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VA HEALTH CARE

**Progress and Challenges in
Providing Care to Veterans**

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VA Health Care: Progress and Challenges in Providing Care to Veterans

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Department of Veterans Affairs' (VA) new system for enrolling veterans for health care. Historically, VA's health care system was a network of hospitals established to provide specialty care to veterans with injuries or conditions directly resulting from their military service. Over time, eligibility was expanded to provide both inpatient and outpatient care to low-income veterans for conditions not directly resulting from military service—establishing VA's role as a safety net provider for indigent veterans. VA typically provided inpatient hospital care to these veterans and restricted outpatient care by linking it to inpatient admissions. VA also had different eligibility rules for care, based on veterans' degree of injury or condition directly resulting from military service.

The Veterans' Health Care Eligibility Reform Act of 1996 was enacted to equip VA with ways to provide veterans with medically needed care in a more equitable and cost-effective manner. The act required VA to establish a system for enrolling veterans for health care and to use this system for managing delivery of services. VA is to annually enroll veterans according to seven priority groups established by the act—with the highest priority given to veterans with significant service-connected disabilities. VA is also required by the act to enroll only those veterans for which it has sufficient resources to provide timely health care. For fiscal year 1999, VA decided that it had adequate resources to enroll veterans in all seven priority groups; by August 1, 1999, VA will decide which veterans it will enroll in fiscal year 2000.

A number of stakeholders, including Members of this Subcommittee, have raised concerns about VA's basis for offering enrollment to veterans in all seven priority groups and whether VA's budget was sufficient to provide care to these veterans. These stakeholders also raised concerns about the basis that VA would use in deciding which veteran priority groups to enroll in fiscal year 2000. To the extent data are available, you asked that we evaluate the effect of VA's decision to enroll all veteran groups in fiscal year 1999 on veteran demand for health care and the timeliness of that care. You also asked us to identify the challenges and options VA has in making its fiscal year 2000 enrollment decision. My remarks today are based on information we received from VA headquarters, contractors, and Veterans' Service Organizations as well as surveys of all 22 directors of VA's Veterans Integrated Service Networks (VISN).

In summary, since implementing its enrollment system at the beginning of fiscal year 1999, VA has enrolled about 4 million veterans and, according to VA's latest enrollment data, its health care expenditures for these enrollees are on track with VA's projections.¹ However, each of the 22 VISN directors we surveyed told us that demand for care has increased in fiscal year 1999 and that this increase has affected the delivery of timely care to veterans in some VISNs. Eighty percent of the directors we surveyed said that the waiting time to schedule primary and specialty care appointments has increased since the beginning of fiscal year 1999. While 21 of the 22 directors told us that enrollment was a factor to some extent in the increased demand, 13 cited the expansion of health care benefits and 12 cited additional VA outpatient clinics as other factors contributing to this increased demand. In addition, 8 of the 22 VISN directors reported that VA's decision to open enrollment to all veterans has negatively impacted access to care for veterans in higher priority groups to some extent. Nine told us that they had less than adequate capacity to meet the increased demand, and three directors, believing that their VISN's capacity to deliver health care was limited, chose to limit outreach efforts that would attract new veterans into the VA health care system. This, in turn, has created uneven access to care by making care available to veterans in some locations but not in others.

As VA nears its fiscal year 2000 enrollment decision, VA's ability to continue its current level of care—or to enroll more veterans—is unlikely, primarily because its fiscal year 2000 budget request is based on, in our view, an overly optimistic assumption that it will realize \$1.4 billion in management efficiencies. In prior testimony before this Subcommittee, some VISN directors stated that they will have difficulty achieving these management efficiencies; all of the 22 directors we surveyed told us that they anticipate having problems meeting veteran demand for health care in fiscal year 2000. If VA does not have the resources available to continue to enroll veterans in all priority groups in fiscal year 2000, it will need to consider limiting health care eligibility to only those veteran priority groups or subgroups to which VA can provide timely care, as the act requires; modifying the benefits it offers to all enrollees; or both. VA may have difficulty determining the financial effect of these options because its data on treatment costs and veteran income levels are insufficient. Although VA has efforts under way to improve its data, it is unlikely that these improvements will occur in time for VA's fiscal year 2000 enrollment decision.

¹Prior to fiscal year 1999, VA did not enroll veterans in its health care system. Therefore, VA tracked only the number of patients it served, not those that might seek care in the future.

Background

The Eligibility Reform Act was enacted to help VA improve its management of care and provide this care in more cost-effective ways; it also sought to increase veterans' equity of care. To improve cost-effectiveness, the act allowed VA to provide needed hospital care and health care services to veterans in the most clinically appropriate setting—including care for conditions not directly resulting from military service. To administer this care locally, VA established, in fiscal year 1996, 22 regional VISNS to serve as the basic budgetary and decisionmaking units for how best to provide services to veterans within these VISNS' geographic boundaries.

To improve VA's management of health care, the act required VA to establish and implement a national enrollment system. VA is to use this system as a tool to manage veterans' access to care through the seven priority groups established by the act; each year, VA must decide which of these priority groups it can afford to enroll so that it can provide timely care. VA is also required to maintain capacity for veterans with special disabilities, including spinal cord injury, blindness, amputation, and mental illness. If VA decides it cannot enroll veterans in all priority groups, veterans in the lowest groups—beginning with priority group 7—would not be offered enrollment. Table 1 summarizes the seven veteran priority groups.

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Table 1: Seven Veteran Priority Groups

Priority group	Eligibility criteria
1 (highest)	Veterans with service-connected conditions resulting in disability of 50 percent or more
2	Veterans with service-connected conditions resulting in disability of 30 to 40 percent
3	<ul style="list-style-type: none"> — Veterans with service-connected conditions resulting in disability of 10 to 20 percent — Former prisoners of war — Veterans discharged from active duty for a disability incurred or aggravated while on active duty — Veterans with special eligibility classification
4	<ul style="list-style-type: none"> — Veterans receiving aid and attendance or who are housebound — Veterans with catastrophic disability
5	Veterans with incomes below the means-test threshold (currently, \$22,351 for single veterans and \$26,824 for veterans with one dependent)
6	<ul style="list-style-type: none"> — World War I and Mexican-border veterans — Veterans receiving care for radiation or toxic substance or environmental hazard exposures
7 (lowest)	All other veterans who agree to pay established copayments (that is, veterans who have non-service-connected disabilities and/or noncompensable 0 percent service-connected disabilities above the means-test threshold)

Note: Groups 1 through 6 were covered under VA's former health care system. Veterans under group 7 were only covered when space and resources were available. Under the new enrollment system, VA has offered care to all veteran priority groups for fiscal year 1999.

To ensure that all enrolled veterans have access to the same level of health care, VA has expanded its health care benefits by offering a comprehensive and uniform benefits package to all enrollees. VA's 22 VISNs administer these benefits, and each has the flexibility to decide where and how medical care is provided—through in-house services, contracts, or other arrangements. Through this benefits package, enrollees are eligible for any medically necessary outpatient or inpatient care that (1) will promote, preserve, or restore health; (2) has been prescribed by a VA clinical care provider; and (3) is consistent with generally accepted standards of clinical practice. Once enrolled, veterans can receive care, regardless of their priority group.

The act specified that, after October 1, 1998, VA may not provide hospital care or medical services to veterans unless they are enrolled in VA's health care system. VA began accepting applications for enrollment in October 1997, as a test period, and officially began enrolling veterans on October 1, 1998, as mandated by the act. Veterans who had used the VA

health care system in the previous year were automatically enrolled.² Further, veterans who meet the following criteria do not need to enroll: (1) veterans with a service-connected condition of 50-percent disabled or more; (2) veterans seeking care for a service-connected condition; and (3) veterans discharged from active duty for a disability incurred within the prior 12 months but who have not yet received a disability rating from VA.

Veterans may enroll in person or through the mail. When completing the one-page enrollment application, veterans choose a primary care provider employed by VA. Once enrolled, veterans receive a letter from VA confirming their enrollment. VA uses a “rolling” enrollment system, meaning that veterans may submit an application for enrollment at any time and are generally enrolled for the duration of the fiscal year.

In making its decision to offer enrollment nationwide to veterans within the seven priority groups for fiscal year 1999, VA estimated the number of veterans who would enroll, their need for services, the portion of services they would seek from VA, and VA’s expenditures to provide these services under its Uniform Benefits Package. VA then compared its estimated expenditures for the Uniform Benefits Package to the anticipated funding and concluded that it could afford to offer enrollment to veterans in all priority groups.³

VA’s Fiscal Year 1999 Enrollment Decision and Other Factors Increased Veteran Demand for Care and Waiting Times in Some Locations

Since implementing its enrollment system, VA has expanded its health care services and locations of care to increasing numbers of veterans. Halfway through the fiscal year 1999 enrollment year, VA is generally on track with its projections of enrollee demand for health care and its expenditures on these enrollees at the national and VISN levels; VA has spent about half of its \$14.1 billion available to fund the Uniform Benefits Package. Table 2 shows VA’s most recent data on the number of enrollees and users and the associated costs for each by priority group for the first 6 months of fiscal year 1999.

²VA defines these veterans as “past” enrollees, since they have used VA health care since 1996. In contrast, veterans who have not used VA health care since 1996 are defined as “new” enrollees.

³VA is required by the Eligibility Reform Act to report on its experience in implementing certain sections of the act, including management of health care. Although the report for fiscal year 1999 was due by April 1, 1999, VA expects to issue this report by July of this year.

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Table 2: Number of Enrollees and Users and Associated Costs by Priority Group, October 1998 Through March 1999

Priority group	Total number of enrollees	Number of users	Cost per user ^a	Total costs
1	443,134	362,240	\$4,514	\$1,635,117,425
2	297,480	205,256	2,394	491,465,728
3	532,913	329,059	2,216	729,292,271
4	120,398	94,786	11,733	1,112,088,333
5	1,378,924	1,047,098	2,679	2,805,336,809
6	58,678	27,095	1,542	41,767,687
7	486,260	243,080	2,629	316,213,510
Unprioritized	685,921	141,253	1,991	281,186,735
Total	4,003,708	2,449,867	\$3,026	\$7,412,468,498

^aTo determine the cost per user, VA divided the total costs by the number of users.

Source: VA's Office of Policy and Planning.

VISN directors told us that, during this time, veteran demand for health care services has increased in all 22 VISNs. While 21 of the 22 directors told us that the decision to offer enrollment to all veterans was a factor in the increased demand, 13 directors cited the expanded health care benefits and 12 noted the additional VA outpatient clinics as factors contributing to this increased demand.⁴ One VISN recently applied for and was granted supplemental funding from VA's National Reserve Fund, in part, to help meet veteran demand for health care.⁵

VA conducted activities at a national level to inform veterans about enrollment. After VA made its decision to offer enrollment to all veterans, however, several VISNs expressed concerns about potentially excessive demands on capacity.⁶ Similarly, 9 of the 22 VISN directors we surveyed told us that given their present level of demand, the facilities within their VISN had less than adequate capacity to meet this demand. Over two-thirds of the 22 VISN directors told us they made moderate efforts to inform veterans about enrollment, but 3 directors made small or little to no

⁴To enhance primary care access, VA has over 1,000 primary care teams at large medical facilities and opened over 183 outpatient clinics. These clinics provide primary care closer to veterans' homes, especially those living in underserved areas. Currently, VA plans to open 272 community clinics in fiscal years 1999 and 2000 and expects to open about 200 more by fiscal year 2003.

⁵This fund was established to provide a source of funds during each fiscal year for unanticipated needs in VISNs or in headquarters-administered programs. The initial source of these reserve funds is the annual appropriation to the Medical Care account.

⁶Department of Veterans Affairs: Veterans Health Administration, Office of Communications: VA Eligibility Reform, VISN Outreach Programs and Initiatives, Survey Report, prepared by Loudon Associates, Inc.; Jan. 3, 1999.

effort—believing they had less than adequate capacity to meet the increased veteran demand for health care. By making care available to veterans in some locations but not in others, access to care is uneven.

The Eligibility Reform Act requires VA to ensure that enrollees receive timely health care. However, 17 directors told us the waiting times to schedule primary care have increased since the beginning of fiscal year 1999, and 16 directors told us that the same had occurred for specialty care appointments. In addition, VA's guideline states that new patients wanting routine care—that is nonemergent and nonurgent—and specialty care patients will receive appointments within 30 days. However, information we obtained from two VISN directors suggests that VA is not always meeting these timeliness standards. For example, one VISN director told us that veterans have to wait 150 days to obtain a follow-up appointment with a primary care provider and that the waiting time for specialty care appointments exceeds 30 days on average. Another VISN director told us that some veterans must wait more than 40 days to obtain primary care and between 50 and 100 days to obtain specialty care. Further, 8 VISN directors told us that VA's decision to offer enrollment to veterans in all seven priority groups has reduced access to care for higher priority veterans (priority groups 1 through 4) to some extent.

In addition to surveying VISN directors, we also spoke with representatives of Veterans' Service Organizations, such as the Paralyzed Veterans of America and Disabled American Veterans, to obtain their views on the timeliness of veterans' health care. Like some VISN directors, these representatives expressed concerns about increased waiting times for veterans—especially those waiting to see specialty care providers. For example, according to a representative of the Paralyzed Veterans of America, veterans had to wait 3 to 5 months to obtain orthopedic or urology appointments at one VA medical center.

Currently, VA does not gather and track information on primary and specialty clinic appointment waiting times. However, it is designing a system to collect this information and testing is under way at four medical centers. VA expects to install software for this system at all of its medical centers by the end of August 1999 and to generate its first report on waiting times by September 1999. We plan to monitor VA's efforts to measure veteran waiting times.

Budget and Other Challenges Confront VA in Making Its Fiscal Year 2000 Enrollment Decision

To provide timely notification to veterans, VA must decide soon who it will enroll in fiscal year 2000. VA is facing budget constraints for fiscal year 2000 that may limit its ability to enroll and fully serve all priority groups, as it did in fiscal year 1999. Recognizing this potential dilemma and its need to realize savings in the short-term, VA is exploring two options to manage the delivery of health care within its proposed fiscal year 2000 budget request: (1) limit health care eligibility to only those veteran priority groups or subgroups for which VA can provide timely care or (2) modify the benefits it offers to all enrollees. However, VA may have difficulty calculating the cost savings it could achieve through these options due to some data limitations. Further, VA will not know what its fiscal year 2000 appropriation will be until after it makes its enrollment decision in August.

VA's Budget Dilemma in Fiscal Year 2000

As we testified in April 1999, VA will be severely challenged to serve all veterans seeking to enroll in fiscal year 2000 within its proposed budget.⁷ This is primarily because the budget is based on, in our view, an overly optimistic assumption that VA will realize substantial savings through management efficiencies in fiscal year 2000. In addition, VA may have underestimated the cost of treating veterans with hepatitis C.

VA estimates that it will need \$19.23 billion—\$870 million more than its estimated fiscal year 1999 spending level of \$18.36 billion—to maintain current service levels in fiscal year 2000 if no management efficiencies were realized. This \$870 million difference primarily involves payroll increases for existing employees, inflation, and other mandatory rate changes. In addition to these increases, VA plans to use another \$525 million to enhance services provided to veterans. In total, VA will need to reduce other expenditures by nearly \$1.4 billion to effect these increases.

In general, VA estimates that it could save about \$514 million of this \$1.4 billion in personal services savings. To reach this level of personal services savings, using VA's average cost of \$60,236 per full-time equivalent, VA would need to reduce its employment level by 8,529 full-time equivalents. This is significantly higher than the reduction of 3,606 that VA achieved in 1998 and the 2,518 reduction that VA expects to achieve in 1999. Further, VA needs to achieve the employment reduction of 8,529 before fiscal year 2000 starts, less than 3 months from now. If VA does not achieve this reduction until after the beginning of fiscal year 2000, it will have to eliminate even more positions in order to meet its savings goal. VA

⁷Veterans' Affairs: Progress and Challenges in Transforming Health Care (GAO/T-HEHS-99-109).

estimates that the remaining \$876 million in efficiencies will be achieved through savings in nonpersonal services, such as prosthetics and pharmaceuticals. This, too, could prove challenging, given the rapid increases in demand for these services. If VA is unable to meet its employment reduction goal, it will have to increase nonpersonal services savings beyond this target level.

Although all VISNs have prepared a plan indicating the strategies and actions they may have to take to realize management efficiencies, some VISN directors have expressed concern about their ability to achieve these required efficiency savings. At a hearing before this Subcommittee in February 1999, two VISN directors stated that these efficiency savings in VA's fiscal year 2000 budget would require significant furloughs of employees. Further, two VISN directors told us that they believe that the cost savings achieved from transitioning care from costly inpatient hospital settings to less costly outpatient settings are approaching their maximum and that many VISNs have exhausted their efficiency options. All 22 VISN directors told us that they will have difficulty meeting veteran demand for health care services in fiscal year 2000 if VA continues to offer enrollment to all veterans. As a result, VA may not be able to offer the same level of care to veterans in fiscal year 2000 as they have been providing. Nonetheless, 11 VISN directors told us that they are generally in favor of offering enrollment to all veterans again in fiscal year 2000, for varying reasons.

Further, VA's fiscal year 2000 budget submission may have underestimated the cost of treating veterans with hepatitis C. For example, VA's budget submission included \$135 million to expand treatment of veterans who have hepatitis C, based on an assumed prevalence rate of 5.5 percent among the veteran population. However, VA's most recent estimate of the prevalence rate is 8 to 10 percent. According to a VA official, if an 8-percent prevalence rate proves accurate, it may cost VA \$100 million more than it previously estimated to provide services to veterans with this disease.

VA Enrollment Options and Information Challenges

Recognizing the potential budget dilemma for fiscal year 2000 and its need to realize short-term financial savings, VA is exploring two principal options to manage the delivery of health care. The first option is to limit health care eligibility to a subgroup of veterans by dividing priority group 7 into two subgroups: (1) those veterans who have a service-connected condition but receive no compensation for their disabilities and (2) all other priority group 7 veterans. VA is contemplating discontinuing

enrollment to veterans in the second subgroup as a way to reduce its costs. Using VA's preliminary cost data for the first half of fiscal year 1999, veterans in this second subgroup represent about \$284 million of VA's total health care expenditures of approximately \$7.4 billion. However, priority group 7 veterans typically have other health insurance that VA can bill; thus, VA's net cost for these veterans is generally small, and any savings it could achieve by no longer enrolling them would also be small.

If VA does not realize the \$1.4 billion it plans to save in management efficiencies from personal and nonpersonal services, it may have to consider cutting deeper into the priority groups. As shown in table 2, according to VA's preliminary cost data, it has spent \$2.8 billion (about 38 percent) of its expenditures on veterans in priority group 5. Since its role has been defined as providing a safety net for veterans in this group—who are generally lower-income—VA would have difficulty discontinuing care to these veterans. However, if this were unavoidable, VA may need to identify those veterans who do not have sources of health care other than VA and continue offering enrollment to these veterans.

The second option VA is considering is to modify the benefits it now offers to all enrollees. VA has established a task force to explore possible changes to these benefits to reduce costs, and it plans to use the results of this task force in making its fiscal year 2000 enrollment decision. In our discussions with VISN directors, nine suggested that they believe VA should consider modifying the existing Uniform Benefits Package.

Calculating the cost savings VA could achieve through these options may be difficult, however, due to insufficient data on treatment costs and veteran income levels.

- Currently, VA's data systems do not fully track treatment-specific costs, making it difficult for VA to determine the exact cost savings it could realize by discontinuing care to some veterans or reducing benefits. Recognizing this limitation, VA hired an actuarial firm to project the total number of veterans that might enroll for health care and forecast their utilization of VA health care and associated costs for fiscal year 2000, similar to its fiscal year 1999 decisionmaking process. Further, VA is developing a database—the Decision Support System—to capture patient- and treatment-specific cost data. This database is being implemented throughout VA's medical facilities, but according to VA officials, it will not fully replace VA's existing database until September 2001.

- To determine if veterans are above or below a particular income level (means test) and to place them into one of the seven priority groups, VA needs veteran income data. However, many veterans do not have information on their income status readily available to complete the enrollment application form when arriving at a medical facility. As a result, almost 686,000 of the 4 million enrollees (or about 17 percent) were not assigned to a priority group, as of March 26, 1999. To address this problem, VA recently verified the income of about 435,000 of these veterans and placed them in appropriate priority groups. Further, VA officials are planning to annually send enrollment applications to each veteran's home, allowing the veteran to complete the application in the home setting and send it back to VA.

These limitations restrict VA's ability to reliably determine its cost savings under these options. Although VA has efforts under way to improve the data, it is unlikely that these improvements will occur in time for VA's fiscal year 2000 enrollment decision.

Conclusions

The Eligibility Reform Act required VA to establish an enrollment system and, through the seven priority groups, to manage and provide timely health care within its resources. While at this time it appears that VA has the funding available in fiscal year 1999 to offer health care to veterans in each of the seven priority groups, it may not be providing timely care to enrollees in some areas of the country. Before the next annual enrollment period begins—less than 3 months from now—VA must decide whether it will continue offering enrollment to veterans in all seven priority groups. In the event that VA cannot realize the \$1.4 billion in management efficiencies it needs to operate within the President's fiscal year 2000 budget, we believe it will need to find other ways to realize significant savings within a very short period of time. If this is the case, VA will need to use the enrollment system as the tool the Congress intended and only enroll veterans in those priority groups for which it has sufficient resources to provide timely care, or it will need to modify the benefits it currently offers to all enrollees, or both. Regardless, VA may have difficulty calculating the cost savings it could achieve through these options due to insufficient data.

Mr. Chairman, this concludes my prepared statement. At this time, I will be happy to answer any questions you or other Members of the Subcommittee may have.

GAO Contacts and Acknowledgments

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