

PRIORITY GROUP 8 VETERANS

HEARING BEFORE THE COMMITTEE ON VETERANS' AFFAIRS U.S. HOUSE OF REPRESENTATIVES

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PRIORITY GROUP 8 VETERANS

WEDNESDAY, JUNE 20, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:07 a.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Brown, Michaud, Herseth Sandlin, Mitchell, Hall, Hare, Rodriguez, Space, Walz, Buyer, Stearns, Miller, Boozman, Brown-Waite, Turner, Lamborn, Bili-rakis, Buchanan.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. The Committee on Veterans' Affairs will come to order. I thank all the Members of the Committee and members of the audience and panelists who will be here to discuss this very important issue.

The issue of the Administration's continued ban on enrollment of Priority 8 veterans is an important one and I hope that we will leave here today with a sense as to the cost, and the effects of rescinding the ban, as well as the costs, measured in the effect of denied access to healthcare, of continuing the Administration's policy of shutting the doors to an entire class of veterans.

We are the richest Nation in the history of the world at a time when we are spending a billion dollars every 2½ days on a war, and yet we are rationing care to our Nation's veterans. I think that is unacceptable.

We started this era in 1996, Public Law 104-262, the Veterans' Healthcare Eligibility Reform Act, and the U.S. Department of Veterans Affairs (VA) has remade itself into a healthcare system that is really a model. But in January 2003, then-Secretary Principi made the decision to bar enrollment of new Priority 8 veterans. These veterans are nonservice-connected and are called "high income" because they make \$27,790 or more. There is also geographic income thresholds.

Although comparably better off than veterans in lower priority groups, they are by no means all rich, as some would have you believe. And yet, for 4½ years, the doors to VA healthcare have been closed to them.

When we submitted the Majority Views and Estimates for the budget for fiscal year (FY) 2008, we noted that the authority of the Administration to deny enrollment to an entire class of veterans was never meant to be an infinite grant of authority. It was pro-

vided to the VA as a management tool at the time in order for it to address unexpected shortfalls that arose. Unfortunately, the situation we face today is that this continues as a permanent policy and the Administration fails year after year to request specific funding for enrolling Priority 8 veterans and treats the January 2003 decision as permanent.

The VA has estimated that reopening enrollment will bring in an additional 1.6 million veterans and cost an additional \$1.7 billion. The *Independent Budget* (IB) prepared by our veterans service organizations (VSO's), has estimated that reopening enrollment would cost \$366 million. So I hope that we look at the differences among cost estimates and what it means if we continue the ban.

Taking care of veterans is a continuing cost of war. All veterans should have access to their healthcare system. I hope the views of our witnesses will help us have a better understanding of this issue. As I look at the history again, this is rationing of healthcare to veterans, those who have served our Nation. And I think it is unacceptable in a nation of our wealth and our ability to provide for these veterans.

For seconding my views on this issue, I call on the Ranking Member, Mr. Buyer.

[The prepared statement of Chairman Filner appears on p. 52.]

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Thank you, Mr. Chairman. Mr. Chairman, I have a markup today in the Energy Subcommittee, so I probably won't be able to stay for your entire hearing and Mr. Stearns will take over. Knowing that, I have a little longer statement to enlighten you further on my views, Mr. Chairman.

When I spoke on the floor last week during consideration of the VA Appropriations bill, I commended the majority for your strong veterans funding. You have broken ranks with your predecessors, i.e., the previous Democratic majority of the 1970's and 1980's that gave us a VA system that was depicted in the movie, "Born on the Fourth of July," which is not a pleasant picture.

You also have broken ranks with the Clinton Administration whereby they flatlined budgets to this Committee. So Republicans, we are not strangers to budget increases. The VA funding doubled during our majority after decades of these low budgets. So I congratulate you on your veterans funding.

Our experience teaches us, though, that these increases cannot be a substitute for good management. A challenge before this Committee will be to ensure that the VA manages its resources to produce the best possible outcomes for eligible veterans. The values that I have learned in the military have taught me that we care first for our wounded and only then do we consider ourselves. To do otherwise is shameful conduct and contradictory to those values.

During the 2 years that I chaired this Committee, the budgets reflected those values which shape these priorities that we must care for veterans who have service-connected disabilities, those with special needs, the indigent, veterans returning from war, ensure a seamless transition for military service to the VA and provide veterans every opportunity to live full and healthy lives.

Veterans with service-connected disabilities, those with catastrophic disabilities and the indigent are the core constituency, our highest priority, individuals entitled to the highest priority of quality care.

Now, I know, Mr. Chairman, you don't care for the term "core constituency" and we have had this debate over the years, but it is not new. VSO's considering eligibility reform in 1995 used the term "core group." The Veterans of Foreign War has recently also used the term "core constituency" to identify these particular veterans.

Providing core constituency veterans with quality care has been a traditional mission of the VA. Veterans' Healthcare Eligibility Reform, Mr. Chairman, that you referred to, in 1996 established a system of patient enrollments based on priorities in which core veterans were assigned the highest priority.

So when you use the term "rationing," it was almost meant to be a negative term, but when we establish the priority of care, it was set up in a system by priorities to make sure that we care for individuals according to our military values. Care for the non-service-connected veterans and those with higher incomes was authorized only when resources were available, meaning lower priority veterans. After care was opened to Category 7 and later Category 8 veterans, the number of VA patients increased from just under 3 million to over 5 million. VA has not been able to keep up, even with the near doubling of the healthcare budget.

We are now learning that waiting times for appointments are longer than the VA had reported. Core constituency veterans wait longer because of the millions of low priority veterans competing against them for healthcare. This was not the intent of Congress when House Report 104-190 stated, "In designing the enrollment system and providing care, the VA may not enroll or otherwise attempt to treat so many patients as to result in either diminishing the quality of care to an unacceptable level or unreasonably delaying the timeliness of VA care delivery."

VSO's didn't intend this outcome either. Statements by major VSO's at the time of eligibility reform showed widespread support for giving top priority to veterans with service-connected conditions. David Gorman, then the Deputy National Legislative Director for the Disabled American Veterans, referred to "the priority that must be afforded to service-connected veterans before you can go ahead and start taking care of nonservice-connected veterans."

The VFW's National Legislative Service Director, James McGill, warned against the VA being "relieved of its primary mission of caring for those who have sustained injuries while in the service to the Nation." Passage of reform was partly based on VA studies indicating that with third-party collections, it would be budget neutral and, in fact, that it would be revenue enhancing. Reform would encourage veterans to seek preventive care in new VA outpatient clinics, reducing the need for expensive in-patient treatment. And you and I have had this conversation, Mr. Chairman, over the years.

The Congressional Budget Office (CBO), however, believed reform would attract so many enrollees that it would dramatically drive up costs. As it turned out, CBO's predictions have been the

most accurate. My regret at this time is that I did not insist on the requirement to use accepted healthcare management tools such as the enrollment fees and copays and giving the discretion to the Administrations that reflected the true value of the costs of healthcare and giving them the ability to manage the health system.

I did that when I created the TRICARE for Life and I regret that I created a system for military retirees now that is different from that of someone who is a veteran with only 2 years of service, and they don't have the same enrollment fees and copays and deductibles and things like that. So we have a very strange system and we did the job half right.

Congress also gave the Secretary of Veterans Affairs the authority to limit enrollment based on funding. The law required the Secretary to ensure that high priority veterans get the care they need and deserve. In 2003, Secretary Principi, as you said, Mr. Chairman, suspended new enrollments for Priority Group 8 so that VA could fulfill its obligation to core constituency veterans as agreed to by the VSO's in 1996.

Some say the government is obliged to provide essentially free healthcare for life to anyone who served more than 1 or 2 years in the military, so long as they have an honorable discharge. I have concerns about that predicate. The government has long agreed to provide healthcare based on the systems of priority and I endorse protecting the core constituency first.

And earlier when I brought up the issue, Mr. Chairman, with regard to our retirees, the military healthcare for retirees is not free. They must pay the enrollment fees. They make their copays according to their TRICARE plans, and I was really amazed to hear someone I have known for a lot of years, Steve Robertson, with the American Legion, argue against such comparisons between TRICARE and the enrollments, whether there should be enrollment fees and how we compare Category 7's and 8's.

It has been bothersome to me for a long time, because we have this military retiree sitting in a waiting room that has to pay these fees, Sergeant Major, that is different from someone who may have only served one term and they get a better deal. So we have some challenges ahead of us.

The latest *Independent Budget* cites VA data that indicates, and this number, Mr. Chairman, I think is sort of all over the place, how many Priority Group 8 veterans are awaiting admission, pick a number, it seems. I think once enrollment is offered, we have an example, it will open the gates and the surge will come in. Those who think that mandatory funding will increase access and maintain quality, I think ignore the challenges entailed in expanding this system.

Does VA have the capacity to accept millions of new nonservice-connected veterans? Even with this year's funding increase, can VA absorb these new patients? How fast can we build new clinics? Can VA hire the doctors, the nurses and other caregivers when the Nation has experienced a shortage in clinicians? How will communities cope with the siphoning of scarce clinicians with the opening of these clinics?

If we cannot satisfactorily answer these questions, then we have merely raised expectations and I think that is wrong. The VSO's

advocate opening the doors to Priority 8 veterans and simultaneously complain about the waiting times for appointments. But more money isn't the solution. As we have learned, the VA carries over hundreds of millions in healthcare dollars. And for example, in 2005–2006 alone, take the money that we put in on a bipartisan basis for mental health, they couldn't even spend all the money we gave them.

This is not to say that the VA hasn't tried. Over the past several years, the Department has worked hard to manage not only the waiting times, they have opened 800 outpatient clinics and improved collections, but there is still much work yet to be done. We are working to improve the centralization of the IT system. Mr. Chairman, you and I worked jointly together on this, along with other Members of this Committee. We implemented an advanced clinic access program. The VA has provided the priority care to the veterans returning from Global War on Terror. The Department's developed a system of barcoding to reduce medical efforts, but there is still a lot of coding and in-coding challenges.

VA instituted a patient safety program, but a system of electronic health records still has a way to go. And on top of this, the VA's Secretary has told us regarding the medical center directors, he has ordered them to stay open longer to ensure their facilities "are available when veterans need them." Despite these improvements, core constituency veterans are waiting too long, meaning they are being crowded out by the lower priority veterans.

So I am cringing at the moment. I am glad you are having the hearing. We can talk about it. But we better move carefully.

And Mr. Michaud, there is great pressure upon you. You are going to be like the auto mechanic, to make sure that the systems are there and it works and it is prepared to receive, because I know you don't want to recreate the problems that were created when we had the majority, when we opened the doors and didn't prepare a system to receive.

And so I look forward to working with you, but we need to be mindful of the challenge ahead of us. Just don't throw the money and say well, we are going to open it up if we have not prepared the system. And I thank you for your indulgence.

The CHAIRMAN. I thank the Ranking Member for being so clear as to the differences on this panel and for making clear why your side may support a surge when it comes to military action, but we cannot have a surge, in your words, when it comes to treating our veterans.

Is there anybody that wants to make an opening statement on this side? Ms. Brown?

OPENING STATEMENT OF HON. CORRINE BROWN

Ms. BROWN OF FLORIDA. Thank you, Mr. Chairman, and I have to leave also because we have a Transportation and Infrastructure (T&I) markup. I want to thank the Chairman for holding this hearing, long overdue, on the reasons for excluding 1.7 million veterans from the VA system and the promises made when they put their life on the line to defend this Nation.

I am reminded of the words of the first President of the United States, George Washington, whose words are worth repeating at

this time. "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the veterans of earlier wars were treated and appreciated by their country."

President Bush failed to maintain veterans medical care funding over time. The Bush budget asked veterans to pay new and increased healthcare fees and after 2008 cut veterans funding. Over 5 years, those cuts total \$3.4 billion below the level needed to maintain the 2007 level. President Bush's priorities included imposing enrollment fees and increasing copayments for veterans—the budget raises fees on veterans for their healthcare by \$355 million in 2008, \$2.3 billion over 5 years and \$4.9 billion over 10 years.

We, in the Congress, on a bipartisan basis, have rejected it in each of the last 4 years and we will continue to reject these schemes. President Bush can send 484 tons of money, now, that is \$12 billion to Iraq and this \$12 billion cannot be accounted for. Now, \$12 billion is a cruise ship full of one hundred dollar bills. We can't tell you what happened to \$12 billion. One billion dollars would serve these 1.7 million veterans.

So we need to close up the waste, fraud and abuse that has existed in sending money over to Iraq. This House just passed the largest increase in veterans healthcare in the history of VA and what does that President do? He threatens to veto it. I don't believe it. We are going to put it on his desk. What is the priority of President Bush? He threatens to deny coverage to veterans who serve this country, those Priority 7 and 8 veterans who do not have service-connected disabilities rated above zero percent, have an income above \$27,790.

You know, we all, everybody up here, we talk the talk. It is time that we walk the walk. And I yield back the balance of my time.

The CHAIRMAN. Thank you, Ms. Brown.

Mr. Stearns?

OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Mr. Chairman, thank you very much. I might just correct a couple items here. You had mentioned the surge and likened it to this Priority 8 and I am not sure a lot of the Members realize that the Priority 8 was established when Republicans were in the majority. In 1996, the Veterans' Healthcare Eligibility Reform Act was passed and then in 2001 the new Category Priority 8 for veterans was created for those who had served, but who had income or net worth above the VA income threshold.

So, Mr. Chairman, it was under Republican watch. I think it was Chairman Stump who got the legislation passed and the President signed, so it really is a Republican accomplishment in that respect.

I would say to my distinguished colleague—

The CHAIRMAN. Thank you for taking the credit.

Mr. STEARNS [continuing]. Colleague Ms. Brown, that the Milcon-VA Appropriations bill I think the President is going to sign and I, like many of the Members, support increased funding for veterans and we applaud the amount of the increase.

But again, Mr. Chairman, I would like to point out something that all of us, even though we have been veterans or not veterans,

we serve on this Committee. We expect to be accountable and to understand that the dollars that are being spent are spent wisely. Now, you mentioned, Mr. Chairman, that the salary of a veteran is \$27,000, I think you said. But I think the Members should realize that a Priority 8 veteran is a nonservice-connected, his income has to be above the Priority 7, plus it is U.S. Department of Housing and Urban Development geographic means tested that varies based upon where you live.

So the quote you gave of \$27,000 doesn't apply to San Francisco. It does not apply to Boston. It does not apply to New York. Do you know what it is for San Francisco, the means test? It goes up to \$63,400. That is a single veteran. Then when you add that he has one dependent, it goes up another six and it keeps going up. When you talk about New York, it is over \$40,000.

So you are talking about something that is much higher and allows people that are making \$70,000 with one dependent to be eligible. Now, I am not saying that we should not stop that, but I am saying let's be understanding that even the Disabled American Veterans (DAV) have come out to say that they have some concerns. And let me read what they say. "The Category 8 issue is only a symptom of a larger problem and not the source of the problem itself." And they caution us because they say that the budget restraints in the appropriation process and conditions still do not provide the disabled veterans all the funds they need.

Now, these are people that have served, are disabled, are functioning in a limited capability and we should obviously, as Members of this Committee, look at these people first and make sure that all the resources go to these people and not necessarily disadvantage them to somebody who is a Priority 8 with nonservice-connected, no disability, who is making almost \$70,000 a year. Obviously, Secretary Principi was trying to say to us, and it was a very difficult thing for him to do, was to say listen, I want to see the disabled veterans get the money first and then if we can, let's take care of Priority 8.

Having said that, maybe with this new surge in the budget that the Chairman has provided this for, that we can take care of the disabled veteran to the point where the DAV is not feeling that they are disadvantaged, and then we can provide money to the Priority 8. But I do caution the Members that our job is to make the hard choices, not come up here and just continually vote to service more and more programs at the expense of the people who really need it.

So that is the only point I try to make.

Ms. BROWN OF FLORIDA. Mr. Stearns—would you yield for a second?

Mr. STEARNS. Sure.

Ms. BROWN OF FLORIDA. In those categories that you were discussing, the financial area, you do know that our district, the \$27,000 would apply?

Mr. STEARNS. In your congressional district?

Ms. BROWN OF FLORIDA. Not just my congressional district. My congressional district borders your congressional district. So we are talking about our mutual constituents.

Mr. STEARNS. No, and I—we have one of the poorest in—

Ms. BROWN OF FLORIDA. Okay. I just wanted you to know—

Mr. STEARNS. I understand that.

Ms. BROWN OF FLORIDA [continuing]. That we share these constituents—

Mr. STEARNS. You know, from Jacksonville, which is a large city in my congressional district, and yours, we both go through the University of Florida and Gainesville. But we also have portions—I have Bradford County and other counties where obviously this would apply. But again, I think you will agree with me, that we want to make sure the people that need it, get it without any problems and that is what my—

Ms. BROWN OF FLORIDA. Yes. And one other thing, I wish as you are discussing, that waste, fraud and abuse I brought up, the \$12 billion that we can't account for and if we were more conservative with the dollars, then we would be able to serve more veterans and make sure that they have the care that they need.

Mr. STEARNS. Well, I will just conclude by saying, the Ranking Member Buyer made this point well when he talked about all the different problems that exist in the VA and we have been trying—interoperability, transparency, being able to get a hold of IT. I mean he has gone through a litany of these problems that he feels are pretty important to servicing our veterans with not allowing waste, fraud and abuse. So with that, Mr. Chairman, and I ask that my prepared statement, can that be part of the record?

[The prepared statement of Congressman Stearns appears on p. 52.]

The CHAIRMAN. Without objection.

Mr. Hall?

OPENING STATEMENT OF HON. JOHN J. HALL

Mr. HALL OF NEW YORK. Thank you, Mr. Chairman. I also have a T&I markup to go to in a little bit. So let me just say that this Priority 8 veterans situation is one of the things I hear about the most in my district from veterans. I do understand Mr. Stearns' concern and the Ranking Member's concern about being able to provide service for an additional returning group of veterans at the same time that we are trying to bring the waiting times down and the service up for the veterans who are already taken care of.

So I am here to learn and to hear all the various facets of it. But I would just mention that this geographical adjustment that allows the numbers to float from \$27,000 to \$40,000 or higher, in my district, and especially the County of Westchester, one of the five counties I represent, 23 percent of our homeless population are veterans and one of the reasons that might be is that \$40,000 doesn't go very far in Westchester County, nor does it in any of the other counties, and Hudson Valley.

So those numbers might sound like a lot of money, but I think it is all relative and one needs to—and the law is written to try to take in these geographical differences. But I really would like, if we can do this, I would be in favor of providing for our Priority 8's and that is what we are here to learn about. So thank you very much, Mr. Chairman. I yield back.

The CHAIRMAN. Any others on the Republican side?

Ms. BROWN-WAITE. Mr. Chairman?

The CHAIRMAN. Yes. Ms. Brown-Waite?

Ms. BROWN-WAITE. I did prepare a statement which I would ask unanimous consent to be able to submit.

The CHAIRMAN. Without objection, all written statements will be made a part of the record.

Ms. BROWN-WAITE. I appreciate that very much. Thank you.

[The prepared statements of Congresswoman Ginny Brown-Waite, Congressman Miller and Congressman Mitchell appear on pgs. 53 and 54.]

The CHAIRMAN. Thank you. Mr. Hare?

OPENING STATEMENT OF HON. PHIL HARE

Mr. HARE. Thank you, Mr. Chairman. I too have a markup here in a few minutes. I admit to being new on this Committee and I understand there has been terms to describe me such as youthful, exuberant and, but you know, I just want to make myself very clear when it comes to this issue. The reason that I am on the Committee, it seems to me, is to do everything I can as a Member of Congress to provide benefits for every veteran this country has. I don't care whether you are a Filipino veteran, Merchant Marine veteran, whether you happen to fall into this particular category that we are talking about today.

And I would just have to say to my friends across the curve here, and I repeat this often. The question I think that we should be handling here, Mr. Chairman, is not can we afford to do these things. The question is, the statement is we can't afford not to do these things. We make promise after promise after promise to different groups and yet we don't keep them. We are told we don't have the money. We do have the money. We don't have the will, it seems to me, and we don't have a President, but that will change, to get somebody to stand up for our Nation's veterans.

If you put people in harm's way, you protect them from the minute you send them to the minute they come home and beyond. That is what we are supposed to be about. The VA estimates that lifting the ban would result in approximately 1.6 million veterans seeking healthcare. Well, that is just a tragedy. You know, woe to the poor VA. Last year, Democrats estimated it would cost \$341 million, including subtracting estimated collections to lift the enrollment ban.

And again, I know this may not seem like a lot of money to my friends, but again, I still, with all due respect, shake my head and wonder when we talk about, well, we have to make sure we have the money, but we doled out almost, the VA doled out almost \$4 million of their money to give benefits to people that most of them didn't even have coming from my perspective.

And I am angered by this because I—we had bills yesterday that came up. We had a VA person come up who couldn't answer us when these bills were going to—the VA hadn't even taken a look at them yet, and they were to help widows. And they were to help people who had been injured, a person who lost his leg on a aircraft carrier in a training episode and the VA sits and tells us we will get back to you when the time is right for us.

Well, the time for us now, Mr. Chairman, I think is now. And there are people that try to live on \$27,000. They are not high in-

come. And those who are combat decorated are shut out of the system because they make as little as \$27,000. My statement, again I go back, and I will continue to say this as long as I serve on this Committee and I support legislation to help veterans and I will continue to do that. This is not whether or not we can afford to do this. This is we cannot afford not to do this.

And every time we have a piece of legislation that I believe is in the best interest of veterans in this country, I am not going to ask how much is it going to cost. I am going to want to know how many veterans are going to be served by what we do here today. That is how we should be judged, not on a dollar and cents basis. I think that when we start doing that to our veterans, I think we diminish their service, because if you are serving—I don't know what the pricetag is for that widow who lost her husband in the United States Marine Corps.

I have to make a call today to a mother who lost her son in Afghanistan. What is the price? I think enough of this whether or not we can afford it. And I will say to you, Mr. Chairman, I will continue to work on this stuff. But I applaud you for being steadfast in this and for standing up for what you believe in. And you know, we are going to have battles on this Committee and we will have disagreements on this Committee. But those disagreements should never be over whether or not we think we have the cash available to help any group of veterans out that served this country.

And with that, I just want to say to the Priority 8 veterans from my perspective, you have these benefits coming and we are going to work very hard to make sure you get them. To our Filipino vets, to our Merchant Marines and to our other people, I am not going to quit working and this Committee is not going to quit working until we provide the benefits that we promised people over 60 years ago.

And with that, Mr. Chairman, I thank you and I yield back.

The CHAIRMAN. I thank the gentleman.

Mr. BOOZMAN. Mr. Chairman?

The CHAIRMAN. Mr. Boozman?

OPENING STATEMENT OF HON. JOHN BOOZMAN

Mr. BOOZMAN. I would just—and again, I don't disagree with what Mr. Hare is saying or the sentiment that he is expressing. On the other hand, one of the things that we have worked really hard to do as a Committee—and everybody that is on this Committee, this certainly is not, we are not here for the glamour of the Committee or whatever. We are here because we want to help people and want to help veterans.

But one of the things that we have really worked hard, and I think Congressman Stearns was alluding to this and Mr. Buyer and others, but we have really worked hard to get our wait times down. That is the other thing that veterans get so frustrated, those that are in the system, you know, having to wait for appointments. But I think at the very least—and again, I am sympathetic. But in looking at the potential of going forward, then I would think that we probably want the VA to come up with a plan and tell us what kind of staffing we are talking about.

What would that do to wait times? How would you—what kind of facility increase and things as you put hundreds of thousands of people in the system, because again, I think we can be very proud that—we have two problems. We want to serve as many people as we can. On the other hand, those that we do serve, we want to do a very good job of serving. And that has not always been the case in the past.

And to the Committee's credit, working together in a very bipartisan way, I think we have worked very hard on that and we are continuing, I think we are going to continue to work on that under Mr. Michaud's leadership, to continue to get our wait times down. But that is a real problem.

So I would encourage, just like I said, at the very least, we need something from the VA as to how this would affect the system. Thank you.

The CHAIRMAN. Thank you, Mr. Boozman.

OPENING STATEMENT OF HON. TIMOTHY J. WALZ

Mr. WALZ. Well, thank you, Mr. Chairman, and to the Ranking Member. And thank you, all the witnesses. I know we are here to hear you. And Dr. Woolhandler, thank you for your patience. It is you that we are here to hear. This is a very complicated issue and you hear the passion on both sides. The one thing that is consistent amongst the people up here and with each of you is how best to treat our veterans, how best to ensure that they get the care that they so richly deserve and this Nation has an obligation to provide.

I am glad to hear my colleague from Florida discuss the Disabled American Veterans and their concern about Priority 8. And I know when our friends get up here and discuss that, they will take that, to which I think they are probably right on, the next step on this is full funding, mandatory funding. So you can't have half of that argument without making the second half of their argument, which is don't just go with the Priority 8's. We need to get this all the way right with the full funding.

So I hope my colleague will embrace that along with me. And I agree with my colleagues. There are limited amounts of resources and it is very, very clear that when you make a budget, it is a monetary exercise in terms of balancing a budget sheet. But the second part of that is, it is a moral imperative, an ethical imperative.

And make no mistake about it, when we create a budget, what we are doing with those limited amounts of resources is prioritizing our collective values as a nation. And I do not disagree that you must balance it. I am absolutely adamant making sure with PAYGO and making sure we balance our budget. It is very difficult for me, though, when you put all of these things out there on the budget sheet, be very clear about what you are saying yes to and what you are saying no to.

It is very difficult for me to justify throwing Priority 8 people off of the rolls when we have the most massive tax cuts to the wealthiest amongst us, at a time when we are doing that, when we have massive subsidies to oil and gas companies at the same time we are telling veterans we don't have the resources to accept them.

I will agree and absolutely adhere to the policy that there is limited resources that must be allocated according to our Nation's pri-

orities. My difficulty is when people prioritize those other things over what I believe is in the best interest of this Nation, not just morally taking care of our veterans, but from a security standpoint.

So I thank you. I don't want to take up any more of our distinguished witness' time and I hope you can help enlighten us how we can best do this and serve all of our veterans.

So I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Walz. And we will use that as an introduction to our panelist, Dr. Stephanie Woolhandler, who is Associate Professor of Medicine at Harvard Medical School and Co-Founder of Physicians for a National Health Program. We thank you for being here and look forward to your testimony. We hope you will summarize your written statement which will be made part of the record, in about 5 minutes and then we will be asking you questions.

**STATEMENT OF STEPHANIE J. WOOLHANDLER, M.D., M.P.H.,
ASSOCIATE PROFESSOR OF MEDICINE, HARVARD MEDICAL
SCHOOL, AND CO-FOUNDER, PHYSICIANS FOR A NATIONAL
HEALTH PROGRAM**

Dr. WOOLHANDLER. Okay. Well, in my written testimony I am going to present, I detail information on health insurance coverage and problems and access to care for America's veterans. But all of this is data based on Federal studies, surveys carried out annually, one by the Census Bureau, and this is a 2005 Census Bureau data, and the other one, the National Health Interview Survey. So it is mostly going to be about the data on how many veterans are actually uninsured.

We are going to find out how many veterans are uninsured and also, do these uninsured veterans suffer the same kind of problems and access to care that other uninsured Americans suffer. Okay.

So based on the Census Bureau's 2005 data, in 2004 there were 1.8 million military veterans who had neither health insurance, nor ongoing care at Veterans Health Administration's (VHA) hospitals. Now, you have to note the survey did ask veterans if they had health insurance and if they had veterans or military healthcare. And we counted them as uninsured only if they answered no to both questions, that is, they had no insurance, they had no veterans or military healthcare.

The number of uninsured veterans was 1.8 million and it had increased by nearly 300,000 since 2000. The proportion of non-elderly veterans who are uninsured rose from less than one in ten in 2000 and is currently one in eight. One in eight non-elderly veterans has no health coverage. An additional 3.8 million members of veterans' households were also uninsured and of course, they are going to be ineligible for VA care.

And then when we looked at who these uninsured veterans are, we found that virtually all Korean War and World War II veterans were covered by Medicare. They are over the age of 65. However, among Vietnam-era veterans, there were nearly 700,000 who had no health coverage. Among veterans who served in other eras, which would include the Persian Gulf War, 12.9 percent, 1.1 million veterans had no health coverage. So people are returning from

the Persian Gulf, 1.1 million of them have no health coverage when they get back.

Almost two-thirds of the uninsured veterans were employed and nearly nine out of ten had worked in the past year. So these are indeed working Americans. Most uninsured veterans, like other uninsured Americans, are working. Many earn too little to afford health insurance, but too much to qualify for the means test at the VA or obviously from Medicaid.

Now, uninsured—when we looked at the problems that people had getting care, it turned out that uninsured veterans have the same problems getting care they need as other uninsured Americans. Moreover, many of them have serious illnesses that should be getting medical care from doctors like me.

Among uninsured veterans older than the age of 45, nearly one out of five were in fair or poor health, so they had health problems. And nearly one in three uninsured veterans of all ages had at least one chronic condition that limited their ability to function. A disturbingly high number of uninsured veterans reported needing medical care and not being able to get it in the past year. More than a quarter of uninsured veterans failed to get needed care due to cost. Thirty-one percent had delayed care due to cost. And among uninsured veterans, 44 percent had not seen any doctor or any nurse within the past year, and two-thirds said they got no preventive care anywhere.

By almost any measure, these uninsured veterans had as much trouble getting healthcare as any other uninsured American. And that is the data part. And now I am going to get to the opinion part of what I am going to say.

We believe the Veterans Health Administration is a rare success story in the American healthcare system. Currently the VA offers more equitable care and higher quality care than the average care in the private sector. And I have provided citations for that, several studies, scientific studies comparing care, show higher quality in the VA than the average care in the private sector. And the VA has become a medical leader in research, primary care and computerization.

And while we support opening VA enrollment to all veterans, this would still leave many veterans unable to access care because they live far from VA facilities. Moreover, even complete coverage of veterans would leave 3.8 million of their family members uninsured. Hence, my colleagues and I support a universal national health insurance program that would work with and learn from the VA Health Administration system in covering all Americans.

Any questions?

[The prepared statement of Dr. Woolhandler appears on pg. 54.]

The CHAIRMAN. Thank you. How would you, Doctor, respond to the basic issue raised by the Republican side here that you have just got to go with core constituencies which has no basis in law, as far as I know, by the way, that term, and other people will suffer if we allow, if we open the system up to more—

Dr. WOOLHANDLER. Okay. Well, I am a physician and when I think about priorities, I think the sickest people have the most priority. So a sick person to me has a priority, whether they earn \$28,000 or \$26,000 a year. The priority is to take care of sick peo-

ple and what our data is showing is that many veterans have no coverage and they are sick and need care and can't get it.

The CHAIRMAN. Okay. Questions from those who didn't have opening statements? Ms. Brown-Waite, did you have any questions?

Ms. BROWN-WAITE. I would just like to ask the doctor, certainly you are a proponent of universal healthcare. So if there is universal healthcare, do you see also the need for the VA healthcare system, or do you envision it all being under one universal healthcare?

Dr. WOOLHANDLER. Okay. Well, the VA has turned into a leader in American medicine. It wasn't that way when I went to medical school. But in the years I have been practicing, it has gone from, if you will, something of a backwater of American medicine to a real leader. Their computer systems are the best. Their quality is the best. So I think a national health insurance system should build on what is best in American healthcare and that is why I think the VA should and would continue to exist as an option with some sort of national health insurance system.

Ms. BROWN-WAITE. So your concept would be universal healthcare for everyone in America and simultaneously the VA system to be there and to expand because of its excellence?

Dr. WOOLHANDLER. Yes.

Ms. BROWN-WAITE. Because we hear so many people tearing down the VA healthcare system, and certainly as a doctor you know there are errors made, unfortunately, every place, because it is a system that is carried out mostly by human beings and so there are certainly medical errors and bad judgment that takes place, whether it is in the VA or whether it is in the proprietary hospital setting.

But, so your concept is to have a VA run healthcare system along with universal healthcare?

Dr. WOOLHANDLER. Okay. Yes, it is—I don't work for the VA. I don't work in a VA hospital. What I am reporting is actually the scientific evidence that has come out in the medical literature over the last 5 years or so which does show that the quality is better at the VA than the average in the civilian sector. National health insurance would give people their choice. They could go to a private hospital, a public hospital, a VA hospital. But if people are smart, they would take the national health insurance and in many instances choose VA care because the data is that the quality at the VA is at least as good, in many cases better, than civilian sector.

Ms. BROWN-WAITE. You are absolutely right. I have a huge, I have the second highest or the highest number of veterans of any Member of Congress. Representative Miller from the panhandle and I, each year we go back and forth as to who has the highest number of veterans. And I can tell you that my veterans are very, very supportive of the VA healthcare system, because they know that the quality exists there.

I yield back the balance of my time.

The CHAIRMAN. Thank you.

Ms. HERSETH SANDLIN?

Ms. HERSETH SANDLIN. Thank you, Mr. Chairman. Just maybe a couple of questions. I understand there is a followup study that you and your colleagues have been undertaking; is that correct?

Dr. WOOLHANDLER. Yes, there is. These numbers that I gave today are the most recent numbers.

Ms. HERSETH SANDLIN. Okay.

Dr. WOOLHANDLER. But there is a full publication coming out this December.

Ms. HERSETH SANDLIN. And are there any trends that you have been able to identify or changes? I know there are some statistics here about half of the uninsured veterans in the survey had incomes that would make them completely ineligible for VHA enrollment because of the Priority Group 8 freeze. What changes have you been able to determine for those Priority Group 8 veterans that were able to enroll prior to the freeze, their access to primary healthcare and to outpatient services as it relates to annual appointments with doctors and preventive care? Are you doing anything to compare the relative health of those Priority Group 8 veterans versus those that are uninsured that are Priority Group 8 that didn't get access to the veterans, to VHA?

Dr. WOOLHANDLER. Okay. The Census Bureau is not detailed enough for us to figure out precisely who is a Priority 8 and who isn't. Specifically, we don't have any information in the Census Bureau about assets. There is an assets test. And so we can just be kind of approximate. But things have not changed. That is, about half of uninsured veterans have incomes above 250 percent of poverty and that hasn't changed over the years. And virtually none of them would be eligible other than as a Priority 8. They would flunk the means test because of their income.

Ms. HERSETH SANDLIN. I appreciate the response.

Mr. Chairman, I would just suggest that perhaps working with the doctor or working with those that we meet with on a regular basis, with the veterans service organizations or officials in the VA, that it would be, I think, worthwhile to inquire as to a study—my concern here, separate from the equity issues and some of the statements made by my colleagues at the outset, is the issue of access to primary healthcare and the importance of cost savings over time of annual doctor's appointments and preventive care and whether or not we can get an analysis of the healthcare received by Priority Group 8 veterans who got into the system before the freeze versus a subset of Priority Group 8 veterans who are uninsured and not getting access to that type of primary healthcare, to help make the case about the importance of having access to the system, understanding as most of the veterans I talked to who are Priority Group 8, that service-connected disabled veterans who are lower income are first in line, but they shouldn't be disallowed from even getting into line. And it might be something that would help shed light on the importance of the access to care.

I thank you and I yield back.

The CHAIRMAN. Thank you very much. Any questions on this side?

Mr. Buyer?

Mr. BUYER. Thanks. Mr. Chairman, you mentioned about the reference to core constituency, you are correct, is not in law, but looking at the eligibility reform, it sets out for the Secretary the priorities of care that we all know about. There is even a provision in here that says in the case of a veteran who is not described in the

above paragraphs, the Secretary has the extensive resources and facilities available and subject to the provisions of F and G, has furnished hospital care, medical services and nursing home care which the Secretary determines to be needed. I just wanted to let you know that when you say it is not in law, it is in law.

To the witness, I would just like for you to know that when you come to Congress and you want to present your paper, it was one of the most challenging things for me to get beyond your title. You titled it "Stains on the Flag" to promote your view of a social policy for a national healthcare system. Very challenging for me to get beyond the title—I just want you to know that, very difficult and challenging to me, especially coming—now I will give you this view—from Harvard, from Harvard that has a faculty with an anti-military bias, so much so—let's see, Harvard, you don't even allow ROTC.

You don't allow military recruiters on your campus. But that same Harvard, let's see, you take the money. You take students who go to Harvard who have ROTC, who will pay the money, but they have to go to class at MIT. And you will take DoD grants because you want the money to enrich your school.

But there is this 1960's style of anti-military bias that still permeates at Harvard. And when you come here and you title your paper about a stain on the flag, I just want you to know, to me as a veteran who served my country for 27 years in uniform, in war and in peace, I can't get—it is hard for me to get beyond the title when I look at Harvard as an intolerant institution at times. So I just share that with you.

Dr. WOOLHANDLER. Okay.

Mr. BUYER. It was challenging for me. But I dove into this. And so I just want to share with my VSO colleagues that are here, all right, we weren't so crazy after all. All of our offsites and things, where I went and shared with you that there is a huge challenge here, a philosophical difference between those who believe in a private health system versus those who believe in a national health system or single-payer system.

And that is why the Chairman has this witness here. And I don't question the Chairman's sincerity. He told me in our budget hearing 2 years ago, I want the VA to be there to open up to all veterans and their dependents. And so it is a bigger puzzle in the national health insurance pie and that is a reality that we have to challenge, that we have to struggle with, that I am going to try to struggle with.

But I just want to end with this. One thing that we didn't talk about in our opening statements—that was a very good dialogue, Mr. Chairman. I am glad you allowed that to happen, because we also have all this influx of our veterans who are returning from the war and we just, you know, we just voted here to open it up for 5 years, which is even more.

So it is about preparing the system to receive them and we have been challenged here over the years in preparing that system and I think that is when the Secretary closed off the 8's. And he closed off the 8's thinking that we could be a good mechanic—and I wish Mr. Michaud were still here—on all these systems' analytical ap-

proaches and working with the VA and then we end up ourselves in a war.

And that was one of the reasons we wanted to give discretionary authority to the Secretary, because we couldn't foresee what would happen into the future.

But thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Buyer.

Dr. WOOLHANDLER. I just want to respond to that.

The CHAIRMAN. Please.

Dr. WOOLHANDLER. With all due respect, sir, I think you are changing the subject. This hearing is actually not about Harvard. This hearing is about 1.8 million uninsured veterans. And I grew up in Shreveport, Louisiana. I have lived in a lot of different places. And it breaks my heart to see veterans come in and not have any health coverage. People come in, they haven't had their blood pressure taken care of. They haven't had their diabetes taken care of. They are selling their homes in order to pay for medicines. And they are veterans. But they just can't get access to the VA care. And the VA should be an important safety net for my patients and it is not. And I do consider that a stain on America's flag.

The CHAIRMAN. Thank you.

Mr. Rodriguez?

Mr. RODRIGUEZ. First of all, let me thank you for being here with us today. And I wanted to ask you, we haven't been able, apparently as a nation, haven't had the will or the votes to be able to come up with any form of universal healthcare. So we have tried to go after it incrementally. So looking at it from an incremental perspective, do you have any suggestions as to how we can deal with—I know we have some 46, 48 million Americans uninsured. But for those veterans, that 1.7 or 1.8 million that are out there, what approaches might there be—I know we have the State Children's Health Insurance Plan (SCHIP). Maybe we could include the parents of those veterans as part of that SCHIP program that takes care of their kids and includes the parents and provides some kind of access to healthcare to maybe veterans, where we could include them, if nothing else. If we don't include the rest, maybe we could do that. And I wonder if you have any other options there, any other alternatives in terms of approaching it incrementally and trying to cover our veterans.

Dr. WOOLHANDLER. Okay. Well, the VA has become a safety net for low-income and middle-income people. Most have been male. The SCHIP and Medicaid programs have primarily served children and women. While we support national health insurance, we also support maintaining a safety net for the time being. I think clearly the most straightforward way to provide a safety net for veterans is through the VHA system. The SCHIP program has not been very successful in enrolling men.

The CHAIRMAN. Is your microphone on, Mr. Rodriguez?

Mr. RODRIGUEZ. It isn't. Is there a possibility of maybe looking at some options that allow, for example, some kind of a program that ties them to the VA and their families if they are uninsured? We have been able to come up with Medicare for our seniors, Medicaid for our indigent, the SCHIP for those uninsured kids. But maybe we ought to come up with a program that is just for vet-

erans period and their families that could be comprehensive in nature, that if they join the military, that is maybe something that they can bet on and where they could participate, maybe something similar to TRICARE that is out there right now that could be comprehensive, and, at least that population could have some degree of access, and especially their families, because right now their families are not included in that. Has anybody given some thought in that area?

Dr. WOOLHANDLER. We have mostly given thought to the idea of national health insurance that covered everyone, nonprofit national health insurance.

Mr. RODRIGUEZ. But as you heard from the Ranking Minority Member, there are a lot of people who feel that way, for us to be, we haven't been able to pull it off and historically we haven't, and that would be the ideal. But in the meantime, what do we do?

Dr. WOOLHANDLER. Okay. Well, I think you do need to defend the pieces of the safety net that you can defend and for this Committee that would be the Veterans Health Administration by making sure the funding is adequate to take care of all veterans in need and get rid of the problem of 1.8 million uninsured veterans. I personally think that is unacceptable in any system.

Mr. RODRIGUEZ. And I agree with you. But I am more concerned about them and their families—

Dr. WOOLHANDLER. Mm-hmm.

Mr. RODRIGUEZ [continuing]. And their kids.

Dr. WOOLHANDLER. Yeah. Well, the problem with trying to extend coverage without national health insurance has to do with the question, how are you going to pay for it? The idea behind national health insurance is you get tremendous savings through administrative simplification. So by having a single payer like Social Security or Medicare, if you will, and expanding Medicare, you get tremendous administrative savings. We estimate that you could cut the administrative costs from about \$700 billion a year to \$350 billion a year in the U.S. and then you use the savings to cover people.

If you try to cover people without going to a national health insurance model, you don't get the administrative savings and you have to come up with more money.

Mr. RODRIGUEZ. And I agree with you, because I know that when the other side pushed the privatization of Medicare and Medicare Plus versus straight Medicare/Medicaid to the taxpayers, they sold it to us that it was going to be cheaper, but as we all know, the Medicare Plus, even though they pay \$300 out of their own pocket, to the regular taxpayer it still costs us more. So it hasn't worked and so I am hoping we can come to grips with that.

Thank you.

The CHAIRMAN. Thank you, Mr. Rodriguez.

Mr. Stearns?

Mr. STEARNS. Doctor Woolhandler, thank you for being here. I know how busy you are. We don't want to take a lot of your time because we have other witnesses. But I did want to just clarify a couple things.

You had indicated that obviously you support universal health-care. You are the Co-Founder of Physicians for a National Health Program, as I understand it.

Dr. WOOLHANDLER. Yes, but I am mostly here to present this data. I don't know that I was brought primarily to express my opinion, but—

Mr. STEARNS. Well, the difficulty is, because of your desire for universal healthcare, that would influence how you felt about veterans. For example, you have indicated to my colleague from Florida that you would like to see a universal healthcare. So my question to you, if I am a veteran in the veterans program, under your understanding of a universal healthcare, would I as a veteran have a choice to stay in the VA or would I have a choice to have my private doctor in this universal healthcare system that you advocate?

Dr. WOOLHANDLER. Absolutely. Under national health insurance, everybody gets a card like a Social Security card and they can use it at any doctor or hospital. So if they want to go to a private doctor, they can. If they want to go to the VA, they can.

Mr. STEARNS. Okay. So you advocate giving all veterans a choice, so they could—

Dr. WOOLHANDLER. Giving all Americans a choice, yes.

Mr. STEARNS. So veterans could opt out of Veterans Affairs and go to the private, to this universal healthcare that you advocate; is that correct?

Dr. WOOLHANDLER. Well, they will have insurance which would allow them to do that. As you are probably aware, most of the veterans who use the VA actually have some form of health insurance. So many people who do have a choice about where to go end up going to the VA.

Mr. STEARNS. But isn't it possible, would you perhaps comment on the fact that if you do that, that we might—deterioration of the Department of Veterans Affairs because a lot of these people would opt out and it might in a sense, the Veterans Affairs medical system would deteriorate because a lot of these people would be leaving. Is that a possibility?

Dr. WOOLHANDLER. I don't actually think that is true, because one of the things you would want to do is provide people better information about where the quality programs are. People are often very confused and they assume that private is always going to be better. But if they have good, solid information, scientific information that compares quality, I think they will see that the current standard is that Veterans Affairs is at least as good as the private sector, and by many measures higher quality than the private sector.

So I am not very worried about the VA shriveling up and dying. I don't think that is going to happen if people get good, accurate information.

Mr. STEARNS. So it is your universal—

Dr. WOOLHANDLER. A lot of it—the Member was talking about the primary care system at the VA is excellent. The drug coverage system is excellent. The computer system is excellent, better than most of what is out there in the private sector.

Mr. STEARNS. I will just tell you that the staff told me that the DAV does not share your idea that if that occurred, they think there would be deterioration. But let me just go on here.

Dr. WOOLHANDLER. I am sorry. Who is that who didn't—

Mr. STEARNS. Disabled Veterans Association.

Dr. WOOLHANDLER. I—

Mr. STEARNS. The DAV.

Dr. WOOLHANDLER. That may be—

Mr. STEARNS. I don't expect you to know. Let me ask you this—

Dr. WOOLHANDLER. No, I have heard of them, of course. I just didn't know their opinion on this particular issue.

Mr. STEARNS. Right now a veteran's family is not covered. Would you advocate, in addition to the Priority 8, would you say, for example, a family of four, a veteran who is a Priority 8, that both his wife and his four children should also be covered in terms of your advocacy?

Dr. WOOLHANDLER. Okay. Well, we did identify 3.8 million family members of veterans who have no health coverage.

Mr. STEARNS. Is this under Priority 8, what you are talking about?

Dr. WOOLHANDLER. No. That is, that is all priorities.

Mr. STEARNS. Let's focus just on the Priority 8.

Dr. WOOLHANDLER. As I mentioned before, the data from the Census Bureau doesn't actually tell us if they are Priority 8 or Priority 7, for instance.

Mr. STEARNS. Well, forgetting the data, in terms of your advocacy, if there is a Priority 8 that has, that is married and has two children, would you advocate that the VA cover the wife and the two children?

Dr. WOOLHANDLER. I would advocate that they be covered in a national health insurance program. Covering them in the VA is not something we have advocated. That might be reasonable as a stop-gap measure, but that is not something our group has advocated.

Mr. STEARNS. Okay. And, when I got back to my opening statement, in Boston the threshold is, for a Priority 8 is \$84,100 for a family of four. And so with an income that high, I think both the service organizations and others are saying the long waiting list that we have trying to get veterans in, and we have a lot of veterans coming back who are disabled, who are harmed or have post-traumatic stress disorder (PTSD), and the dollars can't seem to flow there, do you think sometimes in your mind's eye, isn't there a case where there is a priority of one veteran group getting at least service completely before another or are you saying whatever it takes, we should make sure that all the Priority 8's get service with a person who comes back with post-traumatic stress disorder?

Dr. WOOLHANDLER. We were able to look at where most uninsured veterans live, because that is very clear in the Census Bureau data. And they don't mostly live in high-cost cities like San Francisco or Boston. Most of them live in the American southeast, in rural parts of the country. So picking and choosing high-cost cities and paying attention to those cut-offs is not actually going to tell you the reality that most veterans face. Most of them live in areas where the cut-off is closer to that \$27,000, \$28,000 a year.

Mr. STEARNS. No. I think that is a valid point, yeah.

On that, Mr. Chairman, thank you.

The CHAIRMAN. Thank you. Are there further questions for the panelist?

Mr. Miller?

Mr. MILLER. Thank you, Mr. Chairman. Tagging on to what my colleague just asked, first of all, I apologize for being late. I am going through your resume as well, and how many times have you testified before Congress?

Dr. WOOLHANDLER. I think this may be the first time. Our organization has testified—

Mr. MILLER. No, you.

Dr. WOOLHANDLER. Personally?

Mr. MILLER. Yes, it just said you—

Dr. WOOLHANDLER. This might be the first.

Mr. MILLER. It just said you have spoken to several congressional conferences and Committee meetings. I just wanted to help you understand, we know what you may have been called here to talk about, but sometimes Members of Congress would like to talk about other things.

Dr. WOOLHANDLER. Well, that is fine. That is fine. Okay.

Mr. MILLER. You also, in your resume, say that you brief Members of Congress and Presidential candidates of any party. Can you tell me what Presidential candidates currently running for office you have been briefing lately?

Dr. WOOLHANDLER. Lately?

Mr. MILLER. Well, in this, in the 2008 campaign.

Dr. WOOLHANDLER. The only one I have briefed so far who is declared in the 2008 is Kucinich. In previous years we have briefed a variety of Democratic candidates. I don't work for them and I don't lobby, but—

Mr. MILLER. Well, you said that you briefed any party, and I am just trying to find out which Republicans you have briefed.

Dr. WOOLHANDLER. Well, any Republican who calls me and wants information, I would be happy to speak with them.

Mr. MILLER. That is not what your vitae says. It says you have briefed them, and I just wanted to know who they were.

Dr. WOOLHANDLER. I was a congressional health policy research fellow here in 1990–91, and I met with several dozen Congressmen and if you—

Mr. MILLER. You can't remember any names?

Dr. WOOLHANDLER. If you would like, I can get you the names.

Mr. MILLER. Okay.

Dr. WOOLHANDLER. I would have to go over my calendar—

Mr. MILLER. Okay. Yes.

Dr. WOOLHANDLER [continuing]. And get that, but that is already, you know, 15 years ago.

Mr. MILLER. Well, you feel strongly enough to put it in your resume. I would just like to know other than Mr. Kucinich, who you have been briefing. Now—

Dr. WOOLHANDLER. Okay. You asked the 2008 year and that would be—

Mr. MILLER. Well, you decided to go back to 1990, not me, you did.

Dr. WOOLHANDLER. Okay.

Mr. MILLER. Would you—

Dr. WOOLHANDLER. The vitae——

Mr. MILLER. Excuse me. That is all I need to know.

Dr. WOOLHANDLER [continuing]. Covers my career. Yes, okay.

Mr. MILLER. For the record, if you would provide that for me.

Dr. WOOLHANDLER. Mm-hmm.

[The following was subsequently received.]

Here is what I could glean from my records (and memory) regarding national level politicians whom I have briefed. My records do not include a complete list of attendees at meetings with multiple attendees, and all of my calendar records from 1992 have been lost. Occasionally, meetings occurred on short notice, and would not have been recorded in my calendar.

I have had meetings with Senators Sanders, Wellstone, Kohl, Rockefeller and Daschle. I have met with Congressmen Pete Stark and Jim McDermott. While I worked with Senator Paul Wellstone and Congressman Bernie Sanders, I participated in briefings for the delegations from Minnesota and Vermont respectively. I was keynote speaker at a conference in Shreveport, Louisiana, organized by Republican Congressman Jim McCrery, who attended along with several other local politicians. I spoke at a similar event organized by then-Congressman Sanders in Vermont. I have met with most of the Congressmen and Senators in the Massachusetts delegation at one time or another, and have spoken at town meetings that they have sponsored in different parts of the State. I presented information on national health insurance at a meeting sponsored by Congressman John Conyers which was attended by 14 Members of his Committee (at the time, Government Operations). I have spoken at two other briefings on the Hill organized by Congressman Conyers, most recently in the House Judiciary Committee room. Several Congressmen (whose names I do not have on my records) were present at each. One of the Congressmen at the most recent briefing identified himself as a Republican. During their campaigns for the Presidency (various years), I met with Jerry Brown, Bill Clinton, Ralph Nader, Jessie Jackson, and Dennis Kucinich. I have met with Hillary Clinton, although not during this campaign season. In addition, I spoke at two congressional briefings in 1991, one attended by five Congressmen and about 200 congressional staff. The second briefing was attended by about 80 congressional staffers, but there were, to my knowledge, no Members in attendance. I recently spoke at a meeting of the Kentucky Medical Association, which was attended by the recently elected Congressman from that district.

Mr. MILLER. Back to Mr. Stearns' question, do you advocate getting rid of all of the categories, 1 through 8, within the VA system?

Dr. WOOLHANDLER. I don't have a specific position on that. My position is everyone should be eligible for all the medical care they need.

Mr. MILLER. Should they be treated equally?

Dr. WOOLHANDLER. I think they should all get full access to care.

Mr. MILLER. Should they be treated equally?

Dr. WOOLHANDLER. I think they should be treated equally in terms of their access to medical care. There may be access——

Mr. MILLER. That is not what I am asking.

Dr. WOOLHANDLER [continuing]. To other——

Mr. MILLER. Again, that is not what I am asking. Their access to care is one thing.

Dr. WOOLHANDLER. Mm-hmm.

Mr. MILLER. When they get access, should they be treated the same?

Dr. WOOLHANDLER. Yes. I think that is—well, my understanding is that is the current policy in the VA. Once you are enrolled, you have equal access.

Mr. MILLER. Category-wise, 1 through 8, who comes first?

Dr. WOOLHANDLER. Okay. It is my understanding that the categories are about enrollment—

Mr. MILLER. I know how it works.

Dr. WOOLHANDLER [continuing]. And once you are enrolled—

Mr. MILLER. What do you advocate?

Dr. WOOLHANDLER. I think I advocate equal access to medical care for everyone—

Mr. MILLER. Okay.

Dr. WOOLHANDLER [continuing]. Including all veterans throughout the VA.

Mr. MILLER. I think based on your extensive writings about the Canadian healthcare system, am I correct that you write extensively about their universal healthcare system? Could you explain to me—

Dr. WOOLHANDLER. I most—

Mr. MILLER. No. My question—

Dr. WOOLHANDLER. I mostly write comparisons of the U.S. and Canada. I am not—

Mr. MILLER. Could you explain to me, please, while I ask the questions, how do the Canadians deal with their veteran population? How do they handle the healthcare for their veterans?

Dr. WOOLHANDLER. Well, every Canadian has a card like a Social Security card that they can use to go anywhere they want.

Mr. MILLER. Veterans?

Dr. WOOLHANDLER. Yeah, I am not—

Mr. MILLER. Do they have a VA system?

Dr. WOOLHANDLER. I am not sure. I can look that up for you.

Mr. MILLER. Let me, let me tell you—

Dr. WOOLHANDLER. But they can go anywhere they want.

Mr. MILLER. My time is about to run out. Let me explain how the Canadians do it. They don't have a VA. They buy slots within their system. I know you are hoping it will turn to red, but they will buy slots within their system for veterans. So veterans go in the same system everybody else goes in.

I think that is what my colleague, Mr. Stearns, was saying. We do have some very strong concerns with universal healthcare and what it will do to the VA system, because to cover people universally, that money is going to come from somewhere. I believe that you are talking about putting veterans in the same healthcare system with everybody else, and I don't think you will find that the veterans service organizations think that is a good idea.

If anybody would like the rest of my time—

Ms. BROWN-WAITE. Would the gentleman yield?

Mr. MILLER. I have just run out of time.

Ms. BROWN-WAITE. Would the gentleman—

Mr. MILLER. I am sorry.

The CHAIRMAN. Okay. Again, the hearing is on Priority 8 veterans, not on national healthcare. But we have—any final questions?

Ms. Brown-Waite, would you like to ask the panelist a question?

Ms. BROWN-WAITE. Following up on my colleague's statement about Canada and questioning about Canada, before Dr. Boozman left I told him that I was on vacation and met a doctor from Canada who had a heart attack and he happened to have it in Florida.

And he said he was so grateful that he had it in Florida because of the quality of care in the United States. And he said that was an absolute to him, the differentiation between the Canadian healthcare system and the healthcare system in the United States. This, mind you, was a doctor.

What I don't want to be hearing if we ever went to such a system is from veterans that their care was diminished in one, in any way, shape or form, because the doctor from Canada who once embraced universal healthcare tells me that he was so glad that he had the heart attack, if he had to have it, that he had it in the United States. That tells me a lot about the Canadian universal healthcare system.

And I have heard that from other Canadians also and I am a—while I live in Florida now, I am originally from New York. And I can just tell you that the hospitals along the border have always been filled with Canadians who buy that extra insurance, who can come here for quality healthcare, because they know the long waiting times in Canada. I do not want that for my veterans or veterans in anybody else's congressional district.

And I yield back the balance of my time.

Dr. WOOLHANDLER. Well, again, I think we would have to look at the data and not just an anecdote. The data is that Canadians live 2 to 3 years longer than Americans, that death rates are lower from preventable and treatable cancers, that death rates are lower from heart disease. When people look to see if Canadians are coming across the border, they find that fewer than 1 percent of Canadians get any healthcare outside of Canada in any given year and the vast majority of them just got emergency care when they were on vacation and got ill.

So the rumor that there are lots of Canadians in American hospitals isn't true. I have to say that I attend at Massachusetts General Hospital sometimes. I would get people from all over the world flying in to get care because it is such a famous hospital. And I don't remember ever seeing a Canadian there. So, that is, again, just an anecdote. But if you look at the data on America's 60 most famous hospitals, they treat very, very few Canadians.

So the data, in fact, shows the quality is as good or perhaps better in Canada. I think it is a similar situation to what you are facing in the VA. You get—the VA has a reputation. Maybe it is based on movies or old information. But the current information on the VA is your quality is pretty good.

The CHAIRMAN. Thank you, Dr. Woolhandler. We appreciate your testimony here and—

Mr. BUYER. Mr. Chairman?

The CHAIRMAN [continuing]. We will call on the next—

Mr. BUYER. Mr. Chairman?

The CHAIRMAN. I am going to call on the next panel. If they will come forward, the next panel. Thank you.

Mr. BUYER. So you are not going to allow me to ask a question?

The CHAIRMAN. You had your time.

Mr. BUYER. You, you are not going to allow—

The CHAIRMAN. We will have the second panel, please. Thank you, Dr. Woolhandler.

Mr. BUYER. What happened to this bipartisan spirit of cooperation?

The CHAIRMAN. It has got to be bipartisan, Mr. Buyer.

Will the second—

Mr. BUYER. So you are not going to allow me to ask a question of a witness? Mr. Bilirakis didn't even get a chance to ask a question.

The CHAIRMAN. Will the second panel please come forward?

Mr. BUYER. Mr. Bilirakis—

The CHAIRMAN. If you want to take part in the hearing, follow the rules. The second panel will come forward, please.

Mr. BUYER. Follow the rules. If you want me to follow the rules, we will do that, Mr. Chairman.

Mr. BILIRAKIS. Mr. Chairman?

The CHAIRMAN. Yes? Go ahead.

Mr. BILIRAKIS. Mr. Chairman, I have a question. I have a question to the panelist.

The CHAIRMAN. We have moved on to the second panel, Mr. Bilirakis. I asked if anybody had any questions—

Mr. BUYER. This is outrageous.

Mr. BILIRAKIS. Mr. Chairman—

The CHAIRMAN. I asked if anybody had any questions and you didn't indicate that and no one else did. So—

Mr. BUYER. Mr. Bilirakis has a hearing aid, too.

The CHAIRMAN. Mr. Buyer, would you please quiet down?

Mr. BILIRAKIS. I did at one time. I did ask and—but all right. Okay, Mr. Chairman. Thank you.

The CHAIRMAN. Thank you.

Mr. BUYER. You have rights.

The CHAIRMAN. We have a panel consisting of members of various veterans service organizations, the Paralyzed Veterans of America, Disabled American Veterans, the American Legion and Vietnam Veterans of America.

Mr. Blake, who is the National Legislative Director for PVA, you have 5 minutes and we appreciate your being here—we appreciate all of you taking part in this hearing today.

STATEMENTS OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; PETER S. GAYTAN, DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; AND JOHN ROWAN, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA

STATEMENT OF CARL BLAKE

Mr. BLAKE. Chairman Filner, Ranking Member Buyer, Members of the Committee, on behalf of PVA, I would like to thank you for the opportunity to testify today on the ongoing policy to prohibit enrollment of Category 8 veterans into the VA healthcare system.

Due to severely constrained budgets, former Secretary Anthony Principi made an administrative decision to place a prohibition on enrollment of new Category 8 veterans into the VA healthcare system beginning in January of 2003. As you know, PVA, along with

the co-authors of the *Independent Budget*, strongly opposed this decision at that time.

However, the VA assured us that the decision was strictly a 1-year moratorium. And yet, more than 4 years later, these veterans are still prohibited from enrolling in the VA healthcare system. In accordance with the recommendations of the *Independent Budget*, we urge the VA to take the steps necessary to reopen the system to the Category 8 veterans.

We believe that adequate resources should be provided to overturn this policy decision. Current VA estimates suggest that as many as one and a half million Category 8 veterans will be denied enrollment in the VA healthcare system by fiscal year 2008.

When budget estimates are developed for the cost of providing care to Category 8 veterans, often a worst-case scenario whereby all one and a half million of these veterans will seek care in the VA healthcare system is considered. However, we believe this is simply unrealistic.

In a report entitled, "The Potential Cost of Meeting Demand for Veterans' Healthcare," published by the Congressional Budget Office in March of 2005, the CBO explained the actual utilization rate of Category 8 veterans was only about 20 percent. Based on this information, the *Independent Budget* estimated that only about 314,000 Category 8 veterans would have actually used the system for fiscal year 2008, meaning that the VA would only be responsible for the costs for that number of veterans. With this in mind, for fiscal year 2008, the *Independent Budget* estimates that the VA will need approximately \$366 million in real appropriated dollars to reopen the system.

We would also like to draw your attention to a particular concern that we have regarding a seemingly inequitable application of the enrollment policy. As you all know, current law allows Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans to receive 2 years of healthcare from VA immediately following their release from active duty. Once that 2-year period expires, any OEF/OIF veteran who sought care from the VA is permanently enrolled in the healthcare system in the enrollment category that they would have otherwise been assigned.

This means that any OEF/OIF veteran who is a Category 8 veteran is allowed to permanently enroll in the VA healthcare system, despite the current prohibition on similar enrollments. PVA certainly has no objection to these men and women receiving the care that they have earned and deserve from the VA healthcare system.

However, we believe this is wholly unfair to any other veteran who would qualify for enrollment in Category 8, and whose service was no less important. The example has been used many times, but is certainly worth repeating about the World War II veteran who stormed the beaches at Normandy and spent nearly a year of continuous combat service and subsequently returned home without injury or illness and eventually went on to lead a successful life.

However, because he now has a yearly income above the maximum allowed by the VA for Category 8 veterans, he is denied enrollment. We do not see how this veteran's service is any less honorable or important than the young man or woman currently serving in the Global War on Terror.

Finally, I would like to emphasize that PVA believes that we would not be having the discussion about who can or cannot get into the VA if the Veterans Health Administration was funded through assured funding. The simple fact is that despite positive steps in the appropriations process and a positive outlook for fiscal year 2008, nothing will prevent the VA from facing the same uncertainty in coming years. Recall that even though the VA received a very good appropriation for fiscal year 2007, which is something we thank all of you for, it was still provided nearly 5 months into the current fiscal year. This is no way for the VA to be forced to manage healthcare systems.

In the end, none of these veterans should be denied enrollment into the VA healthcare system. No veteran's service is any more or less honorable than another, and it should not be treated as such. We hope the VA will choose to overturn this policy without being forced by Congress to do so. It is the right thing to do.

Mr. Chairman and Members of the Committee, I would like to thank you again for the opportunity to testify and I would be happy to answer any questions you might have.

[The prepared statement of Mr. Blake appears on p. 60.]

The CHAIRMAN. Thank you, Mr. Blake.

Mr. Atizado, the Assistant National Legislative Director for Disabled American Veterans.

STATEMENT OF ADRIAN M. ATIZADO

Mr. ATIZADO. Mr. Chairman, Members of the Committee, I want to thank you for inviting the DAV to testify regarding the current VA policy for Priority Group 8 veterans who are presently barred from enrollment in the VA healthcare system.

It would seem natural to ask why DAV would be concerned about Category 8 veterans given our focus on the service-disabled veteran populations, the veterans who are guaranteed by law high-priority access in VA healthcare. The DAV has conditionally supported re-entry of Category 8 veterans because we believe that when VA manages a proper mix of veteran patients, it offers a better healthcare plan to all veterans, including service-disabled veterans.

Mr. Chairman, putting this issue in historical context, when Congress authorized the Veterans' Healthcare Eligibility Reform Act of 1996, it did so fully cognizant that the veterans classified in the current Category 8 would enroll and bring with them additional funding sources. Since the delivery of VA healthcare underwent a systematic change, in the midst of this change Congress passed the Balanced Budget Act of 1997, and during the 3-year life of that law aggravated VA's financial situation.

This resulted in the supplemental appropriations in 2000 at the urging of both this Committee and your Senate counterpart which could not undo what had been done in the last 3 years. By 2002, the list of veterans waiting to receive medical care inched toward 300,000 nationwide. The following year, Secretary Principi himself said it publicly that VA faced "a perfect storm" of insufficient funding and overwhelming demand. And accordingly, VA used the authority provided to it by the Veterans' Healthcare Eligibility Reform Act of 1996 and barred new enrollment of Category 8 veterans.

Since the January 2003 decision, the frustration over this policy has been subject to congressional administration proposals, from the splintering of VA medical's benefits package to a prescription only benefit, to a VA+Choice Medicare and later still, VAAAdvantage, much to the concern of DAV.

Moreover, we are troubled by the differentiation among veterans through the policy of providing timely access for our newest generation of combat veterans in contrast to the policy on Category 8 veterans as my colleague had just mentioned. While it is clear that the VA opposed the decision to bar enrollment to Category 8 veterans, we were not surprised by it. In fact, the decision fueled our determination at DAV to seek legislation reforming VA's budget formulation and discretionary appropriations process.

We acknowledge and applaud the continued support from this Committee to VA's healthcare funding over the last several budget cycles and hope the Committee will schedule a hearing in the near future to consider funding reformations to help stabilize the system.

In summary, Mr. Chairman and Members of the Committee, we believe VA's current policy on Category 8 veterans is largely about sufficiency, reliability and dependability of the discretionary appropriations process for VA healthcare. At present, the DAV is reluctant to endorse immediate readmission of Category 8 veterans without major reformation of VA's funding system addressing VA's capital and human resource needs. Such are the things that will hold that "perfect storm" at bay.

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

[The prepared statement of Mr. Atizado appears on p. 62.]

The CHAIRMAN. Thank you.

Peter Gaytan is Director of the Veterans Affairs and Rehabilitation Commission of the American Legion. Thank you for being here.

STATEMENT OF PETER S. GAYTAN

Mr. GAYTAN. Thank you, Mr. Chairman. Mr. Chairman, Ranking Member, again, thank you for this opportunity and I appreciate this healthy debate on this issue that has been of concern to the veterans community since the enactment in 2003.

The American Legion strongly believes that all veterans who are eligible to receive benefits from VA should have timely access to the VA healthcare system. For VA to operate under a policy that restricts veterans who, prior to the enactment of this policy, were eligible for VA healthcare is unacceptable. Honorable military service qualifies a veteran for access to the VA healthcare system and the American Legion opposes any policy that redefines eligibility for benefits in an attempt to limit enrollment.

The response from new veterans enrolling when the change occurred during the eligibility reform was somewhat overwhelming, largely unanticipated and drastically underfunded, leading to an unprecedented backlog of veterans waiting to receive timely access to quality care at VA medical facilities across the country.

In an effort to reduce that backlog, then VA Secretary Principi suspended enrollment of new Priority Group 8 veterans in January

2003, as we all know and have heard this morning. The American Legion strongly opposed this decision when it was first made and we continue to call for the reinstatement of the enrollment of Priority Group 8 veterans.

In FY 2007, we have seen a continuation of suspension of enrollment of new Priority Group 8 veterans due to the increased demand for services. According to VA, the number of Priority Group 8 veterans denied enrollment in the VA healthcare system as of January this year is over 378,000. And then, as the Global War on Terrorism continues, fiscal resources for VA will continue to be stretched and veterans will continue to urge their elected officials to provide the funds needed to create a viable VA.

The American Legion shares the concerns that were expressed by my colleague from PVA regarding the enrollment of Priority Group 8, or the 2-year access to VA healthcare by any combat veteran coming back from OIF/OEF. While we applaud that and we welcome that and we appreciate the support for increasing that 2-year window to 5 years, what the American Legion questions is the fairness of allowing a Priority Group 8 veteran from OIF and OEF to remain enrolled in the VA healthcare system when other Priority Group 8 veterans are denied access to the very same system.

Unfortunately, as we have heard this morning, we have heard over the years since 2003, some believe that Priority Group 8 veterans are not the core of VA's patient population. The American Legion believes every servicemember is a core element of the national security—the total force. The willingness of young Americans to serve will diminish if this country continues to neglect those who have served. Timely access to quality healthcare offered by VA is an earned benefit and should not be denied.

The American Legion strongly supports lifting the suspension of enrollment of Priority Group 8 veterans in the VA healthcare system. VA can no longer restrict enrollment due to inability to meet the demand of care. Those who have served have earned the right to choose healthcare at VA.

Thank you again for this opportunity and I look forward to answering any questions you may have.

[The prepared statement of Mr. Gaytan appears on p. 65.]

The CHAIRMAN. Thank you so much.

And concluding this panel, John Rowan, who is the National President of Vietnam Veterans of America.

STATEMENT OF JOHN ROWAN

Mr. ROWAN. Thank you, Mr. Chairman, Mr. Buyer, other Members of the Committee. We thank you for giving us this opportunity here this morning.

The bottom line is very simple. You have heard why and when this happened and all of a sudden what was a temporary thing has now become a permanent fixture. What really happened was, the VA put a big sign on Uncle Sam out there. But instead of saying "We want you," it is "We don't want you." And they have really gotten that word out.

And what they have also done is cut outreach to veterans for healthcare, period. And we think that this came at a particularly bad time for Vietnam veterans in particular because, unfortu-

nately, we just started to finally get presumption for many diseases related to Agent Orange and many, many veterans did not know that occurred. And it is my opinion that many of these Category 8, or so-called Category 8, veterans might very well rise up into the ranks of other categories if they got into the VA system and learned about what was going on in veterans healthcare.

Interestingly, in the discussion earlier about whether or not we had a national healthcare, would we still have the veterans healthcare, I believe we should definitely still have a veterans healthcare. Serving in the military sets people apart. Not just setting them apart as being different than other citizens, but by going out to war, by going into combat zones, by going into foreign areas where they are exposed to certain elements in that particular area, parasites, et cetera, which again are also hurting many people many years after the fact, that sets them apart. It is not that they are any different just because they raised their right hand, it is that military and veteran healthcare needs and knowledge must be continued inside the VA. But it also needs to be expanded to private-sector physicians. It really bothers me that every time I run into a Vietnam veteran, the first question I ask him, and I get into conversations all the time, is, "How is your health?" How are you doing, and time after time I have run into people who say well, I am doing okay, but I have a touch of diabetes, or well, I have prostate cancer. We are more likely to have prostate cancer than anybody else. We are more likely to have diabetes than anybody else. We have all of these things.

I am the classic case. I am a Category 1. I am rated 90 percent by the VA. That only occurred in the last 6 years, when they finally presumed diabetes was related to Agent Orange exposure. When I filed for diabetes the first time in 1994, I got denied. I was still a Category 8 because I made too much money. I think many of these people need to come into the system. We need to bring all the veterans into the veterans healthcare system and that is the bottom line, because we need to get all the veterans to understand that being in the military may have an impact on their long-term health and life.

And unless they are in the system and unless that system starts looking at what being in the military means, which is another issue in the VA, we are not going to get the real treatment needed for all veterans. And that is simply it. And we really think, frankly, the veterans' organizations were fooled. We accepted that temporary respite because of various issues and now it has become a permanent fact of life and they say well, we can't change it now.

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

The CHAIRMAN. Thank you, Mr. Rowan.

Ms. Herseith Sandlin, would you like to ask any questions?

Ms. HERSEITH SANDLIN. Yes. And before I ask my question, I do want to make it a part of the record that I did clearly see Mr. Bili-rakis seek recognition at the same time Mr. Miller did. However, I would suggest that in the future it will be easier to identify those seeking recognition if those of us perhaps more senior on the Committee, once we have our 5 minutes of questioning, would defer and make sure that others on the Committee who have not, clearly get an opportunity to seek it with the Chairman.

I certainly agree, Mr. Rowan, with you about the importance of being in the system and I agree with the statements of some of my colleagues, as well as with the position of the Disabled American Veterans Organization about the importance of a predictable and adequate funding system so that we can serve effectively those who, as I mentioned earlier, all veterans agree should be first in line receiving the care in the VA system.

And I think particularly as you described, the diagnostic screening and the line of questioning I pursued with the first witness on the first panel, about primary healthcare and annual doctor visits and preventive care and these diagnostic screenings that are so important, particularly given the importance of being in the system so that the healthcare professionals in the VA who understand the longer term impacts of military service and what they, a veteran may or may not have been exposed to and the presumptions that you had mentioned in your testimony.

Now, you had stated that you think that the veterans service organizations maybe got duped back when there was this need for a temporary freezing of Priority 8 veterans, the freezing of their enrollment. If Congress were to act to open up enrollment to Priority 8 veterans, how would each of your organizations address the very real concerns—well, let me—I think I want to ask a different question.

Assuming adequate funding was provided, would there be any tools or authority that you would feel comfortable with or that you would recommend providing to the Secretary of the VA to meet unexpected emergencies either dealing with unforeseen lack of resources or unforeseen demand and would that include a temporary ban on enrollment for certain priority groups?

Mr. GAYTAN. Well, on behalf of the American Legion, because the action to restrict enrollment of any eligible veteran is so drastic, I think any specific situation would have to be taken into account. Your number of enrolled veterans changes daily. We are in two wars right now. The number of eligible veterans we are creating every day as a nation at war increases. So as a blanket response to your question, I personally am not prepared enough to speak for the American Legion. But I will say that that situation has to be taken into consideration individually.

And what the American Legion supports is, of course, what you have heard here and everybody knew before the hearing even took place, that the American Legion supports lifting the suspension on enrollment. However, I urge the Chairman and the Members of this Committee to remember that the suspension of enrollment was decided by the Secretary. The Secretary stopped that enrollment. So I suggest the Chairman listen closely to Dr. Kussman's testimony and maybe even give a call over to Secretary Nicholson and ask him what his position is and if he feels we have overcome whatever situations have occurred that caused then-Secretary Principi to suspend enrollment.

The decision is made by the Secretary in this case and right now. I suggest we back up, ask that question to the Secretary. But in response to your direct question, because that is such a large issue and affects so many veterans, on behalf of the American Legion, we would have to take that into consideration in specific cases.

Ms. HERSETH SANDLIN. Well, let me just rephrase the question though and maybe for the benefit of everyone. Do you think that the Secretary should continue to have that discretion, or if we lifted the restriction, do you think it should require congressional action to impose a temporary ban or should we leave it within the discretion of the Secretary?

Mr. ROWAN. I would not leave it at the discretion of the Secretary. I don't think there is a reason for it and I think the issue should be adequate funding, which is the question you mentioned earlier. If you had adequate funding?

I can remember back in the day when my father was in the system and we had the huge number of World War II veterans around. I was still relatively young when my father was in his 50's receiving healthcare through the VA. He happened to have some slight disability. I think he was getting 10 percent or something. But there was even a priority then. And very clearly, obviously, if somebody—if you had to choose between two patients, you know, somebody who had the higher rating probably got a little faster service.

But the doctor had the real question earlier. The priority should be to the sick person, not to an artificial priority. I am a Priority 1, but if I happen to be okay today, it doesn't mean I automatically get to see the cardiac surgeon that day, if I have no need to see that person, whereas if some Category 8 needs to see the cardiac surgeon, they ought to see the cardiac surgeon. It is a healthcare question, not an artificial category necessarily.

I can understand some priorities. We do have priorities. We make that understood. But if the system is there and available and I think the VA is doing a very good job of expanding the system. All healthcare is changing. We are getting away from the monolithic hospital systems. They are creating this substantial outpatient clinic system, which is what happens everywhere else.

I happen to be one of those people that does have private healthcare, that I got through my retirement from my employer, which I pay for partially, by the way, as was mentioned earlier with the TRICARE folks, who are also retirees getting healthcare.

But I still have to wait to see my doctor. I still have to get an appointment when I go to see, even in the so-called private sector, a particular physician to get some service, I still may have to wait somewhat. There is no system that is going to automatically give everybody everything every day of the week.

Ms. HERSETH SANDLIN. Mr. Chairman, I know my time is expired, but if any of the other witnesses on this panel would be inclined to want to respond to the question about the Secretary's authority?

Mr. ATIZADO. Thank you. I just want to make one brief comment. I was not here and I am not well versed in the discussion that was had by this Committee when they passed the Eligibility Reform Act. But I think the idea that the main goal of this Act which allowed the Secretary to manage a program that he is responsible for, which includes this tool to ensure the quality and the access standards that they hold it to, does so well. I would have to say that I think it is proper that the Secretary have the tool that he has, since he is responsible for this program.

And I think one thing that has not been, that I wish would be addressed is the accountability of this Act. If the Secretary decides that the budget he requests or submits to Congress for his program does not include Priority Group 8 veterans, then I think we should ask the question why. Is this in fact a shift in priority of not only the Secretary or the Administration, that Priority Group 8 veterans shouldn't be allowed? And if so, then is it incumbent upon my community and my organization to advocate otherwise?

The CHAIRMAN. Thank you.

Mr. Bilirakis, I am sorry I didn't see you in the last panel. You are recognized for any questions for this—

Mr. BILIRAKIS. I don't have any questions for this panel. Thank you.

Mr. Buyer?

Mr. Stearns?

Mr. BUYER. Mr. Rowan, I have here in front of me the testimony of VVA when we were doing the eligibility reform. And it says, "VVA believes that service-connected disabled veterans and low-income veterans should always remain VA's highest priority." Do you still believe that to—

Mr. ROWAN. Yes.

Mr. BUYER. Okay.

Mr. ROWAN. If I have to have priorities, yes.

Mr. BUYER. All right. I know the Chairman threw a lifeline to rescue the first witness at the first panel and was perhaps disturbed that Members were asking questions about the universal national health insurance program and said, you know, we are here only to talk about 8's. She came here to testify and in her written testimony, I just want all of you to know, about her support for the universal national healthcare system and how it is to work also with the VA. It is her testimony, okay?

So let us think about that, because that is what is in front of us. I serve on the Health Subcommittee over there on the Commerce Committee. I know what the goals and the aims are, and I respect them. It is their belief about the incremental approach. I mean that is, in fact, what is happening. So we better talk about this.

So if that is, in fact, where we are headed and the Chairman brings his witness from Harvard here to testify, to give counsel to this Committee and her counsel to this Committee—this is really close. I don't want to put words in her mouth. But given Mr. Miller's questioning that the priorities and the categories that we created, she really doesn't see those priorities and categories, they all should be treated the same.

Now, she is looking through the prism as a doctor, I suppose. So let me ask this question of you. Should we get rid of the system of priorities and categories as was espoused in the 1996 Act? Let's go right down the line. Yes or no?

Mr. BLAKE. No.

Mr. ATIZADO. No.

Mr. GAYTAN. No.

Mr. ROWAN. No.

Mr. BUYER. Thank you. The first witness also talked about her idea of a national health, single-payer system whereby everyone could have a card and those veterans then could have that card

and they get to choose whether to be in the VA system or go into the private system. Do you advocate such an idea? Yes or no?

Mr. BLAKE. No.

Mr. GAYTAN. No, but may I add something? I am sorry that we are spending our time debating this. As was mentioned, our focus is Priority 8 veterans. I am sorry.

Mr. BUYER. It is the big picture though.

Mr. GAYTAN. I understand it and I just, I am sorry that it has come into our picture of focusing on providing quality healthcare in a timely manner for—

Mr. BUYER. It is pretty important—

Mr. GAYTAN. I am not discounting—

Mr. BUYER. It is where they are going.

Mr. GAYTAN. I am not discounting the need to discuss it. It is just a shame that we spent time today in this hearing talking about an issue that is not directly relating to veterans. I am saying, I see the big picture, but also the debate that we spent time on today talking about the behavior of Members of the Committee.

Mr. BUYER. Mr. Gaytan, you have been around here long enough to know that when the Chairman calls a hearing and he puts his first witness forward, that is telling everybody where he is going. So I have been around here 15 years, so I understand this system. So—

Mr. GAYTAN. I appreciate the hearing and it is valuable time and I hope we spend it productively.

Mr. BUYER. Thank you, me too.

Mr. ROWAN. Can I—however, I understand that everybody wants to jump on the national health insurance angle of the witness, but I also listened to what the witness had to say, and about all the uninsured veterans there are out there. And again, I get to the point of the VA telling people don't come. Don't even bother to show up at the door because you are not qualified unless you have been disabled.

Mr. BUYER. Mr. Rowan—

Mr. ROWAN. And what I am saying is, a lot of those people that are sitting out there, those million, 1.1 million—

Mr. BUYER. John—

Mr. ROWAN [continuing]. Should very well, in fact, be entitled to compensation.

Mr. BUYER. John, this was a witness that said she is not distinguishing the Category 8's. So of the number that she gave, many of these, of the uninsured could be covered in these categories. So that is—

Mr. ROWAN. If they were, in fact, knowledgeable about the VA issues and what they were entitled to.

Mr. BUYER. And let me ask—

Mr. ROWAN. And what I suggest to you is when the VA cut the outreach—

Mr. BUYER. John, I don't have the time.

Mr. ROWAN [continuing]. I don't have the ability to understand that.

Mr. BUYER. Come on. The *Independent Budget*, you estimated about \$366 million to care for the Priority 8's and you said that that would be offset by collections. I don't know how you got to that

number. It is unusual for the *Independent Budget* to do that, because you never really wanted to do that. You always wanted a separate appropriation. So help me on that. And did you take, when you came up with this number, did you take into account estimates for the costs of services to lift the suspension, facilities, operations, personnel?

Mr. BLAKE. Mr. Buyer, I feel like that is probably my principal focus area, so I will try to explain it as best I can how we got to that number and how it relates to what the VA has testified to. First, I would say that last year the IB made the decision not to include our recommendation for funding for Category 8's in our medical care recommendation, and that is reflected in 2007 and 2008. So it is not a part of the line items that make up our recommendation.

If we took the 2008 number that we believe it would cost for Category 8 veterans, being consistent with the way that we have always done our budgeting, the actual number that would have to be added to our medical care number would be the \$1.1 billion that you see reflected in our testimony. That would be consistent with the way we have always done our budgeting.

However, trying to be realistic and just give an honest assessment of what we believe the costs would be and something for the Committee to chew on, the cost that we believe in real appropriated dollars would be about \$366 million. The way we figured this out is, the overall cost per user was principally what we used as our baseline number. In our testimony, I believe I mentioned that was about \$3,500. When you back out the collections that would be recognized from Category 8 veterans, that cost per user goes down significantly, something on the order of \$1,165, or something like that.

I believe that the VA principally sees it the same way we do. And where we differ in our cost estimate is the one assumption about what would be the utilizing of those new Category 8 veterans. The VA testified, I believe, earlier this year that they estimate the cost to them would be about \$1.7 billion, somewhere in that range, if they open the system up again.

If you take the 1.5 million thereabout estimate that we have heard from them in various opportunities earlier this year that they have testified to, if you take the 1.5 million projected denied enrollment up to fiscal year 2008 and took the \$1,165 and applied it to it, that cost would come out somewhere pretty close to the \$1.7 billion. Whereas, we looked at what the utilization rate was prior to the closure of enrollment for Category 8 veterans that was about 20 percent at the time.

Now, I would be foolish to say that I thought that that universally still applied, because we just don't know. So we take that as our assumption as to what the utilization rate would be and come up with the number of users we believe would be using the VA system. That is how we came up with the 300 plus thousand Category 8 veterans who would use the system. And the cost associated with those veterans is \$366 million in appropriated dollars. That is what the Committee or what Congress would have to appropriate additionally to provide for their care.

Short of that, I think the major question that still lies out there is the assumption of what will the utilization be. An honest answer is, we don't know. I would say it is unreasonable to take the worst case scenario which is the 1.5 million, because the entire VA healthcare system has far more enrollees than they have actual users of the system.

The CHAIRMAN. Thank you, Mr. Blake.

Mr. Rodriguez?

Mr. RODRIGUEZ. Thank you very much and let me—it is unfortunate but I heard very clearly there is 1.8 million or 1.7 million veterans that are uninsured and we know that there are some 46 million people out there, Americans that are uninsured. And there is a real need for us to see how we can incorporate and provide the need for everyone, and have some degree of access, because it is still a system—and you can tell by the debate that is going on that it is an area that at least a lot of us feel that some degree of access needs to occur. And when it comes to veterans, it has to happen.

Let me ask you, one more step in one of the areas—because I know that there is a tendency to pit one group against the other. They have done it all the time, and I apologize, but on Social Security they pit the young against the elderly, on education the private against the public, in VA, one group against the other. The problem is right now, if you look at the veteran, I know I would be concerned also about my family as a veteran and whether they have access or not.

And I don't want you to respond now, but there is a real need—and I am proud to say I can't pull it off, something I am going to try incrementally. How do we begin to look at providing access to Priority 8 and others, but also family members of veterans? Because I am sure that maybe not through the VA system, but through another process that is out there, and I had mentioned the SCHIP program, because that begins to at least take care of some of the kids of those working families that are out there. They are paying their taxes, make \$60,000, \$40,000, but find themselves uninsured. How do we take care of the families of veterans that are uninsured and—because I presume the others have some degree of insurance—if there would be a way either through the system or an external group, a process like TRICARE that we try to provide that care for?

Mr. GAYTAN. Not that the American Legion ignores the healthcare needs of the family members of veterans, but when we were wrapped in debate over veterans alone receiving access to the VA healthcare system, I think it is a little bit premature to debate the ability or process that VA would use to open up the doors or provide as a payer to the family members of veterans. So with that in mind, taking one step at a time, I think fighting for all veterans, eligible veterans to receive healthcare would be the first step. Getting VA established—

Mr. RODRIGUEZ. I don't disagree with you.

Mr. GAYTAN [continuing]. To handle that task would be, is monumental already. And then not ignoring the needs of the family members is something that needs to be taken into account further down the road. And I appreciate your concern over the family mem-

bers of veterans who need healthcare as well. But we can work together to hopefully achieve that as well.

Mr. RODRIGUEZ. And it could be a separate system that responds to that, like we have had the SCHIP program now.

Mr. ROWAN. Actually, my wife signs people up for that every day. She works in the New York City Department of Health and signs people up for Child Health Plus Programs every day. It is a maddening system and I don't wish anybody into that system.

Truthfully, as my colleague said, we are dealing with veterans. We don't deal with the families. However, the one difference is, when the families are impacted by military service and we only have in the Agent Orange category the spina bifida children. That is the only one we have. We believe there are probably many others, unfortunately, that have never been done.

But one area where there has been studies is the area of PTSD. Post-traumatic stress disorder has a big impact on the family. And unfortunately, in the vet center program we need to get more funding and more impact and more working with treating the entire family unit. And it is going to—obviously I think with new troops, given the fact that many of them are Guard and Reserve and many of them are older, many of them have families, I mean in the Vietnam era, most of us were not. I mean most of us were not married, didn't have kids, et cetera, et cetera. We were single.

But the new folks are in a different ball game. And that part, only because the service-connection, if you will, having had PTSD from military service which impacts in the secondary condition into your family life is something that definitely needs to be addressed and needs to be thought of. And quite frankly, our colleagues in Australia, while they may have screwed up their healthcare system by putting the veterans into the general population which is, by the way, what was mentioned earlier with Canada. They did that in Australia.

What they have done right is they treat the children of veterans for PTSD issues up to the age of 40 and they keep raising the age for the Vietnam veterans' children.

Mr. RODRIGUEZ. And at the present time I understand that we don't treat any of the family members unless it is directly tied into it. Is that the way it is worded?

Mr. ROWAN. Yes.

Mr. RODRIGUEZ. Okay.

Mr. ATIZADO. If I may, the whole idea—first of all, I would like to echo Peter's comments about making sure that we take care of the veterans first. On a second note, I would like to emphasize the fact that the discussion with regards to providing care to family members, spouses or parents, whoever is caring for the veteran, is very, is not nearly as mature as it should be for us to legislate on it, in my opinion.

I believe that, because of the change of the delivery of healthcare by VA from inpatient to outpatient, this is a very timely conversation to have, particularly with our newest generation of combat veterans whose family, spouse and children are very much an integral part of healthcare. Whether or not VA has spoken about it, they are in fact placing a lot of responsibility and burden of that care on the family member. And I think it is high time that this Com-

mittee, if not this Committee, somebody speak about this issue and have a healthy debate about it.

The CHAIRMAN. Mr. Stearns, briefly?

Mr. STEARNS. Thank you, Mr. Chairman. I will be quick here. Just two points I wanted to make that the witnesses mentioned. We have quadrupled the number of outpatient clinics in America. They are up to 800. So every veteran should be able to get access and they should do that.

Second of all, the priorities, the categories are set up just for enrollment. They are not set up for priorities in health and I think we should establish that.

Mr. Atizado, you mentioned that you support the Priority 8 with a caveat and you mentioned that as long as the capital resources and the human resources are provided. I thought you might just expand briefly on this caveat. You are saying you would support the Priority 8 reinstatement only under these two conditions and you might explore those for me.

Mr. ATIZADO. Well, it is quite simple. What we would like is not to have what had happened—what we would like is not to have the situation that led up to the January decision, which is that access and quality care were being placed in danger of veterans who were already using the VA healthcare system.

And having said that, I think the idea of providing simply money is not enough. It was mentioned earlier about increases in funding cannot be a substitute for good management. I think that in order for us to provide the kind of care that private groups say they are going to need is not only going to include additional resources as far as funds, capacity as far as the number of providers, and obviously a number of providers themselves and the infrastructure.

Much was talked about last, I believe it was 1 or 2 years ago, about the idea of what kind of care Priority Group 8 veterans are seeking and in fact, out of that, one of the main thrusts was their high utilization or their seeking prescription benefits from VA. In fact, there was a whole hearing by the Subcommittee about that one issue, about parsing out the pharmacy benefits of VA.

And all we are saying is, while that is probably not a very good idea, we should ensure that VA has what it needs to keep itself intact. If, in fact, they need X number of staff, you know, X number of examining rooms and however much more dollars it needs to provide whatever care this group of veterans is going to need, then that really is what we recommend, is that be provided to VA.

Mr. STEARNS. I thank you and I think your statement providing more money is now a substitute for good management is a telling statement. Thanks.

The CHAIRMAN. Thank you, Mr. Stearns.

We do have to adjourn for votes. I do want to say I thank this panel. I think there is remarkable unanimity. I would point out to the Ranking Member, if he were here, that those Members who represent the core constituency which he keeps referring to, favor including Priority 8 veterans, provided there is funding, providing nobody else is disadvantaged.

I am sorry? Recess, okay. If I said adjourned, I meant recess for the votes.

That is, we want to, and I think you want to, provide for all veterans, but we have to have and we are going to take up this issue of mandatory funding in coming months. But clearly as a nation, we have a responsibility to fund the needs of our veterans. I don't care what category they are in. I know the Ranking Member forced you to say you believe in categories. You believe in adequate funding for everybody, I think is your first priority, if I really had to poll you.

And I appreciate that. I appreciate DAV and PVA working for a certain group of veterans, but saying the quality of care for the whole system would be improved if we can serve all our veterans. So I appreciate your willingness to do that and we commit to you that if we get to this, if we do have any legislation about Priority 8 veterans, there will be sufficient funding for all the veterans to receive it. So I thank you so much.

And we will recess until 12:30 and hear from the Under Secretary for Health.

[Recess.]

The CHAIRMAN. The meeting will come back to order.

I apologize, Dr. Kussman, for the intrusion. You never know when the votes are going to occur. And we look forward to your testimony.

Dr. Michael Kussman, Under Secretary for Veterans Health in the U.S. Department of Veterans Affairs.

Dr. KUSSMAN. Is your microphone on?

The CHAIRMAN. Mine is on.

Dr. KUSSMAN. Then maybe it is my hearing. I need to get tested really.

The CHAIRMAN. Well, you are going to have to confront the VA bureaucracy and it may take about 6 or 7 years before—

Dr. KUSSMAN. I was going to start off by saying good morning, but it is good afternoon, Mr. Chairman, and I don't see any other Members of the Committee. So—

The CHAIRMAN. Is your microphone on, Dr. Kussman?

Dr. KUSSMAN. It is on.

The CHAIRMAN. Okay.

Dr. KUSSMAN. Am I too far away? Is that better?

The CHAIRMAN. Perfect.

Dr. KUSSMAN. Okay.

**STATEMENT OF HON. MICHAEL J. KUSSMAN, M.D., M.S., MACP,
UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION,
U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PATRICIA
VANDENBERG, MHA, BSN, ASSISTANT DEPUTY UNDER SECRETARY FOR
HEALTH FOR POLICY AND PLANNING, VETERANS HEALTH ADMINISTRATION,
U.S. DEPARTMENT OF VETERANS AFFAIRS; AND WALTER A. HALL,
ASSISTANT GENERAL COUNSEL, HEALTHCARE, ETHICS, AND HUMAN
RESOURCES, U.S. DEPARTMENT OF VETERANS AFFAIRS**

Dr. KUSSMAN. I am pleased to address the current policy and status of Priority Group 8 veterans. I would like to request that my written statement be submitted for the record. Joining me today are Walter A. Hall, the VA Assistant General Counsel, and Patricia

Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning.

The Veterans Health Administration's mission is to provide healthcare to enrolled veterans. Before 1996, VHA offered primarily a hospital-based healthcare system. Over the last decade, with the support of Congress, we moved from an inpatient model of care characterized by a limited number of specialized facilities often far from veterans homes to an outpatient model which provides care at more than 1,400 locations.

VA's resources are focused on our highest priority medical care mission—to provide care to recent combat veterans and veterans with service-connected disabilities, lower incomes, and special needs. Before 1999, veterans not meeting this criteria were able to receive VA healthcare only on a case-by-case, space-available basis. In the Veterans' Healthcare Eligibility Reform Act of 1996, Public Law 104-262, Congress directed the VA to establish a system of annual patient enrollment managed in accordance with priority groups, first seven, and later eight, and contingent upon available resources.

In 2003, after careful consideration, VA discontinued enrollment of additional Priority Group 8 veterans to ensure that we could provide timely and quality healthcare to those most in need. Our research indicated nearly 90 percent of non-enrolled veterans who would have entered as Priority 8's had access to other healthcare systems. Based upon the services currently used by Priority 8's, it appears that most in need entered the system prior to the change.

Today, meeting the healthcare needs of our current enrollees and effectively responding to the needs of a new generation of veterans from Operation Enduring Freedom and Operation Iraqi Freedom are VA's highest priorities.

The President's FY 2008 budget is based on the Department's needs for providing enrolled veterans with timely, high-quality healthcare. Patients in Priorities 1 through 6 will comprise 68 percent of the total patient population in 2008, but they will account for 85 percent of our healthcare costs. The number of patients in Priorities 1 through 6 will grow by 3.3 percent from 2007 to 2008.

Based upon the President's FY 2008 budget, we expect to treat about 263,000 veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom. Currently, the President's budget fully funds enrolled veterans in Priority Groups 1 through 7. Our budget also fully funds those Priority Group 8 veterans already in the system, as well as those returning veterans who will migrate to this group after the expiration of their post 2-year enhanced enrollment authority. This will ensure that no veteran currently in the system will be denied care.

However, as demand for healthcare services continues to grow, VA must allocate resources according to the priorities set by law. In keeping with Congress' requirement to establish and manage a system of annual patient enrollment, VA annually reviews the demand for services and the resources required to assure timely and high-quality services.

We believe the current restriction on enrollment of new Priority Group 8 veterans is necessary to maintain the timeliness and quality of the healthcare we provide to currently enrolled veterans. This

policy allows VA to focus on fulfilling our mission of meeting the healthcare needs of those veterans given higher priority by Congress, service-connected veterans, those returning from combat, those with special needs and those with lower levels of income.

This concludes my prepared statement and I would be pleased to answer your questions.

[The prepared statement of Dr. Kussman appears on p. 67.]

The CHAIRMAN. Thank you, Dr. Kussman. Did you say 90 percent of Priority 8 veterans have insurance, other insurance?

Dr. KUSSMAN. My understanding is the surveys that we have done on people who are in the systems, the Priority 8 people and others, is that nine out of ten have access to some other kind of insurance. It could be Medicare or something like that.

The CHAIRMAN. So why are you worried about bringing them in if you can get third-party collections, right? I mean—

Dr. KUSSMAN. Well, first of all, we don't get a payment from Medicare and—

The CHAIRMAN. What if they are on Medicaid?

Dr. KUSSMAN. The third party doesn't pay the whole cost.

The CHAIRMAN. Okay. But that is at variance with the testimony we had earlier that 1.8 million did not have any health insurance. Did you see that at variance with your statistic?

Dr. KUSSMAN. Yes, Mr. Chairman. I heard that. But I believe that the witness at that time was talking about the 24 million veterans that are in the country, the total, and used census data to determine that. And quite frankly, and I haven't reviewed her study and I haven't talked with her, so I will just tell you what my impression is, is that of those 1.7 million veterans that are in the 24 million that don't have access, some of them may be already enrolled in our system as Priority 1's through 6's or 7's because indeed, when the Census Bureau asks do you have insurance, the person may say no which is indeed true. But they are a veteran who is enrolled in our system. So I don't know exactly what the 1.8—

The CHAIRMAN. I think she said, although I won't—I have to let her speak for herself, but the census asked two questions. Do you have VA care or are you insured? And she only took the ones that said no, I think. Is that what she said?

Dr. KUSSMAN. I didn't understand that. If that is true, then I—

The CHAIRMAN. Anyway, we should check on those statistics, obviously. But you don't see any basic contradiction right now based on what you know of those two numbers?

Dr. KUSSMAN. Of the 1.7 million that—

The CHAIRMAN. Yeah, and the 90 percent?

Dr. KUSSMAN. I don't know if that is—

The CHAIRMAN. Okay.

Dr. KUSSMAN [continuing]. Correct or not.

The CHAIRMAN. All right. Now, as I understand it, and according to the VSO's who met with the Secretary at that time, this Category 8 enrollment ban was meant to be a temporary thing. Have you asked in your budget request to fund the Category 8's so it would not continue to be a permanent ban?

Dr. KUSSMAN. Mr. Chairman, I think that the issue here is that, as prescribed by law, every year the Secretary has to look at that.

I don't think it is meant to be permanent in any way because it is supposed to be reviewed on a yearly basis.

The CHAIRMAN. Yes, but the original request came because supposedly there were insufficient resources. So why don't you just ask for sufficient resources so you don't have to make the determination that you can't enroll Category 8's? I mean do you ask for the—you expect it to cost, is that \$1.6 billion an accurate figure?

Dr. KUSSMAN. I believe from our estimate that if 8's were, if it was open again for 8's to come in, it would be 1.7 enrolled, 1.7 enrollees. There is a difference between—

The CHAIRMAN. Okay.

Dr. KUSSMAN [continuing]. Enrollees and unique people and a cost of about \$1.8 billion.

The CHAIRMAN. So did you ask for that money so you wouldn't have to reject their enrollment?

Dr. KUSSMAN. I think we asked for a budget that would allow us to continue to expand what we were doing for the enrollees that we had and—

The CHAIRMAN. So you didn't ask for the resources, to get rid of the Category 8 ban, you didn't ask for the money?

Dr. KUSSMAN. The budget request presumed that the prohibition on Priority 8's would continue. But as you know—

The CHAIRMAN. I just find that backward. Again, the request for a ban or the determination there should be a ban is based on insufficient resources.

Dr. KUSSMAN. Well—

The CHAIRMAN. Just ask for sufficient resources.

Dr. KUSSMAN. But it is more—as was commented on in the second panel, it is more than just resources that drive what our primary, what Congress said for us to determine, is access and quality. And if that came in, we would be challenged to be able to maintain the access and quality with a large bolus of people coming in irrespective of the money.

The CHAIRMAN. So ask for that money to keep the quality up. I mean I think you have decided that you don't want the Category 8's—not that you don't want but, I don't mean that as a personal decision. But the system cannot deal with Category 8's so you just make all your projections and all your budgets based on the decision that we are not going to treat them, rather than asking, "What do we need to treat them," and getting the resources to do that. I mean is that an accurate conclusion that I should draw?

Dr. KUSSMAN. No, sir. I don't agree with that conclusion.

The CHAIRMAN. Then why don't you just ask for the money?

Dr. KUSSMAN. Because as I mentioned to you, the priority is to maintain the quality and access and we—

The CHAIRMAN. So what do you need to maintain the quality?

Dr. KUSSMAN. We would—the infrastructure and the ability to hire people. We still have opportunities to improve—

The CHAIRMAN. So ask for that.

Dr. KUSSMAN [continuing]. Veterans that we have taken care of with the waiting times and things and we are spending—

The CHAIRMAN. Well, can you tell me—you don't have to do it this minute—how much money, or whatever else you need to ensure access and quality to take care of the Category 8's? Tell me

what you need. You can't very well say you don't have the resources when you haven't asked Congress to make it happen. I mean I don't understand how you can just assume you can't do it when you haven't even talked about doing it.

Dr. KUSSMAN. We cannot do it with the infrastructure and the—as you saw in the Washington Post yesterday, an article was written on the fact that even in the civilian community they are building a lot of infrastructure but cannot hire the number of people that they need to provide adequate and quality care because we are faced with—

The CHAIRMAN. I read that, but tell us what you need. I mean if you are telling me that because you have 300 vacancies in diabetes specialists or something, whatever, I can tell you that Congress can find a way to incentivize programs so we will get those cardiac or diabetes specialists. You can't assume we can't do it if you don't ask for it. And unless you specify what you need, we can't provide it. We needed scientists and engineers in 1957 after Sputnik went up.

So we just gave scholarships to everybody who had a signer on their pass, including me. They were going to make me an engineer so we could keep up with the Russians. So we got all the engineers we needed. We could do that to anything if you just tell us what it is that you need—you can't keep saying the infrastructure is not there if you don't tell us what infrastructure you need. Then it is your fault, not our fault, because you keep saying you don't have it.

But the VSO's said that, they estimated something around 20 percent of the Category 8's would actually utilize the system. How come you don't have any utilization percentage? You are assuming everybody is going to utilize it? What is your 1.7 or 1.8 billion based on?

Dr. KUSSMAN. As I mentioned, Mr. Chairman, those are the number of people who would take advantage of the opportunity to enroll. About half, 800,000 would actually come in and be categorized as uniques, the people we would have to provide care for.

The CHAIRMAN. So you are assuming 50 percent and they assume 20 percent; is that fair?

Dr. KUSSMAN. I don't know where they got their number from. I think that—

The CHAIRMAN. Where did you get your number from?

Dr. KUSSMAN. Historical data of what happened to 8's when it was open.

The CHAIRMAN. So yours is based on historical data or theirs is?

Dr. KUSSMAN. I think ours is derived from—let me ask Pat.

The CHAIRMAN. So what is our database, or your database? I don't take any ownership of it.

Ms. VANDENBERG. Our databases are actual enrollment experience. Prior to the suspension of Priority 8's, we had a pattern of enrollment and utilization among the Priority 8's and today we still have Priority 8's in the system who had been enrolled prior to the suspension. And so we extrapolate from that pattern of utilization what the demand for service would be if we reopened Priority 8's.

The CHAIRMAN. Mr. Blake, you testified a minute ago. Can you just say, do you agree or disagree with that utilization rate estimate?

Mr. BLAKE. I think it is not the same thing. I think it is 100 percent based on users and the system and there is some variation on enrollment and my statement is what I am saying, that our assumption is based on the CBO report. Now, it is not accurate, but our assumption is based on that. Given that I don't work for the VA, I don't have all the same data that is available to them.

The CHAIRMAN. Okay. Again, Dr. Kussman, I want a request from you, not just generalities, but to serve with high quality, however you want to caveat it, the Priority 8 veterans that will use the system, what do you need from Congress to do that? Is it, you said \$1.8 billion to serve them? Do you need more clinics? Do you need more hospitals? If you want to do it now, fine, or give us a report on it.

Dr. KUSSMAN. Let me, that \$1.7 billion was for 1 year. Over 10 years, the estimated cost would be cumulatively \$33 billion to bring in the Priority 8's that we believe would take advantage of—

The CHAIRMAN. Thirty-three billion dollars?

Dr. KUSSMAN. Thirty-three billion dollars.

The CHAIRMAN. Let's see. That is about 8 months of the war going on now. So it is a question of priorities. We have the money. Do we want to spend it as a nation? I mean \$33 billion doesn't scare me, if that is what you were trying to do. We can accommodate that. So ask us for it. I want you to tell this Committee and this Congress and the American people what it takes to serve those who have served us. I mean that is a pretty simple question. And somehow you are not taking it as a simple question.

I don't think you are prepared now to do it. I agree with you. I don't think you are prepared now for the OEF/OIF veterans. So you need some more resources. So tell us what you need. I think the American people understand that it is a cost of war to treat our veterans. I don't care whether they are from World War II or they are from yesterday in Baghdad.

But you have to tell us if we gave you another \$1.8 billion, could you take all the Category 8's?

Dr. KUSSMAN. No.

The CHAIRMAN. What else do you need?

Dr. KUSSMAN. It would take—

The CHAIRMAN. I have asked this five times now.

Dr. KUSSMAN. It would take us a great deal of time to be able to put an infrastructure and hire people that could absorb 800,000 projected in 1 year. We—

The CHAIRMAN. But the \$1.7 billion will pay for the infrastructure. You just need time to put it in place?

Dr. KUSSMAN. It would—I don't know how long that would take to be able to increase the capacity and the only other way to do it would be to outsource the care to maintain access and quality. I believe that if all 800,000 came in, even with the \$1.7 billion that came, we would find ourselves in the same situation that drove the decision in 2003 with increasing access, wait times and concerns about getting appropriate care.

The CHAIRMAN. So what does the \$1.7 billion cover then, if it doesn't cover that? I want the cost of giving the new folks access and quality without diminishing the access and quality of those in the system now. What does the \$1.7 billion give us then, if you keep telling us that is the cost for the 800,000?

Dr. KUSSMAN. I believe it is an estimate of actually if we were going to provide the care and had the access and capacity to do it, that is what it would cost in-house.

The CHAIRMAN. Okay. I will ask one more time, and again, I want a report from you. What would it take, and how long would it take, to absorb all the 800,000 Category 8's that exist now? What is the cost, how long, what do you need to do, what infrastructure do you need, what capital costs, what costs for new hires, whatever? That is what we thought we were getting when we get a number like \$1.7 billion. I thought that is what that means. And you are saying no, it doesn't mean that.

Let me ask you one more thing—so I hope you can get us that.

Dr. KUSSMAN. Yes, Mr. Chairman.

The CHAIRMAN. How many, you have almost 250,000 employees in the system, 235,000 or something like that?

Dr. KUSSMAN. It is around 200,000 for the VHA, around 235,000 for the whole VA.

The CHAIRMAN. How many of those, I mean is it one person or is it 10,000 people, who are dealing with these eligibility questions for healthcare? Someone has to determine if you are eligible, I assume, when you come to the VA, right?

Dr. KUSSMAN. Right.

The CHAIRMAN. How many people are involved in that, would you estimate?

Dr. KUSSMAN. I apologize. I will have to get you that number. I think every facility has a process under which the eligibility is determined. I don't know how many people work in that, but I will be happy to get you that number.

[The following was subsequently received.]

In Fiscal Year 2007 (FY 2007), VHA employed 4,581 persons in eligibility and related administrative support activities at an annual cost of \$185,549,820. These employees served at 153 VA medical centers and 895 outpatient sites of care, including America Samoa, Guam, the Philippines, Puerto Rico, and the Virgin Islands. Employees in these positions work with veterans to ensure they receive every benefit for which they are eligible. In FY 2007, more than 5.5 million people received care or services in VA healthcare facilities. On a day-to-day basis, VHA intake and eligibility staff members work with veteran and other eligible beneficiaries to ensure they receive their VA healthcare benefits.

VHA's intake and eligibility staff members are often the first points of contact for veterans and other beneficiaries as they seek healthcare services from VA, they provide an important first impression. These staff members provide invaluable assistance by educating and supporting veterans as they complete their Department of Veterans Affairs (VA) healthcare enrollment application, either in person or by phone. The intake and eligibility employees are essential participants in VA's revenue process by ensuring VA possesses accurate demographic information, including military service and health insurance information. Our eligibility team members fulfill an important role in our outreach efforts, like the "Stand Downs" VA holds for homeless veterans. Our eligibility staff educates beneficiaries on VA's comprehensive Medical Benefits Package and other services, including the provision of prosthetics, sensori-neural aids, extended care services, beneficiary travel, non-VA fee care, dental care, and, as needed, the appellate process. VA staff provides benefits counseling for special veteran populations, such

as combat veterans of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), former prisoners of war, service-connected veterans and others. In addition, these staff members help determine applicable health benefits for persons who are eligible for treatment under other authorities, including the dependents of veterans, Allied Beneficiaries, Department of Defense (DoD) beneficiaries, and beneficiaries of other types of sharing agreements.

The CHAIRMAN. If you could figure that out. It would seem to me that if we didn't have all these people working in eligibility, those resources could be used for care of our veterans. We are spending all this time dividing people into categories, determining whether they are eligible one way or the other. To me, if they can prove they are a veteran, take them in, assuming we have the resources that you outlined earlier.

Wouldn't that save a whole lot of pressure on the system, to take that kind of burden off it for all the eligibility determinations?

Dr. KUSSMAN. Are you suggesting, Mr. Chairman, that we would potentially take care of 24 million veterans?

The CHAIRMAN. Potentially, yes. I mean why don't 20 million come in now?

Dr. KUSSMAN. I presume that they have chosen for whatever reasons not to use the system. But the priority system that we are using right now has been defined and established, as I understand it, by Congress who has told us what to do.

The CHAIRMAN. Yes, but we also told you—we didn't tell you to establish a ban on Category 8's, so don't say—

Dr. KUSSMAN. No, no—

The CHAIRMAN [continuing]. In this case we told you to do it and in the other case—

Dr. KUSSMAN. No, I am not trying to—

The CHAIRMAN. You have to tell us what you think is necessary and what you think is good for the veteran population.

Dr. KUSSMAN. It says, the criteria that we are operating under clearly says that the priorities are established and it is up to the Veterans Health Administration and the VA to determine how many veterans and what priorities can be seen, giving, maintaining the quality and the access. And that exists right until today.

The CHAIRMAN. Right. But as I said earlier, that was meant to be a responsive action, not a proactive action, that you then plan, so it seems to me that you are doing, for continuing the ban on Category 8's. You are ignoring them now, because they are not part of the system. That is not what was intended. The intention was if something happened that led you to a decrease of resources, you would have to temporarily start limiting access.

But at some point then, you should say well, we had this emergency in 2006 so now in 2007 we are going to have the resources to deal with them. And you need to ask for that and we need to give that to you.

Mr. Stearns, did you have some questions?

Mr. STEARNS. I did. Thank you, Mr. Chairman. I am glad I got back in time.

And let me just say that we all appreciate your advocacy for veterans and, I think a lot of people may disagree on different points, but the Chairman is making a strong case to help our veterans and we are all on the same side of the aisle here on that effort.

When the second panel was on, Atizado was asked a question about more resources and of course he is the Assistant National Legislative Director for the DAV. And I thought he said something that was pretty striking. He came out with some caveats, before we do the Priority 8's in which we must have the capital resources and the human resources. I asked him to go forward on that and talk about it.

He indicated that throwing more money at a problem is no substitute for good management. And I think, if I understand you, Dr. Kussman, that you are saying that if we give you more money, we are not sure you have the ability to actually implement this, because you might not have—in addition to not having the full amount of money, you might not have the human and capital resources. I thought you might follow up on what the DAV from the second panel said.

Dr. KUSSMAN. Well, thank you for the question and I basically concur with what DAV said. I would caveat it a little bit though. When he said it was due to mismanagement or inadequate management, I don't think that is the issue. The challenge is to use the money that the taxpayer and the Congress so graciously gives us, to use it effectively. And we have been challenged in the past of being able to hire people and things of that sort that are in great demand in the civilian community as well as ours.

And before you came back, sir, I mentioned the article in the Washington Post yesterday, which I think was on the second page, that really went over the problem that exists in the country. There is a verse of resources and certain disciplines and you can build all the infrastructure you want, but if you can't get people to come and work there, then you haven't effectively accomplished what you—

Mr. STEARNS. Like a nurse shortage with that.

Dr. KUSSMAN. A nurse shortage, other provider shortages as well, physician and nonphysician.

Mr. STEARNS. I think you touched on, either in your opening statement or your written statement, another possibility that you don't necessarily support, but the idea you would have to outsource some of this. You might just give me a clarification what you mean by that.

Dr. KUSSMAN. Well, in my opinion, as a physician and the Under Secretary for Health, if we are going to enroll people and provide them a full range of benefits package, you have three opportunities of what to do there. One is unacceptable. First is in-house, second is you buy it, and the third is not to provide it. And the third one is unacceptable under anybody's opinion. So if we don't have the infrastructure and the personnel capacity to do it, we would have to go out and buy it.

Mr. STEARNS. So the question next is, do you have the authority to outsource the VA activities?

Dr. KUSSMAN. Yes, sir. We contract and fee base all the time in certain disciplines, in areas of the country where we can't provide—

Mr. STEARNS. No, I mean for Priority 8's, I am talking about.

Dr. KUSSMAN. Whether it is a Priority 8 or anybody else. They are enrolled in the system. We would—

Mr. STEARNS. So you have the authority to outsource the Priority 8 if you want, if you so choose, taking your three occasions, not doing anything, outsourcing, doing it in-house. And you indicated that perhaps outsourcing is an alternative.

Dr. KUSSMAN. Right. And we do that now for the whole spectrum of 1 through 8's that are enrolled in the system.

Mr. STEARNS. So you do have the authority to do that?

Dr. KUSSMAN. Yes, sir.

Mr. STEARNS. Now, I don't know if Congress, Dr. Kussman, I don't know if Congress gave you the authority to outsource. I am not familiar with that. Just a moment, just let me ask the staff here a second.

Okay. Well, in the 1996 bill it appears, staff is saying that we gave you the authority to outsource, so—

Dr. KUSSMAN. Sir, I would ask my legal counsel.

Mr. HALL. Yes, sir. We have authority to contract for healthcare resources under our general—it is called share and authority, general contract authority for healthcare resources. And it wouldn't be limited to—we couldn't outsource one particular priority group. We couldn't outsource all Category 8, Priority 8 care.

But I think Dr. Kussman's point was to get the resources we needed to take care of everybody, we would have to acquire services, resources, facilities by contract.

Mr. STEARNS. It usually doesn't happen that the Chairman leaves and lets the minority take over. So I have a distinct opportunity here to continue beyond the red light. So I will take—by unanimous consent, the Ranking Member—

Dr. KUSSMAN. I didn't hear the gavel go down—

Mr. STEARNS [continuing]. Is allowed to continue for as much time as he may consume. Not hearing any objections, so ordered.

[Laughter.]

Well, frankly, I don't know how pleased the VSO's will be with the idea that you can outsource, because I think they and others want to make sure the veterans have the responsibility and the authority and the money to do the job without outsourcing it. And so I am not sure that is a viable thing. But you know, I guess earlier you indicated you would need an additional \$33 billion to Category—

Dr. KUSSMAN. Over 10 years, sir.

Mr. STEARNS. Over 10 years, okay. So that would be \$3.3 billion. I think that is doable, that is feasible. But if we gave that money to you today for the next 10 years, you are saying you still could not satisfy taking care of Priority 8 because you don't have the human and capital resources. That is what you are saying?

Dr. KUSSMAN. That is correct.

Mr. STEARNS. Okay. So if you follow what the DAV said, then they do not believe they could support doing the Priority 8 because you have just admitted you can't take care of them because of the two caveats that they conclude. So I think the question would be then, how do we get where you have these capital and human resources? I mean what in your mind with all your background—and you have been in charge of a large hospital, a VA hospital. I mean what in your mind, if you could wave a magic wand, could we in

Congress or could you do other—is outsourcing the only way you could solve the problem?

Dr. KUSSMAN. Well, there are—I think there are multi-disciplinary ways to look at that. One would be to allow the people we have in the system to be more efficient. And as you know, we have some challenges in our infrastructure. Our hospitals are on the average of 57 years old. We have some challenges in minor construction and nonrecurring maintenance.

So there would be ways to—using advanced clinic access, and we are putting in place some initiatives to expand the hours that the clinics are open to be more efficient, not only to allow us to see more patients, but particularly to allow veterans to come in at times that are more convenient for them, particularly when they work. So those are things we could do.

One of the challenges is there aren't enough nurses in the country. There aren't enough gastroenterologists in the country. There aren't enough dermatologists in the country. And so even with the very generous pay bills that the Congress approved 2 years ago—and we are making some headway. But we are still at a challenge to hire some of the subspecialty clinics. We are making some headway in mental health services. We hired more social workers, psychiatrists and psychologists, but we still have a ways to go.

And part of it is driven by availability and the other is geography, is that we have, you know, 1,400 sites of care all over the country. People sometimes don't want to live in some of the areas that we would like to hire people. So it is a multi-faceted problem that limits our ability to take in large numbers of people and keep them in the system.

And by the way, I might add, we want to keep them in the system because we believe that we are the best quality healthcare system in the country. And one of the ways we do that is keeping track of our patients with our pharmacy benefit, our electronic health record, our performance standards. And when you outsource, then you lose some of that edge with that because of the inability to—even though we want to monitor quality, we will be sure that who we hired were good quality, but they don't have all the things, the infrastructure that we have.

Mr. STEARNS. Following what you said then, the limitations that you talked about are also the limitations in the private sector too. So you might not be able to even outsource these successfully in the private sector.

Dr. KUSSMAN. That is correct.

Mr. STEARNS. So knowing that and what you said, then is there compromise that if we and Congress decide to allow Priority 8 veterans to come into the system, it should be phased over a period of time? I mean what do we do? What would you suggest legislatively? Are you saying today you do not want to do Priority 8 ever or are you just saying you don't want to do them immediately?

Dr. KUSSMAN. I don't think anybody in the VA is saying never—

Mr. STEARNS. Right.

Dr. KUSSMAN [continuing]. With the Priority 8's. I think that we need to sit down and figure out a way that would make sense to incorporate, and maybe not all at once and some criteria—

Mr. STEARNS. So over a time phased in?

Dr. KUSSMAN. The same—

Mr. STEARNS. Yeah, and what time phase-in do you think that could be?

Dr. KUSSMAN. I hadn't really thought about that, but I think over—together maybe over the next 6 months or a year we could come up with a plan that would look at how we would try to incorporate the maximum number of Priority 8's back into the system given the rules of engagement that exist now.

Mr. STEARNS. Well, I think that is probably a good way to end this and I would suggest—I am a Member of this. I am the Vice Ranking Member. But I would suggest that you put together your thoughts on that and send it to the Chairman and to the Ranking Member, Mr. Buyer, on how you would incorporate this over the 6 months to a year and perhaps we don't need legislation, because the Secretary himself put in the requirement that you could take them, so obviously he has the authority to start taking them. And if you could come up with some definitized plan, I think that would go to helping us solve this problem. Hold on 1 second.

[Pause.]

Well, the staff had reminded me that some of this money that you need could be found through third-party collections and some of the problems the VA has had in linking billing to services provided in clinical care and, this billing for third-party collections has always been a problem as long as I have been on Veterans, so that there are ways to even make this money up by \$3.3 billion a year without necessarily an appropriation, an authorization from this Committee.

But I think that would be one way to do it, is to see your written explanation how we could solve this problem from the Administration. And with that, there are no further Members. I think we will thank you for your testimony and for waiting through the other two panels. Is there anything that perhaps in the other two panels you would like to comment on?

I know it is an open-ended, but is there something you would like to clarify that was said by the early panelists? We welcome your comment.

Dr. KUSSMAN. I will probably terrify my staff by volunteering anything, but—

Mr. STEARNS. No, I know.

Dr. KUSSMAN [continuing]. I just wanted to make a point that I think came up, about the issue of clinical need driving the availability of care. And I think you mentioned, sir, that once you are enrolled, then the clinical acuity drives what is going on. It doesn't make any difference whether you are a—

Mr. STEARNS. Yeah.

Dr. KUSSMAN [continuing]. Priority 1 versus a Priority 8. I just wanted to make sure everybody understood that. If you are not enrolled with us, that is a moot question actually, because we don't know who they are. But when you are in with us, the clinical thing, not the priorities, take precedence.

Mr. STEARNS. I wanted to make that—after Mr. Rowan, the National President of the Vietnam Veterans of America, because when

he was talking, he sort of implied that people are not getting services because of this priority system and that is not the case.

That priority is just set up to get them enrolled and then from there, they are all set. So I think, you know, we have established that and I think that is important.

With that, I think the Committee will be adjourned and we thank everybody.

Dr. KUSSMAN. Thank you, sir.

[Whereupon, at 1:20 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Bob Filner Chairman, Full Committee on Veterans' Affairs

The Committee on Veterans' Affairs will come to order. I would like to thank the Members of the Committee for being here this morning.

The issue of the Administration's continued ban on enrollment of new Priority 8 veterans is an important one. I hope that we will leave here today with a sense as to the costs and effects of rescinding the ban, as well as the costs, measured in the effect of denied access to healthcare, of continuing the Administration's policy of shutting the doors to an entire class of veterans.

P.L. 104-262, the "Veterans' Healthcare Eligibility Reform Act of 1996" ushered the VA into the modern era of medicine. In the decade that has followed, VA has remade itself into a healthcare system that is a model to others.

In January 2003, then-Secretary Anthony Principi made the decision to bar enrollment of new Priority 8 veterans. These veterans are noncompensable, non-service-connected, and have incomes above \$27,790. They also fall above the geographic income threshold established by HUD. Although comparably better off than their fellow veterans who fall within Priority Group 7, they are by no means all rich veterans, as some might have you believe. For 4½ years, the doors to VA healthcare have been closed to these veterans.

In the Majority Views and Estimates that we submitted to the Budget Committee for FY 2008, we noted that "the authority of the Administration to deny enrollment to an entire class of veterans was never meant to extend *ad infinitum*, but was provided to the VA as a management tool in order for it to address unexpected shortfalls that might arise during the course of the year."

Unfortunately, that is the situation we face today—the Administration fails year after year to request specific funding for enrolling Priority 8 veterans and treats the January 2003 decision as permanent.

The VA has estimated that reopening enrollment will bring in an additional 1.6 million veterans and require an additional \$1.7 billion. The *Independent Budget* has estimated that reopening enrollment would cost an additional \$366 million. I look forward to our witnesses addressing, with specificity, the various cost estimates regarding the effects of rescinding the enrollment ban. I also look forward to our witnesses today addressing the continued costs of maintaining the ban.

Taking care of veterans is a continuing cost of war. All veterans should have access to "their" healthcare system. The Committee looks forward to hearing the views of our witnesses as we examine the effects of the Administration's ban on our Nation's veterans.

Prepared Statement of Hon. Cliff Stearns a Representative in Congress from the State of Florida

Mr. Chairman:

I appreciate the opportunity to be here today at this important hearing on the eligibility of Priority 8 veterans for VA healthcare. There are many issues that must be considered before any changes are proposed, and I look forward to hearing the insight of our panels of witnesses on these issues.

As many of us are aware, the Veterans' Healthcare Eligibility Reform Act of 1996 reformed the very confusing previous system of categorizing the eligibility of veterans for enrollment in the VA system. In the new legislation, seven categories were created, ranging from those veterans with 50% or more service-connected disabilities to veterans not covered by other classifications but who cannot afford to defray the cost of necessary care. Then in 2001, the new category of Priority 8 veterans was

created for those who had served but have income or net worth above the VA income threshold, but who would agree to paying copayments for their care.

This eligibility category was later suspended under former VA Secretary Anthony Principi. His reasoning was that, "both quality of care and timeliness are placed at risk by the larger number of veterans seeking VA medical care." I believe that all of us want to ensure that all veterans have healthcare coverage. That is absolutely one of my primary goals as I serve on this Committee. In our search for providing for veterans, it is important that we care for our disabled veterans, veterans with special needs, and our country's poorest veterans.

We are all aware that the VA is operating under an enormous burden at present. Currently, the VA has about 7.9 million enrollees in its system. Returning veterans from Afghanistan and Iraq will continue to swell the number of veterans seeking care, with anticipated new enrollments in the coming year of about 5.8 million veterans. The concern is that without wise budgeting and prioritizing spending, the resources will be stretched so thinly that the incorporation of Priority 8 veterans will inhibit the VA's ability to provide quality care for all the veterans in the system, including the disabled and lower income vets. As we consider incorporating Priority 8 veterans into the system, let us also consider how we are getting the resources for the Department to care for them and practice fiscal discipline to ensure the needs of no veterans are overlooked.

**Prepared Statement of Hon. Ginny Brown-Waite
a Representative in Congress from the State of Florida**

I want to thank Chairman Filner for holding this hearing today.

Everyone on this Committee is aware of the restriction imposed in 2003 upon the enrollment of new Category 8 veterans into the VA healthcare system. While these individuals might be fortunate enough to have access to healthcare from other sources, there are instances where this policy is unfair and arbitrary. In my district, I hear from countless veterans who want to know when this prohibition will end. Some have been waiting for over 4 years for an opportunity to access VA care. Unfortunately, we do not always have a clear answer for them.

While I was not in Congress when the Department of Veterans' Affairs Healthcare Program Enhancement Act passed, I do recall the legislation was popular. I look forward to hearing from the VA about its plans to address the needs of Category 8 veterans.

Thank you.

**Prepared Statement of Hon. Jeff Miller
a Representative in Congress from the State of Florida**

Thank you, Mr. Chairman.

Since its inception, the Priority 8 veteran category has caused its share of controversy. The arguments made for its creation and the suspension of Priority 8 enrollment raise very valid points and concerns. The Department of Veterans Affairs has a grave responsibility to ensure our brave veterans receive top-notch healthcare in a timely fashion. On that same line, this healthcare should be for all veterans.

Levels of disability, both service-connected and nonservice-connected, are a fact of life, and there are different disabilities that require more frequent and more urgent care. However, I do not think that VA should address the more urgent healthcare needs by completely shutting out those with less urgent needs. A veteran is a veteran, and VA needs to adjust its operations, its budgeting, and its healthcare system so that all veterans can be treated.

For several years, this Committee has seen requests from the Administration in its annual budget requests to establish enrollment fees and increase pharmacy copayments for certain Priority 8 veterans. Consistently, Congress has overwhelmingly not supported those proposals. The message is clear that all veterans have earned quality care. I look forward to today's testimony and hope that some constructive solutions can be offered so that veterans are not shut out of the system. If VA cannot adequately address the issue with their current structure, perhaps a more significant change needs to be proposed.

**Prepared Statement of Hon. Harry E. Mitchell
a Representative in Congress from the State of Arizona**

Thank you, Mr. Chairman.

The eyes of our country are on this Congress as we continue to learn about the difficulties of not only our newest generation of veterans, but also those who served many decades ago. Each group presents its own set of needs to the veterans health system, and we must determine how best to care for these needs in as equitable and efficient a manner as possible.

My thanks to the members of the panel who are here today. I look forward to hearing your thoughts and recommendations and working with this Committee to ensure that we do the best we can for our Nation's veterans.

**Prepared Statement of Stephanie J. Woolhandler, M.D., M.P.H.
Associate Professor of Medicine, Harvard Medical School, and
Co-Founder, Physicians for a National Health Program**

Uninsured Veterans: A Stain on America's Flag

Summary/Oral Testimony

In my written testimony I present detailed information on the health insurance coverage and problems in access to healthcare of America's veterans, based on analyses of multiple years of data from two annual national surveys carried out by the government: The Current Population Survey and the National Health Interview Survey.

I will address two questions: (1) How many veterans are currently uninsured? And (2) Do uninsured veterans suffer problems in access to care—similar to other Americans who are uninsured?

In 2004, 1.8 million military veterans neither had health insurance nor received ongoing care at Veterans Health Administration (VHA) hospitals. Note that the surveys asked veterans if they had health insurance, and if they had veterans or military healthcare. We counted them as uninsured only if they answered no to both questions. The number of uninsured veterans has increased by 290,000 since 2000. The proportion of non-elderly veterans who were uninsured rose from less than one in ten (9.9%) in 2000 to more than one in eight (12.7%) in 2004.

An additional 3.8 million members of veterans' households were also uninsured and ineligible for VHA care.

Virtually all Korean War and World War II veterans are over age 65 and hence covered by Medicare. However, 645,628 Vietnam-era veterans were uninsured (8.5% of the 7.56 million Vietnam-era vets). Among the 8.6 million veterans who served during "other eras" including the Persian Gulf War, 12.9% (1,105,891) lacked health coverage.

Almost two-thirds (64.3%) of uninsured veterans were employed and nearly nine out of ten (86.4%) had worked within the past year. Most uninsured veterans, like other uninsured Americans, were in working families. Many earned too little to afford health insurance, but too much to qualify for free care under Medicaid or VA means testing.

Uninsured veterans have the same problems getting the care they need as do other uninsured Americans. Moreover, many uninsured veterans have serious illnesses requiring extensive care. Among uninsured veterans older than 45 years, nearly one in five (19.1%) were in fair or poor health. Nearly one in three uninsured veterans (of all ages) reported at least one chronic condition that limited their daily function.

A disturbingly high number of uninsured veterans reported needing medical care and not being able to get it within the past year. More than a quarter (26.5%) of uninsured veterans failed to get needed care due to costs; 31.2% had delayed care due to costs. Among uninsured veterans, 44.1% had not seen a doctor or nurse within the past year, and two-thirds failed to receive preventive care. By almost any measure, uninsured veterans had as much trouble getting medical care as other uninsured persons.

The VHA is a rare success story in our healthcare system. The VHA offers more equitable care¹ and higher quality^{2,3,4} care than the average care in the private sector, and has become a medical leader in research, primary care, and computerization.

While we support opening VHA enrollment to all veterans, this would still leave many veterans unable to access care because they live far from VHA facilities. Moreover, even complete coverage of veterans would leave 3.8 million of their family members uninsured. Hence, my colleagues and I support a universal national health insurance program that would work with and learn from the VHA system in covering all Americans.

Additional Written Testimony

Background

Forty-five million Americans were uninsured in 2005, the latest year for which reliable data are available. While the Census Bureau's annual survey on health insurance includes questions about previous military services, the Bureau's report on coverage does not include tabulations of veterans' coverage. In addition to the sources of health coverage available to other Americans—Medicare, Medicaid and private coverage—some military veterans obtain care through the network of hospitals and clinics run by the Veterans Health Administration (VHA).

While many Americans believe that all veterans can get care from the VHA, even combat veterans may not be able to obtain VHA care. The 1996 Veterans' Healthcare Reform Act expanded eligibility for VHA care to all veterans, but instructed the VHA to develop priority categories for enrollment. The VHA priority list includes eight priority categories, with veterans offered care based on their priority status and the resources available (Appendix).

As a rule, VHA facilities provide care for any veteran who is disabled by a condition connected to his/her military service, and care for specific medical conditions acquired during military service. Any veteran who passes a means test is eligible for care in VHA facilities but has lower priority status (Priority 5 or Priority 7, depending upon income level) and is enrolled on a space-available basis. Veterans without service-connected illnesses or disabilities, and with incomes above 80% of the median income in their area are classified in the lowest priority group, Priority 8.

In the 7 years after the passage of the Veterans' Healthcare Reform Act, VHA enrollment grew 141%, from 2.9 million to 7.0 million. However, funding increased by only 60%. Because VHA funding did not keep pace with the demand for care, long waiting lists developed at many VHA facilities. By 2002, there were almost 300,000 veterans either placed on waiting lists for enrollment or forced to wait for 6 months or more in order to receive an appointment for necessary care (Memorandum from Department of Veterans Affairs to Chairs and Ranking Members of Senate and House Veterans' Committees and VA-HUD Appropriations Subcommittees, July 2002).

In January 2003, President Bush's Secretary of Veterans Affairs halted enrollment of Priority 8 veterans. Since that time these veterans have remained ineligible for VHA enrollment.

VHA analysts have estimated that about three-quarters of VHA-enrolled veterans have other health coverage such as Medicare or private insurance, and that 1.013 million VHA patients were uninsured in 1999 (Donald Stockford et al. *Uninsured Veterans and Veterans Health Administration Enrollment System*, 2003. Department of Veterans Affairs, April 2003.). The 2001 National Survey of Veterans (NSV) found that 10.0% of veterans—2.52 million vets—were uninsured, 0.9 million of whom used VHA hospital, outpatient or emergency care (2001 National Survey of Veterans: Final Report and supplemental tabulations, available at: <http://www.VHA.gov/vetdata/SurveyResults/>). Thus, the NSV data indicate that more than 1.6 million veterans had neither health insurance nor VHA care in 2001.

¹Jha AK, Shlipak MG, Hosmer W, Frances CD, Browner WS. Racial differences in mortality among men hospitalized in the Veterans Affairs healthcare system. *JAMA*. 2001; 285:297–303.

²Asch SM, McGlynn EA, Hogan MM et al. Comparison of quality of care for patients in the Veterans Health Administration and patients in a national sample. *Ann Int Med* 2004; 141:938–945.

³Petersen LA, Normand S-LT, Leape LL, McNeil BJ. Comparison of use of medications after acute myocardial infarction in the Veterans Health Administration and Medicare. *Circulation* 2001; 104:2898.

⁴Kerr EA, Gerzoff RB, Krein SL et al. Diabetes care quality in the Veterans Affairs health-care system and commercial managed care: The TRIAD Study. *Ann Intern Med* 2004; 141:272.

This report uses data from two large, recent surveys of the U.S. population to examine two related questions: (1) How many veterans and their family members lacked any health coverage in 2005 (i.e. they had neither insurance nor VHA care)?; and (2) What problems in access to healthcare did these uncovered veterans and their families experience?

Methods

Our principal analysis used data from two large surveys of the U.S. population: the Current Population Survey Annual Social and Economic Supplement (CPS) for multiple years (most recently March 2005), and the 2002 and 2004 National Health Interview Survey (NHIS).

The CPS is the standard source for estimates of health insurance coverage in the U.S. We used weights supplied by the Census Bureau to extrapolate the findings to the entire U.S. population. The CPS asks only about prior U.S. military service. Hence, both honorably discharged and other veterans are included under the rubric “veteran.” We considered a person insured if they had any private insurance, Medicaid, SCHIP, Medicare, other insurance, or were “covered by Champus, veterans or military healthcare.” Thus, persons enrolled in VHA (or military) healthcare were classified as insured even if they had no other coverage. We considered a person to be a veteran’s family member if they resided in a household with a veteran. Because the CPS is considered the standard source for data on health insurance coverage, we based most of our analyses of veterans’ insurance coverage on these data.

Because the NHIS includes more detailed healthcare access and utilization measures than the CPS, we used the NHIS for analyses of these issues. This survey is conducted annually by the National Center for Health Statistics of the U.S. Department of Health and Human Services. We used the NHIS to analyze health status and healthcare utilization—questions that are not asked in the CPS. The NHIS asks if subjects have been “honorably discharged” from the armed forces, and hence identifies slightly fewer persons as veterans than does the CPS. Because the NHIS is specifically designed to assess health and healthcare issues, its questions are generally more specific than those on the CPS. For instance, the NHIS survey allows differentiation of persons who have only “veterans or military healthcare” from those who have military-paid insurance plans such as Champus, “ChampusVA,” or TRICARE. NHIS also contains information on specific medical conditions, access to medical care and use of healthcare services.

Data were analyzed using SAS statistical software.

Lack of Health Coverage is Common Among Veterans

1.77 million American veterans were uninsured in 2004, according to the CPS data, including 12.7% of all non-elderly (age <65) veterans. In this survey, veterans with “Champus, TRICARE, veterans or military healthcare” were categorized as having health coverage. Hence, the 1.77 million figure represents persons with neither health insurance nor ongoing access to VHA medical facilities.

As expected, because of their age, virtually all World War II and Korean War veterans had Medicare coverage. However, many veterans with more recent military service were uninsured. Among the 7.56 million Vietnam-era veterans, 646,000 (8.5%) lacked any coverage. Among the 8.6 million veterans who served during “other eras,” including the Persian Gulf War, one in eight was uninsured.

Table 1—Number and Percentage of Uninsured Veterans for Recent Veterans, by Service Era, 2004

Era of Military Service	Number of Living Veterans, Total	Number Lacking Health Coverage	Percent Lacking Health Coverage
Other (includes Gulf War)	8.60 million	1,105,891	12.9%
Vietnam	7.56 million	645,628	8.5%

Source: Analysis of Current Population Survey, March 2005 Supplement.

The 2004 figures represent an increase of 290,000 in the number of uninsured veterans since 2000. In 2000, 9.9% of veterans under the age of 65 were uninsured, rising to 12.7% in 2004.

In addition to the 1.77 million uninsured veterans in 2004, 3.8 million members of veterans’ families lacked coverage.

Veterans Without Health Coverage Are Not Currently Receiving VHA Care

According to the NHIS, 1,670,410 honorably discharged veterans had neither health insurance nor “military or veterans’ healthcare” in 2002. This number is statistically indistinguishable from the CPS-based estimate of uninsured veterans for that year. In the NHIS, an additional 1,426,897 veterans indicated that they had military or veterans’ healthcare but no other coverage.

Table 2—Health Insurance of Veterans and Their Family Members—2002

	Family Members of Veterans	Veterans
Private coverage	73.2%	70.6%
Medicaid coverage	6.4%	2.3%
Medicare coverage	19.1%	37.1%
Champus/TRICARE/ChampusVA	5.5%	7.2%
Military/veterans’ medical care only	0.8%	6.3%
Uninsured and no military/VHA Care	9.4%	7.4%

Source: Analysis of National Health Interview Survey, 2002. Public Use Data Release, December 2003.
Note: Individuals may have more than one type of coverage.

Which Veterans Are Uninsured?

The typical uninsured veteran was an employed male in his late forties living with one or two family members. Compared to the uninsured nonveteran population, uninsured veterans were older, and more often employed, male and high school graduates (data not shown).

Compared to veterans with health coverage, uninsured veterans were younger, more likely to be working, and had lower incomes. 64.3% of uninsured veterans were working at the time of the survey, and 8.7% were in the labor force but currently unemployed or laid off. 70.1% of uninsured veterans had family incomes at or above 150% of the Federal poverty level, and 46.7% had incomes above 250% of poverty (a level that would likely place them above the income threshold for Priority Group 7, leaving them ineligible for VHA enrollment).

Table 3—Veterans’ Demographic and Employment Characteristics, by Insurance Status—2004

	Insured Veterans	Uninsured Veterans
Female	5.4%	7.4%
Age <18	0%	0%
18–44	16.3%	44.5%
45–64	40.7%	55.2%
>64	43.0%	1.3%
Income <150% of poverty	11.4%	29.9%
Income <250% of poverty	28.9%	53.3%
Currently employed	48.8%	64.3%
Currently unemployed or laid off	1.9%	8.7%

Source: Analysis of Current Population Survey, March 2005.

Veterans Lacking Health Coverage Are Not in Good Health

Many uninsured veterans had serious health problems. When asked to rate their health as “excellent,” “very good,” “good,” “fair” or “poor,” less than one-quarter of uninsured veterans indicated that they were in excellent health; one in six had a disabling chronic illness.

Table 4—Share of Veterans in Fair or Poor Health, by Age and Insurance Status—2004

	Insured Veterans (%)	Uninsured Veterans (%)
Fair or poor health (%)		
Age 0–17	N/A	N/A
18–24	5.6	3.7*
25–44	7.7	7.9
45–64	18.8	19.1
>64	30.3	N/A

*Based on small numbers of respondents—note almost all persons over 65 are covered by Medicare.
 Source: CPS March 2005 Supplement. Respondents were asked to rate their health as excellent, very good, good, fair or poor.

Uninsured Veterans and Family Members Forego Needed Healthcare Due to Cost

Uninsured veterans indicated that they faced major barriers to obtaining medical care. Among veterans age 18–64, those without coverage were five times more likely than insured veterans to delay care because of costs, five times more likely to forego medications because of costs, and six times more likely to forego medical care because of costs than those with insurance (Table 5).

Table 5—Healthcare Access Problems During the Past 12 Months of Veterans and Family Members 18–64 Years Old—2004

	Insured Veterans	Uninsured Veterans
Delayed care due to cost	6.6%	31.2%
Didn't get needed care due to cost	4.3%	26.5%
Couldn't afford medications	5.5%	25.1%
Couldn't afford glasses	5.3%	20.8%

Source: Analysis of the National Health Interview Survey, 2004.

Uninsured Veterans Use Less Healthcare

Our analyses of the amount of care actually used by uninsured veterans and their families confirmed that they, indeed, lacked access to care. Two-thirds of uninsured veterans did not get any preventive care. Nearly half of uninsured veterans had not made **any** office visits to any health professional in the past year, and a similar number had **no** usual place to go when they got sick (Table 6).

Table 6—Healthcare Access and Utilization of Veterans and Family Members Under Age 65, By Insurance Status—2004

	Insured Veterans	Uninsured Veterans
No office visits, past year	15.5%	49.1%
Did not get preventive care anywhere	51.8%	66.4%
No contact with health professional in past year	14.9%	44.9%
No usual place to go when sick	8.9%	51.4%

Source: Analysis of National Health Interview Survey, 2004.

Uninsured Veterans' Access is No Better, and in Most Respects Worse, Than That of Other Uninsured People

Indicators of access to care for uninsured veterans were strikingly similar, and in some cases worse, than those for other uninsured individuals (Table 7). This indicates that VHA care did little or nothing to fill the gaps for uninsured veterans.

Table 7—Healthcare Access and Utilization of Uninsured Veterans Compared to Other Uninsured People, Age 18–64

	Other Uninsured Persons	Uninsured Veterans
No contact with health professional, past year	42.3%	44.9%
Doesn't get preventive care anywhere	69.8%	66.4%
No usual place to go when sick	48.9%	51.4%
Delayed care due to cost	26.3%	31.2%
Didn't get needed care due to cost	22.1%	26.5%
Couldn't afford medications	23.9%	25.1%
Couldn't afford glasses	17.5%	20.8%

Source: Analysis of National Health Interview Survey, 2004.

Discussion

Almost 5.6 million American veterans and members of veterans' families are uninsured and not receiving care in the VHA system. They account for 1 out of 8 uninsured people in our Nation. Like other uninsured adults, most of the uninsured veterans were working; many had two jobs. All Americans deserve access to high-quality, affordable healthcare. Yet it is especially troubling that many who have made sacrifices and often placed themselves in harm's way are later denied the healthcare they need.

Were the veterans who were classified as uninsured in the surveys we analyzed truly denied access to the care they need? Several pieces of evidence suggest that the doors to medical care—including the VHA system—are effectively closed to most of this group.

First, both surveys we analyzed asked respondents if they had "veterans or military healthcare" and considered anyone answering "yes" as insured. The National Health Interview Survey was highly specific in this regard. We considered all veterans reporting veterans or military healthcare to have coverage. Hence, veterans who lacked insurance but were enrolled in the VHA system would be considered insured in our analysis. The data suggest that the VHA currently cares for only about 45% of the more than 3 million veterans without any other coverage.

Second, the veterans we identified as lacking coverage had substantial problems in gaining access to healthcare. Like other uninsured people, they were often unable to afford care, had low rates of healthcare utilization, and frequently went without needed services. Indeed, for virtually every measure of access to care, uninsured veterans were indistinguishable from other uninsured persons, and they fared much worse than insured veterans. Even if some of these uninsured veterans are theoretically eligible for VHA care, their real-world access to healthcare is just as bad as—and by some measures worse than—that of other uninsured people.

Finally, about half of the uninsured veterans had incomes that would make them completely ineligible for VHA enrollment (Priority 8). For many others (Priority 7), care would only be available with substantial copayments (e.g. \$50 for specialty care). Moreover, low-priority veterans are generally ineligible for free transportation to VHA facilities, leaving care inaccessible to many vets.

Appendix

Priority Groups for VHA Healthcare Enrollment

Priority 1

Service-connected disability rated 50 percent or more disabling.

Priority 2

Service-connected disability rated 30 percent or 40 percent disabling.

Priority 3

Former POWs.
 Purple Heart recipients.
 Discharged for a disability that was incurred or aggravated in the line of duty.
 Service-connected disability rated 10 percent or 20 percent disabling.
 Special-eligibility classification under "benefits for individuals disabled by treatment or vocational rehabilitation."

Priority 4

Veterans who are receiving aid and attendance or household benefits.
 Veterans who have been determined by the VHA to be catastrophically disabled.

Priority 5

Income and net worth below VHA Means Test threshold.
 Receiving VA pension benefits.
 Eligible for Medicaid benefits.

Priority 6

World War I veterans.
 Mexican Border War veterans.
 Veterans solely seeking care for disorders associated with:

- Exposure to herbicides while serving in Vietnam.
- Exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima or Nagasaki.
- Disorders associated with service in the Gulf War.
- Any illness associated with service in combat in a war after the Gulf War or during any period of hostility after November 11, 1998.

Priority 7

Veterans who agree to pay copayments with income and/or net worth above the VHA Means Test threshold and income below the HUD geographic index.

Priority 8 (Not currently eligible for enrollment)

Veterans who agree to pay specified copayments with income and/or net worth above the VHA Means Test threshold and the HUD geographic index.

**Prepared Statement of Carl Blake
 National Legislative Director, Paralyzed Veterans of America**

Chairman Filner, Ranking Member Buyer, and Members of the Committee, on behalf of Paralyzed Veterans of America (PVA), I would like to thank you for the opportunity to testify today on the ongoing policy within the Department of Veterans Affairs (VA) to prohibit enrollment of Category 8 veterans into the healthcare system. As our position is consistent with the policy recommendations of the *Independent Budget*, I will comment on this issue accordingly.

With the establishment of eligibility reform in 1996, the Secretary of Veterans Affairs was given the authority to manage the enrollment categories established by that law. Subsequent to eligibility reform, the VA witnessed a dramatic increase in veterans enrolling in the VA healthcare system. Unfortunately, the pace of appropriations did not keep pace with this rapidly growing demand on the system.

Due to severely constrained budgets only a few years ago, former Secretary Anthony Principi made the administrative decision to place a prohibition on enrollment of new Category 8 veterans into the VA healthcare system beginning in January 2003. PVA, along with the co-authors of the *Independent Budget*—AMVETS, Disabled American Veterans, and the Veterans of Foreign Wars—strongly opposed this decision at that time. However, the VA assured us that the decision was strictly a 1-year moratorium as the VA sought to improve healthcare services while dealing with chronic and severe underfunding.

And yet, more than 4 years later, these veterans are still prohibited from enrolling in the VA healthcare system. Despite repeated calls by Congress as well as all veterans service organizations for the VA to overturn this policy decision, the policy remains unchanged. In accordance with the recommendations of the *Independent Budget*, we urge the VA to take the steps necessary to reopen the system to Category 8 veterans.

As we testified back in February at the time of the release of the President's Budget Request for FY 2008, the healthcare funding recommendations of the *Independent Budget* do not include additional money to provide for the healthcare needs

of Category 8 veterans now being denied enrollment into the system. We made the decision 2 years ago to include this as a separate line-item as it would have artificially inflated our overall healthcare recommendation, particularly since the VA did not seem to have any interest in reversing the policy. We felt that it was not appropriate to build our healthcare budget recommendation on the desired change.

However, we certainly believe that adequate resources should be provided to overturn this policy decision. Due to ever-growing difficulty in seeking care in the broader healthcare market, more and more veterans have chosen to seek care from the VA. They have also chosen to seek care from the VA because they, as we all do, recognize that VA healthcare is the best option in this country. With this in mind, it makes no sense on a larger scale to turn these veterans away from the most cost-effective and cost-efficient healthcare system in America. Ultimately, the cost of their care in the private sector will be even greater.

Current VA estimates suggest that as many as 1.5 million Category 8 veterans will be denied enrollment in the healthcare system by FY 2008. When budget estimates are developed for the cost of providing care to Category 8 veterans, often a worst-case scenario whereby all 1.5 million of these veterans would seek care in the VA healthcare system is considered. However, this is simply unrealistic. In a report entitled "The Potential Cost of Meeting Demand for Veterans' Healthcare," published by the Congressional Budget Office (CBO) in March 2005, the CBO explained that the actual utilization rate of Category 8 veterans, prior to the enrollment prohibition being put in place, was only about 20 percent. Based on this information, the *Independent Budget* estimated that only about 314,000 Category 8 veterans would have actually used the system, meaning that the VA would only be responsible for the cost for that number of veterans.

For FY 2008, the *Independent Budget* estimates that the VA will require approximately \$366 million in real appropriated dollars to reopen the healthcare system to Category 8 veterans. Initially, we determined that the overall cost to allow 314,000 Category 8 veterans back into the system would be approximately \$1.1 billion. This was based on an estimated average cost-per-user of approximately \$3,500. However, the simple fact is that if Congress makes the decision to allow these men and women to enroll, these veterans will be paying copayments and any other required fees. As a result, the real dollars cost-per-user drops significantly to approximately \$1,165. As a result, the actual money that Congress would be responsible for providing to allow the estimated number of new Category 8 users into the system is \$366 million.

We would also like to draw your attention to a particular concern that we have regarding a seemingly inequitable application of the enrollment policy. As you all know, current law allows for a veteran of Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) to receive 2 years of healthcare from the VA immediately following his or her release from active duty. Once that 2-year period expires, any OEF/OIF veteran who sought care from the VA is permanently enrolled in the VA healthcare system in the enrollment category that they would normally be assigned. This means that any OEF/OIF veterans who are Category 8 veterans are allowed to permanently enroll in the VA healthcare system, despite the current prohibition on similar enrollments. PVA certainly has no objection to these men and women receiving the care that they have earned and deserve.

However, this is wholly unfair to any other veteran who would qualify for enrollment in Category 8, and whose service was no less important. The example has been used many times, but it certainly is worth repeating about the World War II veteran who stormed the beaches at Normandy and spent nearly a year of continuous service in combat and subsequently returned home without injury or illness. Following the War, that veteran took advantage of the GI Bill to get an education, and eventually lead a successful life. However, because he now has a yearly income above the maximum allowed by VA for Category 8 veterans, he is prohibited from enrolling in the VA healthcare system.

We do not see how this veteran's service is any less honorable or important than the young man or woman currently serving in the Global War on Terror. There is simply no reason for that veteran to be turned away from the system. Just as we fully support the enrollment of the OEF/OIF veterans into the VA healthcare system, so too should any previous veteran who would otherwise be a Category 8 veteran be allowed into the system.

Finally, I would like to emphasize that PVA believes that we would not be having any of this discussion about who can get into VA and who cannot if the Veterans Health Administration was funded through assured (or mandatory) funding. The simple fact is that despite positive steps in the appropriations process and a positive outlook for FY 2008, nothing will prevent the VA from facing this same uncertainty in coming years. The budget and appropriations process over the last number of

years demonstrates conclusively how the VA labors under the uncertainty of not only how much money it is going to get, but, equally important, when it is going to get it. Recall that even though the VA received a very good appropriation for FY 2007, it was still provided nearly 5 months into the fiscal year. This is no way for the VA to be forced to manage its healthcare system. It is not surprising that the VA took such a drastic step in 2003 given the budget climate at that time.

In the end, none of these veterans should be denied enrollment into the VA healthcare system. No veteran's service is any more or less honorable than another, and it should not be treated as such. We hope that the VA will choose to overturn this policy without being forced by Congress to do so. It is the right thing to do.

Mr. Chairman and Members of the Committee, once again I would like to thank you for the opportunity to testify. I would be happy to answer any questions that you might have.

**Prepared Statement of Adrian M. Atizado
Assistant National Legislative Director, Disabled American Veterans**

Mr. Chairman and other Members of the Committee:

Thank you for inviting the Disabled American Veterans (DAV) to testify today. DAV is an organization of 1.4 million service-disabled veterans, and along with our auxiliary, we devote our energies to rebuilding the lives of disabled veterans and their families. Thank you for scheduling this hearing to consider current policy of the Department of Veterans Affairs (VA) for Priority Group 8 (PG8) veterans. New veterans who seek access to VA healthcare and fall into this category are presently barred from enrollment in the VA healthcare system.

DAV is an organization that advocates beneficial Federal policy and legislation on behalf of 2.6 million American veterans who were wounded or made ill during wartime service. Given our focus on the service-disabled veteran population—veterans who are guaranteed by law high-priority access to VA—it would seem natural to ask why DAV would be concerned about the absence in VA healthcare of nonservice-connected veterans with incomes above the geographically adjusted Means Test threshold. DAV, along with the other veterans service organizations making up the *Independent Budget*, has supported reentry of PG8 veterans because we believe that to be a viable healthcare system, VA needs a wide range of patients, including those who are physically well and want to maintain their good health, those with acute and chronic illnesses, and veterans with catastrophic healthcare problems who need highly specialized services. When VA manages a proper mix of patients, it offers a better healthcare plan to all patients and is a more attractive place of employment for clinical and health professions, educational, and research professional staff. For DAV, a better system for all veterans' care means a better system for service-disabled veterans.

Mr. Chairman, while DAV opposed the decision taken by then-Secretary of Veterans Affairs Anthony J. Principi to close further PG8 enrollments on January 17, 2003, we were not surprised by that decision. As Secretary Principi himself stated publicly, VA faced "the perfect storm," with insufficient funding and overwhelming demand. Going back to that time, VA was under a tremendous workload strain, with eventually more than 300,000 enrolled veterans waiting more than 6 months for their initial primary care appointments, and with all enrolled veterans' care being rationed. We understood then and now the reason for this decision—clearly, VA was suffering from severe underfunding across its healthcare programs. The run-up to that decision by Secretary Principi also fueled our determination at DAV to seek legislation reforming VA's healthcare budget formulation and discretionary appropriations process. The system in place then and now does not fund known and expected needs and remains subject to political manipulation, the imposition of gimmicks and questionable policy proposals. To address these issues the then-Chairman of this Committee, the Honorable Christopher H. Smith, introduced legislation (H.R. 5250) in the 107th Congress; in the 108th and 109th Congresses the then-Ranking Member, the Honorable Lane Evans, introduced similar bills, H.R. 2318 and H.R. 515, respectively. No congressional actions were taken on those bills.

Enactment of these proposals would have established certainty of VA healthcare funding through the application of a defined formula based on the actual cost of care and the actual number of veterans under VA care, with a built-in inflation adjustment. Under these bills, the Administration and Congress would retain their executive and oversight responsibilities as under current law. While we supported these bills in part because of our desire that PG8 veterans be readmitted to the system, the PG8 issue is only a symptom of the larger problem and not the source of the

problem itself. Obviously, even with the exclusion of the PG8 veterans, now numbering more than 1 million veterans, those budget and appropriations conditions continue to exist today. We at DAV remain hopeful that funding reforms will eventually permit reentry of PG8 veterans to VA healthcare.

Mr. Chairman, when Congress authorized the Veterans' Healthcare Eligibility Reform Act of 1996, Public Law 104-262, it did so fully cognizant that employed veterans with higher incomes and workplace-based health insurance—most being classified in the current PG8 category—would enroll in VA healthcare, and that their costs as consumers of VA healthcare would be offset or significantly subsidized by first- or third-party insurance collections. The primary objective of the Act was dissolving the irrational eligibility system in place before, that prevented some veterans, even service-disabled veterans, from receiving holistic care by VA, particularly in the outpatient setting. Also, the Act eliminated a tangled web of rules and internal VA policies that made healthcare eligibility decisions bureaucratic, complicated, confusing, and harmful to the health of veterans who depended on VA to meet their vital healthcare needs.

Mr. Chairman, the decision to exclude PG8 veterans from VA healthcare enrollment at the beginning of 2003 also must be taken into historical context. While the Veterans Health Administration (VHA) was in the midst of unprecedented systemic—even revolutionary, change, closing 25,000 hospital beds, shifting its emphasis to community-based primary and preventative services and moving away from reliance on complicated inpatient services and medically unnecessary hospital admissions, Congress passed the Balanced Budget Act (BBA) of 1997, Public Law 105-33. That Act was intended to flatline all increases in domestic discretionary Federal spending, across the board, including funding for VA healthcare. As the effects of the BBA took hold during the 3-year life of that law, VA's financial situation shifted from challenging to that of crisis. In 2000, at the urgings of both this Committee and your Senate counterpart, Congress relented and provided the Veterans Health Administration (VHA) a supplemental appropriation of \$1.7 billion. Nevertheless, a 3-year funding drought built up conditions that could not easily be surmounted by one infusion of new funding. VHA began queuing new veteran enrollees, the waiting list lengthened and rationing of care was commonly reported. Eventually, by 2002, the list of veterans waiting more than 6 months for their first primary care appointment inched toward 300,000 nationwide. Given an Administration that would not permit additional funding to stem the waiting list buildup, Secretary Principi, using the policy available to him, shut off new enrollments of PG8 veterans and set about a plan to get the waiting list under control.

Another consideration important to this discussion is that the BBA also authorized a ten-site "Medicare subvention" demonstration project within the Department of Defense (DoD) healthcare system as a precursor to the advent of Medicare subvention in VHA. This program eventually failed in DoD and, later known as "VA+Choice Medicare" and later still, "VAAdvantage," never got off the ground in VA due to opposition by the Office of Management and Budget (OMB) and the Department of Health and Human Services. This failure meant that no Medicare funds would ever be received by VHA for the care it had been providing (and is still providing) to fully Medicare-eligible veterans receiving care as enrolled VA patients, at a huge savings to the Medicare trust funds. Approximately one-half of VHA's enrolled population is eligible for Medicare. Many PG8 veterans, in and out of VA, are Medicare eligible as well.

By 2002, DAV and the veterans organization community began advocating for significant change in VA's funding system, by shifting the budget function to a mandatory formula. It was and is obvious to us that this system of an "educated guess" made almost 2 years in advance of what level of funding VHA would actually need, including gimmicks and other manipulations, is fatally flawed. Given what is at stake, we will continue to press for assured funding for VA healthcare or some alternative method to achieve timely and adequate budgets for veterans healthcare. We acknowledge and applaud the continued support from this Committee to increase VA healthcare funding over the last several budget cycles and hope the Committee will schedule a hearing in the near future to consider funding reforms to help stabilize the system.

An additional perspective to consider with respect to funding and the status of PG8 veterans is that of the President's Task Force to Improve Healthcare Delivery for Our Nation's Veterans. Dr. Gail Wilensky, Co-Chair of that Task Force, testified before your Committee on March 26, 2003, 2 months following the exclusion of PG8 veterans from VA enrollment. She stated:

"As I noted earlier, as the Task Force addressed issues set out directly in our charge, we invariably kept coming up against concerns relating to the

current situation in VA in which there is such a mismatch between the demand for VA services and the funding available to meet that demand. It was clear to us that, although there has been a historical gap between demand for VA care and the funding available in any given year to meet that demand, the current mismatch is far greater, for a variety of reasons, and its impact potentially far more detrimental, both to VA's ability to furnish high quality care and to the support that the system needs from those it serves and their elected representatives.

The PTF members were very concerned about this situation, both because of its direct impact on VA care as well on how it impacted overall collaboration [with DoD]. Our discussion on the mismatch issue stretched over many months and, as anyone following the work of the Task Forces already knows, it was the area of the greatest difference of opinion among the members.

Although we did not reach agreement on one issue in the mismatch area—that is, the status of veterans in Category 8, those veterans with no service-connected conditions with incomes above the geographically adjusted means test threshold—we were unanimous as to what should be the situation for veterans in Categories 1 through 7, those veterans with service-connected conditions or with incomes below the income threshold.”

Unfortunately, we must surmise based on the above historical recounting and our analysis that the readmission of PG8 veterans to VHA, absent a major reformation of VA's funding system, will stimulate and trigger a new funding crisis in VA healthcare. While Congress is poised to add a significant new funding increase to the VA medical accounts for fiscal year 2008, one that we deeply appreciate, we are uncertain that even that generous increase will be sufficient to offset all of VA's financial requirements. Also, it should be pointed out that the needs of these newly-admitted patients would be challenging for VHA's human resources and capital programs. We are concerned whether sufficient health professional manpower could be recruited to enable VHA to put them into place in an orderly fashion to meet this new demand. Also, VA's physical space may be insufficient to accommodate the new outpatient visits that PG8 patients will generate.

In summary, Mr. Chairman and Members of the Committee, the question about PG8 veterans reenrolling in VA healthcare is not a question only about them and their needs for healthcare. It is also a larger question about the sufficiency, reliability and dependability of the current system of funding VA healthcare through the domestic discretionary appropriations process. As far as DAV is concerned, we should not have one without the other. To that end, DAV challenges this Committee to identify an American business that could operate successfully and remain viable if, in 12 consecutive years, it had no advance confidence about the level of its projected revenues or the resources it needed to bring a product or service to market, no ability to plan beyond the immediate needs of the institution day-to-day, and no freedom to operate on the basis of known or expected need in the future. In fact this has been the situation in VHA, with 12 consecutive Continuing Resolutions to begin its fiscal years, creating a number of conditions that are preventable and avoidable with basic reforms in funding. Until those reforms are enacted to guarantee that on October 1 of each year, VHA will have a known budget in hand, will have the means and methods to spend those funds in accordance with need, and that VA's budget will be based on a stable, predictable and sufficient methodology, we are reluctant to endorse immediate readmission of PG8 veterans into the VA healthcare system. We take this position despite our acknowledgement that PG8 veterans bring vitality to the system that is important to service-disabled veterans who need sustained VA healthcare.

One final matter warrants attention of the Committee on the question of PG8 veterans. Veterans of our current overseas wars are granted 2 years of eligibility for VA healthcare post-discharge. For those without service-connected disabilities, they are enrolled as PG8 veterans. When that 2-year eligibility window closes, those who are enrolled remain enrolled as PG8. A nonservice-connected Vietnam veteran, or a veteran of an earlier war, who applies for enrollment and whose income exceeds the PG8 threshold, is denied access under the current policy. This kind of differentiation between classes of veterans sets the stage for a “two-tiered” healthcare system, one that provides ready access to the newest veterans but may deny any access to older ones. DAV is very troubled by this inequity.

Mr. Chairman, this concludes my statement, and I will be pleased to respond to your questions and those of other Members of the Committee.

**Prepared Statement of Peter S. Gaytan, Director
Veterans Affairs and Rehabilitation Commission, American Legion**

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to present The American Legion's views on the current policy of the Department of Veterans Affairs (VA) on Priority Group 8 veterans.

The American Legion strongly believes that all veterans, who are eligible to receive benefits from VA, should have timely access to the VA healthcare system. For VA to operate under a policy that restricts veterans who, prior to the enactment of this policy, were eligible for VA healthcare is unacceptable. Honorable military service qualifies a veteran for access to the VA healthcare system and The American Legion opposes any policy that redefines eligibility for benefits in an attempt to limit enrollment.

In passing the Veterans' Healthcare Eligibility Reform Act of 1996, P.L. 104-262, Congress required VA to furnish hospital care and medical services to, among others, any veteran with a compensable service-connected disability or who is unable to defray the expenses of necessary medical care and services. It further authorized VA, with respect to veterans not otherwise eligible for such care and services, to furnish needed hospital, medical, and nursing home care within existing appropriations. To help supplement the discretionary appropriations, Congress required certain veterans, desiring to enroll in the VA healthcare delivery system, to agree to make copayments and allow VA to seek third-party reimbursement from private health insurers, with the exception of the Centers for Medicare and Medicaid Services (CMS) for those beneficiaries.

Although a small percentage of the total veterans population enroll, the response from new veterans enrolling was somewhat overwhelming, largely unanticipated, and drastically underfunded, leading to an unprecedented backlog of veterans waiting to receive timely access to quality care at VA medical facilities across the country. In an effort to reduce that backlog, then VA Secretary Anthony Principi suspended enrollment of new Priority Group 8 veterans in January 2003. The American Legion strongly opposed this decision and continues to call for the reinstatement of enrollment for Priority Group 8 veterans.

FY 2007 saw the continuation of suspension of enrollment of new Priority Group 8 veterans due to the increased demands for services. According to VA, the number of Priority Group 8 veterans denied enrollment in the VA healthcare system as of January 2007 is 378,495. The American Legion believes this number would be significantly higher if it were possible to include those veterans who have not even tried to use the VA since the suspension took effect. The American Legion does not agree with the decision to deny healthcare to veterans simply to ease a backlog. Denying earned benefits to eligible veterans does not solve the problems resulting from an inadequate Federal budget.

As the Global War on Terrorism continues, fiscal resources for VA will continue to be stretched and veterans will continue to go begging to their elected officials for the money to sustain a viable VA. A viable VA is one that cares for all eligible veterans, not just the most severely wounded or the poorest among us. VA is often the first experience veterans have with the Federal Government after leaving the military. This Nation's veterans have never let our country down; Congress should do its best to not let them down.

Currently, recently separated veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are granted access to the VA healthcare system for 2 years regardless of possible priority group ranking. By the time the 2 years expires, they are placed in their appropriate priority group, to include Priority Group 8. Veterans of OIF/OEF who, after the initial 2 years are placed in Priority Group 8, remain enrolled and continue to receive healthcare (even though they are Priority Group 8). Those placed in Priority Groups 7 or 8 must agree to make copayments and allow VA to bill, collect, and receive third-party reimbursements from private health insurers in order to receive healthcare through VA.

Veterans of OIF/OEF who chose not to use VA for their healthcare needs within the 2-year time period, and fall into the Priority Group 8 category, will be denied access under the current regulations. This is a travesty, as many times service-connected injuries and illnesses do not manifest until much later in life. For these veterans, medical care must be sought outside of VA.

Access to VA healthcare will only result in one of two ways. The first way is when a veterans' claim for disability is granted as service-connected and compensable (a 0 percent service-connected disability that is noncompensable will not lift a veteran out of the Priority Group 8 category). This process can take years if the claim is initially denied. The other is if the veteran's income level falls below the income

threshold. That threshold is based on the Department of Housing and Urban Development's geographical index; therefore, the veteran's official zip code influences the formula.

Legislation has been introduced that seeks to increase the amount of time a combat veteran of OIF/OEF can access the VA healthcare system from 3 to 5 years. While The American Legion supports this legislation, we also strongly urge Congress to recognize the needs of all eligible veterans and repeal the denial of access to VA healthcare for veterans in Priority Group 8.

Unfortunately, some believe Priority Group 8 veterans are not the "core" of VA's patient population. The American Legion believes every servicemember is a "core" element of the national security—the total force. The willingness of young Americans to serve will diminish if this country continues to neglect those who have served. Timely access to quality healthcare offered by VA, the Nation's best integrated healthcare delivery system, is an earned benefit.

The American Legion strongly supports lifting the suspension of enrollment of Priority Group 8 veterans in the VA healthcare system. VA can no longer restrict enrollment due to inability to meet the demand for care. Those who have served have earned the right to choose healthcare through the very system created to meet their unique needs.

If an increase in existing appropriations is the problem, then The American Legion strongly recommends looking to alternative revenue streams. Currently, VA is authorized to bill Medicare for the treatment of nonservice-connected medical conditions of enrolled Medicare-eligible veterans in order to collect from private Medicare supplement insurers; however, VA does not receive any reimbursements from CMS for allowable services. This means Medicare, the Nation's largest health insurance program, is literally subsidized by VA. Over half of VA's enrolled patient population is currently Medicare-eligible—most of these veterans are currently in Priority Groups 7 and 8.

The American Legion believes many of the veterans currently prohibited from enrolling in Priority Group 8 may very well have alternative health insurance—whether Medicare, TRICARE, TRICARE for Life or private health insurance. Please remember, these veterans agree to make copayments and allow third-party reimbursement from health insurance companies to cover their cost of care. Therefore, the focus should be on collection of accounts receivable from private insurance companies, improvements in billing and coding, and a serious re-evaluation of Medicare reimbursements.

Thank you again for this opportunity to present the views of The American Legion on this important issue. I look forward to working with you and all of the Members of the Committee to ensure VA is capable of providing quality healthcare in a timely manner to all eligible veterans.

**Prepared Statement of John Rowan
National President, Vietnam Veterans of America**

Good morning, Mr. Chairman, Mr. Buyer, and Members of this Committee. On behalf of the families and members of Vietnam Veterans of America (VVA), I thank you for the invitation to testify on an issue of significant importance to us—and to thousands of eligible veterans who are now denied access to the VA healthcare system.

It is VVA's unwavering position that the VA healthcare system should be reopened to Priority 8 veterans. The decision to close the system to new Priority 8's in January of 2003 was supposed to be a temporary palliative for a system that was hemorrhaging, a system that was unable to provide, VA officials argued, high-quality healthcare for an influx of new Priority 8's. But temporary quickly morphed into permanent—and we now wonder if this was the intent of the Administration at the time—because no VA planning document we've seen since accounts for new Priority 8's entering the system.

Who are these veterans? They are, as you know, individuals who have an income in excess of just under \$27,000 a year, are not afflicted with a service-connected disability, and agree to make a copayment for their healthcare and prescription drugs. They are also veterans who are unaware that they have a condition associated with their military service; when this malady flares up, they may be facing imminent poverty. Their banishment from the system not only hurts those who would choose the VA for their healthcare needs, it also hurts the VA: Priority 8 and 7 veterans account for some 40 percent of third-party collections.

A little history is instructive.

Back in 1996, when Congress passed the Veterans' Healthcare Eligibility Reform Act, the VA was able to implement major cornerstones of its plan to reform the manner in which it provided healthcare. The rationale behind this initiative was to ensure a patient base that would support the infrastructure needed to develop a modern, integrated healthcare system. This the VA has accomplished, and in the process has transformed a mediocre, inefficient system into a national model that has won praise and plaudits.

However, the law—Public Law 104–262—gave the Secretary of Veterans Affairs the authority and the responsibility to determine eligibility for enrollment based on available resources in any given fiscal year. Although the law did not mandate a level of funding or a standard of care, it did establish an annual enrollment process and categorized veterans into “priority groups” to manage enrollment.

On January 17, 2003, the Secretary made the decision to “temporarily” suspend Priority 8 veterans from enrolling. While this decision may be reconsidered on an annual basis, every budget proposal from the Administration since has omitted funding for Priority 8 veterans not previously enrolled and has attempted to discourage use by and enrollment of those “higher income” veterans.

Priority 8 veterans are, for the most part, working- and middle-class Americans without compensable disabilities incurred during their military service. In its budget proposal for the current fiscal year, the VA estimated that some 1.1 million of these “higher income” veterans would be discouraged from using *their* healthcare system because of an enrollment fee and increased copays for prescription drugs. Thankfully, you in Congress have not let this scheme get much beyond the proposal phase.

Still, it has been estimated that in excess of a quarter of a million veterans who would be classified as Priority 8's have been barred from enrolling in the system since January 2003.

Readmitting those Priority 8's who might choose to enroll in the VA healthcare system if given the opportunity is yet another reason to hold hearings and move to pass Congressman Hare's assured funding bill, H.R. 2514. Because, no matter how you cut it, the bottom line is funding. And there should be enough funding in a compassionate nation that respects the service and sacrifice made by those who don the uniform to give this more than lip service. We can, and we should, accommodate Priority 8's who opt to use the VA's healthcare system.

We strongly urge that you truly honor the commitment we as a Nation have made that honors our veterans. Of course, we recognize that the bottom line is funding—the funding Congress provides—to enable the VA to accommodate those Priority 8 veterans who want to avail themselves of the VA's healthcare services. We recognize the realities of “PAY-GO.” But we hope you will recognize the inherent justice in reopening the VA healthcare system to those who have earned the right to utilize it.

Thank you for considering these comments. We would be pleased to answer any questions you might have.

**Prepared Statement of Hon. Michael J. Kussman, M.D., M.S., MACP
Under Secretary for Health, Veterans Health Administration
U.S. Department of Veterans Affairs**

INTRODUCTION

Good morning, Mr. Chairman and Members of the Committee. I am pleased to be invited here today to address the current policy and status of Priority Group 8 veterans.

The Department of Veterans Affairs (VA) mission is to serve veterans through a variety of benefits and services. Prior to 1996, VA was primarily a hospital-based healthcare system. Over the last two decades, VA has moved to an outpatient-care-based system with over 1,200 access points. This shift enhances service and access to healthcare for veterans and has been accomplished with the support of Congress, veterans' service organizations, and other stakeholders.

VETERANS HEALTHCARE ELIGIBILITY

VA resources are focused on its highest priority medical care mission—to provide service to recent combat veterans and veterans with service-connected disabilities, lower incomes, and special needs. Veterans not meeting these criteria (higher-income and nondisabled) were able to receive VA medical care only on a case-by-case, space-available basis until 1999. Implementation of the Veterans' Healthcare Eligibility Reform Act of 1996 (Public Law 104–262) directed VA to establish a system

of annual patient enrollment managed in accordance with seven priority groups and contingent upon available resources. Congress further required the enrollment system be managed in a manner ensuring the provision of timely and high-quality care to enrollees.

Between 1999 and 2002, the Secretary determined each year that all categories of veterans were able to enroll. However, greater recognition of the high-quality care provided by VA, more accessible locations, and rapid growth in the population of higher-income and nondisabled veterans (from 2% to over 30% of enrollees) threatened VA's ability to deliver quality and timely care to service-connected and lower-income veterans. In the Department of Veterans Affairs Healthcare Programs Enhancement Act of 2001, (Public Law 107-135) Congress created another priority level—Priority Group 8. Priority Group 8 includes veterans who do not have compensable service-connected disability and whose household incomes exceed geographical based means test. To preserve care for higher-priority veterans, VA discontinued enrolling Priority Group 8 in 2003. Lower-priority veterans who were already enrolled as Priority 8's in the system before 2003, however, retained their eligibility and today comprise 27 percent of all enrollees. Moreover, VA has authority to enroll combat-theater veterans returning from OEF/OIF in VA's healthcare system during their period of eligibility, making them able to receive any needed medical care or services.

To understand Priority Group 8 veterans, it is important to understand the priority group system established by law for the Department. Our priorities are as follows:

Priority Group 1

- Veterans with service-connected disabilities rated 50% or more disabling.

Priority Group 2

- Veterans with service-connected disabilities rated 30%–40% disabling.

Priority Group 3

- Veterans who are former POWs.
- Veterans awarded the Purple Heart.
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty.
- Veterans with service-connected disabilities rated 10% or 20% disabling.
- Veterans disabled during VA treatment or vocational rehabilitation.

Priority Group 4

- Veterans who are receiving aid and attendance or housebound benefits.
- Veterans who have been determined by VA clinicians to be catastrophically disabled.

Priority Group 5

- Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds.
- Veterans receiving VA pension benefits.
- Veterans eligible for Medicaid benefits.

Priority Group 6

- World War I veterans.
- Veterans of the Mexican Border period.
- Veterans solely seeking care for disorders associated with:
 - Exposure to herbicides while serving in Vietnam; or
 - Exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
 - For disorders associated with service in the Gulf War or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.
 - Who participated in a test conducted by the DoD Desert Test Center (i.e., Project Shipboard Hazard, and Defense (SHAD)).
- Compensable 0% service-connected veterans.

Priority Group 7

- Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and income below the VA's Geographic Means Test.

Priority Group 8

- Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and above the VA Geographic Means Test threshold.

In enacting this legislation, Congress recognized the great obligation owed to veterans requiring care for their service-connected disabilities, with special needs, and low-income veterans—these groups encompass our highest priority.

In 2003, to ensure the quality and improve the timeliness of healthcare provided to veterans in higher enrollment-priority categories in an environment of increased demand from older veterans, VA suspended the enrollment of additional veterans who are in the lowest statutory enrollment category (Priority Group 8), as required by the Eligibility Reform Act.

Today, meeting the healthcare needs of our current enrollees and effectively responding to the needs of a new generation of veterans from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) are VA's highest priorities.

CURRENT DEMAND AND POLICY

In FY 2006, VA enrolled approximately 200,000 additional enrollees raising the total to nearly 7.9 million enrollees. In FY 2006, VA provided care to almost 5.5 million unique patients, an increase of 200,000 from the previous year. VA projects that number to rise to approximately 5.8 million unique patients in FY 2008. These figures represent significant increases from the 2.7 million veterans receiving care in 1996.

The President's FY 2008 budget is based on the Department's needs for providing enrolled veterans with timely, high-quality healthcare. Changes in the demographic characteristics of our previously enrolled patient population account for a significant portion of the increased resource requirements in our FY08 budget request. Our patients, as a group, will be older, will seek care for more complex medical conditions, and will be more heavily concentrated in the higher-cost priority groups.

Patients in Priorities 1–6—veterans with service-connected conditions or special healthcare needs, or lower incomes, and recently discharged combat veterans—will comprise 68 percent of the total patient population in 2008, but they will account for 85 percent of our healthcare costs. The number of patients in Priorities 1–6 will grow by 3.3 percent from 2007 to 2008.

Based on the President's FY08 budget, we expect to treat about 263,000 veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF), an increase of 54,000 (or 26 percent) from our 2007 estimates and 108,000 (or 70 percent) more than the number we treated in 2006.

VA assigns great importance to the prompt processing of disability compensation claims, which veterans are submitting for an increasing number and variety of medical conditions, resulting in the need for more complex, costly, and time-intensive disability compensation medical examinations by the Veterans Health Administration. These projected changes in the case mix of our patient population and the growing complexity of our disability claims process result in greater resource needs, which we have included in our FY08 budget request. Many of the benefits claims awaiting decision will require a medical evaluation, and VHA's projections for demand and our budget is based on providing this service and reducing this backlog.

Since the onset of combat operations in Iraq and Afghanistan, VA has provided new services and adjusted our resource allocations to address the unique medical needs of returning veterans. VA established the Polytrauma System of Care, expanded our Readjustment Counseling Service by establishing new Vet Centers across the country, and instituted significant changes to our mental health system to address post-traumatic stress disorder (PTSD) and suicide, among other issues. VA has authority to enroll combat-theater veterans returning from OEF/OIF in VA's healthcare system, making them eligible to receive any needed medical care or services. When OEF/OIF veterans seek care from VA they are placed in Priority Category 6 and make no copayments for covered conditions potentially related to their theater of combat service. Veterans with service in Iraq and Afghanistan continue to account for a rising proportion of our total veteran patient population. In 2008, they will comprise 5 percent of all veterans receiving VA healthcare compared to the 2006 figure of 3.1 percent.

Currently, the President's Budget fully funds enrolled veterans in Priority Groups 1 through 7. Our budget also fully funds those Priority Group 8 veterans already in the system—as well as those returning veterans who will migrate to this group at the expiration of their post 2-year enhanced enrollment authority. This will ensure no veteran currently in the system will be denied care. However, as demand

for healthcare services continues to grow, VA must, of course, allocate resources according to the priorities set by law.

The increased demand for VA services is set against a backdrop of changes in the overall healthcare system. The shift from inpatient to outpatient care, increased emphasis on health promotion, and disease prevention has made new demands on infrastructure and resources, while the increased use of new technologies and pharmaceuticals has added significantly to costs.

In keeping with Congress' requirement to establish and manage a system of annual patient enrollment, VA annually reviews the demand for services and the resources required to assure timely and high-quality services.

We believe the current restriction on enrollment of new Priority Group 8 veterans is necessary to maintain the timeliness and quality of the healthcare we provide to currently enrolled veterans. This policy allows VA to focus on fulfilling its mission of meeting the healthcare needs of those veterans given higher priority by Congress, i.e., service-connected veterans, those returning from combat, those with special needs, and those with lower levels of income.

The restriction on enrollment of new Priority 8 veterans has proven to be effective in focusing our healthcare resources on these highest priority patients. This system is consistent with the priority healthcare structure enacted by Congress.

This concludes my prepared statement. I would be pleased to answer any questions you or any of the Members of the Committee may have.

POST-HEARING QUESTIONS AND RESPONSES FOR THE RECORD

Committee on Veterans' Affairs
Washington, DC
July 19, 2007

Stephanie J. Woolhandler, M.D.
Associate Professor of Medicine
Harvard Medical School
1493 Cambridge St.
Cambridge, MA 02139

Dear Stephanie:

In reference to our Full Committee hearing on Priority Group 8 Veterans on June 20, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 31, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please fax your response to Debbie Smith at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

BOB FILNER
Chairman

Hearing on Priority Group 8 Veterans

1. The VA is part of our overall national healthcare system, and changes to one part of our system have effects that ripple to other segments of our healthcare system.
 - As to the VA, if enrollment was reopened, would you have any recommendations as to how it should address the reality of a finite budget and increased demand for services?
2. Your research shows that uninsured veterans were "younger, more likely to be working, and had lower incomes." Currently, servicemembers returning from Afghanistan and Iraq have 2 years of eligibility for healthcare in the VA. If they fail to seek care in that 2 years and would be classified as a Priority Group 8 veteran they would not have access to VA care.
 - How many, as a percentage, would not have private insurance and hence be without healthcare options?
 - If current trends continue over the next 10 years, do you believe we will see a greater percentage of those under 50 without healthcare insurance?
3. The VA is often held up as a model of healthcare delivery.
 - What lessons should other providers learn from the VA's experience?
 - Is there anything that the VA is doing now in the healthcare delivery arena that it should be doing more of?

Boston, MA
August 15, 2007

The Honorable Bob Filner
Chairman, Committee on Veterans' Affairs
335 Cannon House Office Building
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Filner:

I am responding to your letter of July 19, 2007. You posed several questions as followup to my testimony at the Committees June 20 hearing. Let me respond to your questions in the order that you posed them.

1. In my view, the VA budget should be expanded to accommodate all veterans, regardless of their economic and medical circumstances. There is substantial

evidence (much of it presented at the hearing) that uninsured veterans who do not have access to the VA health system forego needed primary and preventive care. Such an expansion would be a highly cost effective means of providing quality care for uninsured veterans. As you know, these uninsured veterans often forego care at present. It seems probable that care provided to them within the VA will be both less costly and of higher quality than other strategies (short of national health insurance) for assuring access to care for this population.

Such a VA expansion should not come at the expense of downsizing other VA programs. In particular, the VA research program has been vital in providing objective data in many medical fields, and in many cases may lead to long-term cost savings. For instance, VA hospitals were key participants in a recent study showing that cardiac stenting (a treatment for angina and related conditions) is overused in the United States. This study has already led to a substantial decrease in expensive stenting procedures.

Several "ripple effects" are possible, but speculative. First, improved access to care for currently uninsured patients may decrease Medicare spending in future years. Recent data indicates that the previously uninsured incur substantially greater Medicare expenditures once they turn 65 than do individuals who were insured prior to age 65. Second, opening access to care for uninsured veterans may somewhat decrease emergency department utilization by this group, partially relieving the growing burden carried by community hospital ERs.

2. I cannot give a precise answer to your query regarding the insurance status of veterans returning from Afghanistan and Iraq. A rough estimate can be derived from the fact that at present, about 72% of veterans under 65 have at least some private coverage. Hence 38% rely on government programs or have no coverage. I expect that somewhat fewer Afghanistan and Iraq veterans will have private coverage, since they will be (on average) a bit younger than the other under 65 veterans and younger individuals are more likely to lack private coverage.

The number of Americans without health insurance has been rising slowly, but steadily, since at least the late 1980s. This is due to an erosion in employment-related health insurance. Hence, we predict that the number of uninsured, non-elderly Americans (including veterans) will increase in coming years.

3. The VA is one of the few recent success stories in American medicine. The lessons from this story include:
 - A. Publicly funded healthcare systems can work. Care decisions based on medical necessity (rather than patient's ability to pay) can improve both quality and efficiency.
 - B. Innovation is possible (and indeed facilitated) within publicly funded health systems. The VA has made major innovations by reorganizing itself around a primary care model, developing a "home-grown" computer system, and focusing on quality improvement.
 - C. An emphasis on primary care improves quality and efficiency.
 - D. Computer systems that are developed with patient care rather than business needs in mind (and that are not based largely around the exigencies of billing) can improve quality.

The success of the VA is now touted by many analysts (myself included). VA staff could be more active in assessing and publicizing their own successes. In particular, the administrative costs of the VA should be compared with those in the U.S. private sector. Such a comparison is likely to provide further documentation of the efficiency advantages of the VA relative to private-sector medicine.

Given the documented successes of the VA, it may be worthwhile to expand the VA's mission to include caring for the families of veterans; serving as a purchasing agent for prescription drugs for other government health programs (e.g. Medicare Part D); and building additional VA facilities to expand geographic access to care, rather than relying on care purchased from the private sector for veterans who reside in regions remote from current VA facilities.

Thanks to you and your colleagues for offering me the opportunity to testify before your Committee. I look forward to working with you and your staff on

these issues in the future, and am happy to provide any additional assistance that you may deem worthwhile.

Yours sincerely,

Steffie Woolhandler, M.D., M.P.H.
Associate Professor of Medicine

Committee on Veterans' Affairs
Washington, DC
July 19, 2007

Carl Blake
National Legislative Director
Paralyzed Veterans of America
801 18th Street, NW
Washington, DC 20006

Dear Carl:

In reference to our Full Committee hearing on Priority Group 8 Veterans on June 20, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 31, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please fax your response to Debbie Smith at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

BOB FILNER
Chairman

Questions from Hon. Bob Filner, Chairman, Committee on Veterans' Affairs, to Carl Blake, National Legislative Director, Paralyzed Veterans of America

Paralyzed Veterans of America
Washington, DC
August 1, 2007

Honorable Bob Filner
Chairman
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Filner:

On behalf of Paralyzed Veterans of America (PVA), I would like to thank you again for the opportunity to testify before the House Committee on Veterans' Affairs during the hearing on June 20, 2007. We greatly appreciate the renewed focus that you have placed on eliminating the prohibition of enrollment of new Priority Group 8 veterans into the Department of Veterans Affairs healthcare system.

I have included with this letter a response to each of the questions that you presented following the hearing on June 20. If you have any additional questions, please feel free to contact me. We look forward to working with the Committee toward reopening the VA healthcare system to those veterans who have earned this care. Thank you very much.

Sincerely,

Carl Blake
National Legislative Director

Question 1: Your organizations take the position that the VA healthcare system should be re-opened to Priority Group 8 veterans. Current law provides the Secretary with the authority to prescribe regulations to “establish and operate a system of annual patient enrollment[.]” It was clearly not the intention of Congress to permanently close out access to VA care to a group of veterans, while at the same time it was felt necessary to provide the VA with the flexibility necessary to meet an unexpected shortfall in resources and to provide care to those veterans in higher priority groups.

If the ban on enrolling Priority 8 veterans was lifted statutorily, how much latitude do your organizations believe the Secretary should retain in the future to limit enrollment and to “establish and operate a system of annual patient enrollment?”

Answer: The Secretary should retain the authority that Congress provided to manage the Department for which he or she is responsible. To remove such an important management tool would relieve him or her of some of the responsibility and by extension some of the accountability for the system and the veterans who seek care in it. Also, losing this management tool may deter future candidates who would otherwise be drawn to the opportunity to serve in such a position of distinction.

However, we do have some concerns about giving the Secretary unilateral authority to make this decision. We believe that the Secretary should be required to submit to Congress in advance his intentions to make a decision regarding closing enrollment, and at the same time, he should be required to submit to Congress what resources would be required to prevent this decision. This would allow Congress to provide whatever additional resources necessary to allow veterans who have earned and deserve this care to continue to enroll and receive it.

Question 2: Arguably, the VA has sufficient resources this year, and it looks like it will have sufficient resources in the coming fiscal year.

If Congress were to act to open up enrollment of Priority 8 veterans, how would your organizations address the very real concerns that VA won’t be able to adequately treat higher priority veterans or that veterans would once again face long waiting times for basic healthcare?

Answer: First and foremost, we would urge Congress to ensure that reliable and adequate funding is provided for VA. We would argue that sufficient resources have not been provided since no specific, dedicated funding has been appropriated for the purpose of reopening the healthcare system to Priority 8 veterans. In fact, as it stands right now, it appears that the VA may once again be forced to deal with a situation where they do not receive their funding prior to the start of the new fiscal year on October 1. Moreover, while the funding included in the already approved House VA appropriations bill and the yet to be completed Senate VA appropriations bill nearly matches the recommendations of the *Independent Budget* for FY 2008, none of these funding levels provide additional resources to open enrollment to Priority 8 veterans.

Secondly, since it has been more than 4 years since the VA made the decision to close enrollment to Priority 8 veterans, Congress must ensure that the VA has the infrastructure and workforce capacity to meet this new demand before reopening the system. As was discussed during the hearing, we remain concerned that the VA does not actually have the capacity to address this new demand across the broader system. While some areas may have excess capacity, other areas in the VA healthcare system are currently operating well above capacity. However, we recall that Dr. Kussman did offer to work with the Committee to ensure that the VA system is prepared for this new demand. Without taking these steps, we believe that longer waiting times and healthcare rationing could be a real possibility.

Committee on Veterans’ Affairs
Washington, DC
July 19, 2007

Adrian M. Atizado
Assistant National Legislative Director
Disabled American Veterans
807 Maine Avenue, SW
Washington, DC 20024

Dear Adrian:

In reference to our Full Committee hearing on Priority Group 8 Veterans on June 20, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 31, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please fax your response to Debbie Smith at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

BOB FILNER
Chairman

Questions from Hon. Bob Filner, Chairman, Committee on Veterans' Affairs, to Adrian M. Atizado, Assistant National Legislative Director, Disabled American Veterans

Question: In your testimony you note that returning servicemembers have 2-year access to VA healthcare. You also note that a nonservice-connected combat Vietnam veteran who applies for enrollment but is a Priority Group 8 veteran would be denied access. You state that "DAV is very troubled by this inequity."

- Absent classifying VA funding as direct spending rather than discretionary spending, what would DAV recommend that we in Congress do to address this inequity?

Answer: The inequity of a "two-tiered" healthcare system is created by providing access to VA medical care to one group of veterans while denying access to another. In this instance, the 2-year access to VA care for servicemembers returning from combat in the Persian Gulf War as contemplated under Section 102 of Public Law 105-368, the Veterans Programs Enhancement Act of 1998, ensures a continuation of healthcare benefits for servicemembers transitioning from active duty to veteran status despite the lack of definitive evidence that unexplained illnesses are related to wartime service. This is likewise being applied to Operations Enduring and Iraqi Freedom (OEF/OIF) combat veterans and the delayed onset of post-traumatic stress disorder and traumatic brain injury.

Noteworthy is Congress' intent to extend the access period for OEF/OIF combat veterans to satisfy concerns that some of the newest generation of combat veterans may be denied access to VA healthcare due to the policy decision to bar enrollment for Priority Group 8 veterans. Indeed, enactment of H.R. 612 or S. 383 would allow some form of guaranteed access to VA medical care; however, it only partly addresses the inequity between demand and health resources that lead to the ban on enrollment for Priority Group (PG) 8 veterans. Moreover, it does not provide parity to combat veterans of previous wars when they are denied access to VA medical care.

As you are aware, the DAV opposed the decision to close future enrollment of PG 8 veterans and supports the extension of access to VA medical care for our newest combat veterans. Further, as Congress is poised to add a significant new funding increase to the VA medical accounts for fiscal year 2008, one that we deeply appreciate, we are uncertain that even that generous increase will be sufficient to offset all of VA's financial requirements. Accordingly, the DAV recommends this Committee conduct hearings on the source of this issue which is the sufficiency, reliability, and dependability of VA healthcare funding through the discretionary appropriations process. In addition, we recommend the Committee conduct hearings on VA's workforce and infrastructure issues to include discussion on the effects of lifting the ban on Priority Group 8 enrollment. Finally, we encourage the Committee to ensure VA timely provides the report requested by Committee Members on VA's plan to reverse the enrollment decision on Priority Group 8 veterans.

Committee on Veterans' Affairs
Washington, DC
July 19, 2007

Peter S. Gaytan
Director, Veterans Affairs
and Rehabilitation Commission
The American Legion
1608 K Street, NW
Washington, DC 20006

Dear Peter:

In reference to our Full Committee hearing on Priority Group 8 Veterans on June 20, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 31, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

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Sincerely,

BOB FILNER
Chairman

Questions from Hon. Bob Filner, Chairman, Committee on Veterans' Affairs, to Peter S. Gaytan, Director, National Veterans Affairs and Rehabilitation Commission, American Legion

The American Legion
Washington, DC
September 12, 2007

Honorable Robert Filner, Chairman
Committee on Veterans' Affairs
United States House of Representatives
Room 335, Cannon HOB
Washington, DC 20420

Dear Chairman Filner:

Thank you for allowing The American Legion to participate in the Committee hearing on Priority Group 8 Veterans on June 20, 2007. I am pleased to respond to your specific questions concerning that hearing:

- 1. Your organization takes the position that the VA healthcare system should be re-opened to Priority Group 8 veterans. Current law provides the Secretary with the authority to prescribe regulations to "establish and operate a system of annual patient enrollment[.]" It was clearly not the intention of Congress to permanently close out access to VA care to a group of veterans, while at the same time it was felt necessary to provide the VA with the flexibility necessary to meet an unexpected shortfall in resources and to provide care to those veterans in higher priority groups.**

Question: If the ban on enrolling Priority 8 veterans was lifted statutorily, how much latitude does your organization believe the Secretary should retain in the future to limit enrollment and to "establish and operate a system of annual patient enrollment"?

Answer: The American Legion believes that the Secretary of VA, being aware of the workload VA can handle, should be first to announce when and why any limit to enrollment might be needed due to a lack of resources (or expansion of enrollment due to adequate funding). Any announcement of such an event should be subject to strict congressional oversight. Before a final decision is made on denying access to benefits that were earned through honorable service to our country, Congress, along with the veterans service organizations, should be able to weigh in on the decision.

2. Arguably, the VA has sufficient resources this year, and it looks like it will have sufficient resources in the coming fiscal year.

Question: If Congress were to act to open up enrollment to Priority 8 veterans, how would your organization address the very real concern that VA won't be able to adequately treat higher priority veterans or that veterans would once again face long waiting times for basic healthcare?

Answer: The American Legion believes all eligible veterans in need of timely access to quality healthcare earned the right to enroll in the VA healthcare delivery system as an earned benefit of honorable military service. The American Legion is outraged any time a veteran presents him or herself to the VA healthcare delivery system and is turned away. The American Legion remembers when VA was open to all veterans prior to means testing in the 1980s and the rationing of healthcare.

In order to ensure timely access to VA healthcare for all veterans, VA must be adequately staffed and therefore adequately funded. The American Legion believes that the solution to the Veterans Health Administration's (VHA) recurring fiscal difficulties will only be achieved when its funding becomes a mandatory spending item. Under mandatory funding, VA healthcare funding would be guaranteed by law for all eligible enrollees—patient-based rather than budget-driven annual Federal appropriations.

The American Legion will continue to support legislation that would establish a system of capitation-based funding for VHA. This new funding system would provide all of VHA's funding, except that of the State Extended Care Facilities Construction Grant program, which would be separately authorized and funded as discretionary appropriations. VHA is currently struggling to maintain its global preeminence in 21st century integrated healthcare delivery systems with funding methods that were developed in the 19th century for an antiquated inpatient delivery system. No other modern healthcare organization could be expected to survive under such an inconsistent budget process. Healthcare rationing for veterans must end. It is time to guarantee healthcare funding for all veterans seeking VA healthcare.

It is The American Legion's understanding that when Eligibility Reform was enacted in 1996 to reopen access to VA healthcare, the public law was quite clear that all veterans' enrolling would be subject to copayments and third-party reimbursements from health insurers, both public and private.

The VA Secretary's decision to prohibit the enrollment of new Priority Group 8 veterans had nothing to do with their ability to pay or not pay for healthcare services. It was clearly a management tool to stop the number of veterans enrolling in the Nation's best healthcare system, although their enrollment carried with it the agreed obligation to make copayments and allow VA to bill their third-party insurers. In essence, it stopped the largest potential source of nonappropriated dollars from entering the system, even as Congress was increasing the VA's MCCF collection goals.

The American Legion was disappointed to learn that the largest, federally mandated, public health insurer (Centers for Medicare and Medicaid Services) was exempted from making allowable third-party reimbursements to VA for the treatment of nonservice-connected medical conditions of enrolled Medicare-eligible veterans. Since over half of VA current enrolled patient population lists Medicare as their health insurer, the economic impact severely restricts a major revenue stream for the Medical Care Collection Fund (MCCF) to supplement the annual discretionary appropriations.

VA should no longer be prohibited from collecting any Medicare reimbursements for the treatment of allowable, nonservice-connected medical conditions. As do most American workers, veterans pay into the Medicare system without choice throughout their working lives, including while on active duty. A portion of each earned dollar is allocated to the Medicare Trust Fund and, although veterans must pay into the Medicare system, VA is prohibited from collecting any Medicare reimbursements for the treatment of allowable, nonservice-connected medical conditions. This prohibition constitutes a multi-billion dollar annual subsidy to the Medicare Trust Fund.

Thank you once again for all of the courtesies provided by you and your capable staff. The American Legion welcomes the opportunity to work with you and your colleagues on many issues facing veterans and their families throughout this Congress.

Sincerely,

Peter Gaytan
National Veterans' Affairs
and Rehabilitation Commission

Committee on Veterans' Affairs
Washington, DC
July 19, 2007

John Rowan
National President
Vietnam Veterans of America
8605 Cameron Street, Suite 400
Silver Spring, MD 20910

Dear John:

In reference to our Full Committee hearing on Priority Group 8 Veterans on June 20, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 31, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please fax your response to Debbie Smith at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

BOB FILNER
Chairman

Questions from Hon. Bob Filner, Chairman, Committee on Veterans' Affairs, to John Rowan, National President, Vietnam Veterans of America

Vietnam Veterans of America
Silver Spring, MD
August 17, 2007

The Honorable Bob Filner
Chair
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Dear Congressman Filner,

Attached please find the responses of Vietnam Veterans of America (VVA) to the questions posed to us in your letter of July 19th concerning Priority 8 veterans.

On behalf of the members of VVA and our families, I want to thank you for having held in June the hearing on Priority 8 veterans. It is our hope that Congress will succeed in reopening the VA healthcare system to these veterans, many of whom are just a paycheck or illness away from hitting the financial shoals. It is time to restore this earned benefit to these veterans.

Sincerely,

John Rowan
National President

Question: *If Congress were to act to open up enrollment to Priority 8 veterans, how would your organizations address the very real concerns that VA won't be able to adequately treat higher priority veterans or that veterans would once again face long waiting times for basic healthcare?*

Answer: First off it's a fundamental matter of fairness: Priority 8 veterans ought to have the same right to access the VA healthcare system as higher priority veterans have. Nowhere in Title 38 is there a demarcation between higher priority—or what some had touted as “core constituency”—veterans and “other” veterans. Many veterans are just a paycheck or two away from hitting the financial shoals; in fact, 1.8 million veterans are among the 43 million Americans who are without health insurance.

Secondly, if the VA healthcare system were to be driven by need rather than having to shoehorn veterans in because of a shortfall in funding, this question would not come up. It is the responsibility, indeed the obligation of the American people through the agency of government to live up to the social contract entered into with those who donned the uniform and placed life and limb on the line in defense of the Constitution.

Thirdly, we do not believe there will be any rush by so-called Priority 8's to enter the system. Although it has been estimated that some 250,000 veterans were denied service since the system was closed to additional Priority 8's in January 2003, some older Priority 8 veterans reportedly use the VA only to fill their drug prescriptions.

Furthermore, some veterans who are now classified as Priority 8, or who were earlier classified Priority 8 subsequent to January 2003, have since either become so ill that they cannot work and now qualify as indigent under the income guidelines for nonservice-connected veterans and therefore have been able to access the system. And other veterans who initially wanted to use the VA healthcare system because of conditions or maladies related to their military service have since been adjudicated by VA to be service-connected compensable, and therefore can access the medical system as Priority 1 or Priority 2 veterans. This "migration," if you will, from Priority 8 to a higher priority is very common, VVA contends.

It may be helpful for the Committee to request of VA how many veterans formerly classified as Priority 8 have subsequently become Priority 5 or Priority 1, Priority 2, Priority 3, Priority 4, Priority 5, or Priority 6 by year of the above noted change. Many of these veterans would have been reclassified years ago to a priority group eligible to register for the first time if the Compensation and Pension adjudication system were not such a mess.

Finally, Priority 8 veterans are not a drain on the system. Because Priority 7 and 8 veterans account for some 40 percent of third-party collections, these veterans likely bring more money into the system than the cost of their healthcare. Hence, they will be in some major part paying for themselves.

Question: *If the ban on enrolling Priority 8 veterans was lifted statutorily, how much latitude do your organizations believe the Secretary should retain in the future to limit enrollment and to "establish and operate a system of annual patient enrollment"?*

Answer: The short answer is none, as it is clear that they cannot be trusted. Just as the VA ought to function in the benefits arena as an advocate for the veterans it serves, so should the right and proper role of the VA be as an advocate for veterans who need to, or want to, choose the VA as their healthcare provider. The Secretary, as the CEO of the system, certainly needs the flexibility to make adjustments in the face of an economic downturn, other economic realities, and/or ally influx of enrollees. Unlike the adjustment made by Secretary Principi 4½ years ago, the system should request an infusion of funds in the form of a supplemental appropriation from Congress should the need arise. Under a system of "mandatory," or "assured" funding, the system should have the capacity to grow with its patients.

Committee on Veterans' Affairs
Washington, DC
July 19, 2007

Honorable R. James Nicholson
Secretary
Department of Veterans Affairs
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Full Committee hearing on Priority Group 8 Veterans on June 20, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 31, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please fax your response to Debbie Smith at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

BOB FILNER
Chairman

Questions from Hon. Bob Filner, Chairman, Committee on Veterans' Affairs, to Hon. R. James Nicholson, Secretary, Department of Veterans Affairs

Question 1: Since fiscal year (FY) 2004, VA has omitted specific requests for funding that would allow for the lifting of the enrollment ban on Priority Group 8 veterans. Would you tell us:

Question 1(a): If the enrollment was lifted, how many PG 8 veterans do you estimate would enroll into the system?

Response: Resumption of Priority 8 enrollment is estimated to increase enrollment by 1.6 million in FY 2008 and 2.4 million by FY 2017.

Question 1(b): How much additional funding would VA need to request in order to properly provide healthcare services to all veterans in PG 1-8?

Response: Resumption of Priority 8 enrollment would increase budgetary requirements by \$1.7 billion in FY 2008 and \$4.8 billion in FY 2017. Over the next 10 years, resumption of Priority 8 enrollment would require \$33.3 billion in budgetary resources. This does not include the cost of any capital expenditures needed to meet this increased demand or the additional cost associated with purchasing this care in the private sector until the Department of Veterans Affairs (VA) can build the capacity to provide the care internally.

Question 1(c): Does that figure take into account that PG 8 veterans, if allowed back in, would bring \$571 million into the VA system through third-party and first-party reimbursements?

Response: The \$1.7 billion appropriation requirement is net of \$592 million in collections. VA expects to collect, on average, \$685 from each new Priority 8 patient and his/her insurer, or 26 percent of the cost of their healthcare based on historical collection rates.

Question 2: PVA states in their testimony that VA's budget estimate of providing care to Priority Group 8 veterans is unrealistic. Instead the *Independent Budget* used a utilization figure from a report entitled "The Potential Cost of Meeting Demand for Veterans' Healthcare," published by the Congressional Budget Office (CBO) in March 2005. The CBO explained that the actual utilization rate of Category 8 veterans, prior to the enrollment prohibition being put in place, was only about 20 percent. Based on this information, the *Independent Budget* estimated that only about 314,000 Category 8 veterans would have actually used the system, meaning that the VA would only be responsible for the cost for that number of veterans.

Question 2(a): Would you please tell us what the actual utilization rate of the current Priority Group 8 population is?

Response: Based on historical data reflecting the number of Priority 8 enrollees who become patients in any given year, VA expects that about 55 percent, or 863,000 of the 1.6 million new Priority 8 enrollees, will use the system (be patients) in FY 2008.

Question 2(b): Do you really believe that all of the newly enrolled Priority Group 8 veterans would utilize the system?

Response: Based on historical use patterns, VA expects that about 55 percent of the 1.6 million Priority 8 veterans projected to enroll in FY 2008 will be patients in FY 2008.

Question 3: With the imposition of the enrollment ban in January 2003, the Administration has not requested funding needed to lift the enrollment ban. It certainly seems that the Administration is perfectly happy with continuing the enrollment ban permanently.

Question 3(a): Is it the VA's intention to permanently maintain the enrollment ban?

Response: In keeping with Congress' requirement to establish and manage a system of annual veteran enrollment, VA annually reviews the demand for services and the resources required to assure timely and high-quality services. We continue to act in accordance with Public Law 104-262, as we annually evaluate enrollment of VA's healthcare system in order to ensure that VA has capacity to provide timely, high-quality care for veterans for whom our Nation has the greatest obligation: those with service-connected disabilities, lower-income veterans, and those needing specialized care.

Question 3(b): Do you believe that we should amend Title 38 to permanently ban new Priority Group 8 veterans?

Response: In enacting this legislation, Congress recognized the great obligation owed to veterans requiring care for their service-connected disabilities, veterans with special needs, and low-income veterans. However, as demand for healthcare services continues to grow, VA must allocate resources to the extent resources and facilities are available. Title 38 allows VA to fulfill its mission of meeting the healthcare needs of veterans based on available resources.

