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VETERANS' HEALTH CARE

Efforts to Make VA Competitive May Create Significant Risks

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today as the Subcommittee continues to examine the veterans' health care provisions of the administration's proposed Health Security Act. We are conducting a series of studies--several of which were requested by Chairman Evans--on the potential effects of health reforms on the Department of Veterans Affairs (VA) health care system and options for restructuring veterans' health benefits. My comments this morning will focus on the preliminary results of work on one of those requests. Specifically, we will discuss

-- legal and structural barriers that could limit VA's ability to restructure its health care facilities into managed care plans and compete with private-sector health plans,

-- the extent to which the Health Security Act would overcome those barriers, and

-- the potential risks associated with efforts to make VA competitive with private-sector managed care plans.

Our work is based on meetings with VA central office and medical center officials and representatives from health maintenance organizations (HMO) and managed care associations, our reports over the last 10 to 15 years looking at managed care programs under Medicare and Medicaid, and our reports and ongoing work relating to veterans' health issues. We are currently drafting a report that will expand on the information we are presenting this morning.

RESULTS IN BRIEF

VA faces many challenges as it attempts to restructure its health care system to compete in a managed care environment. We identified more than 25 barriers that could hinder VA's efforts to establish competitive health plans. These barriers relate generally to (1) eligibility for VA health care services, (2) management flexibility to react to local conditions, (3) uncertainties about funding of VA health care services, (4) restrictions on marketing, and (5) VA's health care infrastructure. VA officials believe that for barriers other than those relating to VA's infrastructure, legislative action to exempt VA from a series of existing laws and regulations is essential if VA is to compete with private-sector health plans.

Most legal barriers that might limit VA's ability to compete with private-sector managed care plans would be addressed through the Health Security Act. For example, VA would be exempt from most federal contracting and personnel laws and regulations. In addition, VA eligibility would be reformed and new sources of funding established.

The act, however, would overcome many barriers by expanding entitlement to VA health care or by exempting VA from federal and state requirements developed to prevent fraud and abuse and ensure quality of and access to health care services. In addition, many of the structural barriers, such as VA's lack of adequate cost and utilization data, will likely inhibit its efforts to establish competitive health plans.

As a result, significant risks are associated with efforts to transform the VA direct delivery system into a series of managed care plans:

-- The expanded entitlement to free comprehensive care could add billions of dollars to VA appropriations if all veterans entitled to free care seek to enroll in VA health plans.

-- If capacity in VA health plans is limited, veterans with service-connected disabilities could be denied veterans health care benefits while high-income veterans with no service-connected disabilities are enrolled in VA health plans.

-- The potential for conflict-of-interest violations, kickback schemes, and diversion of patient care funds through related party transactions would be heightened because of exemptions from contracting, HMO, and Medicare requirements.

-- Complex revenue streams would make it increasingly difficult to keep appropriated and nonappropriated funds separate, creating the risk of violating a federal statute that requires that funds only be spent for the purpose for which they are appropriated.

-- Billions of additional dollars in start-up funds could be required to make VA health plans competitive because VA has not completely assessed what it must do to become a competing provider.

-- Setting accurate premiums, determining when it is best to contract for services rather than provide them directly, and recovering the costs of services provided to other health plans through contracts and sharing agreements will be difficult because VA lacks adequate systems to track costs and utilization.

-- Abuse of VA's enrollment process could increase because VA lacks adequate methods for verifying veterans' eligibility status.

-- Further decentralization of VA management could heighten risks created through exemptions from federal laws and regulations.

Obviously, the risks would be decreased to the extent that VA reinstitutes the internal controls that would be eliminated through the exemptions.

BACKGROUND

When the VA health care system was established in 1930, public and private health insurance were virtually nonexistent. VA developed its system as a direct delivery system with the government owning and operating its own health care facilities. It became the nation's largest direct delivery system with 171 hospitals and more than 200 outpatient clinics.

With the subsequent growth of public and private health insurance programs, most veterans now have one or more alternatives to VA health care. In 1990, 9 out of 10 veterans had other health care coverage in addition to access to services provided by VA. For example, about 27 percent of veterans were eligible for Medicare.

Still, about 2.2 million veterans made more than 20 million outpatient visits to VA health care facilities and had more than 970,000 hospital stays in 1991. Of these veterans, about 1 million had disabilities incurred in or aggravated by military service (service-connected), and 1.2 million had no disabling conditions relating to military service (nonservice-connected).

Veterans who use VA health care services tend to have lower incomes and less private insurance coverage than veterans using other providers. In other words, in addition to providing treatment for service-connected disabilities, VA serves as a safety

net for veterans lacking the resources to pay for private-sector health care.

Reforms of the nation's health financing system, such as those under consideration, would reduce the number of uninsured veterans. As a result, many veterans who currently rely on VA because they do not have health insurance or cannot afford the copayments and deductibles that would be required by private-sector hospitals and physicians, might seek care closer to their homes.

Of the many health reform proposals being considered, only one--the administration's proposed Health Security Act--would change the VA health care delivery system or VA eligibility to try to limit VA's potential loss of workload.

The Health Security Act would fundamentally change both how VA operates and the benefits to which veterans using VA are entitled. In this regard, the act would transform VA facilities into a series of managed care plans to compete with private-sector plans. This type of restructuring is already taking place in the private sector as hospitals and individual providers increasingly create or join managed care plans.

BARRIERS COULD LIMIT VA'S ABILITY TO COMPETE WITH PRIVATE-SECTOR MANAGED CARE PLANS

We identified more than 25 barriers that could limit VA's ability to effectively compete with private-sector health plans. VA officials believe legislative relief is needed to overcome many of the barriers, some of which follow:

- Under the complex eligibility and entitlement provisions of chapter 17 of title 38 of the U.S. Code, most veterans are not eligible for the full range of comprehensive health care services required in a managed care environment.

- Veterans' dependents are not currently eligible for care in VA facilities, placing VA at a competitive disadvantage in trying to enroll veterans.

- Complex federal procurement laws and regulations limit VA's flexibility in procuring items and services.

- Requirements under section 510 of title 38 U.S.C. that VA notify the Congress before closing or relocating VA facilities would make it difficult to quickly react to market conditions by closing underused or inefficient facilities.

- Federal personnel requirements under titles 5 and 38 of the U.S. Code make it difficult to hire and fire employees and set pay levels to respond to local conditions.

- VA has to rely almost entirely on federal appropriations to pay for health care services and modernize its equipment and facilities.

- VA is restricted in conducting market research by the Paperwork Reduction Act.

Following are some barriers relating to VA's existing health care infrastructure, however, that could be addressed without legislation, although additional resources would be needed:

- VA's inadequate cost and utilization data do not support its move to a managed care system.

- Many VA facilities are outdated and lack the patient amenities of private-sector hospitals.

-- VA lacks a facilities network that would allow veterans to obtain health care services close to their homes.

-- Many veterans' negatively view the quality of care and customer service at VA facilities.

-- Centralized management limits the ability of VA health plans to react to local conditions.

-- A shortage of primary care physicians needed to quickly adopt managed care. About 20 percent of VA physicians are primary care physicians or generalists; about 60 percent of a managed care plan's physicians are typically primary care physicians.

-- VA lacks expertise in establishing and operating managed care plans.

-- Veterans used to "showing up" for treatment at VA hospitals and clinics without appointments will have to be educated on accessing care through a managed care system.

-- Private-sector health plans may be unwilling to contract with VA unless it grants their physicians admitting rights and meets other requirements established by the health plans.

THE HEALTH SECURITY ACT WOULD ADDRESS MOST LEGAL BARRIERS

The Health Security Act would address most of the legal barriers mentioned, largely through expansions in VA entitlement and exemptions from federal and state requirements. For example, the act would authorize

-- VA to provide the same set of comprehensive health care benefits to veterans enrolling in VA health plans as provided by competing managed care plans;

-- VA to enroll veterans' dependents in VA health plans and to have broad authority to contract for health care services, enabling it to provide care to dependents either in VA facilities or through contract care;

-- VA to contract for services to a VA health plan without regard to laws requiring competitive procedures;[1]

-- VA health plans to be exempt from requirements that the VA notify the Congress before administrative reorganizations;

-- VA to be exempt from most federal personnel requirements and to establish its own personnel system tailored to individual health plan needs;

-- VA health plans to be deemed Medicare providers and Medicare HMOs, exempting VA from Medicare requirements; and

-- VA to market its health plans.

The act also contains several new financing mechanisms to help offset the costs of VA health plans. For example, VA would be authorized to recover and retain from Medicare the costs of health care services provided to higher income nonservice-connected, Medicare-eligible veterans. VA would also be authorized to retain

[1]Under amendments approved by the Subcommittee on Hospitals and Health Care, VA could contract for any health care resource without regard to most procurement laws and regulations.

any premiums (both the employer and employee shares), copayments, and deductibles for veterans enrolling in VA health plans. In addition, VA would be authorized to sell its health care services to other health plans to provide services to veterans.

To give VA additional flexibility in financing health plan operations and construction projects, VA health plan revenues, including premiums, copayments and coinsurance, deductibles, and amounts received as reimbursements from other health plans for services provided to its enrollees, would be deposited in a revolving fund. The funds would be available without fiscal year limitations and could be distributed among VA health plans. VA would not be allowed to retain funds for items and services paid for through appropriations.

Unlike private-sector health plans, VA health plans would not be allowed to put funds from the revolving fund into investments. In addition, the Health Security Act would not establish specific reserves for VA health plans.

Finally, $3.3 billion would be appropriated over a 3-year period to cover construction of additional outpatient clinics, renovation of existing facilities, and other start-up costs for the health plans.[2]

Although these changes would help VA market competitive managed care plans, they would also create significant risks--risks to the government in higher costs and increased exposure to fraud and abuse and risks to veterans in decreased access to and quality of care. I would now like to discuss some of those risks.

EXPANDED ENTITLEMENT COULD ADD BILLIONS TO VA APPROPRIATIONS

Under the provisions of the Health Security Act, about 9 million veterans would be entitled to free comprehensive health care benefits if they enroll in VA health plans (core group veterans). This entitlement could require VA appropriations of about $16 billion just to cover the premiums of core group enrollees. Although the entitlement expansion would increase overall government health care spending, most of the increase in VA appropriations would result from cost shifting from Medicare and other programs.

About 9 Million Veterans Would Be Entitled to Free Comprehensive Care

The Health Security Act would greatly expand the number of veterans entitled to free comprehensive health care services. Currently, about 450,000 veterans with service-connected disabilities rated at 50 percent or higher are entitled to free comprehensive health care services from VA.[3] While millions of other veterans are eligible for free care from VA, they are entitled only to certain services, such as inpatient hospital care or outpatient treatment for their service-connected disabilities. Provision of other services is limited to services that can be provided within available resources. Under the Health Security Act, about 9 million core group veterans, including service-

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[2]Increased to $4.05 billion by the Subcommittee on Hospitals and Health Care.

[3]Nursing home care is currently an optional benefit for all veterans. Under amendments to the Health Security Act approved by the Subcommittee on Hospitals and Health Care, nursing home care would become a mandatory benefit for veterans with service-connected disabilities rated at 50 percent or higher and any veteran whose need for nursing home care results from a service-connected disability.

connected veterans, low-income veterans, former prisoners of war, and veterans of World War I or the Mexican Border period, would be entitled to free comprehensive inpatient and outpatient care if they enrolled in a VA health plan. Many of these veterans--those with incomes below 150 percent of the poverty level--would also be entitled to subsidized care if they enrolled in a private-sector health plan.

These provisions have two implications. First, if VA health plans succeed in attracting all veterans entitled to free care, VA could end up paying the veterans' cost share of premiums and other cost sharing for 9 million or more veterans. For the estimated 3.3 million Medicare-eligible veterans in the core group, VA would pay, through appropriations, the entire cost of their comprehensive benefit package. On the basis of nationwide average Medicare HMO payment rates, this could require about $13.5 billion in appropriations just to cover the costs of premiums. An additional $2.4 billion in VA appropriations could be required to cover the enrollee share of premiums for the core group veterans who are not Medicare eligible. Additional appropriations would also be needed to cover (1) the costs of copayments, deductibles, and coinsurance for the core group veterans and (2) the employer share of premiums for self-employed core group veterans.

Because the veteran population is aging rapidly, the potential cost implications of expanding entitlement to free comprehensive VA services for Medicare-eligible veterans are even more significant. In 1990, about 27 percent of the veteran population was Medicare eligible, but by the year 2000, 37 percent of the veteran population will be over age 65. And, by 2020, 45 percent of the veteran population is expected to be over 65.

On the other hand, if VA health plans do not enroll enough veterans to make those plans financially viable, the government might have to subsidize the plans to keep them operational or allow the plans to fail, leaving one or more regions of the country without a VA health plan. In the latter case, veterans living in the regions without a VA health plan would have to join another health plan and pay the employee portion of the premium. Essentially, veterans from failed VA health plans would no longer have VA benefits. Such a result may not be politically feasible, resulting in legislation to permit the government to pay the premiums and cost sharing of veterans enrolling in private-sector health plans.

SERVICE-CONNECTED VETERANS MAY HAVE MORE DIFFICULTY ACCESSING VA HEALTH CARE

Service-connected veterans could find it harder to access their veterans benefits under the Health Security Act for several reasons.

First, enrollment in a VA health plan would be on a first-come, first-served basis under the Health Security Act, shifting VA priorities away from service-connected and low-income veterans.[4] Nonservice-connected veterans with high incomes and dependents of veterans would have the same priority for enrollment as core group veterans. As long as VA health plans have the capacity to enroll all veterans and dependents seeking to enroll, this shift in priorities will not affect service-connected veterans.

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[4]Chapter 17 of title 38 U.S.C. establishes priorities for care in VA treatment facilities. Generally, veterans with service-connected disabilities, former prisoners of war, and veterans with low incomes have the highest priorities for care when space or resources are not adequate to meet all veterans' needs.

If a VA health plan does not have the capacity to provide services to all veterans seeking to enroll in the plan, some veterans in the core group could be denied enrollment in the VA health plan and thus a significant portion of their veterans health benefits. At the same time, higher income nonservice-connected veterans and their dependents who enrolled in the VA health plan before it reached capacity would be guaranteed the comprehensive benefit package from the VA health plan. VA has stated its intent to market its plans to high-income nonservice-connected veterans, which would enable it to obtain Medicare and employer reimbursements.

Second, service-connected veterans enrolling in non-VA health plans may find it difficult to obtain care for their service-connected disabilities from VA. As I testified before this Subcommittee in April, service-connected veterans participating in our focus groups frequently indicated that they used VA only for treatment of their service-connected disabilities. These veterans choosing to enroll in non-VA plans could no longer use VA for treatment of their service-connected disability if the treatment is a covered service under the comprehensive benefit package unless their health plan agreed to pay VA for the care.

Originally, the Health Security Act would have required the veteran's private-sector health plan to pay the full and actual cost of care provided by a VA health plan. This could have made service-connected veterans liable for any copayments and deductibles imposed by their private-sector health plan. The Subcommittee on Hospitals and Health Care approved an amendment to the act to provide that VA health plans could not impose cost-sharing requirements for specialized services provided to service-connected veterans enrolled in non-VA health plans.

Because the VA health plans would now be liable for such costs without full reimbursement, they would have little financial incentive to provide treatment to service-connected veterans enrolled in other health plans. They would, however, obtain full reimbursement for services provided to nonservice-connected veterans enrolled in non-VA health plans.

EXEMPTIONS FROM CONTRACTING REQUIREMENTS HEIGHTEN POTENTIAL FOR FRAUD AND ABUSE

Reducing contracting requirements heightens the potential for fraud and abuse. The Health Security Act would exempt VA from competitive bidding requirements in the procurement of services by a VA health plan and expand VA's sharing authority. Amendments to the act approved by the Subcommittee on Hospitals and Health Care broadened VA's exemption from contracting requirements. Under these amendments, health plans would be exempt from virtually all federal contracting laws and regulations in obtaining a health care resource, including the Procurement Integrity Act and perhaps even minimum wage statutes such as the Walsh Healy Act. In addition, losing bidders would no longer be allowed to file bid protests, and VA would no longer be subject to any laws or regulations mandating or giving priority to any source of supply, such as small businesses or minority contractors.

VA has a long history of problems in administering contracts and sharing agreements. For example, in a 1987 audit of scarce medical specialist contracts, VA's Inspector General reported that VA medical centers had awarded contracts for more services than were needed, paid for services they had not received, and had not established controls to ensure that contractor performance and billing complied with contract terms.[5] Our July 1992 follow-up to the Inspector General's report found that VA still lacked

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[5]Audits of Selected Aspects of VA's Program for Sharing Scarce Medical Resources, Report No: 7AM-A99-089, July 15, 1987.

sufficient data and evaluation criteria to ensure that problems were identified and corrected.[6]

Because VA medical centers' senior managers often receive part-time employment incomes from medical schools that receive millions of dollars through VA contracts, conflicts of interest could arise. In April 1993, we reported to this Subcommittee that these managers nevertheless participated in award or administration of contracts with medical schools. The expanded contracting envisioned under the Health Security Act both with medical schools and private organizations greatly increases the potential for conflicts to arise.

Although some bid protests may result in delays in individual procurements, we believe the government benefits overall from a system that permits review of procurement decisions and helps to ensure fairness in the procurement process. Revisions to federal procurement procedures are being considered as part of efforts to implement the recommendations made through the National Performance Review. As a general rule, GAO favors a consistent procurement process governmentwide.

EXEMPTING VA FROM RISK CONTRACTING REQUIREMENTS COULD PLACE BOTH THE GOVERNMENT AND VETERANS AT RISK

In addition to exemptions from general contracting requirements, VA health plans would be exempt from specific requirements relating to risk contracting, such as those that apply to Medicare HMOs. Because VA has no prior experience in risk contracting, such exemptions heighten the potential for fraud and abuse and could affect veterans' access to needed medical services. Although VA managed care plans would be expected, to the extent VA decides practicable, to comply with regional alliance standards, the regional alliances could not reject a VA health plan for any reason.

Under risk contracting, individual physicians or groups of physicians are paid a fixed monthly amount per enrolled recipient (capitation) to provide a defined set of items and services to all enrollees. This gives the contractor a financial incentive to control the use of services and ensure that only necessary care is provided. Although capitation has significant potential for containing health care costs, it also poses the danger of diminished quality of care should a contractor try to cut costs by inappropriately reducing services to enrollees.

Generally, the closer financial incentives are to individual treatment decisions and the more risk transferred to individual physicians or small groups of physicians, the higher the potential for adverse effects on quality of care. The amount of financial risk is lowest when the capitation covers only primary care services and increases as the physician or group of physicians is made responsible for a wider range of services, such as care by specialists and hospital care.

Although risk contracting is a common practice among managed care plans, the practice requires that the contractor has sufficient enrollment to spread the risk. VA plans to engage in risk contracting with private health plans and individual providers. If VA contracts with individual providers who have too narrow a patient base, the providers have greater incentive to withhold services, and the potential for their insolvency increases.

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[6] VA Health Care: Inadequate Controls Over Scarce Medical Specialist Contracts (GAO/HRD-92-114, July 29, 1992).

VA health plans would also not be accountable to Medicare safeguards. Because of their deemed Medicare status under the Health Security Act, the Health Care Financing Administration would have little recourse against VA health plans if they fail to enforce Medicare safeguards. These safeguards were instituted over many years in response to a history of Medicare abuses by managed care plans. Practices found in some managed care plans include underfinancing plan operations, disregarding complaints, and denying needed treatments. With limited experience in preventing or detecting such activities, VA health plans would be increasingly vulnerable to fraud and abuse.

Before a managed care plan can enter a risk contract with Medicare, it must meet both Medicare-specific and federal HMO requirements. These requirements essentially establish minimum standards for HMOs. For example, managed care plans must meet certain financial solvency requirements to protect enrollees against the risks of an HMO's bankruptcy.

Medicare and federal HMO requirements

-- establish standards for risk contracting,

-- require disclosure of ownership and control arrangements and related party transactions to prevent diversion of patient care funds,

-- require that health plans have prior operating experience,

-- define minimum quality assurance mechanisms,

-- establish reserve requirements to ensure that health plans maintain adequate funds to pay for health care services, and

-- regulate marketing activities.

As deemed Medicare HMOs, VA health plans would not have to comply with these requirements.

COMPLEX REVENUE STREAMS WOULD INCREASE VA's RISK OF VIOLATING STATUTORY RESTRICTIONS ON USE OF APPROPRIATED FUNDS

Although VA is improving its financial management systems, the systems will face additional challenges under managed care because of the complexities of multiple revenue sources and accounts to which expenses must be charged. Without effective and reliable systems, VA health plans could violate statutory restrictions on use of appropriated funds. VA's financial records would not reflect the costs of the various programs, making informed decision-making difficult.

VA accounting systems were not designed to accommodate the many funding sources and accounts to which expenses must be charged. Under the Health Security Act, expenses of providing medical care to veterans would be charged to two major funds, the medical care appropriation and the Health Plan Fund. Each would receive revenue from various sources. Revenues and payments would flow in many directions and involve many entities both inside and outside of VA. VA estimates that health plans could have 30 different revenue streams. For example, anticipated revenue sources include appropriations, Medicare payments, Department of Defense (DOD) and Indian Health Service reimbursements, enrollee premium payments from health alliances, enrollee copayments and deductibles, fee-for-service payments from private health plans, and intra-VA payments. These revenues would be deposited in one of the two funds depending on whether the patient is in the core group entitled to free care or not. Costs of providing care must also be debited to the correct fund. Failure to charge the cost of each

patient's care to the proper account would violate statutory restrictions on the use of appropriated funds and could lead to shortages in appropriations. Also, the financial records would not reflect the costs of providing care to each type of beneficiary. Thus, no informed decision-making would be possible.

These problems would be partially addressed through an amendment to the Health Security Act approved by the Subcommittee on Hospitals and Health Care by combining appropriated and nonappropriated funds for the comprehensive benefit package in the Health Plan Fund. The issue would still remain, however, for those health care benefits provided under chapter 17 of 38 U.S.C. that are not covered under the comprehensive benefits package.

ADDITIONAL FUNDS MAY BE NEEDED TO MAKE VA PLANS COMPETITIVE

The Health Security Act would create a Veterans Health Care Investment Fund with an initial authorization of $3.3 billion over 3 years.[7] The amendments to the Health Security Act approved by the Subcommittee on Hospitals and Health Care specify that the funds could be used for start-up costs for VA health plans, including consulting services, equipment, improving management information and accounting systems, marketing, minor construction, and, with some restrictions, major construction. The fund could, for example, be used to address the shortage of primary care facilities and the lack of patient amenities in outdated VA hospitals.

The funds to be appropriated to the Investment Fund are not, however, based on an assessment of what changes need to be made to make VA health plans competitive. VA is making such an assessment but has not yet developed an estimate of start-up costs or identified the cost of construction projects needed to bring VA facilities up to private-sector standards. In addition, our ongoing work on planned VA construction projects indicates that VA does not have an effective method for identifying and prioritizing construction needs within its recently established health care networks. As a result, VA does not know where the funds should be spent or whether the funds to be appropriated are adequate.

Without an assessment of start-up costs, the Congress may be faced with having to appropriate billions of dollars more in the future to make VA health plans competitive. In our opinion, the Congress should know in advance what VA believes it will take to improve its facilities and expand its provider network. The Congress could then decide whether to appropriate the funds to establish VA health plans.

Currently, however, the start-up funds could essentially represent a "foot in the door," making it hard for the Congress to limit future expenditures to make VA health plans competitive.

INADEQUATE COST AND UTILIZATION DATA INCREASE RISKS IN PRICING AND CONTRACTING DECISIONS

One of the most significant barriers to VA successfully competing against private-sector managed care plans is VA's inability to generate accurate cost data on items and services that it provides and estimate potential use of health care services. Without such data, VA health plans cannot set accurate premiums, determine when to contract for services rather than provide them directly, or set prices for services sold to other health plans that are adequate to recover costs. As a result, the financial

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[7]Increased to $4.05 million by amendments approved by the Subcommittee on Hospitals and Health Care.

risk of VA health plans incurring substantial losses is significant.

If VA sets premiums too low, additional funds may need to be appropriated to cover any shortages. Without such an appropriation, VA health plans may be unable to provide needed health care services with available funds. This would create an incentive to deny VA enrollees needed health care services or inappropriately divert funds appropriated for VA health care benefits not covered under the comprehensive benefits plan to pay for health care provided to veterans and their dependents under the VA health plan.

Premiums set too high, on the other hand, would decrease the need for appropriated funds by shifting more of the costs of veterans' health care to veterans' employers. It would also benefit enrollees in non-VA health plans--both veterans and nonveterans--by increasing the employers' share of premiums. This is because the employer contribution toward a health plan's premium would be set at 80 percent of the weighted average of the premiums for all participating health plans; the enrollee would pay the difference between the premium and the employer contribution. Under the Health Security Act, the regional alliances could reject non-VA plans but they would be required to accept whatever premiums VA health plans propose. In fact, regional alliances would not be allowed to reject VA health plans for any reason.

VA premiums may be higher than premiums of competing health plans if their costs are higher or their enrollees are more disabled or older.[8] Because veterans are older than the general population, their health care utilization and the costs of providing services can be expected to be higher than those of the overall population.

Just as cost and utilization data are critical in setting VA health plan premiums, they would be critical in setting capitation payments to risk contractors. Rates set too high could affect the financial solvency of VA health plans; rates set too low could affect the solvency of the risk contractors and lead to underservicing of health plan enrollees.

Accurate cost data are also important in determining when to purchase health care services from non-VA providers. We noted in our December 1992 Transition Series report on the VA that it has not provided clear guidance on how cost comparisons should be made to determine if care could be purchased more economically than VA could provide it.[9] Our ongoing work shows, however, that VA medical centers still do not know how to make such cost comparisons.

Finally, VA needs accurate cost data to determine appropriate prices to charge for items and services sold to other health plans. If prices are set too low, funds from other sources would be needed to subsidize losses, and less money will be available to provide services to veterans.

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[8]The effects of inaccurate premiums would depend on the risk adjustments made by regional alliances. For example, if VA premiums are set too low but VA receives a favorable risk adjustment for enrolling an older and more disabled population, then the effects of the low premiums would, at least to some extent, be offset. If, on the other hand, the risk adjustment is not favorable to VA, then premiums set too low would heighten VA's problems in trying to provide care with available resources.

[9]Veterans' Affairs Issues (GAO/OCG-93-21TR, Dec. 1992).

ELIGIBILITY VERIFICATION WOULD BE MORE DIFFICULT FOR VA THAN FOR PRIVATE-SECTOR PLANS

Unlike private-sector managed care plans that can enroll any individual who applies, specific eligibility criteria exists for enrollment in VA health plans. This creates an additional burden on VA health plans to establish mechanisms to quickly (1) verify an applicant's eligibility to enroll in a VA health and (2) determine whether they are entitled to free care. Without an adequate eligibility verification system, VA runs the risk of enrolling ineligible individuals and providing them free care.

Under the Health Security Act, VA health plans could enroll only veterans, their dependents, and Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) beneficiaries. As I discussed earlier, veterans in the core group--service-connected veterans, low-income veterans, former prisoners of war, and veterans of World War I or the Mexican Border Period--would be entitled to free comprehensive health care services if they enroll in VA health plans.

VA does not have a central database on veterans' health care eligibility to enable it to quickly determine whether an individual meets the basic eligibility requirement--that he or she is a veteran or CHAMPVA beneficiary. The Beneficiary Identification and Records Locator System (BIRLS), VA's most complete database of information on veterans, contains Social Security numbers on only about 18 million of the approximately 27 million veterans. In addition, BIRLS contains no data on veterans' incomes and incomplete data on service-connected disabilities. As a result, it would be of limited use in determining an individual's eligibility to enroll in a VA health plan.

In addition, VA currently lacks an adequate system for determining whether a veteran is in one of the core group categories and thus eligible for free care. VA can quickly tell whether a veteran has a compensable service-connected disability through a check against its computerized Compensation and Pension File but has no way of quickly verifying core group status of most other veterans. For example, the Compensation and Pension file does not contain records of most veterans with "0" percent service-connected disabilities because they do not receive cash payments. VA estimates, however, that about 2 million veterans have "0" percent disabilities.

Similarly, VA cannot quickly verify the incomes of nonservice-connected veterans to determine in which eligibility category to place them. Preliminary results from VA's first income verification match against tax records, in December 1993, showed that about 18 percent of nonservice-connected veterans underreported their incomes when applying for VA health care. Without a system that gives VA prompt access to income data, VA may incorrectly place veterans or nonveterans in the core group and provide free enrollment in the VA health plan. The income verification system is still being tested, and VA does not plan to conduct another match against tax records until November 1994.

FURTHER DECENTRALIZATION COULD INCREASE RISKS

The final risk I would like to discuss is VA's plan to further decentralize management.

Failure to monitor policy implementation under VA's decentralized management structure has been a recurring theme in our reports on VA health programs for many years. In both our 1988 and 1992 Transition Series reports on VA, we identified policy

implementation as one of the problems most needing management attention.

Many of the problems addressed by this Subcommittee have focused on the failure of VA's central office and regional offices to identify and correct problems. For example, the Subcommittee's March hearing on women veterans showed that many of the problems in meeting women veterans' health care needs that GAO originally identified in 1982 still existed 12 years later. Although VA central office directed medical centers to improve the thoroughness of women veterans' physical examinations, our 1994 follow-up showed that the central office had not reviewed and followed up on medical centers' action plans for improving compliance with examination requirements.

The combination of exemptions from federal laws and regulations to be authorized by the Health Security Act and VA medical centers' history of problems in complying with current laws, regulations, and procedures creates significant risks both to the federal government through increased costs and losses to fraud and abuse and to veterans and their dependents through poor monitoring of their health care. VA's plans to give medical centers and health plans greater autonomy would, at least until those medical centers and health plans demonstrate the ability to run a managed care plan, further increase the risks.

CONCLUSIONS

In conclusion, Mr. Chairman, the proposed Health Security Act would alleviate most of the legal barriers to VA's developing competitive managed care plans. It would do so, however, by eliminating a series of internal controls developed over many years to protect both the interests of the government and its citizens. VA health plans would be exempt from important fiscal and quality safeguards, greatly expanding VA's financial liabilities, potentially diminishing VA quality of care and veterans' access to care, and increasing the risk of fraud, waste, and abuse.

The challenge facing the Congress is in deciding whether the benefits to VA competitiveness that would be created through the provisions of the Health Security Act and its amendments outweigh the risks that would be created by those same provisions.

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Mr. Chairman, that concludes my prepared statement. We would be glad to answer any questions that you or the other Members of the Subcommittee may have.

RELATED GAO PRODUCTS

VA Health Care: VA and the Health Security Act (GAO/HEHS-94-159R, May 9, 1994).

VA Health Care Reform: Financial Implications of the Proposed Health Security Act (GAO/T-HEHS-94-148).

VA Health Care: Most Care Provided Through Non-VA Programs (GAO/HEHS-94-104BR, Apr. 25, 1994).

VA Health Care: Veterans' Perceptions of VA Services and Its Role in Health Care Reform (GAO/T-HEHS-94-150, Apr. 20, 1994).

VA Health Care: A Profile of Veterans Using VA Medical Centers in 1991 (GAO/HEHS-94-113FS, Mar. 29, 1994).

VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (GAO/HRD-93-94, July 29, 1993).

VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (GAO/HRD/93-68, July 27, 1993).

Veterans Affairs: Accessibility of Outpatient Care at VA Medical Centers (GAO/T-HRD-93-29, July 21, 1993).

VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 14, 1993).

VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (GAO/HRD-93-123, June 30, 1993).

Veterans' Health Care: Potential Effects of Health Care Reforms on VA's Major Construction Program (GAO/-T-HRD-93-19, May 6, 1993).

Veterans' Health Care: Potential Effects of Health Financing Reforms on Demand for VA Services (GAO/T-HRD-93-12, Mar. 31, 1993).

Veterans' Health Care: Potential Effects of Health Reforms on VA Construction (GAO/T-HRD-93-7, Mar. 3, 1993).

VA Health Care: Actions Needed to Control Major Construction Costs (GAO/HRD-93-75, Feb. 26, 1993).

Veterans' Affairs Issues (GAO/OCG-93-21TR, Dec. 1992).

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

VA Health Care: Demonstration Project Concerning Future Structure of Veterans' Health Reform (GAO/T-HRD-92-53, Aug. 11, 1992).

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

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