and the groups that there is a feeling of strong support for the bill. But your comments that you might have along the line, please give them to me or staff as we move this forward.

I think this hearing has been very helpful for us, so I want to thank you for your time. I want to thank all the staff here this morning, too.

And at this time, the subcommittee is adjourned.

[Whereupon, at 12:10 p.m., the subcommittee was adjourned.]

APPENDIX

TESTIMONY OF CONGRESSMAN CHRISTOPHER H. SMITH
VETERANS' AFFAIRS HEALTH SUBCOMMITTEE HEARING
THE MILLENNIUM HEALTH CARE ACT
WEDNESDAY, MAY 19, 1999

Thank you Mr. Chairman for convening this hearing on the future of VA health care in the 21st century. The legislative package which we are unveiling today is an ambitious and very necessary undertaking. It forces the VA to step up to the challenges posed by the aging of our society. It will also ensure that the VA's long term care services reflect the progressive changes already underway in the private sector as well as expand eligibility within the VA health care system.

The Millennium Health Care Act which we will be discussing today includes the following key components:

- ✓ it requires the VA to provide long term care to veterans who are either 50% service connected or in need of such care for a service connected condition;
- ✓ it requires the VA to operate and maintain long term care programs including geriatric evaluation, nursing home care, domiciliary care, adult day health care, and respite care; and
- ✓ it restores the ability of Purple Heart recipients to automatically use VA health care facilities.

One component of this package is especially important to me: respite care. Last week, I introduced H.R. 1762, legislation which expands the definition of respite care within the VA's health care system. This legislation allows the VA to contract with skilled health care professionals to provide care for our aging veteran population, as well as provide care services through non-VA facilities when appropriate. Currently, veterans and their care givers who are in need of respite care must travel to the closest VA nursing home or when a bed becomes available.

While well-meaning, this policy places yet another burden on the care giver, be it a spouse, an adult child, family member, or friend. The closest VA nursing home or state facility may be an hour's drive away. My legislation instead allows the VA to either send someone to the veterans' home to provide this care or to make arrangements for another short-term option.

H.R. 1762 has been endorsed by the American Legion, the VFW, Eastern Paralyzed Veterans of America, Vietnam Veterans of America, and the Disabled Paralyzed Veterans Association. All of these groups know that if it were not for the loving care being providing by spouses and adult children, the VA long term care system would be in dire straits. I cannot underscore how crucial it is for our veterans that we provide assistance for these caregivers and enable them to continue their good works.

Providing caregivers with the occasional day off so that they might attend to their own lives for a few hours will significantly improve the lives of our veterans and unquestionably save the VA money in the long run. Most Americans want to remain in their own homes for as long as possible. Expanding the VA's ability to use respite care as well as other long term care services reflects the flexibility that America's seniors demand and have come to expect.

According to the Caregiver Assistance Network, family and volunteer caregivers provide 85% of all home care given in the United States. These husbands and wives, sons and daughters, are willing to make the sacrifices necessary to ensure that their loved one -- who have served our nation in the Armed Forces -- are able to remain at home in their time of need.

However, these caregivers need our help. In a California statewide survey take by the Family Caregiver Alliance, 58% of the caregivers showed signs of clinical depression. When asked, they responded that their two greatest needs were emotional support and respite care. On average, they are providing 10.5 hours of care per day.

Many of our veterans suffer from Alzheimer's, the aftermath of a stroke, Parkinson's disease, and other adult onset brain-impairing diseases and disorders. By contracting out for respite care services, the VA will make a real difference in the day to day quality of life for a veteran and his or her family member.

This provision, and the overall Millennium Health Care Act, does come with a price tag -- but it is one that our veterans both need and deserve. Enhancing eligibility for veterans on a variety of levels requires that both Congress and the President find the necessary funds for long term care and eligibility expansion. Just last month, Congress voted in our budget resolution to provide an additional \$1.7 billion more for veterans' health care.

I wish that it could have been more and it would have certainly helped if the President had come forth with budget figures more in line with his initiatives. My colleagues and I on the Committee will continue to push for increased funding but success is difficult when the Administration is AWOL -- Absent Without Leadership.

I thank the Chairman and our witnesses today for this opportunity to discuss the future of VA health care and I look forward to today's discussion.

May 19, 1999

To: Veterans Committee
From: Congressman Ronnie Shows
Re: Opening Statement for the Subcommittee on Health hearing regarding draft legislation entitled the Veterans' Millennium Health Care Act.

Date: May 19, 1999

Thank you Mr. Chairman.

This legislation is a step in the right direction. As you know, I am a new member in Congress and on the Veterans Committee. I have sat through testimony about the President's budget, I have sat through, testimony about the state of the VA healthcare system, and more recently, I have read that the VA plans to lay off over 1100 workers at Veterans hospitals. Needless to say, this has not been an encouraging few months with regard to veterans healthcare.

But I am encouraged about the direction of this draft legislation, the Veterans' Millennium Health Care Act. I would like to congratulate Chairman Stearns on bringing forward this comprehensive and ambitious legislation. In the days to come, I hope we can work out the concerns expressed in the testimony such as the issue of co-payments and contracting out services and move forward to pass what we all know is needed, strong legislation that will ensure that we have long-term resources for long-term care.

I have 46,000 veterans in my District alone. With a growing and older veterans population in the South, it is particularly important to address long-term care. The Sonny Montgomery Medical Center is my district. This facility serves a veteran populations of 130,000 in 50 central Mississippi counties and six Louisiana parishes. With an ever-growing veterans population, legislation and resources are needed to ensure that long-term care, including nursing homes care, assisted living, and respite services is required not just desired.

Mr. Chairman, in their written testimony, the Disabled American Veterans urges Congress to restore service-connected disability compensation for smoking related illnesses. I have requested that the Subcommittee on Benefits hold hearings on this very issue. We have an obligation to those veterans who began smoking during their military career, particularly since from WW II through Vietnam, cigarettes were as integral to life in wartime as C-rations. In some cases, cigarettes were issued as part of C-rations. I think this is an issue that must be addressed.

I want to thank you all for the insight you have offered. I am positive that we will bring a bill to the House Floor that will receive broad bi-partisan support.

Thank you Mr. Chairman.

**Statement of Congressman Luis Gutierrez
Subcommittee Hearing on the Veterans' Millennium
Health Care Act
May 19, 1999**

Thank you, Mr. Chairman. I am pleased that this subcommittee is addressing the issue of VA long-term care. I would also like to thank the witnesses for being here today. I am eager to hear their opinions on the Veterans' Millennium Health Care Act, a bill to be introduced by our chairman.

As many of us are aware, VA has recently made substantial changes in its long-term care delivery. VA has significantly reduced the number of beds it uses to meet patients' long-term care needs and has slightly increased its investment in community and home-based care options. Many VA medical centers have changed the missions of nursing homes and other long-term care programs. They are now charged with offering restorative, rehabilitative and palliative care rather than highly skilled nursing home care.

VA medical centers are restricting the amount of care they will reimburse in private sector nursing home beds. VA is investing less in long-term

care programs than Medicare and Medicaid. While there has been some growth in the use of home and community services, VA has not made significant new investments in these programs. There is also a great deal of variability in the types and amounts of long-term care in which the VA's twenty-two networks choose to invest.

Increasingly, the VA is implementing policies that restrict length of stay for long-term care patients. Most of the reductions in inpatient care do not appear to be complemented by increases in care delivered in outpatient settings. Decentralization and tight funding are pushing regional administrators of veterans hospitals to undercut long-term care.

Mr. Chairman, long-term care is an issue that will affect a growing number of veterans as we enter the 21st century. The median age for veterans is now 57 years. According to the Department of Veterans Affairs, the number of elderly veterans will peak during the first decade of the 21st century. In the next twenty years, the number of veterans who are 85 years or older will more than triple. Our nation's aging veterans will need institutional care.

The purpose of the Veterans' Millennium Health Care Act is to improve access, timeliness and quality of VA health care. I am hopeful that this legislation will address many of the current dilemmas that the VA is facing.

Mr. Chairman, I am pleased that this legislation takes a step toward addressing the very serious long-term care crisis our nation's veterans are facing. I am increasingly of the opinion that the desperate health care crisis confronting the veterans of our nation must become a top priority for America.

Statement of Lane Evans

Ranking Democratic Member

Committee on Veterans' Affairs

Hearing on Veterans' Millennium Health Care Act

May 19, 1999

Good morning, Mr. Chairman. Thank you for holding this important hearing today. I also want to thank you and Chairman Stump for working with me to include provisions I believe we have come to agree work in the best interest of veterans served by the Department of Veterans Affairs Medical System. I know that you have also met with our important constituents in the veterans' and military service organizations and look forward to hearing their thoughts today. I also appreciate, Mr. Chairman, that Republican staff agreed to meet with representatives of the American Federation of Government Employees and that Republicans have been amenable to working further with them to address some of their concerns.

This is an ambitious bill and I will proudly join you in sponsoring it. It is a bill that works in a realistic framework, dealing with the disturbing trends we have seen in funding for veterans' health care, notwithstanding the Committee's support of significant funding increases. It is a bill that will better assure Congress that VA is continuing to meet veterans' vital needs for long-term care services. It is a bill that gives Congress better assurance that VA will plan effectively for ways to continue to treat veterans regardless of the health care setting. Finally, it is a bill that will allow veterans who regularly use the VA system to receive reimbursement for emergency care services.

The bill also contains a "report and wait" requirement which responds to a concern I raised that VA is dismantling its inpatient programs without adequate planning to fulfill veterans' needs for these programs in outpatient or community settings. The provision follows other efforts Congress has put in place to ensure that important services and programs remain available to veterans as it restructures under what may be a very austere budget.

Long-term care remains an area of concern as VA continues to tighten

its belt. Last month, I presented findings from a report done at my request to assess recent changes in VA's long-term care delivery efforts to veterans. My staff surveyed VA's Chiefs of Staff to see how VA was responding to veterans' growing need for long-term care. Survey findings indicated that there were substantial erosions in the long-term care program—VA may be treating more veterans, but it is discharging them after much shorter stays that may not satisfy their need for ongoing care. The Report concluded with several recommendations to improve VA Long-Term Care that the Millennium Plan addresses. The findings and recommendations of this report were instrumental in shaping this legislative plan for addressing long-term care in VA.

The Millennium Plan establishes a good baseline for meeting veterans' needs for long-term care. We believed it was best to guarantee that veterans with the highest priority for care—those with health care conditions due to military service—receive *all* of the long-term care they need.

The bill also requires VA to maintain its long-term care program and enhance the services it provides in the home and community. VA is under enormous financial pressure and long-term care is expensive. The survey identified some disturbing changes in VA's long-term care program that obviously stemmed from financial pressure. It is time to give VA clear direction about whom we expect them to treat and what services we will require them to offer.

I have had a long-standing interest in emergency care reimbursement. I introduced two bills in the last Congress and H.R. 135, the "Veterans Emergency Health Care Act", this year, to allow VA to reimburse enrolled veterans for expenditures they made during medical emergencies. Veterans who rely on VA for their health care have been financially devastated by an emergency health care episode. Veterans who try to reach VA during a health care crisis have been told by VA staff to go to the closest health care facility for treatment, but once the bills came, the VA refused to reimburse them. It seems unconscionable that VA would abandon these veterans during their greatest health care crises, but I know it happens.

I also know VA wants to fix this problem. Asked to identify legislation it needs to comply with the President's "Patient Bill of Rights", VA indicated it would need authorization to reimburse emergency health care for the veterans it enrolled. The President ordered its federal agencies to comply

with the Bill, yet a proposal contained in the President's budget only partially addressed VA's request for this authority. The Millennium Bill goes farther by allowing VA to reimburse any high-priority veteran for emergency care services.

I have also advocated allowing more veterans to choose chiropractic care in VA. Last year I introduced a bill to establish a chiropractic service in VA which was supported by the American Chiropractic Association and the International Chiropractors Association. The Millennium Bill will allow VA to work with chiropractors in five sites to create opportunities for more veterans to choose this type of care for their musculo-skeletal conditions. Chiropractors have proven they can often provide equally effective care for certain conditions at less cost than physicians. Veterans deserve the opportunity to choose chiropractic care.

The Millennium Bill contains provisions that will authorize VA to increase copayments for drugs, neurosensory devices and certain other prosthetics, and extended care. A plan for facility realignment also has caused concern among some interested parties. But I believe the Committee must offer leadership in addressing some of these difficult issues head on. I want to make sure that VA can maintain services for veterans that rely on it for their health care—the best way we can do this is by requiring some veterans to contribute more to their health care. VA's costs for pharmaceuticals have doubled over the last ten years; allowing more veterans to acquire hearing aids and eyeglasses from VA has also put a tremendous strain on VA's ability to acquire prosthetics. We need to ask some veterans to chip in for these benefits which are not provided by most health care insurers—it's still a significant benefit for veterans.

Since decentralizing its management, VA has closed acute inpatient beds at a pace that I believe has taken many by surprise. The hardest hit have been the beds for psychiatric, rehabilitation, and other services of a "longer term" nature. Medical and surgical beds have not been immune to this trend. I believe a congressional formula for realigning VA's resources is necessary. The fact of the matter is that this legislation does not create new authority for closures or realignments. Right now we have a situation where Congress is constantly attempting to respond to chaos. Since the VA has allowed so much of its decision making to take place in its 22 networks, Congress's ability to ensure that VA is going through a fair process in determining the need for facility closures has diminished considerably. In the bill, we

provide VA with a framework that better ensures that the views of veterans, employees and other interested parties are taken into account. We will continue to work with employees to ensure that we are responsive to the concerns they have raised.

It is abundantly clear that VA is not operating in a world of unlimited resources. I believe this bill has many positive gains for veterans while not imposing unreasonable new costs onto an already fiscally strapped system. I endorse this ambitious bipartisan legislation.

**STATEMENT OF JOHN R. VITIKACS, ASSISTANT DIRECTOR
 VETERANS AFFAIRS AND REHABILITATION COMMISSION
 THE AMERICAN LEGION
 BEFORE THE
 SUBCOMMITTEE ON HEALTH
 COMMITTEE ON VETERANS' AFFAIRS
 U.S. HOUSE OF REPRESENTATIVES
 ON
 VA HEALTH-CARE REFORM
 AND
 DEPENDENTS PILOT HEALTH-CARE PROGRAM**

MAY 19, 1999

Mr. Chairman and Members of the Subcommittee:

On behalf of its 2.8 million members, The American Legion appreciates the opportunity to comment on legislation designed to overhaul the Department of Veterans Affairs (VA) long-term care programs, realign VA health care facilities and change certain eligibility requirements, among other provisions. The draft legislation under consideration is designated as the "Veterans Millennium Health Care Act." A second draft bill to establish a pilot program for the provision of medical care to certain dependents of eligible veterans will also be considered.

The American Legion is pleased with the leadership's efforts implicit in the Veterans Millennium Health Care Act. All of the topics included in the draft bill are important to the future of the Veterans Health Administration (VHA). Many of the provisions contained in the bill are similar to the goals and objectives of the GI Bill of Health, which is the blueprint of The American Legion for the Department of Veterans Affairs in the 21st Century.

Mr. Chairman, The American Legion recognizes a need to revise VA's long-term care eligibility rules and regulations. Long-term care reform is a logical extension of the patient enrollment process. The availability of a full continuum of care will enhance the health treatment options of deserving veterans. Over the past several years, the absence of a consistent application of long-term care eligibility has created confusion and havoc among veterans and their families throughout all 22 Veterans Integrated Service Networks (VISNs).

Mr. Chairman, the current and projected number of veterans over the age of 65 continues to increase. Veterans aged 65 or older will peak at 9.3 million in the year 2000. This figure reflects the aging of the World War II and Korean Conflict populations. By the year 2010, approximately 42 percent of the entire veteran population -- an estimated 8.5 million of 20 million veterans -- will be 65 years of age or older. By 2030, the baby boom generation and Vietnam Era veterans will reach into their 80's.

Today, an increasing number of Americans require long-term care. Unprecedented growth in the elderly population is projected for the 21st century, and the population age 85 and older -- those most in need of long-term care services -- is expected to outpace the rate of growth for the entire elderly population. Today, the VA is meeting the long-term care needs of only 21.4 percent of disabled and poor veterans.

The American Legion thinks VA is uniquely positioned to provide a greater level of long-term care services to veterans to satisfy the increasing demand. Clearly, the structures of VA long-term care and budgetary considerations affect the delivery of such services. In order to expand the current level of long-term care available within VA, and to meet the growing demand for such care, a means must be developed to help pay for that care.

The American Legion is not satisfied that VA has done all it can to meet the growing demand for long-term care. Recent developments suggest that VA actively seeks out ways to reduce its level of institutional long-term care. Over the past several years, budget constraints require most VISNs to assess how the provision of long-term care fits into its overall strategic plan. Several VA nursing homes have recently closed and many other long-term care beds have been reduced. Many VA facilities have also reassessed how their long-term care beds are used.

The reduction in VA provided long-term care has not resulted in a corresponding increase in contract nursing home care. Since the funding for contract nursing home care was decentralized in 1997, the workload in the program has dropped approximately 40 percent. Many veterans are having their VA nursing home contracts reduced to 60 days or less, prior to placement in a community-based facility.

The American Legion is pleased that VA Secretary Togo West recently announced a moratorium on the further closure of long-term care beds. This action can be viewed as a stopgap measure until a comprehensive solution to the demand for VA long-term care is achieved. The decision may also result in the reduction of other vital services or programs.

The "Report of the Federal Advisory Committee on the Future of VA Long-Term Care", published in October 1998, offers an extensive perspective on the dilemma facing VA, regarding veterans' long-term care. In March 1997, the Under Secretary for Health convened a panel of national leaders and experts in long-term care to evaluate current VA long-term care programs and expenditures, review future needs, and develop a strategy for meeting those needs. The Committee's charge was to advise the Office of the Under Secretary for Health on VA's current and anticipated needs for long-term care in an era of no-growth budgets in VA medical care, and on the adequacy of VA's present and planned programs for addressing those needs. Specifically, the Committee was charged with evaluating current and future programs in four major areas: access and equity; service delivery; long-term care in the context of the overall VA healthcare system; and long-term care investment. The Committee used the year 2010 as the planning horizon.

The Committee concluded that VA should maintain, invigorate, and reengineer the core of VA-operated long-term care services, and new demand for long-term care should be met primarily through non-institutional services and contracts. The Committee concluded that VA long-term care programs would be substantially enhanced through the development of meaningful incentives for VISN directors. The Committee also believes that without changes to the current system, VA is at risk of dismantling its long-term care system. Despite high quality and continued need, long-term care is perceived to be an adjunct entity, unevenly funded and undervalued. Accordingly to the Committee, continued neglect of the long-term care system will lead to further marginalization and disintegration, and have costly, unintended consequences throughout the VA healthcare system.

At a recent field hearing, the VA Under Secretary for Health presented five points that need to be taken to improve VA long-term care services:

- Congress must mandate and clarify eligibility for long-term care as an essential service;
- VA must expand the use of non-institutional care settings;
- VA must have the flexibility to form partnerships with state and local entities;
- VA must have the ability to develop new revenue sources (Medicare and Medicaid);
- Congress must appropriately fund VA long-term care services and programs.

Mr. Chairman, the views of the Under Secretary for Health are consistent with the views of The American Legion.

The American Legion policy on VA long-term care is set forth in 1998 National Convention Resolution No. 173. In the resolution, The American Legion commends a VA long-term care policy that provides a mandatory continuum of care to all 100 percent service-connected veterans; to service-connected veterans whose medical condition requires such care; to Category A veterans whose medical condition requires long-term care; and to all other eligible veterans through the establishment of a health benefit plan that operates on a premium and co-payment basis, as recommended by the GI Bill of Health.

At the time an effective date for a mandatory long-term care benefit plan is established, Resolution No. 173 recommends that veterans already receiving VA long-term care be grandfathered into the plan, and continue receiving an appropriate level of long-term care with no future obligation for payment. The resolution also recommends that VA develop a unified strategy to ensure that comprehensive long-term care services are provided in all VISNs, as outlined in the GI Bill of Health and as recommended by the Federal Advisory Committee on the Future of VA Long-Term Care.

When measured against other health care systems, VA provides a comprehensive array of long-term care services and programs. This grouping includes VA-operated services, contract care, State Veterans Home programs, and services arranged by VA, but financed by another payer. However, with the VA enrollment system, veterans are provided a health services benefit plan that does not offer a long-term care component. This is confusing to many veterans and truncates the continuum of care process. The idea of VA being able to link long-term care with both acute and intermediate levels of care is crucial to becoming a total health care system.

Mr. Chairman, in order to expand long-term care eligibility and treatment to veterans, a new funding mechanism must be developed. Presently, VA spends approximately 13.8 percent of its total healthcare budget or \$2 billion annually, on long-term care. To increase the present level of VA long-term care, within funding levels, would result in fewer resources for other programs. The development of new funding methodologies, in conjunction with traditional funding methods is needed to accomplish the goal of expanding VA long-term care to greater numbers of veterans.

Veterans Millennium Health Care Act

Section 2 - Extended Care Services

Section 2 of the draft proposal would amend section 1710 of chapter 17, United States Code, by establishing a program to provide extended care services to eligible veterans. Such services shall include the following:

- (1) Geriatric evaluation.
- (2) Nursing home care (A) in facilities operated by the Secretary, and (B) in community-based facilities through contracts under section 1720 of title 38, United States Code.
- (3) Domiciliary services under section 1710B of title 38, United States Code.
- (4) Adult day health care under section 1720(f) of title 38, United States Code.
- (5) Such other noninstitutional alternatives to nursing home care, including those described in section 1720C of title 38, United States Code, as the Secretary considers reasonable and appropriate.
- (6) Respite care under section 1720B of title 38, United States Code.

Additional provisions of the draft bill would:

- (1) Require the Secretary to maintain nationally the level of "in-house" extended care services provided as of September 30, 1998.
- (2) Require VA, in addition to maintaining capacity, to develop and begin to implement by January 1, 2000, a plan for carrying out the recommendation of the Federal Advisory Committee on the Future of VA Long-Term Care to increase both home and community-based care options as well as the percentage of the medical care budget dedicated to such care.
- (3) Mandate that VA provide needed extended care services on an ongoing basis in the case of 50 percent service-connected veterans or veterans in need of such care for a service-connected disability; and provide such veterans highest priority for placement in VA nursing homes.
- (4) Provide, in the case of a veteran in need of extended care services for a non-service-connected condition (other than a veteran rated 50 percent or greater service-connected), that VA shall:
 - (a) In providing nursing home care in VA facilities, give priority to placements to rehabilitate patients, for unique patient populations (such as Alzheimer's disease), and for patients for whom there are not other good placement options;
 - (b) Establish a copayment policy (applicable to extended care services of more than 21 days in a year) which would be based on the following principles applied in the State Veterans Home programs:
 - The establishment of a VA-determined maximum monthly copayment.

- The payment requirement would be based on an ability-to-pay formula tied to income and assets of a veteran and spouse.
 - A provision would be made to protect the veteran's spouse (if she/he lives in the community) from financial hardship by exempting at least part of the couple's income and assets from consideration in determining the copayment obligation.
 - Provide for the veteran to retain a monthly personal allowance.
- (5) Establish a revolving fund in the Treasury in which to deposit copayments to be used to expand extended care services.
- (6) Lift the current six-month limitation on the provision of VA adult day health care.
- (7) Authorize VA to furnish respite care services under contract in the veteran's home or in any other setting.
- (8) Authorize VA to expand the scope of the State Veterans Home program to encompass all extended care services.
- (9) Require VA to report to Congress on the feasibility of establishing a pilot program to assist veterans in receiving needed assisted living services.

American Legion Response

Mr. Chairman, The American Legion views the long-term care section of the draft bill as a positive step in meeting the current and future demand for such care. Veterans must have the assurance that they will have access to the full continuum of long-term care services when needed. While we support the draft provisions in principle, there are several considerations that require further discussion.

- (1) What is the definition of nursing home care and extended care as applied in the draft bill? Is the focus restorative care, rehabilitation care, open-ended treatment, or some other meaning or a combination of terms?
- (2) What is the definition of VA extended care services and staffing levels that were provided as of September 30, 1998?
- (3) Over the past several years, VA has closed a significant number of long-term care beds. Therefore, would using September 30, 1998, as a benchmark for future long-term care capacity, significantly reduce the future availability of long-term care?
- (4) For non-service-connected conditions of veterans rated less than 50% disabled, and for non-service disabled veterans, what shall be the guidelines for determining monthly copayments for long-term care? Is the income and assets criteria of the veteran and the veteran's spouse similar to the annual means test criteria?
- (5) Veterans over 50% service-connected and other veterans with service-connected conditions requiring long-term care are appropriately included in the scope of coverage provided by the draft proposal. Additionally, the draft bill would permit non-service-connected veterans in Priority Group 7 to make certain copayments for future long-term care treatment.

The American Legion's primary concern about future access to VA long-term care as proposed in the draft bill involves the non-service-connected, low-income Category A veteran. The draft bill does not adequately address how these veterans' future access to VA long-term care will be met. It appears that these veterans will have the most restricted access to VA long-term care under the bill.

- (6) There are several positive recommendations in the report of the Advisory Committee on the Future of VA Long-Term Care that are not adequately addressed in the draft bill.
 - VA should seek legislative authority to broaden respite care in 38 U.S.C. 1720B, to include its provisions in all settings.
 - VA should seek legislative authority to allow for the payment of assisted living/residential care under 38 U.S.C. 1730.

- VA should seek legislative authority to include a limited, 100-days/patient/year nursing home benefit following a period of VA hospitalization under 38 U.S.C. 1710 and 1720, notwithstanding current nursing home rules and policies.

Mr. Chairman, the above issues are important in that they will in large measure determine the fairness and success of the long-term care provisions of the draft bill. There are many similarities between the draft bill and the GI Bill of Health regarding the future provision of VA long-term care. The bill provides VHA certain flexibility to meet the long-term care needs of many veterans. Congress must provide a sufficient increase in appropriations to meet the anticipated increase in veterans long-term care utilization.

Mr. Chairman, until the definitions used in the bill are clear, and provisions are made to grandfather eligibility for those veterans now receiving long-term care, The American Legion offers qualified support for the long-term care provisions of the Veterans Millennium Health Care Act. The American Legion believes that further discussion with the committee staff is necessary to ensure that all provisions of the Act are fully understood and will meet the long-term needs of all veterans.

Section 3 - Eligibility for Care of Combat-Injured Veterans

Section 3 of the draft bill would amend section 1710(a)(2)(D) of title 38, United States Code, by creating new eligibility criteria for health care by the Department of Veterans Affairs for combat-injured veterans. The provision would place combat-injured veterans in Priority Group 3. The term used in the draft bill to define combat-injured veterans means wounded-in-action as the result of an act of the enemy of the United States or otherwise wounded-in-action by weapon fire while directly engaged in armed conflict (other than as the result of willful misconduct by the wounded individual).

American Legion Response

Mr. Chairman, the intent of section 3 is to create entitlement to VA health care for veterans awarded the "Purple Heart" while in military service even if they have not been rated as service-connected. The American Legion fully supports this measure and commends the Committee for consideration of this matter.

Section 4 - Access to Care for Military Retirees

Section 4 of the draft measure would amend section 1710(a)(2) of title 38, United States Code, to improve access to VA health care for military retirees eligible for care under the Department of Defense (DoD) TRICARE program.

The provision requires the Secretary of Defense, not later than May 1, 2000, to enter into a memorandum of understanding with the Secretary of Veterans Affairs for DoD to reimburse VA for medical care provided by VA to a member of the uniformed services who (A) has retired from active military, naval, or air service, (B) is eligible for care under the TRICARE program, and (C) has enrolled for care under section 1705 of title 38, United States Code. The TRICARE agreement shall take effect on October 1, 2000.

The provision would create a new VA enrollment category to accommodate TRICARE eligible military retirees. The current Priority Group 7 enrollment category would become Priority Group 8 and the TRICARE eligibility group would constitute the new Priority Group 7.

American Legion Response

Mr. Chairman, all military retirees are already eligible for VA treatment because they are veterans. Some retirees receive VA care through sharing agreements with DoD and through certain TRICARE contracts. The American Legion believes these agreements should continue for those retirees who elect not to enroll in the VA health care system. The draft provision would create a new Priority Group 7 enrollment category for retirees who elect to receive their health care through VA.

The American Legion generally supports the proposed concept. However, we recommend that the draft provision also include measures to permit eligible dependents of military retirees to also be incorporated into the veteran's health plan coverage.

The draft bill appears to be directed to military retirees without dependents. This could certainly discourage many potential retirees under this provision from electing to enroll in the VA health care system and contradicts their current entitlement under TRICARE. The American Legion believes the measure should be drafted to encourage more military retirees to use the VA health care system, not less. We also recommend that military reservists and National Guard members have the option of enrolling in the proposed enrollment category.

Section 5 - Medical Care Collections

The draft bill would amend section 1722A of title 38, United States Code, to (1) increase the current prescription copayment amount, and (2) establish a maximum annual pharmaceutical copayment amount for veterans who have multiple outpatient prescriptions; and (3) require certain veterans to pay to the United States a reasonable copayment for sensori-neural aids, electronic equipment, and any other costly item or equipment furnished the veteran for a non-service-connected condition, other than a wheelchair or artificial limb. The proposal would create a Department of Veterans Affairs Health Services Improvement Fund to deposit amounts collected through the new medical care collection authority.

American Legion Response

Mr. Chairman, The American Legion prefers that all veterans have an opportunity to enroll in a VA health plan as proposed in the GI Bill of Health. In that situation, enrollees would have a personal stake in the well being of the VA health care system and possibly would not mind paying reasonable fees for certain services. Today, there is an effort to increase VA revenues from non-appropriated sources to cover funding shortfalls. The GI Bill of Health lays out a clear blueprint for VA in the 21st Century. Most other attempts to increase non-appropriated revenues by raising certain copayments undermines the service and sacrifices already endured by veterans. The American Legion in principle does not support increased copayments for certain services unless the veterans of this Nation have a true stake in the future of the VA health care system. That concept is clearly set forth in the GI Bill of Health. Veterans of this Nation need to receive a guarantee that any increased copayments will be used to strengthen the VA health care system and that their enrollment will continue on a year-to-year basis. The GI Bill of Health also calls for a specific VA trust fund to deposit all related copayments, premiums, and deductibles.

Section 6 - Health Services Improvement Fund

The draft measure would amend section 1729A of title 38, United States Code, to establish in the Treasury of the United States a fund to be known as the 'Department of Veterans Affairs Health Services Improvement Fund'. Amounts received or collected after the date of enactment of this Act, under any provisions of law, shall be deposited in the fund. Amounts deposited in the fund will be available to the Secretary without fiscal year limitation.

American Legion Response

Mr. Chairman, The American Legion supports an interest-bearing fund.

Section 7 - Veterans Tobacco Trust Fund

The draft bill would amend section 1729C of title 38, United States Code, to establish in the Treasury of the United States a trust fund to be known as the 'Veterans Tobacco Trust Fund', consisting of such amounts as may be appropriated, credited, or donated to the trust fund.

The draft bill specifies that if a lawsuit by the United States against the tobacco manufacturers seeking recovery of costs incurred or to be incurred by the United States that are

attributable to tobacco-related illnesses, there shall be credited to the trust fund from any amount recovered by the United States pursuant to the lawsuit, without further appropriation, the amount that bears the same ratio to the amount recovered as the amount of the Department's costs for health care attributable to tobacco-related illnesses for which recovery is sought in the suit bears to the total amount sought by the United States in the suit.

The draft bill further specifies that amounts in the trust fund shall be available, without fiscal year limitation, to the Secretary of Veterans Affairs for the following purposes:

- Furnishing medical care and services under this chapter, to be available during any fiscal year for the same purposes and subject to the same limitations (other than with respect to the period of availability for obligation) as apply to amounts appropriated from the general fund of the Treasury for that fiscal year for medical care.
- Conducting medical research, rehabilitation research, and health systems research, with particular emphasis on research relating to prevention and treatment of, and rehabilitation from, tobacco addiction and diseases associated with tobacco use.

American Legion Response

The American Legion strongly believes the President, the Federal Government and the Congress have a responsibility to protect the interests of veterans as well as the fiscal stability and integrity of VA benefit and medical care programs for service disabled veterans. The President's Fiscal Year 1999 VA budget included legislation to preclude in any future VA claims the grant of service-connection for disability or death due in whole or in part to tobacco use, including entitlement to VA medical care for such disability. The stated need for such restrictive, anti-veteran legislation is predicated upon estimates by VA and the Congressional Budget Office (CBO) of future budget costs totaling \$10.5 to \$17 billion over the next five years. The American Legion believes these estimates are overstated and unrealistic and is on record opposing this legislation and budgetary action.

The American Legion endorses H.R. 832, introduced by Representative Barney Frank and S.72, introduced by Senator Olympia Snowe to reverse the decision to limit VA tobacco-related disability claims. We also support H.R. 691, introduced by Representative Cliff Stearns, which would guarantee VHA receives an appropriate share of any settlement reached through litigation between the Federal Government and the tobacco industry.

The American Legion, therefore, supports section 7 of the draft bill. We recommend, however, in order for VA to receive appropriate reimbursement, that an aggressive pursuit of legislation is needed to effect a Federal settlement with United States tobacco companies.

Section 8 - Benefits for Persons Disabled by Participation in VA's Compensated Work Therapy Program

Section 8 would amend section 1151(a)(2) of title 38, United States Code, to provide benefits for persons disabled by VA's compensated work therapy program, in addition to being disabled by medical treatment or by participation in the vocational rehabilitation program.

American Legion Response

The American Legion supports the measure.

Section 9 - Authority to Accept Funds for Education and Training

Section 9 would amend sections 7361(a), 7362, 7363(a) and 7364 of title 38, United States Code, to provide authority to establish non-profit corporations at VA medical centers to accept funds for education and training purposes, and to prescribe policies and procedures to guide the expenditure of such funds.

American Legion Response

The American Legion strongly supports the measure since it would bolster VA's ability to offer education to patients and employees without affecting the patient care budget.

Section 10 - Enhanced Services Program at Designated Medical Centers

For the purpose of section 10, Congress makes the following findings:

- (1) Historically, health care facilities under the jurisdiction of the Department of Veterans Affairs have not consistently been located in proximity to veteran population concentrations.
- (2) Hospital occupancy rates at numbers of Department medical centers are at levels substantially below a level needed for efficient operation and optimal quality of care.
- (3) The costs of maintaining highly inefficient medical centers, which were designed and constructed decades ago to standards no longer considered acceptable, substantially diminish the availability of resources which could be devoted to the provision of needed direct care service.
- (4) Freeing resources currently devoted to highly inefficient provision of hospital care could, through contracting for acute hospital care and establishing new facilities for provision of outpatient care, yield improved access and service to veterans.

The proposal directs the Secretary of Veterans Affairs to establish an enhanced service program at Department medical centers that are designated by the Secretary for the purposes of this section. Medical centers shall be designated to improve access, and quality of service provided, to veterans served by those medical centers. The Secretary may designate a medical center for the program only if the Secretary determines that the medical center:

- (1) Can, in whole or in part, no longer be operated in a manner that provides hospital or other care efficiently and at optimal quality because of such factors as:
 - The current and projected need for hospital or other care capacity at such center;
 - The extent to which the facility is functionally obsolete; and
 - The cost of operation and maintenance of the physical plant, and
- (2) Is located in proximity (A) to one or more community hospitals which have the capacity to provide primary and secondary hospital care to veterans under contract arrangements with the Secretary which the Secretary determines are advantageous to the Department, or (B) to another Department medical center which is capable of absorbing some or all of the patient workload of such medical center.

The draft bill requires the Secretary, with respect to each designated center, to develop a plan aimed at improving the accessibility and quality of service provided to veterans. Each plan shall be developed in accordance with the requirements for strategic network planning described in section 8107 of title 38, United States Code. In developing such a plan, the Secretary shall obtain the views of veterans' organizations and other interested parties and provide for such organizations and parties to participate in the development of the plan.

The Secretary may not implement a plan described in this section with respect to a medical center unless the Secretary has first submitted a report containing a detailed plan and justification to the appropriate committees of Congress. No action to carry out such plan may be taken after the submission of such report until the end of a 45-day period following the date of submission of the report, not less than 30 days of which shall be days during which Congress shall have been in continuous session.

In carrying out the authority of the Secretary under this section, not less than 90 percent of the funds that would have been made available to a designated center to support the provision of services, but for such mission change, shall be made available to the appropriate health care region of the Veterans Health Administration to ensure that the implementation of the plan will result in demonstrable improvement in the accessibility, and quality of service provided to veterans in the catchment area of such center.

The section does not diminish the authority of the Secretary to:

1. Consolidate, eliminate, abolish, or redistribute the functions or missions of facilities in the Department;
2. Revise the functions or missions of any such facility or activity; or
3. Create new facilities or activities in the Department.

American Legion Response

Mr. Chairman, section 10 of the draft bill sets forth an important set of standards for future medical center closures. The Secretary already has the authority to consolidate, eliminate, abolish, or redistribute the functions and missions within the Department. However, the primary contribution of the draft measure is that the Secretary must follow a collection of predetermined standards prior to any future hospital closures.

The American Legion, in principle, does not support closing VA medical centers. However, we recognize that certain circumstances can arise that may lead to a significant downsizing of certain facilities, including the possible closure of a medical center. The question that is most essential relates to why a particular facility is targeted for closure (or realignment). Logical reasons are if a medical center is antiquated and presents a hazard to its patients and staff, or if the costs of upgrading a facility's infrastructure are greater than other alternatives. The American Legion believes that targeting a VA medical center for closure (or realignment) primarily due to under-utilization is not an acceptable reason. If a medical center operates a low patient census, it would be better to seek ways to increase the patient workload (implementation of the GI Bill of Health is one example). Nevertheless, the standards contained within the draft measure are realistic and prudent with regard to providing important and proper protections for future closure (realignment) considerations. Any future VA hospital closure (or realignment) proposal will be required to pass a series of crucial benchmarks before the decision is approved. This situation would certainly improve upon the current lack of such standards.

Each and every facility considered for closure (or realignment) must be examined on a case-by-case basis. The American Legion would like to see the standards set forth in section 10, regarding future facility realignment, also used in any future Department (or VISN) decision to eliminate, abolish, or redistribute the functions or missions of inpatient services at particular medical centers.

The American Legion questions whether all of the funding saved as a result of facility closure (or realignment) should remain within the affected VISN. Certainly, there should be a protected transition period of a few years. However, if the Department realizes significant savings from one or more facility closures (or realignments), it makes sense that a portion of those funds be used to strengthen the overall needs of the Department.

The Congress and the Department of Veterans Affairs must be aware that even if facility closure (or realignment) of either or both inpatient and outpatient services, may improve patient's access to care, there is no guarantee that VA will be able to contract for care at less cost to the Department. A recent study of the impact of the closure of inpatient services at VAMC Grand Island, NE indicates that veteran patient satisfaction with services at the St. Francis Medical Center is good, while the cost of the contract for the first two years were higher than anticipated. It is plausible that closing inpatient services at certain VA medical centers will have different effects on cost, access, quality and patient satisfaction.

Mr. Chairman, The American Legion supports the provisions of section 10 of the draft bill with the aforesaid reservations.

Section 11 - Expansion of Enhanced-Use Lease Authority

The section provides the Secretary improved enhanced-use lease authority by amending sections 8162(a)(2), 8163 and 8165(a) of title 38, United States Code.

American Legion Response

The American Legion reserves the right to comment on the application of enhanced-use lease authority on a case-by-case basis.

Section 12 - Extension and Revision of Certain Authorities

The following programs are re-authorized under the provisions of section 12:

- Readjustment Counseling Program - extend authorization through the year 2003.
- Committee on Mentally Ill Veterans - revise the committee-reporting period.
- Committee on Post-Traumatic Stress Disorder - revise the committee-reporting period and extend authorization.
- Extension of Authority to Make Grants under section 3 (a)(2) of the Homeless Veterans Comprehensive Service Programs Act of 1992, through September 30, 2002.
- Authority to Make Grants for Homeless Veterans - amend programs which incorporate the procurement of vans.

American Legion Response

Mr. Chairman, The American Legion supports all measures under section 12 of the draft bill.

Section 13 - Patient Services at Department Facilities

The draft bill would amend section 7803 of title 38, United States Code, to make certain technical corrections and to provide canteen support services to medical facilities of the Department. The measure would integrate canteen food production activities with the food production activities of VA Dietetic Services. The measure also provides authority for Canteen Service to sell products to hospital outpatients.

American Legion Response

The American Legion has not had an opportunity to thoroughly review the results of the pilot test program being conducted at six VA medical centers involving the food production services of VA's Canteen and Dietetic Services. We welcome the opportunity to evaluate a final report on this program, with appropriate input from Dietetic Service.

Section 14 - Report on Assisted Living Services

The draft measure requires that, not later than April 1, 2000, the Secretary of Veterans Affairs shall report to the Committees on Veterans' Affairs of the Senate and House of Representatives on the feasibility of establishing a pilot program to assist veterans in receiving needed assisted living services. The Secretary shall include in such report recommendations on:

1. The services and staffing that should be provided to a veteran receiving assisted living services under such a pilot program;
2. The appropriate design of such a pilot program; and
3. The issues that such a pilot program should be designed to address.

American Legion Response

The American Legion wholeheartedly supports section 14. It is important that veterans have lower-cost long-term health care options available. Our only stipulation with the measure is that VA design a proposal that ensures high quality of care is the focus of any future pilot program.

Section 15 - Reimbursement for Emergency Treatment

The draft measure would amend Chapter 17 of title 38, United States Code, by adding after section 1724 the following new section; Section 1725: Reimbursement for Emergency Care.

The draft measure would authorize the Secretary to reimburse an eligible veteran, or make payment to a hospital or other health care provider that furnished treatment to the veteran

for the reasonable value of emergency treatment furnished in non-Department facilities. Reimbursement could also be provided to a person or organization that paid for such treatment on behalf of such veteran.

According to the draft measure, a veteran is eligible for emergency treatment under the following conditions:

1. (A) Who is enrolled in the VA health care system in priority group categories 1 through 6, as described in section 1705(a) of title 38, United States Code; and, (B) to whom the Secretary has provided care under Chapter 17 of title 38, United States Code, within the 12-month period preceding such emergency treatment; and
2. (A) Who is financially liable to the provider of emergency treatment for that treatment; (B) has no entitlement to care or services under a health-plan contract; (C) has no other contractual or legal recourse against a third party that would, in whole or in part, extinguish such liability to the provider; and (D) is not eligible for reimbursement for medical care or services under section 1728 of title 38, United States Code.

Section (c) of the measure prescribes certain limitations on reimbursement for eligible veterans and section (d) prescribes the conditions of the independent right of recovery of the United States.

For purposes of this section:

(1) The term 'emergency treatment' means medical care or services furnished, in the judgement of the Secretary:

- (A) When Department or other Federal facilities are not feasibly available and an attempt to use them beforehand would not be reasonable;
- (B) When such care or services are rendered in a medical emergency of such nature that delay would be hazardous to life or health; and
- (C) Until such time as the veteran can be transferred safely to a Department facility or other Federal facility.

(2) The term 'health-plan contract' includes any of the following:

- (A) An insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement under which health services for individuals are provided or the expenses of such services are paid.
- (B) An insurance program described in section 1811 of the Social Security Act (42 U.S.C. 139c) or established by section 11831 of such Act (42 U.S.C. 139j).
- (C) A State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1936).
- (D) A worker's compensation law or plan described in section 1729(a)(2)(A) of title 38, United States Code.
- (E) A law of a State or political subdivision described in section 1729(a)(2)(B) of title 38, United States Code.

(3) The term 'third-party' means any of the following:

- (A) A Federal entity.
- (B) A State or political subdivision of a State.
- (C) An employer or an employer's insurance carrier.
- (D) An automobile accident reparations insurance carrier.
- (E) A person or entity obligated to provide, or to pay the expenses of, health services under a health-plan contract.

American Legion Response

The American Legion strongly supports the provisions of the emergency treatment proposal. We suggest that current and future enrolled priority group 7 veterans, including the proposed new priority group 7 military retirees, who have other entitlement to care or services under a private health-insurance plan, also be included for emergency treatment within VA

facilities under the provisions of this Act. The VA of the 21st Century must become an inclusive health care system, not exclusive. More veterans may then decide to seek treatment in VA if they were certain they could receive comprehensive health care services without the ever-present threat of involuntary disenrollment. Then, facility occupancy rates would be higher and medical facilities would no longer be underutilized.

The American Legion believes the emergency medical treatment provision represents an important improvement in the continuum of health care services provided to eligible veterans. The inclusion of this provision in the "Veterans Millennium Health Care Act" symbolizes an important step in the reform efforts underway within the Department of Veterans Affairs. This and other reforms under consideration today will help close the gap between the concepts contained in the GI Bill of Health and the efforts underway to modernize the Veterans Health Administration.

Section 16 - Review of Proposed Changes to Operation of Medical Facilities

The draft measure would amend section 8110 of title 38, United States Code, by specifying that the Secretary may not in any fiscal year close more than 50 percent of the beds within a bed section (of 20 or more beds) of a Department medical center unless the Secretary first submits to the Committees on Veterans' Affairs of the Senate and House of Representatives a report providing a justification for the closure.

The report shall include:

- (A) An explanation of the reasons for the determination that the closure is appropriate and advisable.
- (B) A description of the changes in the functions to be carried out and the means by which such care and services would continue to be provided to eligible veterans.
- (C) A description of the anticipated effects of the closure on veterans and on their access to care.

No action to carry out such closure may be taken after the submission of such report until the end of the 45-day period beginning on the date of the submission of the report.

American Legion Response

The American Legion fully appreciates the concern that generates this particular measure. The intent of the proposal is to provide justification for future bed closures, and in some cases, entire program closures. The following data details VHA bed reductions between FY 1995, upon implementation of the VISN organization, through FY 1997 (the last full year of available data):

	<u>September 30, 1995</u>	<u>September 30, 1997</u>
Psychiatric	17,339	12,392
Surgical	8,552	5,070
Medical	27,191	18,255
Nursing Home Care	14,892	15,098
Domiciliary Care	7,305	6,536
Avg. Operating Beds	53,082	35,717

The above data is not intended to demonstrate total patients treated, patient outcomes, or to reflect patient demand for care. The data simply demonstrates that over a particular period of time, VA has already appreciably reduced inpatient capacity.

The American Legion believes that in the instance where entire programs and facilities are targeted for closure, it is appropriate to require a greater degree of oversight than simply at the VISN level. As we testified in section 10 of the draft bill, the establishment of certain standards, prior to VISN level decisions to further reduce inpatient capacity is justified, particularly when specialized treatment programs are involved.

Overall, recent bed reductions have, in some cases, negatively impacted VHA's capacity to treat veterans. We are aware of certain instances where the lack of available hospital beds

results in inappropriate admissions to emergency care beds, and in some instances, delays hospital admissions. The American Legion is concerned that additional bed reductions will further impact VHA's ability to provide timely and quality care to all veterans.

The American Legion generally supports the intent of section 16, particularly where further bed reductions negatively impact VHA's specialized care programs and to the extent that further bed reductions create inappropriate or delayed admissions. Instead of requiring VHA to submit limited bed reduction plans to Congress, we recommend that VHA further develop operational standards to provide future direction on this matter, and include the veterans service organizations in the process.

Section 17 - Chiropractic Treatment Demonstration Program

Section 17 authorizes the Secretary to operate a demonstration program at up to five medical facilities under the jurisdiction of the Secretary to evaluate the effectiveness of providing chiropractic treatment to veterans enrolled for care under section 1705 of title 38, United States Code. The demonstration program shall operate during the period beginning on October 1, 2000, and ending September 30, 2002.

In carrying out the demonstration program, the Secretary is authorized, for the duration of the program to:

- (A) Employ chiropractors in the Veterans Health Administration.
- (B) Contract with chiropractors under such arrangements as the Secretary considers appropriate; and
- (C) Enter into arrangements for chiropractic treatment of veterans under section 8153 of title 38, United States Code.

For purposes of this section, the term "chiropractic treatment" means the manipulation of the spine performed by a chiropractor for the treatment of such musculoskeletal conditions as the Secretary considers appropriate.

Mr. Chairman, The American Legion fully supports the provisions of the chiropractic treatment measure to eligible veterans upon request.

DRAFT BILL ON THE FURNISHING OF VA HEALTH CARE TO CERTAIN DEPENDENTS OF VETERANS

The bill would amend title 38, United States Code, to establish a pilot program for the provision of medical care by the Secretary of Veterans Affairs to certain dependents of veterans who are entitled to health care furnished by the Secretary, and for other purposes. Section 2 authorizes the Secretary to carry out a program to provide primary health care services for eligible dependents of veterans. For the purposes of this section:

- (1) The term 'program period' means the period beginning on the first day of the first month beginning more than 90 days after the date of the enactment of this section and ending three years after that day.
- (2) The term 'eligible dependent' means an individual who:
 - (A) Is the spouse or child of a veteran who is enrolled in the system of patient enrollment established by the Secretary under section 1705 of title 38, United States Code; and
 - (B) Is determined by the Secretary to have the ability to pay for such care or services either directly or through reimbursement or indemnification from a third party.
 - (C) The Secretary may furnish health care services to an eligible dependent under this section only if the dependent (or, in the case of a minor, the parent or guardian of the dependent) agrees:
 - To pay the United States an amount representing the reasonable charges for the care or services furnished (as determined by the Secretary), including any reasonable copayment the Secretary, in the Secretary's discretion, may establish; and
 - To cooperate with and provide the Secretary an appropriate assignment of benefits, authorization to release medical records, and any other executed documents, information, or evidence reasonably needed by the Secretary to recover the Department's charges for the care or services furnished by the Secretary.

The health services provided under the pilot program may consist of such primary hospital care and services and such primary medical services as may be authorized by the Secretary. The Secretary may furnish those services directly through a Department medical facility or, pursuant to a contract or other agreement with a non-Department facility (including a health-care provider, as defined in section 8152(2) of title 38, United States Code).

Primary health care services may not be authorized to be furnished at any medical facility if the furnishing of those services would result in the denial of, or a delay in providing, access to care for any enrolled veteran at that facility. The pilot program shall be carried out during the program period in not more than four veterans Integrated Service Networks, as designated by the Secretary.

American Legion Response

Since The American Legion first introduced the GI Bill of Health in September 1995, VA has implemented many of its key components. For instance, Public Law 104-262 mandated that VA develop a funding model that ensures equity of access to care, and better aligns resources with actual costs on a per veteran basis. The GI Bill of Health also calls for a capitation-based reimbursement system to better align resources with VA's actual cost of care. The Veterans Equitable Resource Allocation (VERA) model is the methodology that VA created to comply with the law. Enrollment covered by Congress in Public Law 104-262 (Veterans Health Care Eligibility Reform Act) was also a part of the initial GI Bill of Health proposal. Other elements of the GI Bill of Health that VA has acted upon are third party collections, contracting authority expansion, and the development of a defined uniform benefits package for all enrollees.

The American Legion wants VA to continue to be the best health care provider it can be for our nation's veterans, but that frankly takes money. Present reality is that a fixed federal appropriation is diminishing VA's "buying power", as it cannot keep pace with medical cost inflation. Third party retention and Medicare Subvention are an integral thread woven into the original draft of the GI Bill of Health. The Medical Cost Care Fund (MCCF) is an integral piece of VA's overall economic solvency, and VA must be encouraged to collect revenue from all potential sources. However, VA is still having difficulty in collecting third party

reimbursements according to the Coopers and Lybrand study, and Medicare Subvention is still only a legislative proposal. VA is working to overcome both of these impediments in 1999, but will need support from VA Central Office, Congress, the White House, and the VSOs. In this light, there are two components of the GI Bill of Health that must be further explored and enacted if VA is to provide cost effective services, additional access points, and quality care to the entire veteran community.

The American Legion eagerly supports the pilots for veterans' dependents. The cry of the VA has long been the quotation from Abraham Lincoln, "To care for him who shall have borne the battle, and for his widow and his orphan." We say that, but then when those spouses and children are sick, we leave them out on the street. The recent way the families of sick Gulf War veterans have been treated only serves to exemplify this point. These are family members who sought out VA for care because of the hazards of war, and are being denied care. As a nation, we care for families while the service member is on active duty or when he or she retires. The Veterans Benefits Administration (VBA) provides some benefits to family members, but the Veterans Health Administration (VHA) turns a blind eye to family members of disabled veterans who need health care. We leave veterans who choose to use VA with no means of providing care for their families. We discriminate against veterans who are married and may have children. The Department of Health and Human Services has realized that our nation's children are too precious to leave uninsured, and have created the Children's Health Insurance Program (CHIP). This test pilot of dependents' components of the GI Bill of Health would provide complementary services to this program for children of veterans.

In addition, many female veterans believe that if there were more wives at VA, then healthcare delivery for them would improve as well. It only makes sense that programs that benefit female veterans would improve, if more women had access to VA. For instance, VA would have a greater incentive to increase mammography and OB/GYN services. We also know that women would use the VA, not just because they have told The American Legion, but because they have also told VA. In a study conducted by the VA in San Francisco, CA, researchers found that "83% of spouses reported that they would choose to receive their medical care at VA if allowed to do so." This research group concluded, "Spouses of male veterans represented a sizable group that could be incorporated into the VA system, especially given their strong desire to do so." These are also the partners VA depends on to care for veterans at home. It is the vested interest of VA to ensure these caregivers are healthy and well supported, if VA intends to shift its focal point of care to outpatient, and keep disabled veterans home as long as possible. Wives also tend to be younger and healthier than their male counterparts, and are usually the health care decision-makers in a family.

There are already provisions under the law that allows VA to treat some non-veteran beneficiaries. In places where VA has a TRICARE contract, DoD families are being seen by VA doctors, and other dependents are treated as well through the CHAMPVA program. This test pilot would be an expansion of an existing but limited authority.

The American Legion believes that adequate safeguards are included in the pilot program to allay concerns about treating eligible dependents at VA health care facilities. The draft measure requires, that if, during the course of the pilot program, the treatment of a veteran's dependent delays or in any way impedes care for veterans, the program must be reevaluated. At this time as VA seeks new sources of income, it makes good sense to begin treating veterans' dependents on a trial basis. The four demonstration sites must be carefully selected, with input from veteran's service organizations.

Mr. Chairman, The American Legion believes that all veterans should have unfettered access to VA health care. Veterans that are not entitled to VA care should be able to identify their payment method at the time of enrollment. We strongly believe that once enrolled, Priority Group 7 veterans should not have to worry about whether their enrollment will only last year-to-year. Many veterans today who use the VA health care system have private managed care health insurance. Unfortunately, VA has few agreements with these third-party providers to reimburse VA for services rendered. In order to achieve the fullest benefit of the draft proposal, VA must make certain that it has adequate reimbursement agreements in place with private managed care health plans.

The American Legion strongly supports carrying out the pilot dependent care program. We are confident that adequate safeguards will be in place to ensure that veterans' health care is not impeded, and that the billing and collection concerns with private health insurers are addressed.

The American Legion is eager to see movement on the proposed dependents' pilot program, and for Congress to take the next steps in implementing the GI Bill of Health.

Mr. Chairman, that concludes this statement.

STATEMENT OF
 DENNIS M. CULLINAN, DIRECTOR
 NATIONAL LEGISLATIVE SERVICE
 VETERANS OF FOREIGN WARS OF THE UNITED STATES
 BEFORE THE
 SUBCOMMITTEE ON HEALTH
 COMMITTEE ON VETERANS AFFAIRS
 UNITED STATES HOUSE OF REPRESENTATIVES
 WITH RESPECT TO
 IMPROVEMENTS IN VA HEALTH-CARE PROGRAMS

WASHINGTON, D.C.

MAY 19, 1999

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the almost two million men and women of the Veterans of Foreign Wars, I thank you for inviting our participation in today's most important hearing. As an organization comprised of combat theater veterans, we are committed to the proposition that VA must be fully enabled to serve as the health-care provider of choice for all of this nation's veterans. Toward this end, it is essential that VA should provide for the long-term care needs of veterans.

Under discussion today is a draft of major a legislative initiative known as the Veterans' Millennium Health Care Act addressing this and other veterans' health care issue. Before discussing its individual provisions, the VFW extends its VFW's heart-felt appreciation for this forward thinking, proactive, and politically courageous bill to ensure that this nation may properly meet its obligation to its former defenders in their time of need.

Section one of this bill represents a comprehensive long-term care reform package. The VFW applauds requiring the Secretary to operate and maintain a national program of extended care services as well as mandating that VA maintain its "in-house" capability as of September 30, 1998. We also support the requirement that VA develop a plan for carrying out the recommendations of the Federal Advisory Committee on Long Term Care. Also vital is that VA expands available community-based care options.

The VFW would voice strong support for the proposed requirement that VA provide such services on an ongoing basis to all 50% service-connected or higher veterans as well as to veterans requiring such due to a service-connected disability.

Further, the VFW supports the establishment of priorities for access to VA extended care for non-service-connected veterans. We are especially supportive of the establishment of monthly co-payment limits on extended care services as well as removing the six-month limitation on provision of VA day health care. The VFW applauds authorizing VA to provide respite care services under contract and expanding the scope of State Home program to encompass all extended care services.

The VFW will next address the sections of the bill addressing improved access through facility realignment. Without commenting on all of the particulars of this highly complex issue, the VFW offers support for the establishment of an enhanced-service program to improve the quality, accessibility, and timeliness of VA care for veterans. For a number of years the VFW has maintained that we are not "married to bricks and mortar" with respect to the provision of VA health care, and our support of this legislative initiative is grounded in this view. We would only add that such a course may

only be pursued for the sake of providing all veterans desiring such with mandated access to the full continuum of VA care.

Next under discussion is the Eligibility Reform language contained in this draft bill. The VFW has no objection to the language providing enhanced eligibility to recipients of the Purple Heart and to certain TRICARE-eligible veterans. We are highly supportive of requiring DOD to reimburse VA for the cost of care provided to military retirees under the TRICARE initiative.

Again, with the goal of providing more and better VA health care to all veterans desiring such, the VFW is supportive of this bill's provisions providing for enhanced revenues. Given VA's current strained funding situation, it only makes sense to establish an expanded and more reasonable co-payment schedule for VA health care, products and services. We insist, however, that all existing statutory exemptions as well as those additional exemptions enumerated in this bill be strictly applied. Further, all benefits derived from such an action must exclusively benefit veteran's health care.

The VFW supports the language addressing other program improvements in this draft bill.

Mr. Chairman, this concludes my statement, I will be happy to respond to any questions you may have.

STATEMENT OF
RICHARD A. WANNEMACHER, JR.
ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
MAY 19, 1999

Mr. Chairman and Members of the Subcommittee:

I am pleased to have the opportunity to appear before you to present the views of the Disabled American Veterans (DAV) on draft legislation to improve the Department of Veterans Affairs (VA) health care programs. The effectiveness of and access to VA's health delivery system is of primary importance to DAV. The DAV is an organization whose more than one million members are service-connected disabled veterans and whose Women's Auxiliary takes a serious interest in and plays a major supporting role in our advocacy on behalf of America's disabled veterans.

Today, there are more than 25 million living veterans and approximately 44 million family members of living and deceased veterans. Our members highly value patriotic service in the Nation's Armed Forces. The depth of their appreciation is revealed in ways that go beyond what VA medical professional can do. DAV's volunteers provide assistance and support which helps patients recover from illness more speedily and more fully adjust to life with a disability.

When travel benefits were cut in 1987, many veterans were left with no way to get to VA medical facilities for needed treatment. Since 1987, the DAV Transportation Network has donated 890 vans, and stationed 189 Hospital Service Coordinators throughout the VA hospital system. During fiscal year 1998, DAV is credited with over 2.3 million volunteer hours with an equivalent monetary value of over \$32.6 million.

DISCUSSION DRAFT
VETERANS' MILLENNIUM HEALTH CARE ACT

Long-Term Care Reform

It has been the long standing position of the DAV that veterans should be afforded quality and timely health care services by the VA because of their honorable service to our Nation. For well over a decade, VA has been faced with the dilemma of ever-increasing demand for medical care and perennially inadequate, decremental budgets. Because of various statutory and administrative barriers, veterans have been denied adequate health care implicitly promised in connection with their military service. There continues to be a critical need to clearly define eligibility for VA long-term care that ensures necessary services will be provided and the system will be sufficiently funded.

Section 2
Extended Care services

The DAV very much appreciates the provisions of this draft to ensure that VA provides needed extended care services. We are especially pleased to see that the same mandates provided in title 38, United States Code, section 1710 (a)(1)(B) are carried forward when addressing extended care entitlement.

While fully aware of the need for additional revenue streams to support VA's inadequate budget, we do not understand why the copayment program could not have an expiration (sunset) of three to five years following enactment. By enactment of this expiration, adequate time will have passed to assess the state of the Nation's economy and the utilization and costs of the program. Copayments for VA health care were instituted as a means of deficit reduction. As our

Nation moves closer to a budget surplus, the need for additional copayments for VA health care should diminish.

The DAV fully supports the provisions of this draft legislation mandating that the Secretary operate and maintain a National program of extended care services and specifying that the program include geriatric evaluations, nursing home care (in house and contract), adult day health care, domiciliary care and respite.

The VA's maintenance of capacity is especially critical and addressed in this draft legislation. As you know, the DAV is an active member of the *Independent Budget (IB)*. In this year's *IB*, we note that the VHA has failed to maintain its capacity to serve veterans with special needs as required under section 1706 of title 38, United States Code. The proposal under section 10, subparagraph (h), SPECIALIZED SERVICES, acknowledges the *IB*'s concerns and properly requires the Secretary not to diminish the obligations contained in section 1706 (b). This recognition strengthens the importance of the Veterans Health Administration's (VHA's) specialized services and reflects the vulnerability of these high-cost services in an underfunded system.

Under section 2, subparagraph (d) of the draft legislative proposal, we note the proposal to add the following to the current statute at section 1720B: "(c) In furnishing respite care services, the Secretary may enter into contract arrangements."

Representative Chris Smith (R-NJ), recently forwarded a proposal to the DAV for comment, regarding respite care which will enable the veteran's spouse, adult child, or other caregiver the ability "to be given a break from their duties" within the veteran's home. This provision would allow VHA to provide health care in a more efficient, patient-centered, health care environment without requiring the veteran to leave his or her home.

The DAV responded favorably to Representative Smith's proposal, and, while we support the language contained in your proposal, we ask that the language in the Smith proposal be added to your proposal to address this necessary change in statute.

State Homes

The DAV has long been an advocate of the State Homes programs. There are currently 95 State Veterans Homes in 43 states throughout the United States. The VA State Veterans Home Program has proven to be a cost-effective provider of quality care services to the Nation's veterans who require domiciliary, nursing home, and hospital care.

By amending section 1421 (a)(2) and inserting "extended care services," the State Veterans Homes programs will be enhanced and provided within a cost effective health care delivery system.

Sections 3 and 4 *Eligibility for Care of Combat-Injured Veterans and* *Access to Care for Military Retirees*

The DAV fully supports Sections 3 and 4 of the draft legislation which provides specific authority for the VA to treat veterans who have been awarded the Purple Heart Medal in defense of America's freedoms, as well as provide specific authority to provide health care to the men and women who have dedicated their adult lives to making the military their career and are entitled to TRICARE.

Section 5 *Medical Care Collections*

Mr. Chairman, the DAV is, and will remain, adamantly opposed to any effort to increase copayments for medical care to the Nation's sick and disabled veterans. Copayments were put into effect to reduce the budget deficit by reducing the costs of VA health care. As our Nation moves into a budget surplus, the need for copayments are diminished.

In our view, it makes good sense for the VA to maximize their efforts to collect whatever is due them from private health care providers for the care of non-service connected medical conditions. However, not at the expense of sick and disabled veterans.

It is the responsibility of the Congress to adequately fund health care to this Nation's sick and disabled veterans. This burden shall not be placed upon the sick and disabled veterans who are, in many cases, unable and unprepared to handle such costs.

Section 7
Veterans Tobacco Trust Fund

Veterans have a higher incidence of smoking and tobacco addiction than the general population. For years, veterans were patently encouraged to smoke. The Federal Government must be involved in any final settlement or legislative solution, and the VA health-care system must be a major beneficiary of this settlement.

As noted under subsection (8) of Section 7, "It is in the public interest for Congress to enact legislation requiring that a portion of any amounts received from manufacturers of tobacco products be used to meet the costs of (A) treatment for diseases and adverse health effects associated with the use of tobacco products by those who served their country in uniform, and (B) medical and health services research relating to prevention and treatment of, and rehabilitation from, tobacco addiction and diseases associated with tobacco use."

Additionally, the DAV requests the repeal of the prohibition against service connection for smoking related illnesses. The Government has imposed a dual standard against veterans because it has not sought to hold other Federal beneficiaries personally responsible for their use of tobacco products or prohibited benefits for tobacco-related illnesses.

Congress has conveniently seized upon the personal choice/personal responsibility excuse and enacted the prohibition against service connection for tobacco-related illnesses solely to finance over-budget spending on politically popular transportation programs and not because of any genuine public policy consideration. It is for these reasons that the DAV supports the legislative proposal submitted to you Mr. Chairman for the recovery of tobacco settlement proceeds for VA health care (H.R. 691) as well as (H.R. 832) introduced by Congressman Frank and (S. 72) introduced by Senator Snowe, which would restore service-connected disability compensation for smoking related illnesses.

Sections 8 and 9

The DAV fully supports Sections 8 and 9 of your draft legislation.

Section 8 will provide benefits administered under title 38, United States Code, section 1151, to those men and women who are participating in VA's Compensated Work Therapy Program. Section 9 would provide authority to VA medical centers to establish non-profit corporations to facilitate research and or education programs.

Section 10
Enhanced Services Program at Designated Medical Centers

The VA health care system is a National asset that must be protected and maintained. The DAV and others are very concerned that VHA's unique contribution to the Nation's health-care delivery system has fallen victim to a budget cutting craze that will ultimately destroy the fabric of the system. VA is at an important crossroad in regard to its long-term funding commitments from the Administration and Congress. The VA health care system must be maintained.

Although VA can benefit by adopting certain management practices from the private health care sector, VA's Congressionally prescribed missions and unique patient population limit the Department's ability to achieve the overall cost savings and efficiencies of for-profit health care. For instance, VA healthcare users are older, have, in many cases, suffered severe disabilities, and are very often medically indigent.

In recent years, numerous government and non-government reports have consistently concluded that fundamental changes are needed in the VHA health care system to make it more patient responsive and efficient. Among the principal changes that have been recommended are the redistribution of resources, the use of innovative approaches to improve veterans' access to health care and the decentralization of decision making.

VHA has been able to provide greater access to VA health care professionals with the creation of Community-Based Out Patient Clinics (CBOCs). Additionally, VHA has consolidated and integrated health care facilities.

All of these changes have occurred within a flat-lined health care budget. VHA has been forced to do more with less while faced with double digit medical inflation, climbing employee costs and increasing demand of a sicker, aging veterans' population.

While most integrating systems in VHA seek to maximize the efficiency of their resources, all VHA systems also seek to improve patient care and customer service by strengthening the continuum of care, using a single standard of care across locations and expanding veterans access to services. Meeting these objectives requires the integration of clinical and administrative services.

Clinical integration is a key to improving patient care. Unlike many private sector hospital mergers, VHA systems were successful in structurally and operationally integrating clinical service, usually at the same time as administrative services.

It is the opinion of the DAV that additional efficiencies can be found, but at what cost.

The men and women who rely on VHA for their health care are currently being forced to wait a long time for primary and specialty health care. Their medications and durable goods are being issued based on cost rather than effectiveness in an environment of over-worked health care professionals and the health care providers.

Section 11
Expansion of Enhanced-Use Lease Authority

The DAV has historically supported VA's enhanced lease and sharing agreement programs. These programs have proven to be an extremely useful management tool, allowing VA to acquire needed revenue, facilities, goods and services that are otherwise unavailable or unaffordable.

Sections 12, 13, and 14

The DAV supports the language contained in sections 12, 13, and 14 of the draft legislative proposal.

Section 15
Reimbursement for Emergency Treatment

Current law limits VA's authority to pay for emergency services that veterans receive outside the VA system. Only veterans who are eligible for fee-basis care or those needing care for service-connected conditions and for whom VA facilities are not readily available may be covered for emergency care in non-VA facilities.

Section 15 of your draft legislation expands emergency services to veterans who are enrolled, who have received VA health care within the preceding 12 months, and who are not otherwise covered by current statute, private/government insurance or any other reimbursable entity.

We commend you, Mr. Chairman, for your insight in including this section in your draft legislation.

Section 16
Review of Proposed Changes to Operation of Medical Facilities

The DAV is pleased to see that you share our concerns with respect to changes of bed sections and the conversion of such beds. The DAV has been witness to the closure of operating beds and the elimination of health care staff, and we are concerned that the VA health care system cannot continue to function under these continued cuts.

It is our belief that, when medical facilities and networks are forced to make financial decisions rather than clinical decisions, high-cost programs and, ultimately, veterans suffer. Clinicians may or may not be making all appropriate efforts to develop community support programs for these veterans, but the decisions about the very existence of long-term psychiatric beds are being made by administrators who are driven by the strong fiscal considerations inherent in a capitation model.

There are no known bed sizing methodologies for health care beds, so it becomes impossible to point to objective evidence that there are too few beds. We believe clinical assessment of veterans has become secondary to fiscal needs due to the flat-lined budget and has resulted in a rapid bed closure. There has been no systematic effort to assess if this is being done well or poorly. It may well vary from place to place. With respect to the seriously mentally ill, we hope that we are not contributing to the well-known trans-institutionalization from hospital to jails that some of the poorly done state efforts have created (especially California, where the Los Angeles county jail is now the largest institution for individuals with schizophrenia in the country). Or that we are creating more homeless veterans.

Properly done, deinstitutionalization can, in certain cases, dramatically improve veterans lives, but it requires understanding, timely planning and reinvestment of a significant proportion of inpatient resources into community support efforts. VHA has no idea what the current and near future impact really is. There is no ongoing assessment of reinvestment, and efforts to examine this have been resisted as promoting "special interests." The flat-lined budget may force funding changes to occur faster than clinical changes can reasonably occur. Without a staffing methodology, it is impossible to objectively assess the ability to get the job done with reduced staff. The clinicians in the best position to understand the impact are not normally involved in the decision to reduce staff or close health care beds.

Section 16, by requiring VHA to report to the House Committee on Veterans' Affairs on a quarterly basis, ensures that additional oversight will be in place to maintain VA's capacity to serve veterans.

A concern that DAV has is that the VA, in its May 5, 1999, draft report to Congress on Maintaining Capacity to Provide for Specialized Treatment and Rehabilitative Needs of Disabled Veterans, defines capacity as follows: "For this report, capacity has been defined as the number of unique individuals with one of the 6 identified conditions treated within specialized bed sections and clinics *and the dollars expended for their care.*" (Emphasis added.)

We are hopeful that you would share our concern that the "dollars expended for their care," would not be accepted as justification for closure of any bed section (of 20 or more beds) for the preceding fiscal-year quarter.

Section 17
Chiropractic Treatment Demonstration

Chiropractic science is concerned with investigating the relationship between structure (primarily of the spine) and function (primarily of the nervous system) of the human body to restore and preserve health. Chiropractic medicine applies such knowledge to diagnosing and treating structural dysfunctions that can affect the nervous system. Chiropractic physicians use manual procedures and interventions, not surgical or chemotherapeutic ones. In 1993, more than 45,000 licensed chiropractors were practicing in the United States. Chiropractic specialty areas are extremely pertinent to other medical specialties, such as radiology, orthopedics, neurology,

and sports medicine. Current chiropractic research interests include back and other pain, somatovisceral disorders, and reliability studies.

The DAV is certainly not opposed to the use of Chiropractic medicine within the VA health care system. We feel that this treatment modality should be available throughout the entire VA health care system as part of the benefits package.

DISCUSSION DRAFT
PILOT PROGRAM FOR THE PROVISION OF MEDICAL CARE
TO CERTAIN DEPENDENTS OF VETERANS

By law, Public Law 102-585, sharing agreements involving the treatment of nonveteran beneficiaries must result in the improvement of services to eligible veterans at the facility, and must not result in the denial of, or delay in providing, access to care for any veteran at that facility. The Under Secretary of Health must certify to the Secretary that any agreement approved will have that result.

Mr. Chairman, as you know, the DAV, AMVETS, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States have joined together for the past 13 years to assess the state of veterans' programs and its funding resource needs. Our collective views on policy questions, programmatic issues, and resource requirements, have been presented in testimony before this Subcommittee, the full committee, and the Senate Veterans' Affairs Committee, as well as published in the *Independent Budget (IB)*, which is endorsed by 61 other veterans and health care organizations.

Since we are not motivated or constrained by the politics of the Federal budget process, our analyses are more objective and can be more candid than the assessments presented by VA officials and others. Because our goals are purely related to what is best for veterans and thus what is best for their programs, and because we are not concerned with the political exigencies of the moment, we focus on long-term efficiency and effectiveness rather than short-term, budget-driven goals inherent in the Administration's approach. We therefore believe our recommendations more accurately reflect the resources necessary to enable VA to provide an acceptable level of benefits and services for our Nation's more than 25 million veterans, their dependents and survivors.

As we have done for the past 13 years, we have prepared our analysis and recommendations in addressing VA's program-specific strategies and goals in the major sections of the *IB*.

High quality health care is the right of veteran patients cared for by VHA. We are concerned that VA's increasing emphasis on cost efficiency has prompted some VA administrators to jeopardize the quality of VHA health care by focusing too much on reducing its cost which, when not implemented properly, may reduce quality of care. DAV believes that savings and quality are not mutually exclusive and that true cost efficiency maximizes both.

It is the position of the DAV that veterans should be afforded quality and timely health care services by the VA because of their honorable service to our Nation. However, for well over a decade, VA has been faced with the dilemma of an ever-increasing demand for medical care and perennially inadequate, decremental budgets.

This year, it was the position of the *IB* that Congress should require VHA to report collection rates for services provided to nonveterans to assure that the costs of all care provided to anyone other than enrolled veterans are fully covered by collections. Additionally, we asked that VHA improve its financial accounting systems to more effectively track its revenues and expenses.

During the upcoming Memorial Day weekend, veterans throughout the Nation will be assembling at most VA Medical Centers to rally support for an adequate VA health care budget. Veterans are deeply worried that the current federal budget for veterans health care could be a recipe for disaster. Not just for the coming fiscal year, but for decades to come.

The years of tight fistd federal spending on discretionary programs have forced VHA to make drastic cuts in health care services to local veterans, even as the demand for that care increases.

As stated earlier, treatment of nonveteran beneficiaries must result in the improvement of services to eligible veterans at the facility, and must not result in the denial of, or delay in providing, access to care for any veteran at that facility.

Until VHA has a billing and accounting system fully in place and verifiable, we can not support the pilot plan proposal to expand treatment to nonveterans.

CONCLUSION

We hope that our statement is helpful to you. We appreciate the Subcommittee's interest in these issues and the opportunity to present our views.



DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Disabled American Veterans (DAV) does not currently receive any money from any federal grant or contract.

During fiscal year (FY) 1995, DAV received \$55,252.56 from Court of Veterans Appeals appropriated funds provided to the Legal Service Corporation for services provided by DAV to the Veterans Consortium Pro Bono Program. In FY 1996, DAV received \$8,448.12 for services provided to the Consortium. Since June 1996, DAV has provided its services to the Consortium at no cost to the Consortium.

Curriculum Vitae
for
Richard A. Wannemacher, Jr.

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Biographical Data

Birth Date: September 30, 1948
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Military Service

U.S. Navy
Enlisted May 1967 and Disability Retired November 1969

Education

AAS Business Administration
BS Environmental Consumer Studies
Graduate Studies Business Administration

Relevant Experience

Associate Legislative Director, Disabled American Veterans (DAV), August 1996 to present

Assistant Supervisor DAV National Service Office Washington DC January 1995 through July 1996

Supervising National Service Officer DAV National Service Office Albany New York November 1980 through December 1995

DAV New York State Legislative Chairman June 1981 through December 1995

Associate National Service Officer DAV National Service Office Buffalo New York October 1978 through October 1980



Non Commissioned Officers Association of the United States of America

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STATEMENT OF

**LARRY D. RHEA
DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS**

BEFORE THE

**SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

ON

**DRAFT LEGISLATION
VETERANS' MILLINEUM HEALTH CARE ACT**

MAY 19, 1999

DISCLOSURE OF FEDERAL GRANTS AND CONTRACTS

The Non Commissioned Officers Association of the USA (NCOA) does not currently receive, nor has the Association ever received, any federal money for grants or contracts.

Thank you and good morning Mr. Chairman and Distinguished Members of the Subcommittee on Health.

The Non Commissioned Officers Association of the USA (NCOA) appreciates the opportunity to express our views on the important issue of veteran health care and to comment on the draft legislation being considered by the Subcommittee. The willingness and desire of the Subcommittee to seek a legislative vehicle to improve VA health care programs is commendable and the members of NCOA salute you for that effort. The Association sincerely hopes that our testimony will be helpful to the important deliberation you have undertaken.

The issue of health care commands a high importance and priority for NCOA. As a Total Force organization, whose membership consists of individuals currently serving in the military, military retirees, veterans, and their eligible beneficiaries, the Association views the issue of health care for veterans in a global aspect. From that perspective, NCOA is pleased that the Subcommittee has prepared a proposal to improve access and quality of VA health care in a more equitable and fair manner. During meetings and hearings on the Fiscal Year 2000 Budget for the Department of Veterans Affairs, NCOA stated its support for the Veterans' Millennium Health Care Act. The Association reaffirms our support for the Act today.

DRAFT BILL VETERANS' MILLENNIUM HEALTH CARE ACT

As the Subcommittee recalls, NCOA was an active force in pushing for and helping to achieve passage of health care eligibility reform measures three years ago. The Association's support for eligibility reform was based largely on the fact that the changes would focus highest priority for care on service-connected disabled veterans. NCOA recognized then though the eligibility reform legislation was not the final answer and additional legislative measures would be required. The Association believes the Veterans' Millennium Health Care Act represents prudent next steps that will help the VA health care system meet current challenges and prepare the system for the challenges that lie ahead.

Long-term Care Reform

NCOA recognizes the growing need for the development of a national veterans' program of extended care service for geriatric evaluation, nursing home care (in-house and contract), adult day health care, domiciliary and respite care. The fact that the proposed legislation would establish such a program and mandate that VA provide needed extended care services to veterans rated 50% and above, and for veterans in need of such care for a service-connected disability, is commendable. This provision alone has the potential to accommodate the needs of more than 450,000 service-connected disabled veterans. As NCOA has stated countless times, VA health care must remain forever focused on the service-connected disabled veteran. The Association fully supports the long-term care reform provisions of the Act for service-connected disabled veterans.

The Act also proposes several changes in long-term cares to meet the needs of non-service-connected veterans. For non-service-connected veterans, the Act proposes highest priority for care for those veterans in need of rehabilitation, unique veteran patients, and for veterans for whom there are not other good long-term care placement options. Further, the Act would establish a co-payment policy similar to that applied in the State home programs. These proposals for non-service-connected veterans have merit. NCOA is concerned however that implementation may become problematic without the assurance of long-term appropriated support for both implementation and management.

The Act also requires that VA maintain nationally the level of "in-house" extended care services provided as of September 30th, 1998. NCOA notes, however, that the aging veteran population in the next two decades will very likely substantiate a far greater level of

support for extended care services. In NCOA's opinion, contracted long-term care should remain the option of last resort to accommodate the extended care needs of service-connected disabled veterans.

Improved Access Through Facility Realignment

The Act proposes several reforms to improve access and quality of health care services at VA medical centers. Foremost among these reforms, in NCOA's view, is the requirement for VA to develop an enhanced service plan and the requirement of stakeholder participation in the development of the plan. NCOA supports the provisions to improve access and quality of care through facility realignment. The requirement that VA cannot implement an enhanced service plan without first submitting the proposed plan and justification to Congress, and waiting for a period of 45 days, should definitely be retained in any legislation advanced following this hearing.

Eligibility Reform

Among the several positive features contained in the Veterans' Millenium Health Care Act, NCOA is most pleased with and lends its strong support to the eligibility reform measures. These provisions would authorize VA to provide care and treatment to veterans awarded the Purple Heart decoration on the same priority as former prisoners-of-war and veterans rated 10 or 20% service-connected disabled. The Act would also, for the first time, provide VA specific authority to provide care and treatment to certain military retired veterans not otherwise eligible for VA care.

NCOA is particularly pleased with the draft bill language relating to military retired veterans. As this Subcommittee knows, NCOA has been an ardent advocate for these "forgotten veterans." In this Association's opinion, no group of veterans has been more ignored or had more "promises broken" than these veterans who honorably served their country for 20, 30, or more years. In fact, the federal government has broken virtually every health care commitment made to military retired veterans. Further, as NCOA has maintained for many years, if a national health care obligation exists for and among veterans, it surely exists to those veterans with service-connected disabilities and to those veterans who predicated career military service based upon a promise of lifetime medical care made by their government. The fact that legislation is now being considered that would recognize military retirees as veterans is a major step forward in NCOA's opinion. The Association salutes the Subcommittee for inclusion of these provisions in the draft legislation.

The provision relating to military retirees proposes to establish eligibility for these veterans as Category A with priority immediately below group 6. While NCOA supports this initiative, the Association must, in complete honesty, express our belief that military retirees have earned and deserve a higher priority than is proposed in this legislation. In view of their long and faithful service to the Nation, and in consideration of the promises made to obtain that service, NCOA believes military retired veterans have a legitimate claim in the VA system to a priority immediately below service-connected disabled veterans. In expressing this belief, NCOA is advocating that the highest obligation and greatest claim for federally provided health care should go to service-connected disabled veterans and military retired veterans. The Association respectfully asks that the Subcommittee consider a higher priority for military retirees than that proposed in the draft legislation.

Enhanced Revenues

NCOA concurs with retaining revenues generated by co-payments, tobacco settlement, etc to be utilized for the expansion of medical care to eligible veterans.

Other Program Improvement

The Association supports all other conceptual program improvements contained in the Act.

**DRAFT BILL
PILOT HEALTH CARE PROGRAM FOR CERTAIN
DEPENDENTS OF VETERANS**

The draft bill proposes to amend title 38, United States Code, to establish a pilot program for the provision of medical care by the Secretary of Veterans Affairs to certain dependents of veterans who are entitled to health care furnished by the Secretary of Veterans Affairs.

NCOA is not inclined to support this proposal Mr. Chairman. If an initiative such as this is to be undertaken, let it be undertaken first with the spouses and dependents of military retired veterans, and those of active military veterans, who were in fact "promised" access to free medical care. Before new expectations are created and elevated, Congress collectively should first honor expectations and promises previously made.

CONCLUSION

Mr. Chairman, NCOA extends its sincere thanks to you and the Distinguished Members of this Subcommittee for the outstanding work you have done to improve the quality and delivery of health care to deserving veterans. The draft act under consideration today is the culmination of many months of effort, including substantial work by Subcommittee staff with NCOA and other veteran's service organizations. As we all recognize, the challenges confronting the VA health care system would be less difficult to solve if unlimited appropriations were available. That not being the case now or in the future, this Association believes the Veterans' Millenium Health Care Act is a reasonable and fair proposal. In supporting this initiative, NCOA asks that you accord military retirees a higher priority as stated above.

Thank you.

**LARRY D. RHEA
COMMAND MASTER CHIEF
UNITED STATES NAVY (RETIRED)
DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS**

As Deputy Director of Legislative Affairs for the Non Commissioned Officers Association, Master Chief Rhea is responsible for veteran and reserve component legislative activities of a 160,000 member Congressionally Chartered military association and veteran service organization.

Master Chief Rhea began his Navy career in August 1960 and following graduation from recruit training as Company Honorman, he served with Patrol Squadron Forty-Six, U. S. Pacific Fleet, and the Navy Training Publications Center, until his release from active duty in September 1963. After a two-year service break, Master Chief Rhea returned to active duty where he served continuously until his retirement in March 1992.

Master Chief Rhea's military assignments were numerous and varied including: Command Master Chief, Naval Air Station, Willow Grove, Pennsylvania; Officer-in-Charge, Naval Reserve Management School; Special Assistant to the Deputy Chief of Staff for Surface Readiness; and the staffs of Commander, Naval Reserve Readiness Command Region Twenty-Two and Commandant, Thirteenth Naval District. He served an unprecedented four-year term on the Secretary of the Navy's National Naval Reserve Policy Board (1982-1985) and is a graduate of the U.S. Army Sergeant's Major Academy, Class Fifteen.

From November 1986 to September 1991, Master Chief Rhea served as the Senior Enlisted Advisor to the Assistant Secretary of Defense for Reserve Affairs as the senior enlisted representative of the 1.6 million enlisted men and women of the seven National Guard and reserve components. He was selected as the outstanding senior enlisted member for the Department of Defense in 1987.

Master Chief Rhea is married to the former Wanda Ann Johnson of New Orleans, Louisiana. They currently reside in Fredericksburg, Virginia, with their son Larry, Jr.

**STATEMENT
OF
KENNETH W. KIZER, M.D., M.P.H.
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
ON
PROPOSED LEGISLATION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MAY 19, 1999**

Mr. Chairman and Members of the Subcommittee, I am pleased to be here this morning to comment on two draft bills that, if enacted, would have far reaching effects on VA health care. The first measure is an omnibus bill that would establish an extended care services program for veterans. It would improve access to VA health care for some groups of veterans and enhance the Department's ability to provide health care services more cost efficiently. The second draft bill would establish a pilot program under which VA would test its ability to provide care to dependents of enrolled veterans. We generally support these proposed measures, although we have concerns about their costs.

DRAFT BILL - VETERANS MILLENNIUM HEALTH CARE ACT

Extended Care Services Program

The draft bill would require the Department to operate and maintain an extended care services program for veterans. Extended care services under the program would include a number of inpatient and outpatient services currently available, such as geriatric evaluation, nursing home care (in VA and community facilities), domiciliary services, adult day health care, non-institutional alternatives to nursing home care such as homemaker services, and respite care.

The bill specifies that VA "shall" furnish extended care services for veterans in need of such care for a service-connected disability and those who need such care for any reason if they have a service-connected disability rated 50% or higher. The draft bill further requires the Secretary to give the highest placement

priority in Department facilities to veterans needing nursing home care for service-connected disabilities and veterans who have a service-connected disability rating of 50% or higher. Any veteran in either of those two groups who is receiving care in a Department nursing home facility and who continues to need such care could be transferred out of the facility only with that veteran's consent. The bill would also require the Secretary to promulgate regulations giving priority for placement in Department nursing homes to those in need of nursing home care for rehabilitation, those in clinically complex patient populations, and those for whom no other suitable placement options exist.

The draft bill would provide that all veterans other than noted above could receive extended care services only if they agree to pay the United States a copayment for extended care services furnished in excess of 21 days in any year. The draft bill would require the Secretary to promulgate regulations establishing a methodology for determining the copayment amounts required of those veterans for extended care services. Such methodology would have to provide for a maximum monthly copayment, provide protection from financial hardship for the veteran's spouse, and provide a monthly personal allowance for the veteran. The new copayment requirements would not be effective until promulgation of the regulations.

The draft bill would also establish a new Veterans Affairs Extended Care Fund. All copayments recovered in connection with the provision of extended care services would be deposited in this fund. Such funds would be available without any fiscal year limitations and would be available exclusively for providing extended care services. Finally, the draft bill would give the Secretary authority to recover any copayments owed to the United States through existing recovery methods.

We are generally supportive of the creation of an extended care program, although various technical issues need to be clarified (e.g., discharge of mentally incompetent patients and what is a clinically complex patient). The draft bill would serve to clarify eligibility for VA long-term care services for those veterans who have traditionally had a high claim to VA health care benefits. It would also establish clear priorities for receipt of such care. It also would provide funding mechanisms, although we have significant reservations about the adequacy of the proposed co-payment funding methodology.

VA is currently in the process of developing a long-term care strategy in response to the recommendations made by VHA's Federal Advisory Committee on the Future of VA Long-Term Care. However, we believe that significant costs would be associated with this provision.

Long-Term Care Planning

The draft bill would require the Secretary to develop and begin implementation, not later than January 1, 2000, of a plan to carry out the recommendations of the Federal Advisory Committee on the Future of Long-Term Care. Specifically, it would require VA to plan for an increase in the options and services available for home and community-based care for eligible veterans from levels provided at the end of FY '98. The bill would also require VA to increase the percentage of the VA medical care budget dedicated to such care from the level provided at the end of FY '98. In implementing such a plan, the draft bill would require the Secretary to ensure that, nationally, the staffing and level of extended care services during any fiscal year is not less than that provided nationally in VA facilities during FY '98.

In our view, these latter provisions of the draft bill are unnecessary. We asked the Advisory Committee to assist us in our long-term care strategic planning, and we have used their advice in developing a strategic plan which is now

undergoing comment both internally in the VA and among stakeholders. It is premature and unnecessary to mandate an additional planning process. Moreover, the Department is already committed to increasing home and community-based care funding levels in the FY 2000 budget, and we intend to continue to shift funds to these programs as recommended by the Federal Advisory Committee on the Future of Long Term Care. The requirement to maintain a certain level of staffing and specified extended care services is unnecessary and is unduly burdensome.

Miscellaneous Extended Care Provisions

The draft bill would clarify that Adult Day Health Care shall be available under the Extended Care Services Program only for enrolled veterans who would otherwise need nursing home care. The bill would also permit VA to furnish respite care under the program to enrolled veterans in any appropriate setting, including the home. Finally, the bill would authorize VA to pay a per diem to State Homes for all forms of extended care. This provision would give VA and the states greater flexibility to work together in furnishing a wider array of long-term care services, a goal the Administration supports. It would continue to enhance the role of states in meeting the needs of older veterans. The VA is supportive of these concepts, which are consistent with recommendations made by the Federal Advisory Committee on the Future of Long-Term Care. Issues of cost, however, remain to be resolved.

Eligibility for VA Health Care for Combat-Injured Veterans

The Eligibility Reform Act of 1996 (Public Law 104-262) directed VA to establish a system of patient enrollment and to enroll veterans in accordance with statutorily established priorities. The draft bill would give a new group of veterans, those who were injured in combat, a specific priority for enrollment and receipt of care. These individuals would have the same priority for enrollment as former prisoners of war and veterans with service-connected disabilities rated

10% or 20%. Veterans included in the definition of "injured in combat" would be those who were wounded in action as the result of an act of any enemy of the United States or otherwise wounded in action by weapon fire while directly engaged in armed conflict. While we philosophically support this provision, which would ensure a high priority for enrollment and VA health care for those most deserving veterans, we also have concerns about the operability of defining "injured in combat". I note, for example, that we have no data on the number of veterans that fall into this category, and consequently cannot assess its impact on resources.

Care for Retired Military Service Members

Retirees eligible for TRICARE are already veterans potentially eligible for VA care. However, many of these veterans do not have a service-connected disability and have an income and net worth such that they have the lowest priority for enrollment in VA's health care system. The draft bill would provide these veterans, who provided the nation with long and valuable service, with priority for VA health care that is higher than those currently placed in priority category VII. In other words, they would have a priority above non-service-connected veterans whose income and net worth exceed VA's means test threshold.

More specifically, the draft bill would establish a new program under which military retirees eligible for DOD's TRICARE program could elect to receive care from VA. Under this new program, DOD would directly reimburse VA for any such care. To carry out the new program, the draft bill would require the Secretary of Veterans Affairs and the Secretary of Defense to enter into an agreement no later than May 1, 2000, under which DoD would agree to reimburse VA for care provided to such military retirees. Such reimbursement would be at the same rates that DoD would pay to contractors under the TRICARE program in the regions in which the retiree resides. The proposed bill

would require that all such DoD payments be deposited in a new "Health Services Improvement Fund" which would be established under another provision of the draft bill to be later discussed in this statement.

This proposed measure is still currently under review by the Administration. Once that review is completed, I will be glad to provide the Department's views on this proposal.

Copayments

The draft bill would give the Department the authority to establish new copayments and flexibility to alter existing copayment requirements. First, the draft bill would require the Secretary to promulgate regulations by which the Secretary may increase above \$2.00 the current copayment amount applicable for each 30 day supply of medication furnished on an outpatient basis for the treatment of a non-service-connected disability or condition. Second, the draft bill would permit the Secretary to establish an annual maximum copayment amount for veterans who have multiple outpatient prescriptions.

In addition, the draft bill would authorize the Secretary to establish reasonable new copayment requirements for veterans receiving sensory-neural aids (e.g. eyeglasses and hearing aids), electronic equipment, and other costly items or equipment furnished for non-service-connected conditions. However, VA could not impose copayments in connection with receipt of a wheel chair or artificial limb. Also, as with the pharmacy copayment requirement, low income veterans and those needing the aid, item, or equipment for a service-connected disability would be exempt from these new copayment requirements. We concur with this measure, which would provide VA with an additional tool to help ensure that we have the ability to provide these items and equipment to more veterans.

The draft bill would further provide that increased revenues from the pharmacy copayments and new copayment(s) imposed by regulation in connection with

sensory-neural aids, electronic equipment, and other costly items or equipment would be deposited in a new Health Services Improvement Fund. (Further discussed later in the statement)

Finally, the draft bill would amend current law to give the Department the flexibility to adjust the copayment that is now paid by priority VII veterans when they receive outpatient care. Under current law, these veterans are required to pay 20% of the average cost of an outpatient visit per treatment episode. VA supports these new co-payment flexibilities. We welcome this change, which will allow the Department to consider imposing copayments that are more consistent with prevailing norms in the health care industry.

Health Services Improvement Fund

The draft bill would establish the "Department of Veterans Affairs Health Services Improvement Fund." VA would be required to deposit into the fund any amount(s) received or collected from four different sources. First, VA would deposit into the fund the amounts collected as a result of any increase in the pharmacy copayment. Second, VA would deposit amounts received from new copayments associated with the provision of sensory-neural aids and costly equipment. Third, VA would deposit amounts generated under VA's amended enhanced use-lease authority. Finally, VA would deposit amounts received under an agreement with DOD for the proposed provision of care to military retirees.

Amounts in the fund would be available without fiscal year limitation for furnishing medical care and services and for recovering amounts owed the United States by reason of such furnished care and services. We support the authorities providing for increased revenues noted in this section, however, we have some concerns about establishing a new fund with essentially the same purpose as the Medical Care Cost Recovery Fund (MCCF). We have particular concerns about the

administrative burden that would result from splitting each pharmacy copayment between two separate funds.

Tobacco Trust Fund

The draft bill sets forth several findings that generally explain that widespread tobacco use by veterans has resulted in many veterans suffering from serious chronic diseases and adverse health effects resulting from their tobacco use. Additional findings address VA's continued obligation to treat and manage these veterans' tobacco-related conditions and the ever-increasing demand these costs place on the Department's medical care budget.

The draft bill would establish a Veterans Tobacco Trust Fund. The fund would be created as a depository for funds that VA may receive in the event the Government pursues litigation against the tobacco manufacturers and is successful. The amount to be credited to the fund would be the Department's appropriate portion of any amount recovered by the United States. That amount would be based on the ratio that VA's costs for treating tobacco-related illnesses for which recovery is sought in the lawsuit bear to the Government's total costs for treating tobacco-related illnesses for which recovery is sought. The fund would be available, without fiscal year limitation, for furnishing medical treatment to veterans. It could also be used for the conduct of research, especially that relating to tobacco addiction and the prevention and treatment of diseases and illnesses associated with tobacco use. The Administration supports dedicating the portion of recoveries from any Federal tobacco litigation that are attributable to veterans costs, to the VA health care system. As this is a cross-agency coordination issue, we are currently looking at the mechanisms through which this might be accomplished, and look forward to working with you on it.

Compensation Benefits under 38 U.S.C. 1151 for CWT participants

VA's Compensated Work Therapy (CWT) program is a therapeutic work program for veterans receiving VA care. These CWT programs are aimed at furthering

the veterans' full rehabilitation. Veterans participate in this therapeutic program in diverse workplace settings. In the event of a work-place injury, these veterans are not eligible for any compensation benefits for the injury absent a finding of negligence. The draft bill would remedy this situation by making a veteran eligible for compensation benefits under section 1151 of title 38, United States Code, for any injury proximately caused by the veteran's receipt of care through this therapeutic work program.

We feel this provision is reasonable since it would help ensure that veterans participating in this health care work program have a remedy similar to other individuals injured in the workplace. However, under pay-as-you-go (paygo) rules, the cost of this provision would have to be offset. We are currently in the process of calculating a paygo estimate.

Adding an Education Mission for Research Corporations

The draft bill would broaden the activities of VA research corporations to include education and training. The corporations, organized under state law pursuant to the power of the Secretary to authorize them, currently exist solely to support VA-approved research. They serve as a "flexible funding mechanism" to accept donations and grants and apply them in support of specified VA research projects. Each is managed under a board of directors that includes, *ex officio*, the VAMC director and chief of staff, and the associate chief of staff for research at the VA medical center it supports. The research corporations are subject to Inspector General audit and are required to obtain independent audits as well, and each year to report, formally and in detail, to the Secretary.

Congress originally authorized the research corporations in 1988. They did so on the basis that the VA lacked explicit authorization to administer research funds from non-VA sources. Corporations were viewed as offering needed flexibility because they were not limited by Government hiring ceilings and their administrative charges could be held below those imposed by the academic

institutions which had been handling support for some research. Research corporations have fulfilled much of their promise. In the last reporting year, 89 corporations had administered some \$98.5 million dollars in donations or grants. Their flexibility has been a significant factor in the success of VA research.

This proposal would convey an alternative corporate mechanism for bringing donations to bear in support of VHA education activities. Under current law, VHA administers such donated support through the General Post Fund, pursuant to VA's statutory gift authority. VHA concurs with these provisions.

Enhanced Services Program

The draft bill would establish a new health services program to improve veterans' access to, and receipt of, quality health care. It would, in effect, permit the Secretary to identify better uses for Department medical centers that do not adequately and efficiently furnish quality hospital care or services, while ensuring the veteran populations served by those centers receive improved access to quality care.

To carry out the program, the draft bill would require the Secretary to designate each medical center that the Secretary finds is no longer able (in whole or in part) to provide hospital or other care efficiently and of optimal quality. In designating any such center, the Secretary must find that the center is located either near a community hospital(s) that has the capacity to provide veterans in the affected catchment area with needed hospital care or another VA hospital that can absorb the center's patient workload.

The Secretary must develop a plan aimed at improving veterans' access to, and receipt of, quality health care at each designated center. Under the draft bill, the Secretary would be permitted to propose any of following different actions with respect to each such center. The plan could provide for the Secretary to contract for needed hospital care for enrolled veterans residing in the affected catchment

area. It could also provide that the designated center cease providing hospital care and other medical services. It would permit the Secretary to lease, if practicable, the center's land and improvements that are no longer needed for furnishing health care. Finally, such plan could permit the Secretary to convert the center into a facility that provides other forms of care, including outpatient care and services that may obviate the need for nursing home care or other long-term institutional care.

Any such plan would have to be consistent with VHA's network strategic planning requirements. The draft bill would require the Secretary, in developing each such plan, to permit stakeholders to participate in the process and to take their views into consideration. It would also require the Secretary to submit each plan to the appropriate congressional committees and would prohibit the Secretary from implementing any plan until 45 days after its submission, 30 days of which shall be during a continuous session of Congress.

In carrying out a plan under the new program, the draft bill would authorize the Secretary to contract for the provision of care for veterans residing in the affected catchment areas using either fee-basis authority or sharing authority.

Importantly, the draft bill would permit use of fee-basis authority without regard to existing statutory limitations on that authority. The authority would be limited, however, to providing care to veterans with mandatory eligibility, i.e., those who are enrolled in priority levels 1 through 6 of VA's health care system. The Secretary, in exercising such authority, must manage and oversee any such contracts.

As to any plan under which hospital care or services would no longer be furnished by the designated medical center, the draft bill would require the Secretary to ensure that reemployment assistance is provided to the center's employees. In those facilities, the Secretary would also have to ensure that not

less than 90% of the funds that would have otherwise been made available to the designated medical center is made available to the appropriate health care region such that the plan will show demonstrable improvement in the affected veterans' access to health care and in the quality of the care that is furnished.

Finally, the Secretary, in carrying out this program, must continue to maintain VA's capacity to provide for the specialized treatment and rehabilitation needs of certain disabled veterans receiving care within distinct programs or facilities dedicated to their specialized needs.

We support the concept of the Enhanced Services Program proposed in the draft legislation. The concept is consistent, in principle, with the OMB Capital Programming Guide, GAO's recommendations regarding a market based capital asset restructuring plan, as well as VHA's Mission Realignment proposal. The goal of the Enhanced Services program appears to be "improved access and quality of services provided to veterans through better alignment of mission and capital resources at VA facilities."

The key to good capital planning is good strategic planning. VA's capital assets have not always been appropriately matched with the missions and need for veterans services in the markets in which they are located. In order to maximize the benefit and minimize the cost of VA's vast capital asset inventory, it is necessary to assess the compatibility of both VA owned as well as other "market assets" with the veterans' health care needs in those markets. As noted during the HVAC March 10, 1999, hearing on VA's Capital Asset Planning, we believe consultant studies would cost as much as \$35 million in FY 2000 to support the recommended market based capital asset restructuring plans in the 40 multiple market locations identified in GAO's report. The criteria for these capital asset restructuring studies would necessarily be essentially the same as those identified in the draft legislation as well as in VHA's Mission Realignment Proposal. Pursuant to the findings and results of those studies, additional future

funds would be requested to complete similar market based asset restructuring plans in the remaining 66 health care markets in which VA operates multiple health care facilities.

One potential shortcoming of the draft legislation is that the draft appears to focus on enhanced service programs at individual facilities or "centers". To get the maximum benefit from such studies and realignment of capital resources, the scope of the assessments should be geographic areas, multiple facility markets or preferably VHA Networks rather than individual facilities or centers. We would note that VHA is also considering establishing advisory committees in each VISN to oversee our planning efforts to assure appropriate participation and local stakeholder buy-in to such plans. Further, the period of time specified for congressional review is excessive and should be reduced to 30 days, maximum.

Expanded Enhanced-Use Lease Authority

The draft bill would expand the existing enhanced-use leasing authority to add as an eligible purpose for an enhanced-use lease a finding by the Secretary that the application of the consideration being offered by a proposed lessee would result in a demonstrable improvement of services to eligible veterans in the geographic service-delivery area where the property is located. It would also increase the maximum length of the lease term to 75 years from the current maximum of 35 years where the lease requires new construction and 20 years where the lease involves minimal rehabilitation. In addition, the draft bill would delete the current limitations on the accounts from which payments for the use of space on the leased premises may be made and by inserting in lieu thereof specific authority for the Department to obtain facilities, space and services on the leased premises, and to make capital contribution payments to the lessee for such space and services from the VA's minor construction funds.

The proposed legislation would also amend existing authority relative to the notice of a public hearing on the proposed designation of a site available for

enhanced-use leasing, and the notice to Congress of a proposed enhanced-use lease to address the expanded eligibility, if appropriate, that the application of the consideration being offered by a proposed lessee would result in a demonstrable improvement of services to eligible veterans in the geographic service-delivery area where the property is located.

The draft bill would further provide that funds received by the Department from enhanced-use lease proceeds would be deposited into a new fund, the "Department of Veterans Affairs Health Services Improvement Fund". A minimum of 75% of the funds earned from a particular lease would be made available to the VISN within which the leased property is located.

This section would provide a 3-year extension of VA's enhanced-use leasing authority until December 31, 2004. This authority has provided a highly beneficial tool for VA. However, a number of questions have arisen regarding the specific form such legislation should take, which are being actively considered within the Administration. When those discussions have been completed, we will be in a position to comment on the Committee's proposal.

Extensions of Various Program Authorities

The draft bill includes four provisions that would extend existing program authorities, committee, and reporting requirements. First, the draft bill would extend, through December 2002, the Department's authority to provide readjustment counseling to Vietnam era veterans who served on active duty but did not serve in combat or in an area of hostilities after May 7, 1975. We support this provision. Currently, this authority is set to expire on January 1, 2000, unless such veterans seek or receive readjustment counseling services before that date.

Second, the draft bill would extend for two more years the Secretary's requirement to submit to Congress updated reports (including Departmental responses) on the activities, plans, findings and recommendations of the

Department's Committee on Care of Severely Chronically Mentally Ill Veterans. VA concurs with this provision. This Committee was established by Congress in 1996, and was charged to report annually to the Under Secretary for Health on VHA's capacity to effectively meet the treatment and rehabilitation needs of severely, chronically mentally ill veterans. In carrying out this task, the Committee supports VA mission goals of Excellence in Health care Value and Excellence in Customer Service espoused in the Prescription for Change (1996). Among the issues addressed by the Committee are: the impact of deinstitutionalization of patients with psychoses, the impact of integration of VA facilities, the development of VISN-based consumer liaison councils, and the impact of VHA's reorganization of health care delivery on special emphasis populations such as homeless veterans and those suffering from addictive disorders. The Committee plans to focus its attention on the proposed enhanced collaboration of mental health and medical/ surgical services in VHA. These are all issues that are evolving, and it is reasonable to assume that the input of the Committee, whose membership includes both mental health clinician/administrators and facility and VISN leadership, will continue to be needed for the increased time proposed in the draft legislation.

Third, the draft bill would renew the requirement of the Secretary to submit a report to the Congressional Committees on Veterans' Affairs on the Department's special programs for the diagnosis and treatment of post-traumatic stress disorder. This would, in effect, require the Secretary to re-establish the Special Committee on Post-Traumatic Stress Disorder. The report must also address the activities, reports, and recommendations of the Committee and must be submitted not later than March 1, 2000. The draft bill would further require the Secretary to update that report not later than February 1, 2001, and by every February 1 of each of the following three years.

VHA does not object to establishing such a committee and submitting the reports, however, it believes that a better alternative is available. In 1996,

Congress created the Advisory Committee on Care of Severely Chronically Mentally Ill Veterans for similar purposes. The Advisory Committee on Care of Severely Chronically Mentally Ill Veterans has specific responsibilities to advise VA on its assessment of VA's effectiveness and capacity for meeting the health care needs of Severely Chronically Mentally Ill veterans, including those suffering with PTSD. Although a new committee could be established under the auspices of the National Center for PTSD & with funding support from the Center, we believe a better alternative would be to establish a sub-committee or working group on PTSD of the Committee on Care of Severely Chronically Mentally Ill Veterans. This arrangement would keep the role of advising VA and Congress on the capacity and effectiveness of mental health programs within one advisory committee structure.

Finally, the draft bill would amend VA's Homeless Providers Grant and Per Diem Program by extending the program's authority through September 30, 2002. We support this proposed change. During the last five rounds of funding, more than 600 applications were received, requesting approximately \$150 million to acquire, renovate, or construct supportive housing or service center facilities for homeless veterans or to purchase vans for outreach and transportation. In FY 94 through FY 98, 127 grants were awarded to 101 non-profit organizations, state or local government agencies, and Indian Tribal Governments in 39 states and the District of Columbia. Currently, over 30 programs now operate, providing over 1004 transitional housing beds for homeless veterans. During FY 98, over 2,580 veterans received services from these community-based programs for a total of 208,102 days of residential care.

The Grant/Per Diem Program gives VA authority to collaborate with community providers to assist homeless veterans. These collaborations have direct implications for VHA Strategic Goals of decreasing the average cost per patient (e.g., the availability of supportive housing for homeless veterans gives VA Medical Centers, for some patients, other alternatives rather than more costly

inpatient treatment); increasing the number of users (e.g., a primary service component necessary for community providers funded under the Grant/Per Diem Program is "targeting" veterans that would not usually have access to VA care. These outreach endeavors increase new user access.); and increasing the percent of operating budget obtained from non-appropriated sources (e.g., each grant recipient must match VA moneys with local or state resources.)

The draft bill would also lift the current restriction on the number of grants that may be awarded to programs that provide for the procurement of vans. Currently, VA may award only 20 grants to programs for the procurement of vans. This proposed change would enable the Homeless Providers Grant and Per Diem Program to provide funds for community providers to procure vans. These vans will be utilized to provide outreach to and transportation for homeless veterans. The need for these vans is exemplified by the fact that over sixty community providers applied for vans in the first two years of the program. Additionally, the VA Inspector General's report "The Impact of Downsizing Inpatient Substance Abuse Rehabilitation Programs on Homeless Veterans and other Frequent Users" (Report 7H1-A28-108) emphasized the importance of transportation resources for homeless veterans to continue courses of treatment or to pursue treatment options. Also, the need for outreach to and transportation for homeless veterans has also been identified as a community priority on yearly CHALENG surveys. VA supports this provision.

Canteen Service Authority

The draft bill would grant the Veterans Canteen Service (VCS) the authority to offer its full product line to all Department patients, regardless of whether the patient is receiving care on an inpatient, domiciled, or outpatient basis. The proposed legislation would also expand the authority of the VCS to provide support services, such as inpatient feeding, to Department medical facilities on a reimbursable basis.

In recent years, the Department has made dramatic changes in how it delivers health care to veterans. The focus has shifted to providing care on an outpatient basis rather than on an inpatient basis. As a result, a greater number of veterans are receiving their care at medical facilities other than VA "hospitals or homes." Current law restricts the sale of VCS items which cannot be used or consumed on the premises at Department facilities which are not "hospitals or homes," such as outpatient clinics. This restriction hinders VCS' ability to provide full service to veteran outpatients. The proposed amendments would remove this restriction by eliminating the "consumable on premises" requirement and replace the words "hospitals and homes" with the words "medical facilities" or "treatment facilities." The draft bill would also authorize VCS to provide the Department support services, such as inpatient feeding, on a reimbursable basis. This change would afford VA the flexibility of merging services that now exist in parallel, such as food preparation by both the Nutrition and Food Service and VCS, where appropriate to decrease duplicative costs and increase Department efficiency. Initial test sites have indicated that eliminating duplication in as few as ten locations could yield annual savings well in excess of two million dollars. The savings are realized in areas such as employee wages and benefits, equipment cost, and raw food cost.

The changes proposed in the draft bill would enhance the services VCS would be able to provide to veterans and the Department without limiting existing VCS obligations under other laws in any way. Moreover, the VA Office of General Counsel advises that this proposal does not limit VA's obligations under the Randolph-Sheppard Act. Accordingly, VA supports this section.

Feasibility Study on the Provision of Assisted Living Services

The final provision of the draft bill would require the Secretary to submit a report not later than April 1, 2000, to the Congressional Committees on Veterans Affairs on the feasibility of establishing a pilot program to provide veterans assisted

living services. The Federal Advisory Committee on the Future of Long Term Care recommends an enhanced role for the Department in providing assisted living services. We support this section.

Reimbursement for Non-VA Emergency Treatment

The draft bill would authorize the Secretary of the Department of Veterans Affairs to reimburse a limited number of veterans enrolled in VA's health care system for emergency treatment furnished by non-VA facilities for any disability. Generally, VA can now reimburse for emergency care only for service-connected disabilities. The proposal would limit eligibility for this benefit to veterans who are enrolled in priority levels (1)-(6) of VA's health care system and who have received VA care within the twelve-month period preceding the emergency treatment.

The draft bill provides that VA would be a payer of last resort. VA would pay for non-VA emergency treatment only when no other third party is liable, in whole or in part, for payment for the treatment. Thus, if the veteran has any insurance coverage that would pay for any of the furnished emergency treatment, no reimbursement would be authorized under the proposal. Moreover, if the veteran were eligible for Medicare or Medicaid, VA would not provide reimbursement for the care.

The Secretary, in lieu of reimbursing the veteran, may directly pay a person who paid for the treatment on the veteran's behalf or pay the provider of the emergency treatment for its reasonable value as determined by the Secretary. If the provider of emergency treatment accepts the VA payment, the provider must consider that as payment in full and may not bill the veteran for any additional amount. Should a third party subsequently make any payment for the veteran's emergency treatment, the bill would give the United States an independent right to recover its payment.

This provision would expand the Administration's proposal to also provide out-of-network emergency care to lower-priority veterans. The President's FY 2000 Budget recommends funding for categories 1-3, but does not include funding for out-of-network emergency care for priority groups 4-6. The Administration is supportive of efforts to address the issue and will work with you in this regard.

Changes to VHA Operations

The draft bill would prohibit the Secretary from closing more than 50% of the Department's beds in any bed section having at least 20 beds until the Secretary submits a justification for such closure to Congress and waits 45 days. The justification would have to include an explanation as to why the closure is appropriate, a description of the changes in the functions to be carried out, the means by which VA would continue to provide care and services to eligible veterans, and a description of the anticipated effects of the closure on veterans and their access to care. The bill would also impose quarterly reporting requirements regarding any medical center's change in the mission of any bed section.

VA opposes this provision. The proposal establishes extensive oversight and reporting requirements for just one healthcare resource – inpatient beds. The imposition of this level of congressional oversight would be burdensome and would impede the Department's ability to effectively manage the delivery of health care. The emphasis on keeping beds open as a way of assuring availability of healthcare is outdated. Since 1995, VA has been reengineering its healthcare system to place the emphasis on providing the right care to veterans in the right location at the right cost. In essence, VA has developed integrated healthcare delivery networks that focus on providing coordinated care to the patient and improving patient outcomes. This section focuses more on existing facilities than on having VA provide high quality healthcare that improves patient outcomes, is cost effective and allows more veterans to be treated. We believe the loss of flexibility to manage bed levels that this provision portends will result

in delayed or denied actions to improve the effectiveness of VA healthcare; increased and unnecessary costs; and less than optimal management actions in trying to comply with these new requirements.

Pilot Program to Evaluate Chiropractic Treatment

The draft bill would allow the Secretary to operate from October 1, 2000, through September 30, 2001, a demonstration program to evaluate the effectiveness of providing chiropractic treatment to enrolled veterans. The program could be established at up to five medical facilities, and VA could hire, and contract for, chiropractors or chiropractic treatment for the duration of the program.

Chiropractors would also have to be involved in planning the program. The proposal would require the Secretary to submit a report to Congress before July 1, 2000, on the plans to implement this program. A final report on the program's operation, evaluation, and cost would be due not later than June 1, 2003.

VA opposes this provision. It is not necessary and creates additional paperwork. Currently, VA can hire chiropractors, or can contract for chiropractic care, and is supportive of such.

DRAFT BILL - PILOT PROGRAM FOR CARE OF DEPENDENTS

The draft legislation would authorize the Secretary to conduct a pilot program allowing certain eligible dependents of enrolled veterans to receive medical care from VA. The pilot program would last for three years and would take place at no more than four VISNs designated by the Secretary. The Secretary's designation would have to be based on a number of factors, including the VISN's capacity to participate in the program without limiting care and services for veterans, its success in billings and collections, the support for the pilot program among the veteran population, and "other appropriate criteria" identified by the Secretary.

Under the pilot program, dependents could receive "primary health care services" from VA, including primary hospital care services and other primary medical services authorized by the Secretary. The services could be furnished directly by VA or pursuant to a contract or other agreement with a non-VA facility. "Eligible dependents" would include the spouse or child of an enrolled veteran. The dependent must be able to pay for services either directly or through reimbursement or third party indemnification. The dependent would have to agree to pay for reasonable charges, including copayments, and must assign benefits and authorize the release of medical records or other "executed documents, information or evidence" needed by the Secretary to recover payment.

The Secretary could not provide services to dependents if doing so would result in a denial or delay in providing care to enrolled veterans. The proposed legislation states that any funds collected will be deposited into the VA Medical Care Collections Fund.

VA supports conducting this pilot effort. The pilot would support VHA's efforts to acquire 10% of resources from non-appropriated sources. Veterans frequently express interest in having their dependents also receive health care through the VA. The pilot would assess the impact of providing such services on VA health care. VA supports these provisions.

I will be happy to answer any questions you may have.

**STATEMENT OF
HARLEY THOMAS, ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
"VETERANS MILLENNIUM HEALTH CARE ACT"**

MAY 19, 1999

Good Morning, Mr. Chairman and members of the Subcommittee, I am Harley Thomas, Associate Legislative Director for Paralyzed Veterans of America (PVA). It is a pleasure to be here to express our views on draft legislation, the "Veterans Millennium Health Care Act," and other provisions which address a broad range of health programs and services provided by the Department of Veterans Affairs (VA).

Extended Care Services.

The provision, for the first time, would mandate that VA operate and maintain a broad range of extended care services. The provision, if enacted, would underscore and clearly identify, by statute, the importance of VA's long-term care mission. VA long-term care programs are currently under great threat. Eligibility reform, enacted four years ago, left long-term care outside the umbrella of mandated services. Extreme budget pressures on the provision of acute care services have allowed local managers to seriously degrade their long-term care programs in order to shift resources to maintain services that fall under the mandated benefit package. It is a sad irony that at the exact time an aging veteran population is looking to VA for long-term care support that veterans find local hospital directors and VISN planners divesting themselves of their long-term care capability.

The provision also clearly identifies the full gamut of long-term care services within the VA's service delivery system. Long-term care is far more than just a nursing home bed. The provision includes geriatric evaluation, domiciliary services, adult day health care and other alternatives to nursing home care. The only addition to this list we would make would be to include assisted living in the same long-term care "tool chest." Section 14 of the draft bill calls on VA to report on the feasibility of assisted living services programs. While encouraging that activity, we believe VA can certainly find existing space or contract arrangements to greatly expand these and other needed long-term care initiatives.

The United States, unlike most western developed nations, has no generalized long-term care policy. Long-term care has been left out of all the discussions over Medicare reform. The combination of public services, private programs, and long-term care insurance initiatives has left major gaps in long-term care coverage for most Americans and their families who face, or could face, catastrophic illness. As PVA members with spinal cord dysfunction (SCD) age, deterioration in physical condition and health status make the eventual need for specialized long-term care services an ever-present threat. In many instances, the veteran's spouse or caregiver is also aging and facing their own inability to provide the same level of services and assistance that they have provided for a lifetime. For these veterans and their families long-term care options are often quite grim.

Anyone who uses a wheelchair is precluded from purchasing long-term care insurance. Medicaid, perhaps the only safety net option, requires the indignity of impoverishment and, in most cases, institutionalization, unsuited to the veteran's need for specialized care. Preferred home care options are limited and expensive. Medicare home care programs have come under increasing cost and eligibility scrutiny. State Medicaid waivers for home and community based care are sporadic and not implemented within every state. For many veterans, particularly PVA members, the VA has been the only option for their specialized health care needs, as well as, for their present and future

needs for specialized long-term care. Sadly, the erosion in VA long-term care capability that has taken place over the past several years has seriously threatened the specialized VA long-term care option that PVA members have thought they could count on.

The draft bill would require VA to maintain, nationally, the level of "in-house" extended care services provided as of September 30, 1998. PVA strongly supports this language. The provision is similar to existing language in title 38 U.S.C. that requires VA to maintain its capacity to provide specialized spinal cord dysfunction services. We have seen this provision as a useful, but not necessarily foolproof (without the implementation of strenuous oversight), tool to bring the importance and maintenance of these programs to the attention of local and national Veterans Health Administration (VHA) officials. As stated above, budget shortfalls, as well as decentralization, have led local VA managers to cannibalize long-term care programs in order to fund what they see as other priorities. This language clearly sends the signal from the Congress that in-house nursing home and other long-term care services are a major component of the VA's total health care mission. They must not be reduced below a certain level.

The draft bill would also, for the first time, attempt to address the heretofore unclear reality of exactly which veterans are eligible for nursing home and other long-term care services. The bill would spell out eligibility for veterans requiring care for a service-connected disability and for veterans rated 50 percent disabled or more for service-connected disability. For other veterans it would require the Secretary to prescribe regulations governing the priorities for the provision of "in-house" nursing home care indicating that priority would be given for (A) patient rehabilitation, (B) for clinically complex patient populations, and (C) for patients for whom there are not other suitable placement options. This language applies clearly to veterans in need of long-term specialized care, particularly those, such as veterans with spinal cord dysfunction, who rely on existing specially designated SCD long-term care beds not available or not suitable in the private sector. We believe, if this language is enacted, the Committee

should ensure that statutory or report language should clearly acknowledge access to special patient populations, such as SCD veterans, who, because of the clinically complex nature of their disabilities require such long-term care. The provision should also acknowledge that this care is an essential adjunct and component of the entire range of specialized SCD care that VA has developed. The capacity and availability of these services must be maintained and made available to any veteran in need.

Long-Term Care Fees:

The provision would allow the Secretary to establish fee schedules for veterans receiving VA long-term care services who are not service-connected rated 50 percent or more, or who are receiving services for their service-connected disability. PVA considers fees charged for these services to be a basic retrenchment of existing eligibility. Despite certain guidelines and protections included in the legislation, it is not clear exactly how the Secretary would design this fee schedule. Noting the chronic difficulty VA has in collecting what it is owed, it is unclear if VA could implement this fee schedule in a way that was uniformly applied to all veterans, and in a way that could conceivably make an appreciable benefit to enhance other long-term care programs. The provision would establish a "Department of Veterans Affairs Extended Care Fund" that would be the repository of the collections in the attempt to protect these funds from budget or appropriations offset. The goal is well intentioned, but based on previous experience from the authorization of other fees or collections, what was once intended to benefit and enhance one VA program in reality was offset from future appropriations by Office of Management and Budget (OMB). The end result is a zero sum.

Requirement to Increase Extended Care Services

The provision calls on VA to develop a plan to implement the recommendations of the Federal Advisory Committee on the Future of Long Term Care. PVA supports this initiative which includes enhanced alternatives to institutionalization such as Adult Day Health Care, Respite Programs, as well as improvements to the State Veteran Home Program.

Eligibility for Combat Injured Veterans

The provision would provide eligibility for VA health care system enrollment to all recipients of the Purple Heart Decoration. PVA does not object to this provision.

Access to Care for Military Retirees

The provision would provide a new VA health care enrollment category for all military retirees who are not otherwise eligible for care in VA facilities. PVA fully understands the intent behind this provision that greatly expands eligibility to a large segment of the veteran population who are dissatisfied with the deterioration of the Department of Defense (DoD) health care system and disincentives imposed upon them by the TRICARE program. We however caution that merely offering access to VA hospitals does not guarantee military retirees will receive those services. Due to chronic funding shortfalls VA will be hard pressed to provide services to all veterans currently enrolled from Category 1 through Category 6. Creating a new enrollment category (Category 6-B) does not guarantee health care. Military retirees have been over-promised in the past. It would not be fair, noting the chronic funding shortfalls in the VA today, to over-promise again.

Medical Care Collections

PVA opposes increasing prescription fees. Even at current levels many veterans, including PVA members, as they advance in age rely on multiple combinations of pharmaceuticals. For many these costs are too high already. The provision would also establish a Health Services Improvement Fund, which would serve as the repository for these collections. For these same reasons we oppose new fees for medical equipment and supplies. Apart from the unfair burden on the veteran, we believe it is virtually impossible to shield such collections from ultimate budget or appropriations offset. Likewise it could be difficult to monitor exactly how these funds were expended at the local level even if they were retained.

Enhanced Services Program at Designated Medical Centers

This provision would establish a dialogue and procedure whereby a process could be set in motion to close existing VA medical facilities replacing the services provided by the facilities with other options. We understand that the VA is also considering designing a process to achieve the same results. PVA is currently engaged in analyzing various approaches to develop criteria on how and under what circumstances this process might be set in motion. We are tasked with presenting these views to our Board of Directors when they meet in convention this summer. Therefore, it would be premature to endorse any one proposal of this kind at this time. We believe, however, that if such a process were to be set in motion, the activity must not be budget driven but must clearly enhance care to veterans in the short and long-term.

Reimbursement for Emergency Treatment

The provision would establish reimbursement of emergency treatment for emergency services provided to veterans enrolled in categories 1 through 6. PVA believes that all enrolled veterans should be eligible for reimbursement for emergency services. If VA is going to provide a comprehensive health plan; emergency coverage should be universal as it is with practically all private sector plans.

Review of Proposed Changes to Operation of Medical Facilities

Severe budget pressures, decentralization of management authority and lack of oversight have allowed local managers to downsize, reduce staffing and beds, instigate consolidations and transfer missions. In many cases these decisions have been purely dollar driven without consideration of the needs of veterans who are forced to seek existing or non-existing services elsewhere. This provision would require Congressional notification and approval in any situation where a facility intended to close more than 50 percent of the beds within a bed section of 20 or more beds. The provision rightly, and in accordance with VA policy, identifies beds as those beds, which are staffed to operate. It also characterizes the types of beds in "bed sections" including a wide variety of acute, rehabilitative, and long-term care beds. PVA greatly appreciates the

inclusion of spinal cord injury (dysfunction) beds in this section. We would, however, seek clarification. Current law requires VA to maintain its capacity to provide spinal cord dysfunction medicine. SCD medicine is primarily a hospital based specialty. In our opinion, the capacity to provide these services does not allow for reductions in the number of beds at all. If VA were to close 40 percent of the beds in one SCI center, the provision would not require notification to the Committees on Veterans' Affairs. If the hospital closed 50 percent of the beds, the provision would require notification. In either case such closures would violate the statutory mandate to maintain the capacity of specialized SCD care.

Chiropractic Treatment Demonstration Program

The provision would establish a pilot program at up to five medical facilities to evaluate the effectiveness of providing chiropractic treatment to veterans. PVA has no objection to this provision.

Draft Bill: Provision of Medical Care to Certain Dependents of Veterans

The bill would establish a pilot program for the provision of medical care to certain dependents of veterans who are entitled to VA health care. The provision envisions a major expansion of VA users to help enhance the VA patient base and provide an alternative funding stream to help support on-going VA operations. PVA is concerned that the objectives of the pilot program could not be met for several reasons. VA is ill-equipped to respond to many of the complex health needs of women, and particularly children of veterans in need of pediatric care. VA still has serious difficulty in its ability to bill and collect reimbursements in the attempt cover the cost and increase revenues from such activity. VA budgets are such that the system is hard-pressed to provide services to all veterans seeking enrollment. PVA cannot support this expansion of services at this time.

This concludes my testimony, Mr. Chairman. I will be happy to answer any questions that I can.



Harley Thomas

Harley is a veteran of twenty years military service in the United States Navy. During his military career, he spent a tour in Japan and in 1967 served in Vietnam with Fleet Air Reconnaissance Squadron One (VQ1). In 1968, Harley served aboard the USS Piedmont in support of fleet operations in Vietnam. Harley spent his final tour in the service with the Defense Communications Agency in Reston, VA, where he retired in February 1976 as a Chief Data Processing Technician. Following his military career, he worked in the computer industry as a senior system analyst until 1996. As a member of the Mountain States Chapter of PVA, Harley held the position of Director to PVA National, Chapter President, and Chapter Executive Director. Harley holds a degree in business from the University of Virginia. He is currently employed by the Paralyzed Veterans of America National Office, as an Associate Legislative Director.

Information Required by Rule XI 4(2)(g) of the House of Representatives

Pursuant to Rule XI 4(2)(g) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 1998

General Services Administration—Preparation and presentation of seminars regarding implementation of the Americans With Disabilities Act , 42 U.S.C. §12101, and requirements of the Uniform Federal Accessibility Standards — \$15,000.

Department of Veterans Affairs— Donated space for veterans' representation, authorized by 38 U.S.C. §5902, — \$243,912* (as of December 31, 1997).

Court of Veterans Appeals, administered by the Legal Services Corporation — National Veterans Legal Services Program— \$63,656 (as of December 31, 1997).

Fiscal Year 1997

Architectural and Transportation Barriers Compliance Board— Develop illustrations for an Americans With Disabilities Act, 42 U.S.C. 12101, technical compliance manual— \$10,000.

Department of Veterans Affairs —Donated space for veterans' representation, authorized by 38 U.S.C. §5902, — \$975,651.*

Court of Veterans Appeals, administered by the Legal Services Corporation — National Veterans Legal Services Program— \$238,307.

Fiscal Year 1996

General Services Administration— Preparation and presentation of seminars regarding implementation and the Americans With Disabilities Act , 42 U.S.C. §12101,— \$25,000.

Federal Elections Commission— Survey accessible polling sites resulting from the enactment of the Voting Access for the Elderly and Handicapped Act of 1984, P.L. 98-435, — \$10,000.

Department of Veterans Affairs— Donated space for veterans' representation, authorized by 38 U.S.C. §5902, — \$897,522.*

Court of Veterans Appeals, administered by the Legal Services Corporation — National Veterans Legal Services Program — \$200,965.

* This space is authorized by 38 U.S.C. § 5902. These figures are estimates derived by calculating square footage and associated utilities costs. It is our belief that this space does not constitute a federal grant or contract, but is included only for the convenience of the Committee.



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**STATEMENT OF
THE RETIRED OFFICERS ASSOCIATION**

on

**Draft Legislation:
"The Veterans' Millennium Health Care Act"**

before the

**Subcommittee on Health
House Veterans' Affairs Committee**

May 19, 1999

Presented by

**Colonel Robert F. Norton, USA (Ret.)
Deputy Director of Government Relations
The Retired Officers Association**

Biography of Robert F. Norton, COL, USA (Ret.)
Deputy Director, Government Relations
The Retired Officers Association

Colonel Norton is responsible in the TROA national office for legislative matters concerning veterans' health care and benefits.

A native New Yorker, Colonel Norton was born in Brooklyn and raised on Long Island. Following graduation from college in 1966, Colonel Norton enlisted in the U.S. Army as a private, completed officer candidate school, and was commissioned a second lieutenant of infantry in August 1967. He served a tour in South Vietnam (1968-1969) as a civil affairs platoon leader supporting the 196th Infantry Brigade in I Corps. He transferred to the U.S. Army Reserve in 1969 and pursued a teaching career at the secondary school level. He joined the 356th Civil Affairs Brigade (USAR), Bronx, NY and served in various staff positions in the unit from 1972-1978.

Colonel Norton volunteered to return to active duty in 1978 and was among the first group of USAR officers to affiliate with the "active Guard and Reserve" (AGR) program on full-time active duty. He specialized in improving the readiness and manning of the Army's reserve forces. Assignments included the Army Staff office of the Deputy Chief of Staff for Personnel; USAR advisor to the Asst. Secretary of the Army (Manpower & Reserve Affairs); and personnel policy and plans officer for the Chief, Army Reserve.

While assigned to the Office of the Secretary of Defense (Reserve Affairs), Colonel Norton was responsible for implementing the Reserve Montgomery GI Bill. He served as the senior military assistant to the Assistant Secretary of Defense for Reserve Affairs from 1989-1994. During his tour in Reserve Affairs, more than 250,000 National Guard and Reserve component troops were mobilized for the Persian Gulf War. Colonel Norton completed his career as special assistant to the Principal Deputy Asst. Secretary of Defense, Special Operations / Low Intensity Conflict and retired in 1995.

Colonel Norton joined Analytic Services, Inc. (ANSER), Arlington, VA in 1995 as a senior planner. He joined TROA's National Headquarters as Deputy Director of Government Relations in March 1997.

Colonel Norton holds a B.A. in philosophy from Niagara University (1966) and a Master of Science (Education) from Canisius College, Buffalo (1971). He is a graduate of the U.S. Army Command and General Staff College, the U.S. Army War College, and Harvard University's Senior Officials in National Security course at the Kennedy School of Government.

Colonel Norton's military awards include the Defense Superior Service Medal, Legion of Merit, Bronze Star, Vietnam Service Medal, Armed Forces Reserve Medal, Army Staff Identification Badge and Office of the Secretary of Defense Identification Badge.

Colonel Norton is married to the former Colleen Krebs. The Nortons have two grown children and reside in Derwood, Maryland.

INTRODUCTION

The Retired Officers Association (TROA) is very grateful to the Chairman and distinguished members of the Subcommittee on Health of the House Veterans' Affairs Committee for the opportunity to express our views on draft legislation known as the "Veterans' Millennium Health Care Act".

TROA is the fourth largest military veterans organization with nearly 400,000 members. Our membership consists of veterans and survivors who are retired officers, active duty and National Guard / reserve officers of the seven uniformed services and their surviving spouses. Collectively, there are 1.67 million military retired veterans who are eligible to use VA health care either as "mandatory" or "discretionary" veterans.

As a founding member of The Military Coalition (TMC), TROA works closely with the 29 other veterans and military organizations in The Coalition, representing the collective interests of over 5 million current and former members of the seven uniformed services, plus their families and survivors. TMC's Committee structure includes a Veterans' Committee which works veterans issues for The Coalition. This Statement, however, represents the views of TROA alone. TROA does not receive any grants or contracts from the federal government.

VETERANS' MILLENNIUM HEALTH CARE ACT

Long term care reform. The Subcommittee on Veterans' Health Care's legislative proposal would extend and incorporate long term care into the statutory framework of the Veterans' Health Care Reform Act of 1996 (P.L. 104-262). The Veterans' Millennium Health Care Act would:

- Mandate the Secretary of Veterans Affairs to operate and maintain a national program of extended care services including specific types of services identified in the legislation.
- Require VA to sustain the level of effort of "in house" extended care services provided as of September 30, 1998.
- Require VA to implement by January 1, 2000 a plan for carrying out the recommendations of the federal advisory committee on the future of long-term care -- this should result in an increase of the medical care budget dedicated to long term care and increase home and community-based care options
- Establish long-term care as a *mandatory benefit for veterans with a 50% service-connected disability* and for veterans in need of such care for a service-connected disability
- Establish a framework for establishing placement priorities and for a system of co-payments for extended care for non-service connected conditions.
- Authorize VA to furnish respite care services and to expand the scope of the State home program to include long term care services.
- Accomplish or authorize related purposes.

Until recently, long term care services were regarded as optional or add-on services limited for the most part to those with the means to afford them. That view is changing, however slowly. As a matter of health care policy under Title 38 of the U.S. Code, it is now time for

the government to recognize long term care as a fundamental component of health care assessment and delivery for those who require such care.

TROA members and uniformed services retirees generally have expressed growing concern over the need for affordable long term care services. Military retirees have an average age of about 61, with officers averaging 66 years of age and enlisted averaging 59. TROA members themselves average 66 years of age. Many military retirees, therefore, fit the "demographic imperative" of veterans who will potentially need long term care services early in the 21st century.

TROA is supporting legislative proposals that would allow uniformed service retirees to purchase long term care insurance on the same basis as federal civil servants under the Federal Employees Health Benefit Program (FEHBP). Under such legislation, uniformed service retirees would be allowed to buy long term care insurance in advance of need. Since uniformed service members normally retire with between 20 and 30 years service, their relatively youthful ages upon leaving the service (38 - 50 years) would allow them to purchase long term care insurance far in advance of need at modest premiums. Many military retirees, however, still might not be able to afford such insurance. Others have significant service-connected disabilities that would qualify them for long term care from the VA under the proposed legislation.

As with the promise of VA eligibility reform, Congress must be willing to back up long term care reform legislation with the resources to fund the benefit. If not, the VA will once again be forced to "borrow from Peter to pay Paul." The legislation requires the VA to increase the "percentage of the Department of Veterans Administration medical care budget dedicated to such (long term) care." When eligibility reform legislation was passed in 1996, many more veterans became eligible for a wide range of health care services from the VA. In part because of the shift to outpatient services, the VA is seeing record numbers of VA patients, a commendable trend. Under budget caps put in place four years ago, the VA has had no choice but to shave a portion of the medical care budget used for long term care services to provide care for more veterans enrolled in the system. If long term care reform were enacted, will the administration and Congress be willing to back up reform with the necessary resources? In March, TROA testified before the full House and Senate Veterans Affairs Committees that there were about 500 thousand applications still in the queue under the open enrollment policy. If long term care reform legislation is enacted, Congress and the Administration must be willing to support the statutory promise with real growth in the VA health care budget.

The Retired Officers Association supports the Subcommittee's proposal to establish a framework for long term care reform including making the benefit mandatory for veterans with a 50% service connected disability. In making this endorsement, TROA urges the Subcommittee on Veterans Health Care and the entire Congress to support increasing the VA medical care budget to accommodate the structural reforms addressed in the legislation.

Facility Realignment. A second major component of the draft legislation would direct the VA to conduct a strategic assessment of its long term facility needs. Similar in objective to the Department of Defense's Base Realignment and Closure (BRAC) process, the legislation lays out a framework to permit the VA to aggressively re-align its costly facilities

infrastructure in order to better serve the needs of veterans. As history reveals, this will be easier said than done, although almost all military and veterans groups believe the time has come to tackle this problem head on.

The problem is clear. The VA spends roughly 25% -- \$4 to \$5 billion dollars -- per year to maintain its aging infrastructure. The nation's largest health care system was established mostly during the post World War eras when the nation's health care model was predicated on inpatient occupancy rates rather than health care "outcomes". Advances in technology, pharmaceuticals, medical procedures and practice, and cost considerations have led to a gradual shift towards outpatient care as the preferred model. The new model is not without its own set of problems, but the trend appears to be irreversible. The question is how to make the trend towards outpatient care work for the benefit of veteran patients. One way, of course, is to plow back the huge investment in infrastructure into expanded health care services, including long term care, for veterans.

TROA notes and commends the Subcommittee's inclusion of draft language requiring the Secretary of Veterans Affairs to consult with veterans organizations to "obtain their views" on any plan for proposed facility realignment. We also note and fully endorse the provision in the draft bill that reaffirms the obligation of the VA to maintain its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans including those with specialized needs: spinal cord dysfunction, blindness, amputations, and mental illness.

The Retired Officers Association supports the provisions in the Veterans' Millennium Health Care Act draft that direct the VA to carry out a facilities review and realignment process with the primary objective being the enhancement of medical services to America's veterans.

Access to Care for Military Retirees. The draft legislation would establish a new VA health care enrollment category for military retirees eligible for TRICARE benefits from the Department of Defense (DoD).

TROA's number one legislative priority in recent years has been the restoration of the government's promise of **lifetime health care** in DoD military treatment facilities for uniformed services retirees. Our strategy for achieving this goal is comprised of three interlocking objectives:

- Improving the Defense Department's managed care program, TRICARE
- Obtaining passage of permanent authority for DoD "subvention"
- Validating the feasibility of enrolling military retirees in the Federal Employees Health Benefit Program for older retirees -- FEHBP-65

Expanding access to VA care under a new enrollment category would open another option to military retirees not otherwise eligible for assured access to VA care. TROA has long believed that VA health care should be made more accessible to military retirees who are not otherwise eligible for care as a result of a service-connected disability or who are retired as a result of a disability.

The legislation would permit military retirees not otherwise eligible for "mandatory" health care benefits to be enrolled in a separate new category, above the current "priority seven" discretionary category. Establishment of a new category for military retirees is not inconsistent with TROA's goal of improving TRICARE. The proposed amendment to Section 1705 would make military retiree TRICARE beneficiaries (but not their dependents) to have the option of seeking TRICARE benefits through the VA. DoD would be required to reimburse the VA for retirees eligible for care under the TRICARE program.

TROA maintains that retirees enrolled in the VA system in this manner would be seen as TRICARE Standard beneficiaries and would not be required to pay TRICARE Prime enrollment fees to DoD.

Retirees with a service-connected disability or who are eligible for care under a higher category would be accepted for care in the higher category. In addition to making VA health care more accessible, the language would in effect make the entire VA system an "automatic" TRICARE provider to military retired TRICARE eligibles.

There are additional considerations and concerns that we would like bring to the Subcommittee's attention. The language limits enrollment in the new category to service members who have retired from "active military, naval, or air service." The language should be modified to read "uniformed services" retirees so that members of the U.S. Public Health Service and the National Oceanic and Atmospheric Administration Corps of Commissioned Officers (NOAA Corps) could also be enrolled in the VA health care system under this authority.

The phrase "active military, naval, or air service and is eligible for care under the TRICARE program" should be further modified to permit members of the Selected Reserve who retire for pay at age 60 to become eligible for enrollment in the new category. These service members receive military retired pay at age 60 and are eligible for TRICARE services from DOD at that time. They should be allowed to enroll in the new category at age 60 if not eligible otherwise under a higher category.

For older, Medicare-eligible uniformed services retirees with no service-connected disability, the proposed new category would offer no improvement because they lose TRICARE eligibility at age 65. For this reason, the potential of this initiative for many TROA members -- average age 66 -- and for other older military retired veterans is limited. TROA urges, therefore, that the Veterans' Millennium Health Care Act include a statement expressing the sense of the Congress about the need to authorize a demonstration project for VA Subvention.

Finally, TROA would like to emphasize that if military retirees were allowed to enroll as "Category A" veterans and receive TRICARE benefits through VA facilities, that Congress must ensure that DOD maintain its commitment and level-of-effort to provide care for military retirees in military treatment facilities.

The Retired Officers Association supports the provision in the Veterans' Millennium Health Care Act that would authorize enrollment of uniformed services retirees as "Category A" veterans in the VA health care system.

THE NEED FOR VA SUBVENTION

Without at least a test of VA Subvention, the reforms sponsored by the Subcommittee in the past three years will have little impact on non-disabled uniformed services retirees. That's because expanded access to VA health care for military retirees eligible for TRICARE would only "work" until they turn 65 and are cast out of the DoD health care system. In practical terms, that would mean that the average military retiree (age 61) with no disability could be enrolled in the new "VA TRICARE" category for only four years.

If TRICARE Senior Prime (DOD Subvention) became a permanent authority, then non-disabled retired beneficiaries would retain the option of continuing to get TRICARE through a VA facility after age 65. But for now older retirees could not seek VA care (unless otherwise eligible) as "Category A" veterans under the proposed change to Section 1705(a) of Title 38. To strengthen the practical impact of enrolling retirees as Category A veterans, TROA would like to take this opportunity to re-state the need for legislation to at least test VA Subvention.

VA Subvention would permit Medicare funds to be used for Medicare-sponsored services to eligible veterans in VA facilities. A test of VA Subvention continues to be TROA's highest veterans' health care legislative priority.

The majority of stakeholders, including TROA, the other 29 members of The Military Coalition, most veterans service organizations (VSOs), and the Department of Veterans Affairs (DVA), agree in principle on the need to test using Medicare funds for the non-service connected care of older veterans. The problem appears to be whether Congress should also establish a new program along with the subvention legislation to provide alternative care options for certain service-connected veterans who live in remote areas with no VA facilities.

Late in the second session of the 105th of Congress, the House Veterans Affairs Committee (HVAC) and the Subcommittee on Health of the House Ways and Means Committee, which oversees Medicare, reached an agreement on testing subvention and authorizing a new program for certain veterans living in remote-areas. Under the "remote access" program, the VA would enter into agreements with health care maintenance organizations (HMOs) and other providers to provide care for Medicare-eligible veterans with a service-connected disability, injury, or illness. Medicare would reimburse the providers for the non-service-connected care and the VA would reimburse the providers for service-connected care. The new program would be authorized for a period of three years and, if successful, extended or made permanent. The House passed the "enhanced" VA subvention bill but no action was taken in the Senate on its version of VA Subvention. The Senate version of subvention would have authorized only a test of Medicare reimbursement in VA facilities.

The Senate took swift action early in this session to incorporate Senator Jeffords' (R-VT) VA Subvention test legislation (S. 445) into S.4, the Soldiers' Sailors' Airmen's and Marines' Bill of Rights Act of 1999 (S. 4). The Senate passed S.4 by a wide margin (91-8) on February 24.

Resolving the VA Subvention issue, however, goes beyond the politics of House and Senate preferences. The Administration has once again submitted a VA health care budget that is woefully underfunded. Although Medicare resources must not be used to make up the shortfall, they could be used to provide care for more enrolled veterans who have no service-connected health problems. These older veterans are already eligible for Medicare services and should be afforded the opportunity to choose the VA for Medicare sponsored services.

Research conducted recently by the VA demonstrates another reason for passing VA Subvention legislation. The (unpublished) study reveals that the number of "dual-eligible" veterans who receive care from a VA facility and who receive care from a Medicare HMO is "increasing rapidly" and correlates with national Medicare HMO enrollment rates in general - 18%. The study revealed that:

- VA patients covered by Medicare-HMOs already receive substantial amounts of VA care.
- Estimated Medicare payments to Medicare HMOs on behalf of "dual-eligible" veteran patients were \$305 million in one year (FY 1996).
- For veterans covered by Medicare HMOs for a one-year period (FY 1996), VA spending on Medicare services to those same veterans was \$146 million.

Medicare HMO enrollment trends are significant because the VA's funding distribution model -- the Veterans Equitable Resource Allocation (VERA) -- is cutting resources where Medicare HMO enrollments are rising significantly. In the Northeast region, for example, the proportion of Medicare eligible VA patients enrolled in Medicare HMOs is up substantially: Massachusetts -- 3.0% to 12.2%; New York -- 4.1% to 4.9%; New Jersey -- 0.6% to 8.3%; Pennsylvania -- 2.3% to 13.2%.

By contrast, VERA allocations are significantly down in the corresponding VISNs over the FY 1996 - FY 1999 period: Boston (VISN 1), -8.0%; Albany (VISN 2), -5.8%; Bronx (VISN 3), -6.9%; Pittsburgh (VISN 4), -2.0%; Baltimore (VISN 5), -11.0%.

These data suggest that funding pressures in the beleaguered Northeast and elsewhere could be alleviated to a certain extent by allowing Medicare funds into VA facilities for the delivery of NON-SERVICE CONNECTED health care to the growing Medicare-eligible veteran population.

In other parts of the country where VERA distributions are increasing -- presumably reflecting increases in the number of veteran patients and the cost of care in those areas -- VA Subvention would have a salutary effect as well. For example, the proportion of Medicare eligible VA patients also enrolled in Medicare HMOs is significant in those areas where VERA distributions are increasing, as shown in the table on the following page.

Percent Medicare-Eligible Veteran Patients Also Enrolled in Medicare HMO

STATE	% VA Patients Also Enrolled in Medicare HMOs	VISN LOCATION	VERA INCREASES FY 96-99
Arizona	30.5	Phoenix	+16.8%
California	34.7	San Francisco	+ 8.8%
		Long Beach	+ 4.0%
Nevada	24.8	(3 VISNs overlap)	
Florida	20.7	Bay Pines	+ 16.1

(Note: VISN areas of responsibility do not correspond with State boundaries). Texas, Washington, Colorado, and Louisiana also have experienced significant growth in the number of VA patients enrolled in Medicare HMOs and VERA increases to the corresponding networks.

With enactment of VA subvention, veterans already using Medicare HMOs and VA facilities might be attracted to the VA as a preferred provider.

The Retired Officers Association believes that VA Subvention should be a fundamental component of The Veterans' Millennium Health Care Act. TROA urges the Subcommittee and the full Committee to reach an agreement with the House Ways and Means Committee for a VA Subvention test design and to enact implementing legislation as soon as possible this year.

CONCLUSION

The Retired Officers Association deeply appreciates the Subcommittee on Health's outstanding "track record" in championing health care reform legislation for America's veterans, including military retirees. Under the Subcommittee's leadership, military retired veterans have been granted greater access to the VA Health Care system. Weaving long term care into the fabric of health care services will advance the commitment of our nation to its veterans. However, while legislative, policy, and programmatic reforms have been initiated, the resources necessary to truly implement VA health care reforms have not been fully realized. We hope that the leadership and distinguished members of the Subcommittee will re-double their efforts to forge the basis in Congress for bipartisan support to underwrite the health care needs of America's veterans into the 21st century.



TESTIMONY OF

JOHN J. DALY
LEGISLATIVE ASSISTANT

THE RETIRED ENLISTED ASSOCIATION

BEFORE THE

HOUSE VETERANS AFFAIRS COMMITTEE

SUBCOMMITTEE ON HEALTH

CONCERNING VETERANS HEALTH CARE

MAY 19, 1999

**Biography of John J. Daly
Legislative Assistant
The Retired Enlisted Association**

John Daly, a native of Woodbury Heights, New Jersey, first came to Washington, DC in the fall 1994 as an intern in the United States Department of Commerce. Following the earning of a Bachelor's Degree in International Relations from St. Joseph's University in Philadelphia, in May of 1996, Daly returned to Washington, DC as an intern in the White House, serving in the Office of Vice President Al Gore. After completion of the internship program, Daly became the Staff Assistant at American Defense International, Inc., a Washington, DC based government relations and business development firm.

In December of 1997 Daly joined the staff in the Legislative Affairs Office of The Retired Enlisted Association as the Legislative Correspondent. He presently serves as TREA's Legislative Assistant, as well as co-chairman of The Military Coalition's Committee on Morale Welfare and Recreation/Military Construction/Base Realignment and Closure. He is also pursuing a Certificate in Legislative Studies from the Government Affairs Institute at Georgetown University.

John, and his wife Kerry, reside in Alexandria, Virginia.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Retired Enlisted Association does not currently receive, has not received during the current fiscal year or either of the two previous years any federal money for grants or contracts. All of the Association's activities and services are accomplished completely free of any federal funding.

Mr. Chairman, Mr. Ranking Member, distinguished subcommittee members, The Retired Enlisted Association (TREA) appreciates having the opportunity to come before you today to address the single greatest priority for military retired veterans – health care. We are pleased that this committee is looking at VA health care and its future in the 21st Century. It is often mentioned that the number of veterans is decreasing and, most likely, will continue to do so. However, what is not often addressed is the fact that as this number decreases, the average age of a veteran is increasing. This indisputable fact will require the VA to change the type of care it provides. By initiating debate on this issue, TREA hopes Congress will head off any potential problems facing the VA health care system in the future due to the “graying” of America’s veterans.

There are several improvements which can be made in the near future which will have a significant impact on the quality of, and access to, health care received by our nation’s veterans. The draft “Veterans’ Millennium Health Care Act,” in particular, contains several provisions which will be of special importance to military retired veterans.

THE MILLENNIUM PLAN

1. LONG-TERM CARE REFORM

The Department of Veterans Affairs has provided long-term care services to veterans for a considerable period of time using discretionary funds to cover the costs. Now is the time to guarantee that such health care will continue to exist for our nation’s veterans for decades to come. Difficult funding decisions will have to be made but the program outlined in the Millennium concerning long-term care is an excellent foundation to provide veterans with quality care later in life.

As previously stated, the increasing age of veterans will require increased attention to their health care needs. By requiring the VA to develop and maintain a program of extended care services, and providing the additional funding to carry out this mission, Congress will ensure that our nation’s veterans will receive the quality care they have earned through their service.

2. ELIGIBILITY REFORM

This is an area of particular interest to the members of TREA. As outlined in the Millennium plan, a specific category for military retirees will provide retirees, who have often lost their access to military treatment facilities, another option to quality health care. This is a justifiable benefit for those who have contributed 20 or more years of service to the nation. Further, by allowing TRICARE-eligible retirees greater access to the VA and requiring the Department of Defense to reimburse VA for the costs of health care, Congress will be helping VA increase the funding it receives from outside insurance companies. Congress has authorized the VA to apply all revenues generated from outside insurance companies back into veterans health care. With the current spending caps this is one of the few available options to increase funding without cutting existing benefit programs.

Too often our nation’s military retirees are left with few, if any, options for health care. The difficulties with the TRICARE system are well documented. Low reimbursement rates and delays in claims processing are driving doctors away from the program. Further, many retirees have seen the Military Treatment Facility in their region close, and the TRICARE network with it. We are pleased to see VA facilities becoming designated TRICARE providers because this will help increase retirees access to health care. However, this designation will be of no assistance if retirees are told their is no space available at VA facilities. Providing retirees a benefit they can not use will merely be a repetition of their experience with the Department of Defense. Providing a separate eligibility category will help prevent this.

Military retirees were promised health care for life by the United States government. TREA strongly endorses the outline in the Millennium Plan which will modify the eligibility system to provide retirees, those who dedicated the prime of their

lives to our nation, a special category to help increase their chance to receive the health care they earned at Department of Veterans Affairs facilities.

3. ENHANCED REVENUES

The existing budget caps, set forth in the Balanced Budget Agreement, and the pay-go system, have limited the amount of funding available for veterans programs. Further, the rapidly increasing costs of health care have put an ever increasing strain on the VA's ability to provide quality care to veterans to an increasing number of patients. In light of the current budget situation, TREA recognizes the need to develop additional methods of increasing revenues. We believe that eligibility reform is such an example. At the same time we must remember that the VA's top priority are those who do not, and should not ever, pay for their health care. These disabled veterans should not see their care minimized in an effort to treat those veterans whose insurance company will be billed for treatment received at the VA. TREA would like to express its willingness to continue to work with the Veterans Affairs Committee and the Department of Veterans Affairs to develop a program which will protect today's veterans as well as tomorrow's by enhancing revenues.

PILOT PROGRAM FOR CERTAIN DEPENDENTS OF VETERANS

TREA endorses the program outlined in the discussion draft to create a demonstration program to allow certain dependents of veterans to receive health care through the Department of Veterans Affairs. However, if such legislation is to be implemented, military retiree beneficiaries who are eligible to be enrolled in TRICARE Prime should be subject to the same method of payments as outlined in the proposed eligibility reform discussed in the Millennium Plan. Unlike non-military retired veterans, beneficiaries of military retirees rely on the Department of Defense for their health care services. Therefore, they are subjected to the same difficulties outlined in TREA's rationale for eligibility reform. The creation of a demonstration program to determine whether or not the Department of Veterans Affairs is capable of providing dependents with health care provides another option to those who have few options, if any.

CONCLUSION

Mr. Chairman, as stated, health care is a great concern to the members of TREA. Many of our members are those who retired from the military in areas where there was a military presence. In their view, that guaranteed them access to the commissary and exchange, the military lifestyle they enjoyed and, perhaps most importantly, access to the base hospital. In recent years, however, hospitals have been down-sized to clinics or closed, as have the other base facilities retirees have relied on. Retirees have been left empty handed. The programs referred to today, long-term care, eligibility reform and a pilot program for dependents, will be significant steps towards providing retirees with the benefits they were guaranteed for a career in the military. However, TREA recognizes the impact of the Balanced Budget Agreement on any improvements to veterans benefits. It is imperative that other veterans benefits programs do not lose funding to off-set improvements to new programs.

The Department of Veterans Affairs has a unique, and clearly defined mission: provide veterans with quality care they earned through service to the nation. As the year's have passed and that care increased in price, it also increased in usage. Perhaps more than ever, veterans, particularly military retirees, are being forced to turn to the VA to help. Congress now must help the VA by providing the necessary funding to ensure veterans receive the quality care that they have come to expect and was afforded to prior generations of heroes.



Vietnam Veterans of America

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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

Statement of

VIETNAM VETERANS OF AMERICA

Submitted by

**Richard Weidman
Director
Government Relations**

Before the

House Veterans Affairs Subcommittee on Health

Regarding

Veterans Millennium Health Care Act

May 19, 1999

Vietnam Veterans of America

**House Veterans Affairs Subcommittee on Health
Veterans Millennium Health Care Act May 19, 1999**

Mr. Chairman, Vietnam Veterans of America (VVA) thanks you for the opportunity to appear here today to present our views on the draft of the proposal for the "Veterans Millennium Health Care Act" and on the draft for the proposed "Pilot Program of medical Care for Certain dependents of Enrolled Veterans." We thank you and the Chairman of the full Committee, the Honorable Bob Stump, for your leadership in advancing these proposals to try and collectively find mechanisms to better cope with what can only be called a looming crisis in the delivery of health care to veterans.

Vietnam Veterans of America (VVA) is also grateful to you and to your distinguished colleagues on both sides of the aisle for your continued efforts toward securing a reasonable amount of funding for the Veterans Health Administration for FY 2000. While VVA believes that perhaps some of the changes that continue to be wrought by Executive action and administrative changes as well as legislation may ultimately prove to be useful in improving the quality and quantity of health care delivered to our Nation's veterans, the precipitating factor has been that there is simply not enough money being put into the system to keep it from faltering.

The acute shortage of resources is really having a widespread and profound impact this Fiscal year, after all of the "management efficiencies" wrung out of the system in the past four years. Next year will be even more grim. The situation will only worsen in the years to come, unless there is a dramatic change to stop diminishment of resources, and hence the destruction of the system. One veteran commented that observing the unfolding sequence of events is like "watching a train wreck in slow motion." VVA applauds your efforts to make some of those dramatic changes, by seeking additional ways to secure vitally needed resources for the Veterans Health Administration (VHA).

Vietnam Veterans of America (VVA) generally favors the "Veterans Millennium Health Care Act" (Millennium Act). The current state of resources simply dictate that there must be changes if we are to have enough resources to preserve even the minimum of organizational capacity in VHA. Elements of the Millennium Act make hard choices, but this may well be necessary at this time.

In regard to the proposed modifications to Section 8110 of Title 38 that would prohibit the closure of 50 percent of the beds within a bed section, VVA believes that this is a step in the right direction. The problem is that this only slows the diminishment of needed organizational capacity, and does nothing to reverse the diminishment of inpatient bed capacity that VVA maintains has already been inappropriately eliminated at many stations. Neuro-psychiatric bed capacity (particularly for PTSD inpatient and residential treatment programs and substance abuse services programs) have been decimated on a virtual system wide basis. While this is a welcome step, there must still be some sort of remedial effort to rebuild capacity in many areas of the country, particularly in the "specialized services" medical areas, such as Spinal Cord Injury, Seriously Mentally Ill, and Post Traumatic Stress Disorder bed capacity.

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The quarterly reports required will be welcome, as obtaining timely information in this newly decentralized system is problematic at best. While there are many salutary effects of allowing decisions to be made as to how best to accomplish the mission at the lowest possible level of an organization, the mission and goals must be set at the highest level, based on the direction of Congress. The management reporting systems and accountability mechanisms of VHA need to be greatly enhanced and regularly and rigorously employed. This requirement will help VHA to move in this needed direction. Of particular interest to VVA is the requirement that VHA provide justification and plans for providing another means of providing quality medical services to the veterans affected, and to do so in writing in a public way.

The defining of nursing home care for at least those veterans most in need is a move that VVA applauds. While we do not object to co-payments for veterans with the means or resources to pay (i.e., other than low-income veterans), VVA is concerned that the amount for the non-institutionalized spouse be sufficient as to not cause hardship. Frankly, people with high incomes are much less likely to enter into VHA nursing care, so great restraint is called for in order to ensure that the spouse is not made destitute, and her (his) life shortened by having an undue diminishment in loss of quality of life due to income reductions.

The formation of the revolving fund known as the "Veterans Affairs Extended Care Fund" is welcome. VVA also agrees with the requirement that mandates implementation of "Federal Advisory Committee on the Future of Long Term Care," with the resultant increase in current capacity (to greater than the organizational capacity as of September 30, 1997) for long term care, more adequate reporting requirements, and other needed changes. VVA also endorses strengthening the Adult Day Care and Respite Care programs. The requirement that the Secretary provide extended care as an entitlement to veterans is long overdue..

VVA strongly agrees with Section 3 of the draft bill that extends priority care to former prisoners of war and recipients of a purple heart, regardless of service connected disabled status or income. The core of the mission of the Veterans Health Administration is about "Caring for he (or she) Who hath Borne the Battle," and this long overdue extension of eligibility only reinforces this central concept.

VVA endorses eligibility of military retirees to utilize the VHA system, as these men and women are obviously veterans. VVA does urge you, however, to pay very close attention to the required Memorandum of Understanding between VHA and the Department of Defense (DOD) to ensure that VHA is in fact receiving the resources necessary to defray the cost of this treatment at the full rate that would otherwise have been disbursed to the private sector. VVA does, however, believe that the freedom of choice on the part of all veterans will help make the medical care and other services better. This is a first step.

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Vietnam Veterans of America does not have objection to the requirement for reasonable co-payments for prescriptions and medical devices from those who truly have the resources to pay for same, and if the medical condition is truly unrelated to military service. However, VVA can cite many examples of veterans who are being billed for co-payments for medications and devices for which we believe there is a strong case that the condition is derivative from experiences in the military. Given the state of the Veteran Benefits System, timely redress is all too often not available from that quarter. An example would be veterans who often have to wait for years for a decision on PTSD, and in the meantime are billed for medications and other treatment that their insurance will not pay. Another example would be a veterans who has diabetes that is exacerbated by hyper-tension and PTSD, thus leading to a need for prosthetic devices. Should that veteran have to pay a high co-payment? VVA thinks not. The sensitivity with which this requirement is applied will be crucial.

VVA strongly favors the creation of the Department of Veterans Affairs "Health Services Fund" as outlined in the legislation, and further suggests that such co-payments be kept locally. It is crucial that such funds be available without Fiscal Year limitations.

Vietnam Veterans of America applauds the proposed creation of the "Veterans Tobacco Trust Fund." While we strongly disagreed with the actions of the Congress and the President last year in regard to the smoking issue, the establishment of this fund will at least provide some redress and restoration in this regard. VVA would also point out that the Veterans Health Administration can and should move forward on existing authority to design and implement much more effective and "user friendly" smoking cessation programs for veterans. This, and a like effort directed toward alcohol, would do much to reduce costs in both the short run and the long run. It would also be a significant step toward a "wellness" model of care.

VVA favors the extension of authority to accept funds for education and training into not for profit corporations to be established at the local or Veterans Integrated Service Network (VISN) level by VHA. Private resources can and should be usefully garnered in this manner, that would otherwise not be available for useful purposes. VVA does, however, urge that it be an explicit requirement that each and every such entity publish an annual report and publicize that their Form 990 filings available in a very assertive public way to the veterans service organizations in that area, as well as other interested parties.

While VVA believes that there may well be some closures of primary medical centers that may make sense, we are chary of the open ended process proposed in the "Enhanced Services" program. The very term "enhanced services" may seem to many to a euphemism that is reminiscent of "Punishment with extreme prejudice." The safeguards in terms of the process may be enough to allay this concern, but we would suggest some additional limitations. First, that the program be limited to ten sites in the first two years. Secondly, that at least one primary medical facility continue to be located in each of the fifty states and Puerto Rico.

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Given that the President's proposed budget was the equivalent of closing 26 hospitals, some drastic actions must be taken in order to not simply have 172 "empty shells" devoid of the resources needed for the efficient delivery of quality medical care. In some cities where there is arguably a duplication of effort, and a significant overlap of catchment areas, this may be part of the "hard medicine" we referred to earlier in this statement. It is, however, an important symbol of the Veterans Health Administration being a national system that at least one such facility be kept operational in each state, with a long term planning process as to how to utilize these facilities more efficiently and effectively as the locus of care in that state.

VVA also has concerns that some hospitals are the object of "deliberate draw downs" in patient admissions as a prelude to closing. This is not a case of the need for inpatient care not being present in the catchment area, but rather a case of a less than open decision being made to target that facility.

While VVA understands the need for immediate cash, we urge the VHA to make provisions for seeking uses of facilities that are no longer to be used by VHA to be made available to veterans organizations, veterans community based organizations, and other appropriate public and private entities for providing care to veterans, such as transitional housing. The need for transitional housing, and for other housing and respite care arrangements for veterans of every generation, while those veterans are in treatment, has been well documented. Before these existing facilities are divested it seems to VVA that the veterans most in need should be first in line for properties available under the enhanced use authority.

VVA is concerned as well about the details of the "ongoing oversight and management, by the Department of Veterans Affairs, for the hospital care or medical service furnished" to veterans affected by the envisioned downsizing. VVA continues to strongly assert that "Veterans Health Care" is significantly different in some ways from general medicine, or that it should be. The problems that veterans have as veterans need to be systematically addressed in a 'holistic' manner. The mechanism for doing this in the community based network of services is unclear to us. (VVA would point out that VA has yet to successfully do this while delivering care in their own primary care facilities, although we remain hopeful that adequate military histories, and other measures such as primary care teams is leading in this direction.). VVA has particular concerns in this regard as to the provision of Specialized Services such as Spinal Cord Injury units, PTSD, and other areas that are directly related prima facie to the core mission of VHA.

VVA strongly favors the extension of the eligibility for the Readjustment Counseling Services to all Vietnam Era veterans until at least the end of the year 2003. We have never quite understood this discrimination against non-combat "in-country" Vietnam-era Veteran. This will significantly aid in the outreach efforts to homeless veterans and others who have never utilized the system until now. VVA also strongly endorses the enhancement of the Committee on Mentally Ill, and the re-establishment of the "Committee on Post Traumatic Stress Disorder," although we urge you extend the authority for said committee through at least 2004, or for five years.

Vietnam Veterans of America

**House Veterans Affairs Subcommittee on Health
Veterans Millennium Health Care Act May 19, 1999**

In regard to the draft of the proposed "Pilot Program of Medical Care for Certain Dependents," Vietnam Veterans of America would reserve judgement at this time. While VVA strongly believes that involving the "whole family" in a "wellness" program for veterans is essential, this proposal needs some work before consideration of enactment.

Perhaps most importantly, this proposal is not the same as the "GI Bill of Health" as proposed several years ago in that there are no resources that inure to the system at the beginning of coverage. Rather, this system depends on collection of third party payments. By their own admission, VHA has done a poor job of billing and collecting third party payments for veterans. Until VHA can get the current job done in regard to funding collections, it would seem unwise to expand the scope of the task. VVA would also note that if the purpose is at least in part one of bringing more resources into the system, then this may not be the time to try to take on families of veterans who might be eager to use the VHA system.

VVA would also point out that it is widely anticipated that the Office of Management and Budget is expected to eliminate or greatly curtail the ability of "Priority 7" veterans to use Veterans Health Care facilities and services sometime in FY 2000. It may be useful to ensure that we have the organizational capacity to take care of veterans before expanding the system at this point.

Not Enough

While the enactment of the "Millennium Act" and other possible measures, such as moving aggressively toward a 'holistic' health care model based on "wellness" (and beginning with a complete military and medical history of the veterans, to be used in the diagnosis and treatment plans) may well be necessary, and in some cases even desirable, this will not be enough. The plain fact is that there simply have to be more resources put into this system if we are even to come close to honoring our obligation to America's veterans.

The time to move toward modifying the gross inequity of the so-called "Balanced Budget Agreement" rank discrimination against veterans, is now. If the FY 2001 Budget request and ultimate appropriation is as unfair and inadequate as this year, then this already overtaxed and increasingly brittle system will just simply start to implode. Said simply, veterans will literally die from neglect. The Veterans Health Administration needs a Cost of Living Adjustment or "COLA" in the vicinity of three to four Billion more in the near future.

Mr. Chairman, Vietnam Veterans of America thanks you for this opportunity to share our views with you here today.

Richard F. Weidman
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 Silver Spring, Maryland 20910
 Home (301) 650-1954
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General Background

- Knowledgeable in employment, health care, and housing issues that affect veterans
- Extensive communications strategy design and implementation experience
- Maintain good working relationship wide the full range of veterans' organizations from the Veterans of Foreign Wars and The American Legion to Black Veterans for Social Justice and Swords to Plowshares. An active member of Vietnam Veterans of America and several other veterans' groups

Work History

<p><i>Director of Government Relations</i> Vietnam Veterans of America (VVA) - National Office Responsibilities include initiating and coordinating all facets of interaction and advocacy for VVA (Please note that served as <i>Director, Membership Affairs</i> for VVA from June through October of 1998.)</p>	<p>June 1998 to Present Washington, D.C.</p>
<p><i>Principal</i> Weidman Associates (Clients include Vietnam Veterans Assistance Fund, U.S. Department of Energy, National Coalition for Homeless Veterans, Vietnam Veterans of California, LA Vets, Swords to Plowshares)</p>	<p>January 1997 to June 1998 Washington, D.C.</p>
<p><i>Special Advisor to the Chairman</i> Committee on Veterans Affairs New York State Assembly</p>	<p>Fall 1995 - December 1996 Albany, New York</p>
<p><i>Director, State Veterans Program</i> New York State Department of Labor</p>	<p>Fall 1987 - Spring 1995 Albany, New York</p>
<p><i>Director of Government Relations</i> Vietnam Veterans of America</p>	<p>January 1978 - Fall 1987 Washington, D.C.</p>

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Page Two

Other Relevant Experience

- President, Vietnam Veterans of America (VVA) Chapter 641, Montgomery County (MD), 1998-99* (Vice President, 1997-98); member of VFW, The American Legion, Jewish War Veterans, and other veterans' groups.
- President, Veterans Economic Action (VEA) 1994 to present*
- Member, National Advisory Council, U.S. Small Business Administration, Dec. 1998 to Present*
- Member and Vice Chairman, Secretary's Committee on Readjustment of Vietnam Veterans, United States Department of Veterans Affairs - 1982 - 1991*
- Member, Management Assistance Council (MAC) for "Veterans Integrated Service Network (VISN) for Combined VISN #2 and #3 - May to December 1996 (helped organize)*
- Member, Secretary of Labor's Advisory Committee on Veterans' Employment, 1984 to 1987*
- Member, Veterans Advisory Committee, U.S. Small Business Administration, 1982 to 1987*
- Member, Veterans Committee of International Association of Personnel in Employment Security (IAPES) - 1988 to 1995 (Chairman, 1991-1992)*
- Served six years as Educator in Vermont State College system; Worked at various times as Dean of Students, as Director of Student Activities, Lecturer in Humanities, and Director of Continuing Education at Johnson State College campus.*
- A co-founder and Chairman of the Board of Project to Advance Veterans Employment (PAVE), a statewide veterans' community based organization in Vermont, 1974 to 1980*

Education

Business Administration (20 graduate hours)
 The University of Vermont

BA, Philosophy and Religion
 Colgate University

Military Service

United States Army, 1969 - 1971; Served as 1- A- O Medical Corpsman.
 Republic of Vietnam service with AMERICAL Division in 1969;
 Soldier of the Month, Ft. Dix, NJ in August 1970;
 Honorable Discharge as E-5.

References provided upon request.



Vietnam Veterans of America

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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

**VIETNAM VETERANS OF AMERICA
Funding Statement
May 19, 1999**

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:
Director of Government Relations
Vietnam Veterans of America.
(202) 628-2700, extension 127

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Health, Committee on
Veterans' Affairs, House of Representatives

Not to Be Released
Before 10:00 a.m.
Wednesday, May 19, 1999

VETERANS' AFFAIRS

Observations on Selected Features of the Proposed Veterans' Millennium Health Care Act

Statement for the Record by Stephen P. Backhus, Director
Veterans' Affairs and Military Health Care Issues
Health, Education, and Human Services Division



GAO/T-HHS-99-125

Mr. Chairman and Members of the Subcommittee:

We are pleased to contribute this statement for the record for the Subcommittee's deliberations on the draft bill entitled the Veterans' Millennium Health Care Act, which would modify policies and practices of the health care system operated by the Department of Veterans Affairs (VA).

In October 1995, VA began to transform its health care delivery structure from operating hospitals to providing health care through integrated networks of VA and non-VA providers to serve veterans more efficiently and effectively. In 1996, the Veterans' Health Care Eligibility Reform Act was passed, requiring VA to enroll veterans for health care coverage by congressionally mandated priority groups only to the extent that services could be provided within VA's resources. In January 1997, in response to this and other factors, VA proposed a 5-year spending plan to reduce per-patient costs by 30 percent, increase the number of VA patients by 20 percent, and reduce reliance on appropriations by 10 percent.

Through numerous reports and testimonies, we have discussed the progress of VA's ongoing transformation, as well as concerns about critical challenges that VA faces (see the attached list of related GAO products). As you requested, our statement today draws on our previous work to focus on how the draft Veterans' Millennium Health Care Act could affect VA's ongoing transformation, including our previously reported concerns about its future progress. As agreed with your staff, we have limited our comments to certain provisions of the bill that address

- the realignment of services at underused facilities,
- access to long-term care services,¹ and
- cost sharing for medical care.

In summary, the draft bill's facility service realignment, long-term care, and cost-sharing provisions should help facilitate VA's continuing transformation of its health care system and address concerns that we have previously reported to the Congress. These proposals, in combination with VA's enrollment process, provide a rational framework for helping VA address the increasing health care needs of an aging population of higher-priority veterans while operating within available resources. However, even with this enabling legislation, achieving these multiple goals will be a challenge to VA because of their complexity and far-reaching implications.

More specifically, the combination of proposed changes should help VA provide care for veterans in more appropriate settings, as well as help VA achieve its stated goals of reducing per-patient costs, increasing the number of its patients, and reducing reliance on appropriations. Facility realignment and cost-sharing provisions are consistent with options we have suggested to help VA reduce budget pressures and generate the resources needed to serve more veterans and provide enhanced benefits. In addition, long-term care provisions appear designed to reduce variability in veterans' access to such care systemwide, which addresses, in general, our concern about the potential adverse effect of VA's transformation on the equity of veterans' access to care.

BACKGROUND

Over the last 6 decades, VA's system has grown into our nation's largest direct provider of health care, serving veterans at over 600 locations nationwide. During that time, VA's system focused primarily on hospital care, using high technology and

¹We are using the term "long-term care" to refer to the services described in parts of the draft legislation under the term "extended care" because "long-term care" is more frequently used in current discussions of these services in VA, other federal agencies, and the private sector.

medical specialization. The system did not keep pace, however, with such industry and societal changes as the restructuring of health care to emphasize managed care and the evolving medical needs of an aging veteran population.

VA's transformation from a hospital-based operator to a health care provider emphasizing outpatient care began in fiscal year 1996, when 22 regional offices, known as Veterans Integrated Service Networks (VISN), were established to make basic budgetary, planning, and operating decisions for veterans living within defined geographical areas.² VA's goal is to develop local or regional networks of health care providers that offer a continuum of care grounded in ambulatory, rather than hospital, settings. VA is encouraging this transformation by allocating resources on the basis of user populations rather than hospitals.

The Veterans' Health Care Eligibility Reform Act, enacted in 1996, furnishes tools that VA believes are key to a successful transformation, including

- new eligibility rules that allow VA to treat veterans in the most appropriate setting,
- a uniform benefits package for all eligible veterans that allows VA to provide a continuum of services,
- expanded authority to purchase services from private providers when doing so benefits veterans, and
- an enhanced ability to generate revenue by selling excess services to nonveterans.

At that same time, the Congressional Budget Office and we concluded that these reforms could generate additional demand for services because more veterans would use outpatient services.³ The Congressional Budget Office also estimated that rising utilization could produce dramatic cost increases, potentially in the billions of dollars.

To address such concerns, the Eligibility Reform Act required VA to implement an enrollment system to manage access in relation to available resources. The act established seven priority categories, with the highest priority given to veterans with service-connected disabilities and the lowest priority given to higher-income veterans without such disabilities. Each year, VA is to enroll veterans in those priority categories for which it has sufficient resources to provide care that is timely and acceptable in quality. The act also requires VA to maintain treatment capacity for veterans with special disabilities, including spinal cord injury, blindness, amputation, and mental illness.

At VA's request, the Congress also authorized VA to retain all medical care cost recoveries, beginning July 1, 1997, to increase its nonappropriated revenues.⁴ Such recoveries include collections from veterans' private health insurance as well as copayments to VA. VA is to deposit these collections in a Medical Care Collections Fund and use them to supplement appropriations to meet veterans' health care needs. VA may spend these funds in the year collected or in any subsequent year.

VA's health care system currently touches the lives of 15 percent, or about 4 million, of our nation's 25 million veterans. The rest rely on private insurance, other public programs, or their own resources to finance their health care needs.

²VA Health Care: Status of Efforts to Improve Efficiency and Access (GAO/HEHS-98-48, Feb. 6, 1998).

³VA Health Care: Issues Affecting Eligibility Reform Efforts (GAO/HEHS-96-160, Sept. 11, 1996).

⁴In 1986, the Congress had authorized VA to recover third-party payments for medical care, but VA was required to turn over these collections to the Department of the Treasury.

**REALIGNING FACILITIES' SERVICES
COULD BENEFIT VETERANS**

VA's large, aged infrastructure could be the biggest obstacle confronting the agency's ongoing transformation efforts. VA spends a major portion of its health care budget—about 1 out of every 4 health care dollars—to operate, maintain, and improve its facilities.

At the Subcommittee's March 10 hearing, we suggested that VA could reduce significantly the amount of funds used to operate and maintain unneeded or inefficient health care delivery locations and reinvest the savings to enhance care provided to veterans.⁵ By systematically analyzing health markets to identify unneeded delivery locations, VA could redirect the operation and maintenance budgets of these locations to establish and enhance community-based clinics and other service options for veterans. Without such realignment of delivery locations, resources might be increasingly shifted to operating and maintaining unneeded, aged assets at the expense of veterans' health care needs.

At the March 10 hearing, VA agreed to assess 106 markets in which it operates 181 major delivery locations. VA owns 4,700 buildings and 18,000 acres of land at these locations. VA's assessments will include a determination of veterans' health care needs, a survey of existing assets, and an evaluation of alternatives for meeting veterans' needs in the most cost-effective manner.

The draft Veterans' Millennium Health Care Act contains three key features designed to benefit veterans through such facility services realignment. The act requires

- VA to develop enhanced-service plans to address veterans' health care needs,
- VA's stakeholders to participate in plan development, and
- VA to use efficiency savings locally.

Developing enhanced-service plans would provide an appropriate structure for VA to use when addressing its infrastructure challenge. The proposed legislation requires that VA develop enhanced-service plans to provide needed health care to veterans in markets where VA delivery locations are ineffective or inefficient in providing services and alternative health care providers are available. By requiring enhanced-service planning, this proposal would address concerns that we raised during a July 1997 hearing before this Subcommittee that VA was implementing changes at facilities without adequate planning.⁶ This proposal is also consistent with guidelines that VA issued in April 1998 to help VA regional offices improve their planning for service delivery changes.

Requiring stakeholders' involvement in plan development is also an essential element, as we noted during the July 1997 hearing. While facility service realignments could provide significant benefits for veterans, they could also have important consequences for a wide variety of stakeholders, such as VA employees and residents of local communities. For this reason, plans must be developed with comprehensive stakeholder involvement to maximize benefits and minimize adverse impacts. The

⁵VA Health Care: Capital Asset Planning and Budgeting Need Improvement (GAO/T-HEHS-99-83, Mar. 10, 1999).

⁶VA Health Care: Lessons Learned From Medical Facility Integrations (GAO/T-HEHS-97-184, July 24, 1997).

draft bill proposes a process that VA has already used to develop a plan to integrate medical services in Central Alabama.⁷

Requiring VA to use efficiency savings that are generated by facility service realignments locally should provide incentives for developing effective enhanced-use plans. This approach is consistent, for example, with a suggestion we made concerning the potential savings that VA could realize if it realigned the services of four hospitals in Chicago. In essence, we suggested that savings could be used to enhance the services for veterans in the Chicago area through establishing additional community-based clinics or other services.⁸

ENHANCING LONG-TERM CARE SERVICES COULD BENEFIT HIGHER-PRIORITY VETERANS

VA faces major challenges in serving a rapidly aging veteran population. Veterans 65 and older constitute about 34 percent of the veteran population, or about 8.8 million veterans, and will make up 42 percent of the veteran population by 2010. This aging of the veteran population will result in a growing need for long-term care.

VA currently spends about \$2 billion of its \$18.4 billion health care budget to provide long-term care services. Of this, nearly \$1.7 billion is used for care in 131 VA-operated nursing homes, contract nursing homes, and state veterans' nursing homes. The remaining \$363 million is used for noninstitutional care, including residential care and home- and community-based long-term care services, such as adult day health care, respite care, homemaker assistance, home health care, and other services.

About 4 million veterans are currently enrolled in VA's health care system. While VA's uniform health care benefits package includes inpatient hospital care, outpatient care, and other related services, the package does not include long-term care, such as nursing home, domiciliary, and adult day health care. However, enrolled veterans are eligible to receive such services to the extent that resources are available. VA currently provides long-term care services to about 63,000 veterans a day, on average.

The Federal Advisory Committee on the Future of VA Long-Term Care recently reported that VA currently meets about 20 percent of the need for long-term care nationally among veterans with service-connected conditions and those with low incomes.⁹ As a result, most veterans use other systems for long-term care services, such as Medicaid and Medicare.¹⁰ The Federal Advisory Committee also found that access to VA long-term care among veterans with service-connected conditions and those with low incomes varied greatly among VA's 22 regions. We have voiced similar concerns in prior work about the lack of equitable access to a range of VA care,

⁷VA Health Care: VA's Plan for the Integration of Medical Services in Central Alabama (GAO/HEHS-98-245R, Sept. 23, 1998).

⁸VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services (GAO/HEHS-98-64, Apr. 16, 1998).

⁹In Mar. 1997, VA convened this Committee of long-term care experts to evaluate VA long-term care and develop a strategy for meeting veterans' future needs. The Committee recommended 24 measures to enhance VA's long-term care in its report, VA Long-Term Care at the Crossroads (Washington, D.C.: Department of Veterans Affairs, June 1998).

¹⁰For a discussion of other long-term programs, see Long-Term Care: Baby Boom Generation Presents Financing Challenges (GAO/T-HEHS-98-107, Mar. 9, 1998).

including primary outpatient care and more expensive services, such as nursing home care.¹¹

The draft Veterans' Millennium Health Care Act contains three key features designed to enhance veterans' access to long-term care:

- requiring the development of a national program of long-term care services,
- increasing the percentage of VA's budget spent on noninstitutional long-term care services, and
- mandating coverage for long-term care services for certain higher-priority veterans.

Requiring VA to establish a program that provides a comparable continuum of long-term care services nationally is a reasonable way to ensure that veterans have equitable access to care. It is consistent with the Federal Advisory Committee's recommendation that VA create financial incentives and performance measures to ensure adequate access to long-term care services, while preserving the flexibility of VA's 22 regional offices to develop and structure long-term care services. This proposal should also help address our concerns about historical inequities in long-term care and other services, inadequate monitoring of incentives in VA's resource allocation system that could lead to unintended outcomes, and the lack of VA oversight of the equity of the 22 regional offices' allocations of resources to health care delivery locations.

Requiring VA to spend a greater percentage of its budget on noninstitutional long-term care services is a reasonable strategy to address the growing need for long-term care as the veteran population continues to age, and it is consistent with the Federal Advisory Committee's recommendation to increase investment in these services to better meet the long-term care needs of veterans. This approach is also consistent with other long-term care programs' evolution to expand noninstitutional services to offer a continuum of less expensive services and more efficiently serve veterans when care outside the nursing home is clinically appropriate. An expansion of these services would enable VA to serve more veterans in the home and in the community, as most people prefer, rather than in institutions.

Mandating long-term care services for certain higher-priority veterans is also consistent with eligibility reform legislation and addresses concerns we have previously raised about targeting VA health care benefits to those with the highest priority for services. The proposed legislation would mandate long-term care services for veterans with 50 percent or more service-connected disabilities and for others whose need for long-term care is a result of a service-connected disability, essentially authorizing VA to offer an enhanced benefit package for these veterans.

VA's statutory enrollment process provides a mechanism for enhancing benefit coverage for higher-priority veterans and managing the costs of these enhancements within the limits of VA resources. This process requires VA to determine the cost of meeting the needs of higher-priority veterans and to target remaining resources to provide a basic benefits package to as many lower-priority veterans as possible. Although the enrollment process provides the mechanism to adjust VA health care delivery according to congressional priorities, the process is only in its first year of operation. Enrolling veterans, projecting the costs of meeting their health care needs, and managing according to the services required and resources available is a complicated challenge that has far-reaching implications for veterans' access to care and the quality of that care.

¹¹VA Community Clinics: Networks' Efforts to Improve Veterans' Access to Primary Care Vary (GAO/HEHS-98-116, June 15, 1998), VA Health Care: Resource Allocation Has Improved, but Better Oversight Is Needed (GAO/HEHS-97-178, Sept. 17, 1997), and VA Health Care: More Veterans Are Being Served, but Better Oversight Is Needed (GAO/HEHS-98-226, Aug. 28, 1998).

**ENHANCING MEDICAL COST SHARING
COULD BENEFIT VETERANS**

In 1986, the Congress authorized VA to require higher-income veterans¹² without service-connected conditions to help offset the costs of their medical care through copayments for both inpatient care (acute and long-term) and outpatient care. In 1990, the Congress added a copayment requirement for outpatient medications used to treat non-service-connected medical conditions. VA estimates that it billed about \$143 million in copayments in fiscal year 1998.

The draft bill contains provisions that would address VA cost sharing in four areas:

- prescription drugs,
- outpatient services,
- long-term care, and
- certain high-cost supplies.

The draft bill would, for example, authorize the Secretary of VA to increase the prescription drug copayment on the basis of regulations prescribed by the Secretary. Currently, VA is required by law to charge a copayment of \$2 for each 30-day or less supply of medication for the treatment of a non-service-connected disability or condition. The proposal to permit VA to increase the copayment for prescription drugs appears to be reasonable, given VA's rapidly escalating drug costs. Since the \$2 copayment was legislatively mandated, VA's total prescription drug costs have more than doubled. VA billed for about \$64 million in copayments in fiscal year 1998. Increasing the copayment amount for prescriptions is consistent with options we have previously reported to the Congress for helping VA cope with budgetary pressures. In 1996, for example, we suggested that the Congress could offset VA spending for medications by increasing copayment amounts.¹³ Moreover, the draft proposal would provide VA flexibility to adjust rates in a timely manner as conditions change.

The draft bill also proposes to give the Secretary the authority to establish copayment amounts for outpatient services by regulation for veterans with non-service-connected conditions who are above the low-income threshold. VA billed for about \$57 million in outpatient copayments in fiscal year 1998. Currently, the law requires that VA charge a copayment to these veterans of 20 percent of the estimated VA-wide average cost of an outpatient visit. This copayment is currently about \$46.

Giving the Secretary authority to change outpatient copayments appears reasonable, given the transformation of VA outpatient services in recent years. VA now provides many more expensive services in the outpatient setting, like other health care providers, than it did when the current law was enacted. Procedures at VA such as colonoscopy, arthroscopy, and cystoscopy are now frequently performed in an outpatient setting. As a result, the VA outpatient copayment amount has grown and is disproportionately high for low-cost outpatient care, such as immunizations. Authorizing VA to set a schedule of outpatient copayments could help remove financial deterrents that might discourage the use of preventive care. It could also

¹²Higher-income veterans are those whose incomes are above a statutory threshold—for example, a veteran with no dependents with an income of \$22,351 or greater. Income thresholds are higher for veterans with dependents.

¹³VA Health Care: Opportunities to Significantly Reduce Outpatient Pharmacy Costs (GAO/HEHS-97-15, Oct. 11, 1996).

enable VA to establish a copayment schedule more similar to that used by other health care programs.¹⁴

The draft bill also proposes that VA increase cost sharing by charging certain veterans a copayment for long-term care services of more than 21 days in any year. Veterans with 50 percent or more service-connected disability and those who are receiving long-term care services for a service-connected disability would be excluded from making copayments under this proposal. VA would be required to develop a methodology for determining copayment amounts on the basis of the income and assets of the veteran and spouse, protecting the spouse from financial hardship, and allowing the veteran to maintain a monthly allowance. Currently, VA bills nursing home care at a rate equal to the Medicare inpatient deductible for the first 90 days of care during any 365-day period. In addition, VA bills \$5 a day for nursing home care. In total, VA currently bills for about \$4 million from these sources.

The proposal to revise the structure of long-term care copayments appears reasonable because it would give VA flexibility to determine the most appropriate copayment amount for these services by taking into account a veteran's financial resources while protecting the financial independence of a veteran's spouse living in the community. Because these funds would be directed to an earmarked fund for long-term care services, these copayments might also provide additional long-term care services to veterans. In 1992, we suggested a copayment approach using similar principles to offset long-term costs.¹⁵ These principles are already used in VA state homes and in state Medicaid programs.

The draft bill also proposes to establish copayments for certain high-cost items, such as hearing aids, eyeglasses, certain electronic equipment, and other items for non-service-connected conditions. Wheelchairs and artificial limbs would be excluded from these copayments. Currently, VA is not required to collect copayments for these items.

Requiring some veterans to pay a copayment for hearing aids, eyeglasses, certain electronic equipment, and other costly items seems reasonable. Total VA expenditures for these prosthetic items are expected to increase from \$420 million in fiscal year 1998 to about \$524 million in fiscal year 2000. During the course of our ongoing review of VA's enrollment process, several VA network directors commented that they are experiencing increased demand from veterans whose primary care is provided elsewhere but who obtain from VA services not covered by their private insurance or Medicare, such as eyeglasses and hearing aids. Giving VA the authority to establish copayment amounts would provide flexibility to generate additional revenues to enhance veterans' health care while still affording veterans a substantial health care benefit, because the costs for such items, according to VA officials, are not routinely covered by other health care programs.

CONCLUDING OBSERVATIONS

In conclusion, the Veterans' Millennium Health Care Act provides a rational framework for addressing such important needs as

- enhancing services at underused facilities,
- enhancing long-term care services for an aging veteran population, and

¹⁴In general, veterans are subject to less cost sharing than is required under most public and private health benefit programs. See VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (GAO/HRD-93-94, July 29, 1993).

¹⁵VA Health Care: Offsetting Long-Term Care Costs by Adopting State Copayment Practices (GAO/HRD-92-96, Aug. 12, 1992).

- providing VA flexibility to generate additional revenues to offset budget pressures and serve more veterans.

Most importantly, the draft bill strives to achieve these objectives in a manner that is consistent with the overall goal of VA's enrollment process, which is to manage veterans' access to health care in relation to available resources.

RELATED GAO PRODUCTS

Veterans' Affairs: Progress and Challenges in Transforming Health Care (GAO/T-HEHS-99-109, Apr. 15, 1999).

Major Management Challenges and Program Risks: Departments of Defense, State, and Veterans Affairs (GAO/T-NSIAD/HEHS-99-84, Feb. 25, 1999).

Major Management Challenges and Program Risks: Department of Veterans Affairs (GAO/OCG-99-15, Jan. 1999).

Veterans' Health Care: Challenges Facing VA's Evolving Role in Serving Veterans (GAO/T-HEHS-98-194, June 17, 1998).

VA Health Care: Assessment of VA's Fiscal Year 1998 Budget Proposal (GAO/T-HEHS-97-121, May 1, 1997).

Department of Veterans Affairs: Programmatic and Management Challenges Facing the Department (GAO/T-HEHS-97-97, Mar. 18, 1997).

Veterans' Health Care: Challenges for the Future (GAO/T-HEHS-96-172, June 27, 1996).

VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-147, May 9, 1995).

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

**WRITTEN TESTIMONY
OF
ROBERT SHAW, PRESIDENT OF N.A.S.V. H.**

**PREPARED FOR HOUSE VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH HEARING**

**TO EXAMINE THE ISSUE OF
LONG-TERM CARE FOR OUR VETERANS**

ROOM 334 OF THE CANNON HOUSE OFFICE BUILDING

MAY 19, 1999

**NATIONAL ASSOCIATION OF STATE VETERANS HOMES
ISSUE OF LONG-TERM CARE FOR OUR
NATION'S VETERANS**

Thank you Mr. Chairman and members of the Subcommittee on Health, House Committee on Veterans Affairs, for allowing the National Association of State Veterans Homes, presently comprised of 95 Homes in 43 states, to provide a written statement for the record pertinent to section 2, Extended Care Services, of a Bill to amend Title 38 United States Code, to establish a program of extended care services for veterans and to make other improvements in health care programs of the Department of Veterans Affairs.

We are pleased to see that the Secretary shall operate and maintain a program to provide extended care services to eligible veterans as defined under S1710A of this title and section. We support the services outlined and are pleased to see such services are to be available to any veteran needing such care and who has a service-connected disability rated at 50 percent or above. The ranking of priority for such placements is clear and the veteran who requires continued nursing services cannot be transferred out of the facility without the consent of the veteran and/or the legal representative, whichever may be the case.

Through the regulations prescribed by the Secretary governing this priority for the provision of nursing home care in Department of Veterans Affairs facilities lays the foundation for ensuring patients requiring rehabilitation, those with clinically complex health care problems and those patients whom are not suitable placements will receive care.

The recommended program to provide extended care services for a non-service connected disability allows such an individual twenty-one (21) days of such care in any year before paying a co-payment. In review, the recommended co-payment program for the extended care services appears to mirror the philosophy of the State Veterans Home Program.

We are pleased to see under (b) Requirements to Increase Extended Care Services, (f) State Homes - Section 1741 (a) (2) would be amended by striking "adult day health care in a State home" and inserting "extended care services described in any of paragraphs (3) through (6) of a section 1710A (a) of this title under a program administered by a State home."

Section 1741 (a) (2) would then read:

"The Secretary may pay each State per diem at a rate determined by the Secretary for each veteran receiving extended care services described in any of paragraphs (3) through (6) of section 1710A (a) of this title under a program administered by a State home."

It has been noted that the Department of Veterans Affairs is projecting an increase in the number of aging and disabled veterans requiring non-institutional home and community-based care in the next few years. An estimated 173,000 veterans in 1996 needed such care on any given day with this number to rise to 180,000 by 2005. The aging and chronic illness is creating a new balance between acute care needs and chronic, long-term health care needs. With this being the case, the proposed legislation expressed in Section 2, Extended Care Services, allows the State Veterans Home Program expanded options to be even more of a partner in the provision of long-term health care services for veterans with the Department of Veterans Affairs.

We in the National Association of State Veterans Homes appreciate the continued support of Congress and believe such availability of these additional options will enhance and expand the State Home Program and offer a broader range of care for the Nation's elderly veterans in terms of service, efficiency and economy.

We support this proposed legislation.

**Statement for the Record
of the hearing held on
May 19, 1999
Before the
Committee on Veterans' Affairs
U.S. House of Representatives
Regarding
The Veterans' Millennium Health Care Act**

**Submitted by the
National Association of
Veterans' Research and Education Foundations
(NAVREF)**

The National Association of Veterans' Research and Education Foundations (NAVREF) appreciates the opportunity to submit a statement for the record of the May 19, 1999, Committee on Veterans Affairs hearing regarding the Veterans' Millennium Health Care Act. NAVREF strongly supports initiatives such as those proposed in the bill designed to strengthen VA's ability to provide high quality care for veterans. Specifically, however, we wish to comment in detail on Section 9 of the Veterans' Millennium Health Care Act which 1) authorizes the VA nonprofit corporations (NPCs) to accept donations to support VA's continuing education needs and 2) updates the existing statute to reflect changing staff titles at VA medical centers. We strongly encourage the Committee on Veterans Affairs to include these provisions in the final act.

NAVREF is a voluntary membership association formed by the VA-affiliated nonprofit corporations. As such, NAVREF conducts conferences and maintains programs to assure the highest standards of fiscal and administrative management of the corporations. In addition, NAVREF works with congressional and VA policy makers to develop and implement appropriate regulation and oversight of the corporations. NAVREF receives no federal funding.

Background: In 1988, Congress authorized the Secretary of the Department of Veterans Affairs to allow VA medical facilities to establish nonprofit corporations. The intent of Congress was to provide VA medical centers with a flexible funding mechanism to administer private sector and non-VA federal research funds donated in support of the VA medical and prosthetics research program. Subject to VA and congressional oversight, these corporations have been remarkably successful in bringing to VA additional resources and enhanced opportunities for VA investigators. Last year, the NPCs had total revenues of nearly \$100 million. In addition to administering over 3,000 research programs on behalf of VA investigators, the NPCs also made substantial cash and in-kind contributions to the research programs of their affiliated VA medical centers. These included:

- Donating administrative staff, clinical nurses, pharmacists, custodians and animal facility workers.
- Purchasing and donating furniture, office and research equipment, and supplies.
- Providing seed money so investigators can develop new grant proposals as well as bridge funding to maintain laboratories between projects.
- Supporting the costs of recruiting clinicians with a research interest.

- Paying all or part of a VA medical center's hazardous waste disposal costs and other bills that increase as a result of NPC-funded research.
- Helping pay the cost of upgrading outdated research facilities or creating new research space.

While still only a modest component of the total VA research enterprise, the NPCs provide VA with a partner dedicated to supporting the affiliated medical center's research program. When enacted by Congress, the provision contained in the Veterans' Millennium Health Care Act will expand this partnership to include VA's patient and staff education missions.

VA's Expanding Educational Needs: In recent years, VA has established annual continuing education requirements for all VA employees. In addition, physicians, nurses, social workers and other allied health professionals must obtain continuing education credits to maintain or augment their professional credentials. As a result, great demands are being made on VA's limited educational resources at a time when VA is striving to maintain its standard of high quality care for veterans under increasingly severe budget constraints. NAVREF strongly supports increased training for VA employees, but is sympathetic to medical centers facing difficult choices between competing needs for clinical services and education. Clearly, a mechanism to accept and administer new sources of educational funding is needed.

Limited Authority Limits Potential: Under the current legislative authority, the NPCs are limited to supporting only research and research-related activities. This limitation causes two problems:

1. VA General Counsel and VA researchers often disagree on what constitutes research. Investigators view research as a continuum from the conception of an idea through dissemination of knowledge. General Counsel has assumed a narrower view that sometimes constrains the NPCs' ability to support VA staff as they seek new or better ways to provide high quality care for veterans. The revised authority will negate the need to distinguish between research and education.
2. VA is mandated by Congress to provide staff and patient education as well as continuing medical education, yet has no mechanism of its own to take advantage of private and non-VA public funding opportunities to support VA's patient and staff education missions. Affiliated universities and other nonprofits have served in this capacity to some extent, but these are not subject to VA oversight or regulation. Additionally, other institutions may have different priorities and often reduce the available funding by levying a substantial administrative charge. The revised authority will allow the corporations to bring in additional resources to support VA's continuing education requirements, and programs conducted by the NPCs can be tailored specifically for VA patient and staff needs.

Benefits to VA and Veterans: Letters sent to NAVREF by network directors, hospital directors, RMEC directors, health care professionals and a veterans service organization indicate broad interest in a flexible funding mechanism for educational activities. Also, these letters discuss reasons why it is important for VA to have a means to administer non-VA federal and private educational funds. In summary, benefits to VA and veterans include the following:

- VA will have direct access to non-VA federal, nonprofit and private sector funding for education as well as demonstration grants.
- VA can take advantage of the considerable funding for educational activities available from private sources. It is estimated that national expenditures for continuing medical education (CME) courses

conducted by medical schools—the third largest sponsor of CME after community hospitals and professional societies—exceed \$300 million per year. While there are no accurate figures available on how much of this funding comes from private sources, a study conducted by *The Society of Medical College Directors of Continuing Medical Education* discusses *Financial Involvement of Commercial Companies* in medical schools' CME programs. The author of the survey estimates that 20% of CME budgets at medical schools comes from commercial sources. A conservative extrapolation suggests that \$15-20 million could be generated in support of VA continuing medical education. This amount would be modest in the greater scheme of CME, but could make a substantial difference for VA.

- VA health care professionals will have greater access to continuing medical education as well as other educational opportunities to meet increasing continuing education requirements imposed by credentialing institutions and VA. As a result, VA will become a more attractive career choice.
- As VA transitions from an acute care system to a primary care system with a new emphasis on preventive care, more medical centers are conducting patient health education programs. The NPCs may increase the number of such programs offered to veterans by accepting and administering private sector and non-VA federal grants for patient education programs. Additionally, being veteran-specific, these programs may be more readily targeted to veterans' needs in such areas as smoking cessation, diabetes management, substance abuse, hypertension control, weight loss, etc. than programs offered by the private sector.
- Both VA and VA researchers will have expanded opportunities to disseminate research results and foster their application to clinical practice.
- By association, VA will benefit from the prestige and positive public relations generated by sponsorship of educational conferences and courses.
- Any excess funds generated by educational activities will accrue to additional programs that support VA rather than other affiliated administrative organizations. Currently, private education funds offered to VA entities are re-routed to affiliated universities or other nonprofits, none of which are subject to VA oversight and which may assess a substantial administrative overhead charge.
- Ultimately, and most importantly, veterans will benefit from care provided by a more highly trained staff.

Lost Opportunities: For lack of an appropriate administrative mechanism, VA medical centers and staff often must turn down offers of educational funding or must seek out—sometimes ill-suited—alternative administrative mechanisms. The following are just a few of many such examples:

1. C.A.R.E.S., the NPC affiliated with the Hines, Illinois, VA medical center, was offered \$250,000 per year to establish and maintain a minimally invasive surgery training center. In addition, the sponsor would have donated all the necessary equipment. The total estimated value for the first year was \$1 million. VA physicians could have received training in the latest technology and techniques at no charge at the same time as the NPC could have charged non-VA physicians a training fee, thereby generating funds to support research/education activities at the VA medical center. However, due to the prohibition against receiving or expending funds for educational activities, the NPC had to decline the offer.
2. A VA physician in Tucson, Arizona, was offered a \$60,000 unrestricted educational grant to develop and implement a training program in Valley Fever, a potentially serious condition common in the southwest where increasing numbers of veterans reside. Valley Fever is a disease of the lungs caused by a fungus and is often difficult to diagnose and treat. Most otherwise healthy people who contract the disease recover within six months and do not require treatment.

However, approximately 40% suffer from complications and require drug therapy, sometimes for years. There is a critical need for physician and allied health professional training in the diagnosis and treatment of Valley Fever. However, because there was no research component, the NPC was unable to administer the grant.

3. The Hepatology Fellowship Program of Schering Oncology/Biotech recently sought out NAVREF to offer funding for up to nine one-year fellowships at three VA medical centers. Worth as much as \$50,000 each, these fellowships required a half time commitment to training in hepatology (a subspecialty of gastroenterology focused on liver diseases) and clinical activities in caring for patients with liver disease and were available to physicians, nurse practitioners and physician assistants. Unfortunately, as initially proposed, there was no research component to the program description making these unsuitable for NPC administration. After discussion, however, Schering agreed to add a research requirement to the fellowships and the initiative is awaiting VA approval.

Oversight and Regulation: The existing authorization for the NPCs provides multiple layers of oversight and regulation by VA and Congress that will be unchanged by the proposed revision. These include:

- local oversight by senior medical center management who must serve on the NPC board of directors
- access to the records of the NPC by the Secretary, the Inspector General, the Comptroller and General Counsel
- submission of an annual report to VA and Congress which details donations and expenditures
- a full financial audit on a regular basis
- subjecting all NPC employees to the same ethical standards that are required of federal employees to prevent conflict of interest, dual compensation, etc.

In addition, all research projects administered by an NPC must be approved by the VA medical center's Research and Development Committee. Similarly, as provided in the proposed statute, NAVREF recommends that education activities administered by an NPC be reviewed and approved in accordance with policies and procedures prescribed by the Under Secretary for Health consistent with the purpose of the NPCs as flexible funding mechanisms. It is our expectation that the Under Secretary will determine that each donation and the associated educational activity should be scrutinized locally using the same standards that are applied to VA's ongoing educational programs. This scrutiny will include assessment of potential conflict of interest, consistency with and relevance to VA's health related missions, and general appropriateness as a VA activity. VA medical center Education Committees already have extensive prior experience in evaluating educational activities and we expect that policies developed by VA will extend this expertise to review and approval of NPC administered education activities.

Under the leadership of VA's Research and Development and Education Offices, NAVREF is prepared to assist in revising the VA manual chapter specific to the NPCs to reflect the expanded authority. NAVREF will also update its own manual on operating an NPC and will incorporate education-related topics in NAVREF's annual conference and web site.

Minor Changes Necessary to Reflect Changing VA Staff Titles: NAVREF also supports the provision in Section 9 of the Veterans Millennium Health Care Act that updates the existing statute to reflect changing staff titles at VA medical centers. The original statute mandates that individuals

with particular VA medical center titles serve on the board of directors of the affiliated NPC. However, as the VA health care system continues to evolve, many medical centers no longer have staff positions titled exactly as specified in the original statute. The changes provided in the proposed statute will allow individuals responsible for carrying out the responsibilities of the medical center director, chief of staff, associate chief for of research and the associate chief of staff for education to serve on the board of directors. This small change provides the flexibility necessary to assure that all the NPCs will be in compliance with the intent of Congress in mandating local oversight and direct medical center involvement in management of NPCs.

Impact on the Federal Deficit: NAVREF anticipates that enactment of Section 9 of the Veterans Millennium Health Care Act will have a negligible impact on the federal deficit. All of the NPCs are Internal Revenue Code 501(c)(3) organizations. As such, donations made in support of educational activities administered by the NPCs may be tax deductible to the donors. However, tax deductible donations to the NPCs are likely to be reallocated contributions—i.e., given to an NPC instead of another institution—rather than donations made over and above previously budgeted amounts. Therefore, donations to the NPCs have already been incorporated in federal deficit considerations.

Conclusion: Eleven years after their inception, the corporations have well-established policies and procedures, experienced staff and a strong record of providing support for the VA research program. In addition, VA has become accustomed to working with and overseeing a large number of affiliated nonprofits and has developed appropriate regulation. Also, NAVREF exists to provide guidance and to work with both VA and the corporations to develop and implement programs to assure the highest standards of fiscal and administrative management. NAVREF is confident that the corporations can be as successful in supporting VA's education mission as they have been in acting as a flexible funding mechanism to support its research program. We strongly encourage the Committee on Veterans Affairs to approve Section 9 of the Veterans' Millennium Health Care Act which will authorize the VA nonprofit corporations to accept donations in support of VA's continuing education needs, and will update the statute to reflect changing VA staff positions.

Thank you for considering our views. Questions or comments may be directed to NAVREF Executive Director Barbara West at 301-229-1048 or navref@navref.org.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

**Responses to Follow-up Questions
Concerning the May 19, 1999, Hearing**

for
Dr. Kenneth W. Kizer, M.D., M.P.H
Under Secretary for Health
Department of Veterans Affairs

from
The Honorable Bob Stump
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives

Question 1: Dr. Kizer: The draft bill would provide VA new authority to set higher copayments on prescription drugs and new copayments on "costly" items or equipment. It would appear that such new authority could enable the Department to revisit prior decisions on medications like Viagra. It is our understanding that that drug, for example, is not on the VA formulary, based apparently on a decision that it is a very costly and is in the nature of a "quality of life" rather than a "treatment" drug. Given the dilemma that current policy may deny the drug for even a service-connected condition, and the fact that other Federal providers are furnishing such medications, would you consider employing such new copayment authority to set higher copayments for "quality of life" drugs being furnished in connection with a nonservice-connected condition?

Answer: VHA would welcome the option of a new copayment authority to address dispensing these types of medications. We would consider using such authority to provide these medications in connection with a nonservice-connected condition. As similar new therapies continue to be approved for use in this country for this and other categories of "quality of life" products, a new copayment authority is a desirable option for VHA to potentially utilize in providing continuity of care at an affordable price.

Question 2: How would the Department implement and administer the emergency care authority set forth in section 15 of the draft bill. Please illustrate the application of the section by reference to hypothetical patient cases.

Answer: The following cases illustrate how the new authority would apply:

Veteran has Medicare or Medicaid Coverage - VA receives a claim for payment of medical services not previously authorized. Medical center staff verifies the veteran has Medicare or Medicaid coverage. Claim for payment is denied and is returned back to the veteran or provider of care along with a letter explaining the reason for denial. The denial letter will inform the veteran or provider that VA is only authorized to reimburse veterans for emergency medical care services when he/she has no entitlement to care or services under a health-plan contract, has no other contractual or legal recourse against a third party payer, and is not eligible for reimbursement of private medical expenses authorized under Title 38 U.S.C. § 1728.

Veteran has Private Insurance Coverage - VA receives a claim for payment of medical services not previously authorized. Medical center staff verifies the veteran has Private Health Insurance coverage. Claim for payment is denied and is returned back to the veteran or provider of care along with a letter explaining the reason for denial. The denial letter will inform the veteran or provider that VA is only authorized to reimburse veterans for emergency medical care services when he/she has no entitlement to care or services under a health-plan contract, has no other contractual or legal recourse against a third party payer, and is not eligible for reimbursement of private medical expenses authorized under Title 38 U.S.C. § 1728.

Veteran has no Health Care Insurance Coverage - VA receives a claim for payment of medical services not previously authorized. Medical center staff verifies the veteran has no health insurance coverage, and no possible eligibility for coverage under another benefits program such as Medicare or Medicaid.

Automobile No Fault Insurance Case - VA receives a claim for payment of medical services not previously authorized. Medical center staff verifies this is a no fault automobile insurance case. Claim for payment is denied and is returned back to the veteran or provider of care along with a letter explaining the reason for denial. The denial letter will inform the veteran or provider that VA is only authorized to reimburse veterans for emergency medical care services when he/she has no entitlement to care or services under a health-plan contract, has no other contractual or legal recourse against a third party payer, and is not eligible for reimbursement of private medical expenses authorized under Title 38 U.S.C. § 1728.

Reimbursable Insurance (Including Uninsured Motorists) - VA receives a claim for payment of medical services not previously authorized. Medical center staff verifies this is a reimbursable insurance case. Claim for payment is denied and is returned back to the veteran or provider of care along with a letter explaining the reason for denial. The denial letter will inform the veteran or provider that VA is only authorized to reimburse veterans for emergency medical care services when he/she has no entitlement to care or services under a health-plan contract, has no other contractual or legal recourse against a third party payer, and is not eligible for reimbursement of private medical expenses authorized under Title 38 U.S.C. § 1728.

Question 3: You support the draft bill on establishing a pilot to provide care to veterans' dependents. VA is already providing care to dependents under contracts with TRICARE. Does that experience help answer concerns expressed by some of the veterans' organizations which have questioned this measure? If so, please document the experience VA has had under TRICARE contracts.

Answer: Yes. VHA's experience with TRICARE should alleviate any concerns. One hundred thirty-five VA medical centers now have agreements in place with DoD's managed care support contractors to provide a broad range of medical, surgical, and mental health services to TRICARE beneficiaries. We know of no instances in which a veteran has been denied or delayed receiving care as a result of these agreements. Revenue generated from these agreements has been used to enhance care to eligible veterans.

The majority of the TRICARE beneficiaries that our facilities now treat are dependents, rather than active duty service members or military retirees. Many of these beneficiaries are the wives of veterans VA has been serving for years. We have witnessed strong support on the part of the VSOs for our participation as a TRICARE provider. Treating adult female dependents under TRICARE has actually enabled us to improve services to women veterans at a number of our facilities. Our experience treating minor dependents under TRICARE is very limited. I anticipate that most pediatric care offered during the proposed pilot would be provided through contract with specialists in the communities.



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

November 5, 1999

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

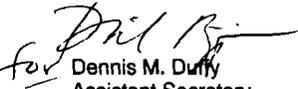
Dear Congressman Evans:

Enclosed are the Department's responses to post-hearing questions you submitted in your letter of May 19, 1999, to the Under Secretary for Health, concerning the hearing on the Veterans' Millennium Health Care Act.

As indicated in the September 16, 1999, interim reply, the responses at that time were still under review by the Office of Management and Budget (OMB). The OMB review and refinement of the answers took more time than initially anticipated. I apologize for the delay in getting these responses to you.

If we can be of further assistance, please contact me or Mary Kay Stack at 202-273-5628.

Sincerely,


for Dennis M. Duffy
Assistant Secretary
for Planning and Analysis

Enclosure
DD/rh

**Post-Hearing Questions
Concerning the May 19, 1999, Hearing**

**for
Department of Veterans Affairs**

**from
The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U. S. House of Representatives**

(NOTE: Dr. Kenneth W. Kizer, former Under Secretary for Health, is no longer with the Department. These answers represent the views of the Department of Veterans Affairs.)

1. Would you agree that VA's distribution of long-term care has been widely variable across VISNs?

Answer: The distribution of long-term care services varies widely across VISNs. This reflects a historical pattern of service delivery, linked to availability of care and the investment of States in State Veterans Homes, among other things.

2. How will VA "standardize" its distribution of scarce long-term care resources if Congress does not act on the bill before us today?

Answer: VA needs to expand long-term care services, notably Home- and Community-Based Care (H&CBC). Such nationwide expansion is highlighted in the President's FY 2000 Budget. As indicated in the Draft Strategic Plan for Long-Term Care, performance measures will be established to improve access to H&CBC. One measurement option, suggested by the Federal Advisory Committee, would link growth in H&CBC to a national average for access. This and other options to help standardize the distribution of long-term care services are currently under consideration.

3. Dr. Kizer, I don't believe that the co-payments proposed for extended care were meant to cover all or even a majority of VA's costs for such services. We expect appropriated funds to cover some of this care. Please share some of your concerns about what you refer to as the "adequacy of the proposed co-payment strategy" in the Millennium Plan.

Answer: The primary concern is whether there will be adequate resources to provide the proposed extended care services to all veterans who enroll for VA care. The committee proposal mandates these services when they are needed

for treating a service-connected condition and for any condition of veterans who have a 50 percent or greater service-connected rating. Priorities would be set for all other patients to provide a mechanism to limit these services when resources are not available. The co-payment strategy will 'stretch' available funds – allowing VA to provide these services to more patients. However, given that we must provide health care to all enrollees in priority groups 1-6, and providing extended care services to the lower priority groups remains discretionary and subject to the overall availability of resources under the Millenium bill, offering the full continuum of care to all enrollees will likely be problematic.

4. Do you personally support a proposal to allow TRICARE eligible military retirees to choose VA as their health care provider? Do you believe that VA could cover the cost of this care without these veterans' co-payments?

Answer: While this would afford an opportunity for joint Federal collaboration, the Administration does not, at this time, support this provision because its preliminary analysis indicates that it would result in increased costs for DOD estimated at approximately \$175 million per year.

Currently, non-service connected military retirees may elect to receive care from VA either by enrolling as veterans or, if they are under 65, they may enroll in TRICARE and be served at one of VA's facilities with TRICARE contracts. When care is provided to retirees as veterans, those in priority level 7 are subject to the same co-payments as other veterans. When care is provided to them as TRICARE beneficiaries, VA is obligated (under our agreements with DOD's managed care support contractors) to collect appropriate TRICARE deductibles and cost shares from the beneficiary and collect the balance of the negotiated reimbursement from the contractor.

The discussion draft of the "Veterans Millenium Health Care Act" provides a significant new benefit for those retirees currently in priority level 7 who elect to enroll as veterans. They will, until age 65 (when they lose TRICARE eligibility), no longer be subject to co-payments when treated as veterans. This group would now have a strong incentive to use their VA, rather than their TRICARE, benefit. Both the DOD TRICARE and VA health care systems individually manage continuity of care for their users, but the uncontrolled interagency utilization of services that this provision encourages could threaten this coordination. Moreover, DOD and VA already cooperate in providing access to high-quality care to the population through resource sharing initiatives, and TRICARE contractors may enter into provider agreements with VA facilities whenever beneficial. This provision would duplicate these efforts.

5. Dr. Kizer, VA objects to the "report and wait" provisions on bed closures, but it addresses a concern Congress and veterans have had about effectively retrenching resources once provided in beds into community and outpatient

settings. What assurances are you able to provide this Committee that care once provided in beds is being replaced with appropriate care in other settings.

Answer: As VA has placed an emphasis on shifting care from inpatient settings to outpatient and community settings, we have instituted a comprehensive measurement and monitoring system to help assure that care delivery in outpatient settings is appropriate and of high quality. Since 1996, Network Directors have been held accountable for a series of performance measures that focus on outpatient care. For example, the Chronic Disease Care Index consists of 13 clinical interventions that assess how well VA follows nationally recognized guidelines for five high volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, and obesity. The Prevention Index consists of nine clinical interventions that measure how well VA follows nationally recognized primary prevention and early detection recommendations for eight diseases with major social consequences. In addition, we have implemented a measure requiring implementation of nationally developed clinical practice guidelines.

VA is particularly interested in our patients' perception of the care they receive from VA. From annual national patient surveys, we are able to gauge overall patient satisfaction in both the inpatient and outpatient settings. Sampling and reporting methodologies allows review of patient satisfaction from the facility, VISN or VHA-wide perspective. The most recent survey indicates that overall satisfaction with VA care has remained stable during the continuing shift from inpatient to outpatient care.

VA has reason to place confidence in its performance measurement system as a fundamental method to assure that any major changes to our system do not adversely affect the appropriateness and quality of care. We now have almost five years of hands-on experience, and a recent report by the Government Performance Project, which systematically measured federal management performance practices, reported that VA was the only federal agency of the 15 reviewed that received a grade of "A" in the category of "Managing for Results." We will continue to design and implement monitors that assess levels of quality and patient satisfaction as VA continues to re-engineer itself to become an outstanding health delivery system for veterans.

If these things do not adequately address the issue of concern that prompts the "report and wait" provision, then we need to work with Congress to specifically address the issue of concern in a direct and more appropriate manner.

6. To what extent does VA provide chiropractic services today? How many chiropractors are currently on staff at VA? How much did VA spend on contracts or fee-based services from chiropractors in FY 1998?

Answer: It is VHA's policy to pay for chiropractic care for a veteran patient if the patient's physician believes such care would be beneficial. The patient may select the chiropractor she/he prefers, and the VA will pay for the number of treatments specified by the VA physician. While there is nothing in VHA's current policy that precludes patients receiving chiropractic services, relatively little chiropractic care has been paid for by VA over the years.

VHA currently provides limited chiropractic services, and, according to VA's electronic personnel files, currently has no chiropractors on staff. According to VHA's Central Fee Basis files, VHA spent \$251,131.89 on chiropractic services in FY 1998. Contracts for chiropractic services are local in nature and centralized data is unavailable.

7. Given VA's problems in the area of billing and collecting, what assurance can you provide the Committee that VA would be able to provide care to veterans' dependents without using funds appropriated for veterans health care?

Answer: The Department has not conducted an analysis of the cost of care for dependents as proposed in the Veterans' Millennium Health Care Act. However, in regard to the concern posed, we note that the bill itself contains certain protections, such as pilot-site selection criteria that direct VA's designation of participating medical facilities based both on their ability to assure that veterans will continue to receive priority care and on their demonstrated success in billings and collections. Moreover, VHA would plan to continually monitor dependent collections. If it were determined that the costs of dependent care were not being adequately reimbursed, and that this situation could not reasonably be remedied, we would immediately recommend that the pilot be terminated.

**The
American
Legion**



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June 2, 1999

Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U.S. House of Representatives
CHOB, Rm. 334
Washington, DC 20515-6335

Dear Representative Evans:

The American Legion is pleased to respond to the follow-up questions regarding the May 19, 1999 hearing before the Subcommittee on Health, Committee on Veterans' Affairs.

Question 1.

Mr. Vitikacs, as you are aware, VA has had some difficulty in billing and collecting veterans' health care insurers. How can Congress be assured that VA would be able to do a reasonable job in billing and collecting dependents' insurance plans when it will presumably have to bill for pediatrics, obstetrics and other services it has never before provided? Do you share my concern that mismanaged billing and collections will eat into an appropriation meant to fund veterans' health care?

Response

Regarding the first part of the question, since a dependent care pilot program would be limited to only a few Veterans Integrated Service Networks (VISNs), it is possible that VA can work out a satisfactory program to bill for services provided to women and children. It is also conceivable that such a program will assist VA in improving its MCCF program in general. If the concern is that VA cannot effectively add this new task on a limited basis, what is the prospect that VA will be able to conduct a successful

Medicare subvention program? VA has recently gained some experience in treating Tri-Care dependents in its outpatient clinics. There must already be a system in place for VA to bill a Tri-Care contractor for the care and treatment of dependents.

The American Legion does not believe that VA's lack of experience in billings and collections for veterans' dependents is a prohibiting factor in conducting a limited pilot program. It currently costs VA more than the private sector to bill and collect from veterans' insurers. It is also unclear whether the proposed pilot program would increase MCCF costs. The American Legion supports conducting a pilot program to obtain reliable data to your answer question.

Additionally, it may be prudent to develop a pilot program to contract out MCCF functions in certain VISNs, for all billings and collections, and evaluate how the private sector compares opposite VHA.

Question 2.

If VA's budget situation causes them to exclude some veterans from enrolling in VA for health care, would you still make the case that VA should venture into offering treatment to dependents?

Response

The short answer is no. The longer answer is a dependent care pilot program is proposed at a time when all veterans have access to VHA. The American Legion hopes this situation does not change beyond Fiscal Year 1999. As long as all veterans have access to VA health care and are being cared for first, additional revenue enhancing programs can help VA meet its goal of obtaining 10 percent of all funding from non-appropriated sources.

The care of veterans' dependents by VA is a part of the GI Bill of Health. The American Legion realizes the GI Bill of Health will not be achieved in one legislative act. However, since some of the components of the GI Bill of Health have already been implemented in one form or another, a dependent care pilot program is an important part of our effort to reinvent the Veterans Health Administration.

A majority of the veterans of this Nation want VA health care to prosper and be successful. In today's budgetary climate, the future of the Veterans Health Administration (VHA) is at best uncertain. If VA can treat military dependents at its facilities under Tri-Care contracts, why is it so difficult to undertake a pilot program for veterans' dependents? Currently, at least three VA clinics are caring for the young children of Tri-Care beneficiaries: Monterey, CA; Rome, NY; and Indianapolis, IN.

Obviously, there are some valid concerns about a dependent care pilot program. As long as appropriate controls are in place, and all veterans continue to have access to VA health care, The American Legion believes the role of veterans' families is important to VA meeting its 30-20-10 objectives. We strongly support conducting a limited pilot program for eligible veterans' dependents, together with appropriate program controls.

It also makes sense to select under utilized VA medical centers for the demonstration project to test the theory of generating additional revenue and resolving the under utilization problem.

Thank you for the opportunity to respond to your concerns.

Sincerely,



John Vitikacs
Assistant Director
National Veterans Affairs and
Rehabilitation Commission

CC: Honorable Bob Stump

Chairman Stump to Non Commissioned Officers Association

Follow-up Questions from the Honorable Bob Stump
From the May 19, 1999, Subcommittee on Health Hearing

1. The Subcommittee would welcome your organization's perspective on the reasonableness of the viewpoint expressed at the hearing that any increase in co-payments on care of non-service-connected conditions is unacceptable.

NCOA response: NCOA very carefully iterated, in both our prepared testimony and oral comments, the perspective that governs the Association's position on the issues surrounding federally provided health care to different categories of eligible federal beneficiaries. From that perspective, NCOA is very sensitive to federally provided health benefits that create anomalies among military members, military retirees and veterans. The issue of co-payments for health care and prescriptions provided to veterans and military retired veterans for non-service connected conditions is a classic example of the anomalies and inequities that NCOA is fighting to overturn.

For example, the current VA prescription co-payment for a non-service connected veteran is \$2; however, at VA facilities that are designated TRICARE providers, a non-service connected military retired veteran is required to make a \$9 co-payment for prescriptions. The majority of health care provided by VA is to non-service connected veterans and for non-service connected conditions; almost universally, these veterans are non-required to make any co-payments for the care received. However, under TRICARE provider agreements between DOD and VA, a military retired veteran, or other TRICARE beneficiary, is required to meet an established deductible and then pay at least 20% of the cost of the care provided. As long as Congress permits inequities such as this among federal health care beneficiaries, NCOA does not believe a co-payment for non-service connected care or requiring a non-service connected veteran to share in the cost of health care or prescriptions provided by VA is in any way unreasonable.

2. Please comment on the likely demand for VA care under section 4 of the draft bill on the part of military retirees who are not otherwise eligible for VA care. Our expectation is that such factors as existing provider relationships, lack of access of dependents to VA care, and the absence of coverage after age 65 would tend to limit their demand for VA care, and therefore limit the fiscal impact of this provision.

NCOA response: NCOA believes your reasoning is sound and concurs that the likely demand will be less than many seem to think. Of the approximately 1.8 million military retirees, 54% are age 65 or older and are not TRICARE eligible. The language in the Veteran's Millenium Health Care Act would not establish eligibility for those retirees over age 65 and, therefore, the maximum potential population of eligible military retirees would be approximately 885,000. The approximately 885,000 must then be reduced by the approximately 218,000 who are disability retired and already have VA eligibility; that number would be reduced further by those retirees who have VA disability compensation ratings and likewise already have VA eligibility. While NCOA could not arrive at the exact number, the likely number of eligible military retirees who would stand to benefit from this legislation is probably between 450,000 - 500,000. Considering that the demographics of the military retired veteran population is not unlike the general veteran population, the number living close enough to VA facilities to actually use the facilities would be considerably less than the 450,000 - 500,000 who might become eligible. NCOA also points out that noncommissioned officers and petty officers comprise 70% of military retirees, have the greatest unmet health care needs, and would be the greatest beneficiaries of this legislation if enacted.



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June 7, 1999

The Honorable Bob Stump
 Chairman, House Veterans Affairs Committee
 United States House of Representatives
 Washington, DC 20515

Dear Mr. Chairman:

In your letter of May 27, you asked me to respond to two questions on behalf of The Retired Officers Association (TROA) regarding issues raised during the Subcommittee on Health hearing of May 19, 1999.

The first question stated: "The Subcommittee would welcome your organization's perspective on the reasonableness of the viewpoint expressed at the hearing that any increase in copayments on care of non-service-connected conditions is unacceptable."

TROA believes that the issue of adjusting copayments must be considered in the context of the VA's historic and statutory obligation to provide care to veterans who have suffered injury or disease as a result of their service. The authority to extend and expand health care services under enrollment reform to "wellness" care and routine non-service connected services brings a reasonable and legitimate expectation in our view that other sources of government and non-government revenues can be used for such care. TROA, therefore, has no objection in principle to reasonable adjustments to copayments for non-service connected conditions. We note in the (draft) transcript of the hearing testimony on 19 May that none of the veterans organization witnesses objected to the use of copayments for non-service connected long term care as proposed in the Veterans Millenium Health Care Act. We note, too, the statement of Mr. Dennis Cullinan, National Legislative Director, VFW: "Again, with the goal of providing more and better VA care to all veterans desiring such, the VFW [is] supportive of this bill[s] provisions providing for enhance[d] revenues. Given VA's current strained funding situation, it only makes sense to establish and expand it in a more reasonable copayments schedule for VA care, products and services. We insist, however, that all existing statutory exemptions, as well as those additional exemptions enumerated in this bill, be strictly applied." We believe this statement captures the essence of the issue.

The second question stated: "Please comment on the likely demand for VA care under section 4 of the draft bill on the part of military retirees who are not otherwise eligible for VA care. Our expectation is that such factors as existing provider relationships, lack of access of dependents to VA care, and the absence of coverage after age 65 would tend to limit their demand for VA care, and therefore limit the fiscal impact of this provision."

TROA believes that the likely demand for VA health care under section 4 of the draft bill (known as the Veterans Millennium Health Care Act) will be tempered by a number of factors.

First, the number of military retirees who could potentially enroll in the new category is much lower than some might assume. As of 30 September 1998 there were 1, 578, 093 million non-disability military retirees (including reserve retirees). Of these, 431,828 were in receipt of a VA offset to their military retired pay. Assuming these retirees would be eligible to enroll in VA categories 1 - 3 for service-connected disabilities, the adjusted number of non-disability retirees is 1.46 million. However, because about 40% of military retirees are age 65 or over and no longer eligible for TRICARE, another 458, 000 must be deducted from the 1.46 million for a net of 688, 000 (rounded). This number represents a reasonable estimate of the theoretical upper limit of non-disabled retirees eligible for TRICARE who could enroll in the new category. (Source: DoD Office of the Actuary, "DoD Statistical Report on the Military Retirement System, FY 1998," pp. 65, 170). Although no estimate can be considered reliable at this time, given the factors discussed below, we would "guesstimate" that perhaps less than 25 percent of the 688,000 non-service connected military retirees might use some VA services from time to time. This estimate considers the following additional factors.

One limiting factor is that many military retirees indicate a strong preference for military health care through military treatment facilities (MTFs). Dependent eligibility for TRICARE is a compelling feature of that preference. The proposed new VA enrollment category apparently would not permit dependents to use VA health care and would, therefore, serve as a disincentive to enrollment.

A related factor, we believe, is the cutoff from benefits (or at least transfer of military retirees to a "discretionary" VA category) at age 65 when they become Medicare eligible. We see little incentive for retirees -- who average 61 years of age -- to sign up for so-called "guaranteed" health care for only about four years. Many officers in fact could not even consider enrolling since their average age according to DoD is 66.

We believe that military retirees might show interest in specific types of services offered by the VA such as pharmaceuticals, routine outpatient services (flu shots, eye exams, wellness visits), and emergency care (if available and authorized). A lot would depend on the proximity of the VA clinic or hospital and the reputation of the facility for quality care. As indicated in the TROA prepared statement, emerging VA research indicates that a growing number of older, Medicare-eligible veterans use VA health care for some services but also seek much of their care through Medicare HMOs or other providers. Because many military retirees have private insurance from second careers or their spouses, or are Medicare-eligible, it is likely that they might use VA care only for certain "convenience" services and use other providers for inpatient and long term care.

TROA has requested the VA to provide a demographic breakout of the 1999 Category 7 enrollees, to shed further light on the question of likely demand. Informally, VA officials indicated that they were working on this information but they did not say when these data would be available. TROA recommends that the Committee request the VA to submit a comprehensive analysis on the demographics of the Category 7 enrollees including information on the number of recently enrolled military retirees. We believe this information along with surveys of military retired veterans would enable the Committee and the VA to establish a reliable baseline to estimate likely demand under a new mandatory care category for TRICARE eligible non-service connected military retirees.

Thank you, again, Mr. Chairman for the opportunity to respond to the questions raised. TROA looks forward to supporting your efforts and the Committee's in expanding health care access for our nation's military retired veterans.

Sincerely,

A handwritten signature in black ink, appearing to read "Bob Norton", with a long horizontal flourish extending to the right.

Robert F. Norton
Colonel, USA (Ret.)
Deputy Director, Government Relations