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# VETERANS' AFFAIRS

# Observations on Selected Features of the Proposed Veterans' Millennium Health Care Act

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# Veterans' Affairs: Observations on Selected Features of the Proposed Veterans' Millennium Health Care Act

Mr. Chairman and Members of the Subcommittee:

We are pleased to contribute this statement for the record for the Subcommittee's deliberations on the draft bill entitled the Veterans' Millennium Health Care Act, which would modify policies and practices of the health care system operated by the Department of Veterans Affairs (VA).

In October 1995, VA began to transform its health care delivery structure from operating hospitals to providing health care through integrated networks of VA and non-VA providers to serve veterans more efficiently and effectively. In 1996, the Veterans' Health Care Eligibility Reform Act was passed, requiring VA to enroll veterans for health care coverage by congressionally mandated priority groups only to the extent that services could be provided within VA's resources. In January 1997, in response to this and other factors, VA proposed a 5-year spending plan to reduce per-patient costs by 30 percent, increase the number of VA patients by 20 percent, and reduce reliance on appropriations by 10 percent.

Through numerous reports and testimonies, we have discussed the progress of VA's ongoing transformation, as well as concerns about critical challenges that VA faces (see the attached list of related GAO products). As you requested, our statement today draws on our previous work to focus on how the draft Veterans' Millennium Health Care Act could affect VA's ongoing transformation, including our previously reported concerns about its future progress. As agreed with your staff, we have limited our comments to certain provisions of the bill that address

- the realignment of services at underused facilities,
- access to long-term care services,[1] and
- cost sharing for medical care.

In summary, the draft bill's facility service realignment, long-term care, and cost-sharing provisions should help facilitate VA's continuing transformation of its health care system and address concerns that we have previously reported to the Congress. These proposals, in combination with VA's enrollment process, provide a rational framework for helping VA address the increasing health care needs of an aging population of higher-priority veterans while operating within available resources. However, even with this enabling legislation, achieving these multiple

[1]We are using the term "long-term care" to refer to the services described in parts of the draft legislation under the term "extended care" because "long-term care" is more frequently used in current discussions of these services in VA, other federal agencies, and the private sector.

goals will be a challenge to VA because of their complexity and far-reaching implications.

More specifically, the combination of proposed changes should help VA provide care for veterans in more appropriate settings, as well as help VA achieve its stated goals of reducing per-patient costs, increasing the number of its patients, and reducing reliance on appropriations. Facility realignment and cost-sharing provisions are consistent with options we have suggested to help VA reduce budget pressures and generate the resources needed to serve more veterans and provide enhanced benefits. In addition, long-term care provisions appear designed to reduce variability in veterans' access to such care systemwide, which addresses, in general, our concern about the potential adverse effect of VA's transformation on the equity of veterans' access to care.

## Background

Over the last 6 decades, VA's system has grown into our nation's largest direct provider of health care, serving veterans at over 600 locations nationwide. During that time, VA's system focused primarily on hospital care, using high technology and medical specialization. The system did not keep pace, however, with such industry and societal changes as the restructuring of health care to emphasize managed care and the evolving medical needs of an aging veteran population.

VA's transformation from a hospital-based operator to a health care provider emphasizing outpatient care began in fiscal year 1996, when 22 regional offices, known as Veterans Integrated Service Networks (VISN), were established to make basic budgetary, planning, and operating decisions for veterans living within defined geographical areas.[2] VA's goal is to develop local or regional networks of health care providers that offer a continuum of care grounded in ambulatory, rather than hospital, settings. VA is encouraging this transformation by allocating resources on the basis of user populations rather than hospitals.

The Veterans' Health Care Eligibility Reform Act, enacted in 1996, furnishes tools that VA believes are key to a successful transformation, including

- new eligibility rules that allow VA to treat veterans in the most appropriate setting,

[2]VA Health Care: Status of Efforts to Improve Efficiency and Access (GAO/HEHS-98-48, Feb. 6, 1998).

- a uniform benefits package for all eligible veterans that allows VA to provide a continuum of services,
- expanded authority to purchase services from private providers when doing so benefits veterans, and
- an enhanced ability to generate revenue by selling excess services to nonveterans.

At that same time, the Congressional Budget Office and we concluded that these reforms could generate additional demand for services because more veterans would use outpatient services.[3] The Congressional Budget Office also estimated that rising utilization could produce dramatic cost increases, potentially in the billions of dollars.

To address such concerns, the Eligibility Reform Act required VA to implement an enrollment system to manage access in relation to available resources. The act established seven priority categories, with the highest priority given to veterans with service-connected conditions and the lowest priority given to higher-income veterans without such conditions. Each year, VA is to enroll veterans in those priority categories for which it has sufficient resources to provide care that is timely and acceptable in quality. The act also requires VA to maintain treatment capacity for veterans with special disabilities, including spinal cord injury, blindness, amputation, and mental illness.

At VA's request, the Congress also authorized VA to retain all medical care cost recoveries, beginning July 1, 1997, to increase its nonappropriated revenues.[4] Such recoveries include collections from veterans' private health insurance as well as copayments to VA. VA is to deposit these collections in a Medical Care Collections Fund and use them to supplement appropriations to meet veterans' health care needs. VA may spend these funds in the year collected or in any subsequent year.

VA's health care system currently touches the lives of 15 percent, or about 4 million, of our nation's 25 million veterans. The rest rely on private insurance, other public programs, or their own resources to finance their health care needs.

[3]VA Health Care: Issues Affecting Eligibility Reform Efforts (GAO/HEHS-96-160, Sept. 11, 1996).

[4]In 1986, the Congress had authorized VA to recover third-party payments for medical care, but VA was required to turn over these collections to the Department of the Treasury.

## Realigning Facilities' Services Could Benefit Veterans

VA's large, aged infrastructure could be the biggest obstacle confronting the agency's ongoing transformation efforts. VA spends a major portion of its health care budget—about 1 out of every 4 health care dollars—to operate, maintain, and improve its facilities.

At the Subcommittee's March 10 hearing, we suggested that VA could reduce significantly the amount of funds used to operate and maintain unneeded or inefficient health care delivery locations and reinvest the savings to enhance care provided to veterans.[5] By systematically analyzing health markets to identify unneeded delivery locations, VA could redirect the operation and maintenance budgets of these locations to establish and enhance community-based clinics and other service options for veterans. Without such realignment of delivery locations, resources might be increasingly shifted to operating and maintaining unneeded, aged assets at the expense of veterans' health care needs.

At the March 10 hearing, VA agreed to assess 106 markets in which it operates 181 major delivery locations. VA owns 4,700 buildings and 18,000 acres of land at these locations. VA's assessments will include a determination of veterans' health care needs, a survey of existing assets, and an evaluation of alternatives for meeting veterans' needs in the most cost-effective manner.

The draft Veterans' Millennium Health Care Act contains three key features designed to benefit veterans through such facility services realignment. The act requires

- VA to develop enhanced-service plans to address veterans' health care needs,
- VA's stakeholders to participate in plan development, and
- VA to use efficiency savings locally.

Developing enhanced-service plans would provide an appropriate structure for VA to use when addressing its infrastructure challenge. The proposed legislation requires that VA develop enhanced-service plans to provide needed health care to veterans in markets where VA delivery locations are ineffective or inefficient in providing services and alternative health care providers are available. By requiring enhanced-service planning, this proposal would address concerns that we raised during a July 1997 hearing before this Subcommittee that VA was implementing

[5]VA Health Care: Capital Asset Planning and Budgeting Need Improvement (GAO/T-HEHS-99-83, Mar. 10, 1999).

changes at facilities without adequate planning.[6] This proposal is also consistent with guidelines that VA issued in April 1998 to help VA regional offices improve their planning for service delivery changes.

Requiring stakeholders' involvement in plan development is also an essential element, as we noted during the July 1997 hearing. While facility service realignments could provide significant benefits for veterans, they could also have important consequences for a wide variety of stakeholders, such as VA employees and residents of local communities. For this reason, plans must be developed with comprehensive stakeholder involvement to maximize benefits and minimize adverse impacts. The draft bill proposes a process that VA has already used to develop a plan to integrate medical services in Central Alabama.[7]

Requiring VA to use efficiency savings that are generated by facility service realignments locally should provide incentives for developing effective enhanced-use plans. This approach is consistent, for example, with a suggestion we made concerning the potential savings that VA could realize if it realigned the services of four hospitals in Chicago. In essence, we suggested that savings could be used to enhance the services for veterans in the Chicago area through establishing additional community-based clinics or other services.[8]

## Enhancing Long-Term Care Services Could Benefit Higher-Priority Veterans

VA faces major challenges in serving a rapidly aging veteran population. Veterans 65 and older constitute about 34 percent of the veteran population, or about 8.8 million veterans, and will make up 42 percent of the veteran population by 2010. This aging of the veteran population will result in a growing need for long-term care.

VA currently spends about $2 billion of its $18.4 billion health care budget to provide long-term care services. Of this, nearly $1.7 billion is used for care in 131 VA-operated nursing homes, contract nursing homes, and state veterans' nursing homes. The remaining $353 million is used for noninstitutional care, including residential care and home- and

[6]VA Health Care: Lessons Learned From Medical Facility Integrations (GAO/T-HEHS-97-184, July 24, 1997).

[7]VA Health Care: VA's Plan for the Integration of Medical Services in Central Alabama (GAO/HEHS-98-245R, Sept. 23, 1998).

[8]VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services (GAO/HEHS-98-64, Apr. 16, 1998).

community-based long-term care services, such as adult day health care, respite care, homemaker assistance, home health care, and other services.

About 4 million veterans are currently enrolled in VA's health care system. While VA's uniform health care benefits package includes inpatient hospital care, outpatient care, and other related services, the package does not include long-term care, such as nursing home, domiciliary, and adult day health care. However, enrolled veterans are eligible to receive such services to the extent that resources are available. VA currently provides long-term care services to about 63,000 veterans a day, on average.

The Federal Advisory Committee on the Future of VA Long-Term Care recently reported that VA currently meets about 20 percent of the need for long-term care nationally among veterans with service-connected conditions and those with low incomes.[9] As a result, most veterans use other systems for long-term care services, such as Medicaid and Medicare.[10] The Federal Advisory Committee also found that access to VA long-term care among veterans with service-connected conditions and those with low incomes varied greatly among VA's 22 regions. We have voiced similar concerns in prior work about the lack of equitable access to a range of VA care, including primary outpatient care and more expensive services, such as nursing home care.[11]

The draft Veterans' Millennium Health Care Act contains three key features designed to enhance veterans' access to long-term care:

- requiring the development of a national program of long-term care services,
- increasing the percentage of VA's budget spent on noninstitutional long-term care services, and
- mandating coverage for long-term care services for certain higher-priority veterans.

[9]In Mar. 1997, VA convened this Committee of long-term care experts to evaluate VA long-term care and develop a strategy for meeting veterans' future needs. The Committee recommended 24 measures to enhance VA's long-term care in its report, VA Long-Term Care at the Crossroads (Washington, D.C.: Department of Veterans Affairs, June 1998).

[10]For a discussion of other long-term programs, see Long-Term Care: Baby Boom Generation Presents Financing Challenges (GAO/T-HEHS-98-107, Mar. 9, 1998).

[11]VA Community Clinics: Networks' Efforts to Improve Veterans' Access to Primary Care Vary (GAO/HEHS-98-116, June 15, 1998), VA Health Care: Resource Allocation Has Improved, but Better Oversight Is Needed (GAO/HEHS-97-178, Sept. 17, 1997), and VA Health Care: More Veterans Are Being Served, but Better Oversight Is Needed (GAO/HEHS-98-226, Aug. 28, 1998).

Requiring VA to establish a program that provides a comparable continuum of long-term care services nationally is a reasonable way to ensure that veterans have equitable access to care. It is consistent with the Federal Advisory Committee's recommendation that VA create financial incentives and performance measures to ensure adequate access to long-term care services, while preserving the flexibility of VA's 22 regional offices to develop and structure long-term care services. This proposal should also help address our concerns about historical inequities in long-term care and other services, inadequate monitoring of incentives in VA's resource allocation system that could lead to unintended outcomes, and the lack of VA oversight of the equity of the 22 regional offices' allocations of resources to health care delivery locations.

Requiring VA to spend a greater percentage of its budget on noninstitutional long-term care services is a reasonable strategy to address the growing need for long-term care as the veteran population continues to age, and it is consistent with the Federal Advisory Committee's recommendation to increase investment in these services to better meet the long-term care needs of veterans. This approach is also consistent with other long-term care programs' evolution to expand noninstitutional services to offer a continuum of less expensive services and more efficiently serve veterans when care outside the nursing home is clinically appropriate. An expansion of these services would enable VA to serve more veterans in the home and in the community, as most people prefer, rather than in institutions.

Mandating long-term care services for certain higher-priority veterans is also consistent with eligibility reform legislation and addresses concerns we have previously raised about targeting VA health care benefits to those with the highest priority for services. The proposed legislation would mandate long-term care services for veterans with 50 percent or more service-connected disabilities and for others whose need for long-term care is a result of a service-connected disability, essentially authorizing VA to offer an enhanced benefit package for these veterans.

VA's statutory enrollment process provides a mechanism for enhancing benefit coverage for higher-priority veterans and managing the costs of these enhancements within the limits of VA resources. This process requires VA to determine the cost of meeting the needs of higher-priority veterans and to target remaining resources to provide a basic benefits package to as many lower-priority veterans as possible. Although the

enrollment process provides the mechanism to adjust VA health care delivery according to congressional priorities, the process is only in its first year of operation. Enrolling veterans, projecting the costs of meeting their health care needs, and managing according to the services required and resources available is a complicated challenge that has far-reaching implications for veterans' access to care and the quality of that care.

## Enhancing Medical Cost Sharing Could Benefit Veterans

In 1986, the Congress authorized VA to require higher-income veterans[12] without service-connected conditions to help offset the costs of their medical care through copayments for both inpatient care (acute and long-term) and outpatient care. In 1990, the Congress added a copayment requirement for outpatient medications used to treat non-service-connected medical conditions. VA estimates that it billed about $143 million in copayments in fiscal year 1998.

The draft bill contains provisions that would address VA cost sharing in four areas:

- prescription drugs,
- outpatient services,
- long-term care, and
- certain high-cost supplies.

The draft bill would, for example, authorize the Secretary of VA to increase the prescription drug copayment on the basis of regulations prescribed by the Secretary. Currently, VA is required by law to charge a copayment of $2 for each 30-day or less supply of medication for the treatment of a non-service-connected disability or condition. The proposal to permit VA to increase the copayment for prescription drugs appears to be reasonable, given VA's rapidly escalating drug costs. Since the $2 copayment was legislatively mandated, VA's total prescription drug costs have more than doubled. VA billed for about $64 million in copayments in fiscal year 1998. Increasing the copayment amount for prescriptions is consistent with options we have previously reported to the Congress for helping VA cope with budgetary pressures. In 1996, for example, we suggested that the Congress could offset VA spending for medications by increasing

[12]Higher-income veterans are those whose incomes are above a statutory threshold—for example, a veteran with no dependents with an income of $22,351 or greater. Income thresholds are higher for veterans with dependents.

copayment amounts.[13] Moreover, the draft proposal would provide VA flexibility to adjust rates in a timely manner as conditions change.

The draft bill also proposes to give the Secretary the authority to establish copayment amounts for outpatient services by regulation for veterans with non-service-connected conditions who are above the low-income threshold. VA billed for about $57 million in outpatient copayments in fiscal year 1998. Currently, the law requires that VA charge a copayment to these veterans of 20 percent of the estimated VA-wide average cost of an outpatient visit. This copayment is currently about $46.

Giving the Secretary authority to change outpatient copayments appears reasonable, given the transformation of VA outpatient services in recent years. VA now provides many more expensive services in the outpatient setting, like other health care providers, than it did when the current law was enacted. Procedures at VA such as colonoscopy, arthroscopy, and cystoscopy are now frequently performed in an outpatient setting. As a result, the VA outpatient copayment amount has grown and is disproportionately high for low-cost outpatient care, such as immunizations. Authorizing VA to set a schedule of outpatient copayments could help remove financial deterrents that might discourage the use of preventive care. It could also enable VA to establish a copayment schedule more similar to that used by other health care programs.[14]

The draft bill also proposes that VA increase cost sharing by charging certain veterans a copayment for long-term care services of more than 21 days in any year. Veterans with 50 percent or more service-connected disability and those who are receiving long-term care services for a service-connected disability would be excluded from making copayments under this proposal. VA would be required to develop a methodology for determining copayment amounts on the basis of the income and assets of the veteran and spouse, protecting the spouse from financial hardship, and allowing the veteran to maintain a monthly allowance. Currently, VA bills nursing home care at a rate equal to the Medicare inpatient deductible for the first 90 days of care during any 365-day period. In addition, VA bills $5 a day for nursing home care. In total, VA currently bills for about $4 million from these sources.

[13]VA Health Care: Opportunities to Significantly Reduce Outpatient Pharmacy Costs (GAO/HEHS-97-15, Oct. 11, 1996).

[14]In general, veterans are subject to less cost sharing than is required under most public and private health benefit programs. See VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (GAO/HRD-93-94, July 29, 1993).

The proposal to revise the structure of long-term care copayments appears reasonable because it would give VA flexibility to determine the most appropriate copayment amount for these services by taking into account a veteran's financial resources while protecting the financial independence of a veteran's spouse living in the community. Because these funds would be directed to an earmarked fund for long-term care services, these copayments might also provide additional long-term care services to veterans. In 1992, we suggested a copayment approach using similar principles to offset long-term costs.[15] These principles are already used in VA state homes and in state Medicaid programs.

The draft bill also proposes to establish copayments for certain high-cost items, such as hearing aids, eyeglasses, certain electronic equipment, and other items for non-service-connected conditions. Wheelchairs and artificial limbs would be excluded from these copayments. Currently, VA is not required to collect copayments for these items.

Requiring some veterans to pay a copayment for hearing aids, eyeglasses, certain electronic equipment, and other costly items seems reasonable. Total VA expenditures for these prosthetic items are expected to increase from $420 million in fiscal year 1998 to about $524 million in fiscal year 2000. During the course of our ongoing review of VA's enrollment process, several VA network directors commented that they are experiencing increased demand from veterans whose primary care is provided elsewhere but who obtain from VA services not covered by their private insurance or Medicare, such as eyeglasses and hearing aids. Giving VA the authority to establish copayment amounts would provide flexibility to generate additional revenues to enhance veterans' health care while still affording veterans a substantial health care benefit, because the costs for such items, according to VA officials, are not routinely covered by other health care programs.

## Concluding Observations

In conclusion, the Veterans' Millennium Health Care Act provides a rational framework for addressing such important needs as

- enhancing services at underused facilities,
- enhancing long-term care services for an aging veteran population, and
- providing VA flexibility to generate additional revenues to offset budget pressures and serve more veterans.

[15]VA Health Care: Offsetting Long-Term Care Costs by Adopting State Copayment Practices (GAO/HRD-92-96, Aug. 12, 1992).

Most importantly, the draft bill strives to achieve these objectives in a manner that is consistent with the overall goal of VA's enrollment process, which is to manage veterans' access to health care in relation to available resources.

# Related GAO Products

Veterans' Affairs: Progress and Challenges in Transforming Health Care (GAO/T-HEHS-99-109, Apr. 15, 1999).

Major Management Challenges and Program Risks: Departments of Defense, State, and Veterans Affairs (GAO/T-NSIAD/HEHS-99-84, Feb. 25, 1999).

Major Management Challenges and Program Risks: Department of Veterans Affairs (GAO/OCG-99-15, Jan. 1999).

Veterans' Health Care: Challenges Facing VA's Evolving Role in Serving Veterans (GAO/T-HEHS-98-194, June 17, 1998).

VA Health Care: Assessment of VA's Fiscal Year 1998 Budget Proposal (GAO/T-HEHS-97-121, May 1, 1997).

Department of Veterans Affairs: Programmatic and Management Challenges Facing the Department (GAO/T-HEHS-97-97, Mar. 18, 1997).

Veterans' Health Care: Challenges for the Future (GAO/T-HEHS-96-172, June 27, 1996).

VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-147, May 9, 1995).

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

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