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# VA HEALTH CARE REFORM

# Financial Implications of the Proposed Health Security Act

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Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the financial and policy implications of the veterans' health care provisions contained in the Administration's proposed Health Security Act. We are conducting a series of studies--many of which were requested by Senator Murkowski--looking at the potential effects of health reforms on the Department of Veterans Affairs (VA) system and the options for restructuring veterans' health benefits. My comments this afternoon will focus primarily on

-- veterans' health care coverage under VA and other federal programs;

-- factors that will likely affect the potential population of enrollees in VA health plans;

-- the potential costs associated with the expanded entitlement and supplemental benefits provisions of the Health Security Act; and

-- the ability of VA to set realistic premiums and the implications of inaccurate premiums on cost, quality, and access to care for VA health plan enrollees.

## RESULTS IN BRIEF

The veterans' health care provisions of the Health Security Act address many of the issues discussed in our reports during the last few years.[1] For example, we believe that eligibility reforms that enable VA to shift the focus of its health care system from inpatient to ambulatory and primary care and its collateral plans to become an increasingly managed care system are long overdue

[1]A list of recent GAO reports is attached.

steps in the right direction. Several financial and policy implications, however, are associated with the reforms of the VA system proposed under the Health Security Act that we believe need to be considered as the Congress debates how to reform the nation's health care system. For example:

-- VA plays a small, but nevertheless important role in meeting the health care needs of veterans. Medicare is the primary source of federal support for veterans' health care needs, but VA provides treatment for service-connected disabilities and serves as a safety net for low-income and uninsured veterans. VA also supplements coverage under other programs by providing such services as long-term nursing home and psychiatric care.

-- Among the factors that will likely affect the number of veterans enrolling in VA health plans are the costs to the veteran, the extent to which VA is able to make its care more accessible to veterans through networks of community providers, and the extent to which VA is able to improve its customer service. If VA is able to improve its customer service and make its services more accessible to veterans, then cost will likely be the deciding factor for many veterans.

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

-- The provisions authorizing the Secretary of Veterans Affairs to offer supplemental benefit policies covering such services as long-term nursing home care could (1) add tens of billions of dollars to VA appropriations and/or (2) shift the priorities for VA care from low-income and service-connected veterans to higher-income veterans likely to purchase such

policies. The effect would depend on how broadly or narrowly the entitlement to free care is interpreted.

-- Problems in setting accurate premiums for VA care could lead to improper denial of needed health care services or cutbacks in the availability of VA services such as long-term psychiatric care or treatment for spinal cord injuries and post-traumatic stress disorder not fully covered under the reform proposal's comprehensive benefit package.

## BACKGROUND

VA operates one of the nation's largest health care systems with 158 medical centers, consisting of 171 hospitals and more than 200 outpatient clinics. In 1991, about 2.2 million veterans made more than 20 million outpatient visits to these centers and had more than 970,000 hospital stays. 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).

When the VA health care system was established in 1930, neither public nor private health insurance programs were available to meet the health care needs of America's veterans. But with the subsequent growth of public and private health insurance programs, most veterans now have one or more alternatives to VA health care. Reforms of the nation's health financing system such as those currently being considered could further reduce the number of veterans without health insurance.

### Without Changes, VA Could Lose a Substantial Portion of Its Work Load

Of the multitude of health reform proposals being considered, only one--the Administration's proposed Health Security Act--would

make changes in the VA health care delivery system or VA eligibility. Without such changes, VA will likely lose a substantial portion of the patients to whom it now provides services.

While VA currently serves as a safety net for veterans without insurance or other resources to pay for health care in the private sector, the importance of this mission could be decreased under health reform. Many veterans who currently use VA because they either have no health insurance or cannot afford the copayments and deductibles that would be required by private sector hospitals, might seek care closer to their homes if they obtain health insurance or insurance coverage with lower out-of-pocket costs. VA might lose as much as half of its acute hospital work load and over 40 percent of its outpatient work load if veterans who currently rely on VA as a safety net are given a choice of health care providers under health reform. Of course, the magnitude of any decline would depend on many factors, including the comprehensiveness of the benefits offered in the new reform program and the cost sharing imposed.[2]

## Health Security Act Would Authorize VA to Establish Health Plans

The proposed Health Security Act would make fundamental changes both in how VA operates and in the benefits to which veterans using VA are entitled. In this regard, the act would (1) transform VA facilities into a series of managed care plans to compete with private sector plans and (2) expand entitlement to free comprehensive health care services for veterans choosing to enroll in a VA health plan. In addition,

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

-- VA services not covered under the comprehensive benefit package would continue to be offered to all veterans under existing eligibility and entitlement provisions. In most cases, the provision of such services would be subject to the availability of resources and facilities.

-- VA would be given the authority to provide services to the dependents of veterans.

-- VA would be authorized to establish supplemental benefits and cost-sharing policies.

-- VA health care facilities would be deemed Medicare providers, and VA health plans deemed Medicare health maintenance organizations (HMOs).

The proposed Health Security Act also contains several new financing mechanisms to help offset the costs of VA health plans:

-- VA would be authorized to recover from Medicare for services provided to higher-income nonservice-connected Medicare-eligible veterans. VA would be allowed to retain funds recovered from Medicare.

-- VA would be authorized to retain premiums (both the employer and employee shares), copayments, and deductibles for veterans enrolling in VA health plans.

-- Revenues received by VA health plans, 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.

-- About $3.3 billion would be appropriated to a VA Health Care Investment Fund over a 3-year period to cover construction of additional outpatient clinics and other start-up costs for the health plans.

## VA PLAYS A SMALL BUT IMPORTANT ROLE IN MEETING VETERANS' HEALTH CARE NEEDS

VA plays a small but important role in meeting the health care needs of America's veterans. Two recent GAO reports provide insight into where veterans currently obtain their health care, expenditures on veterans' health care under federal programs, and the incomes of veterans using VA health care facilities. In 1990,

-- Nine out of 10 veterans had other health care coverage in addition to access to services provided by VA. Overall, about 22.9 million (81 percent) of the estimated 28.2 million veterans in 1990 had private health insurance and almost 7.4 million (26 percent) were eligible for Medicare.

-- Veterans with Medicare coverage relied more on Medicare than VA for their health care. About 4.6 million (61.8 percent) of Medicare-eligible veterans used Medicare, but no VA services during 1990. By contrast, fewer than 500,000 (6.6 percent) of Medicare-eligible veterans used VA services but no Medicare services during 1990. Slightly more than 560,000 (7.6 percent) used a combination of VA and Medicare services. We are currently studying the types of VA services used and the extent of Medicare coverage of these groups of veterans to learn why some veterans use VA while most veterans rely exclusively on Medicare.

-- Seven out of 10 federal dollars spent on veterans' health care came from programs other than VA. Medicare accounted for about $20.6 billion of the $36 billion in federal expenditures under

the programs studied (VA, Medicare, Department of Defense, the Civilian Health and Medical Program of the Uniformed Services, and the Federal Employees Health Benefits Program) compared with about $10.9 billion under VA.

-- Although no precise data exist, expenditures on veterans' health care through private health insurance also likely exceed those under VA. If veterans' use of private insurance is similar to that of the general public, then payments for veterans likely amounted to over $22 billion.[3]

## Veterans Using VA Health Care Tend to Have Lower Incomes and Less Insurance Coverage

In general, veterans using VA 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 care in the private sector.

At the request of the House Committee on Veterans' Affairs, we measured incomes of veterans who used VA facilities. We did this through computer matching of VA's inpatient and outpatient records against federal income tax data maintained by the Internal Revenue Service.[4]

In summary, our match of VA and tax records showed that

-- Of the 1.2 million nonservice-connected veterans using VA

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

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

health care facilities in 1991, about 927,000 (75 percent) had family incomes under $20,000.

-- Veterans with disability ratings between 10 and 40 percent generally had higher incomes than other service-connected veterans using VA facilities.

-- Of the 897,000 veterans aged 65 and older who used VA health care services during 1991, about 332,000 (37 percent) had incomes under $10,000 compared with at least 585,000 (45 percent) of the 1.3 million veterans under age 65.

-- About 933,000 (42 percent) of the 2.2 million veterans using VA facilities during 1991 had one or more dependents, most typically a spouse.

We could not determine insurance coverage from tax records, but VA's Survey of Medical System Users indicates that about 40 percent of VA users have neither public nor private health insurance coverage.[5]

## FACTORS AFFECTING THE NUMBER OF POTENTIAL ENROLLEES IN VA HEALTH PLANS

Three of the primary factors likely to influence veterans' choice of health plans are out-of-pocket costs to the veteran, convenience, and customer service. VA's ability to attract enrollees to its health plans will likely depend in large measure on the success of VA's plans for improving customer service and making VA health care more accessible to veterans and on the cost differences between VA health plans and other health plans.

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[5]VA surveyed 2,865 veterans who had been inpatients in a VA medical center during fiscal year 1987. The survey developed a sociodemographic profile of VA medical system users including age, income, and insurance coverage.

## Perception of Customer Service Likely to Be Important Factor

The preliminary results from focus group meetings we held with veterans provide insight into veterans' satisfaction with the care obtained. Between December 1993 and March 1994, we held meetings with groups of veterans in five cities--Baltimore, Maryland; Charlotte, North Carolina; Denver, Colorado; San Francisco, California; and Martinsburg, West Virginia--to determine their satisfaction with the current VA health care system and their opinions about VA's role under health reform.

One of the recurring themes we heard in the focus group meetings was dissatisfaction with customer service at VA facilities. Comments focused on such customer service issues as waiting times for VA appointments and staff attitudes.[6] Not surprisingly, veterans in cities having veterans' facilities with good reputations for customer service, like Martinsburg, expressed more interest in enrolling in VA health plans.

## Veterans Would Be Required to Choose One Health Plan

Veterans participating in our focus groups, other than those without health insurance, seemed to use VA only for certain services, such as treatment of service-connected disabilities, rather than relying on VA for all of their care. This fact has important implications for the number of veterans likely to enroll in VA health plans because such veterans would be required under the proposed Health Security Act to choose between a VA health plan and private sector plan to provide all of their comprehensive health care benefits. For example, veterans who currently use VA

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

only for treatment of their service-connected disabilities may no longer be able to obtain such treatment from VA if they enroll in a non-VA health plan.

## VA Plans to Improve Customer Service and Build Network of Community Providers

VA has announced before this committee and other committees that it plans (1) to develop a network of community providers by expanding the number of VA outpatient clinics, contracting with private sector facilities and physicians, or both and (2) to improve customer service. Without such efforts, VA health plans are likely to have little success in attracting veteran enrollees, even with reduced cost sharing. At the same time, however, shifting VA care to community hospitals closer to veterans' homes would tend to decrease use of VA hospitals. To maintain work loads at VA hospitals, VA would need to increase its market share of veterans living near its hospitals.

## FINANCIAL IMPLICATIONS OF HEALTH SECURITY ACT PROVISIONS

Under the provisions of the proposed Health Security Act, about 9 million veterans would be entitled to free comprehensive benefits if they enroll in VA health plans. In our opinion, these veterans may also be entitled to receive any supplemental benefit policies offered by VA health plans with no cost sharing. These provisions, depending on the number of veterans enrolling in VA health plans and the types of supplemental benefit policies offered, could potentially require tens of billions of dollars in appropriations. In addition, because (1) the cost of the VA health plan and any supplemental benefit policies would be funded entirely through appropriations for Medicare-eligible veterans with service-connected disabilities or low-incomes, and (2) the number of Medicare-eligible veterans is rapidly increasing, VA appropriations

would likely increase steadily even without increases in the costs of providing VA health care services.

## About 9 Million Veterans Would Be Entitled to Free Comprehensive Care

As currently drafted, the proposed 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.[7] 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 with available resources. Under the proposed Health Security Act, about 9 million veterans, primarily those with low incomes or service-connected disabilities, 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.

There are two implications associated with these provisions. First, if the VA health plan is successful in attracting all veterans entitled to free care, VA could end up paying the veterans' share of premiums and other cost sharing for 9 million veterans. For that portion of the 9 million who are Medicare eligible, VA would pay, through appropriations, the entire cost of their comprehensive benefit package and, as I will discuss later, may have to pay for any supplemental benefit policies.

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[7]Nursing home care is currently an optional benefit for all veterans.

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, the government would have to either (1) require all veterans living in regions that do not have a VA health plan to pay the employee portion of the premium under another health plan or (2) use appropriated funds to pay the veterans' premiums under private sector plans. Choosing the first option would essentially be telling veterans from failed VA health plans that their VA benefits are no longer available. Such an option may not be politically feasible, resulting in the government being forced to start paying the premiums and cost sharing of veterans enrolling in private sector health plans.

## Cost of Providing Services to Most Medicare-Eligible Enrollees Would Be Funded Through VA Appropriations

The treatment of Medicare-eligible veterans under the Health Security Act could result in the shifting of significant costs currently paid through Medicare and the states to VA.[8] The act would authorize VA to recover from Medicare only for services provided to higher-income, nonservice-connected Medicare-eligible veterans. For low-income and service-connected veterans eligible for Medicare who enroll in VA health plans, VA would generally pay the entire cost of their health care coverage through appropriations. Thus, to the extent that VA health plans are successful in enrolling low-income and service-connected, Medicare-eligible veterans currently relying on non-VA providers, costs currently being paid through Medicare and the states will be shifted to VA.

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[8]The Omnibus Budget Reconciliation Act of 1990 requires states through their Medicaid programs to pay the Medicare part B premiums, deductibles, and coinsurance for Medicare beneficiaries with incomes up to 120 percent of the poverty level.

As I discussed earlier, the Medicare-eligible veterans who used VA services in 1991--those seemingly most likely to enroll in VA health plans--tended to have low incomes, service-connected disabilities, or both. About 770,000 (86 percent) of the Medicare-eligible veterans who used VA in 1991 would have been eligible for free comprehensive care had the provisions of the Health Security Act been in effect in 1991. Overall, if the provisions of the act had been in effect then, the government would have been responsible for the full cost of care for about 35 percent of the veterans using VA facilities.

Because the veteran population is aging rapidly, the potential cost implications of the expansion in 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.

## Supplemental Policies Create Significant Financial and Equity Questions

The Secretary of Veterans Affairs would be authorized to offer supplemental health benefit policies through VA health plans in much the same manner they could be offered through private sector health plans. The relationship between the supplemental benefit provisions and the provisions mentioned earlier concerning entitlement to free care has significant implications in terms of potential enrollment in VA health plans, government costs, and equity.

Out-of-pocket costs is clearly a major factor that will influence veterans' health care choices. While the lack of out-of-pocket costs for low-income veterans enrolling in VA health plans may move some veterans toward the VA plan, many low-income

veterans, including those now using VA, would have their comprehensive benefit package subsidized regardless of which health plan they choose. If, however, the provisions relating to the entitlement to free care apply to both comprehensive and supplemental benefits, supplemental benefit policies could prove to be the strongest financial incentive that VA health plans could offer to potential enrollees.

One of the supplemental benefits that has been discussed is long-term care. If the Secretary decided to offer a long-term care supplemental benefit policy, doing so would turn a benefit that is currently optional for all veterans into a contractual obligation to provide free long-term care services for millions of veterans. Obviously, the offer of guaranteed free nursing home care for life would be a strong inducement for elderly veterans, especially those in failing health, to enroll in a VA health plan.

If the free care provisions apply to supplemental benefits, the offering of nursing home coverage through supplemental policies could cost the government billions of dollars. The government would be responsible for the full cost of their policies. Unlike the comprehensive benefit plan where VA would obtain payments through the regional alliances to offset most of the costs for other than Medicare-eligible veterans, the regional alliances would not contribute toward the cost of any supplemental benefit policies. Because the veterans would be "sold" policies, VA would have a contractual obligation to provide medically necessary nursing home care. The government would have little choice but to appropriate funds to cover the costs of nursing home care for the low-income and service-connected veterans enrolling in a VA health plan.

VA officials believe that the free care provisions of the Health Security Act apply only to the comprehensive benefit package and that all veterans and their dependents would be charged for

supplemental benefit policies. This interpretation would decrease the financial incentive for low-income and service-connected veterans to enroll in VA health plans and the associated financial risks. However, it also would raise a question of equity with regard to benefits such as nursing home care. This is because those purchasing supplemental benefit policies would have a contractual right to the nursing home benefits offered through those policies, but low-income and service-connected veterans unable or unwilling to purchase supplemental policies would be able to access the services only if space and resources remained after VA meets the needs of those purchasing supplemental policies.

Another potential problem with supplemental policies is that VA could end up subsidizing the policies of higher-income, nonservice-connected veterans. This could occur because the premiums charged higher-income nonservice-connected veterans would be determined from nursing home utilization by all those "purchasing" the policies. If low-income and service-connected veterans get the supplemental policies cost free, they would likely "purchase" the policies even if there was little prospect of nursing home admission. Higher-income nonservice-connected veterans would, on the other hand, likely buy supplemental policies when they are in nursing homes or at risk of entering nursing homes. If premiums for the supplemental policies were determined from the expected utilization of all policyholders, the premiums would likely be insufficient to cover the costs of providing services to those higher-income nonservice-connected veterans purchasing the policies.

As you know, Mr. Chairman, the cost implications of offering policies guaranteeing unlimited nursing home care are immense, particularly when much of that care might be paid through appropriations. VA currently spends about $1.2 billion a year on long-term care services, with a goal of serving only 16 percent of the veterans in nursing homes. With the rapid increase in the age

of the veteran population, demand for nursing home care is expected to increase dramatically during the next 20 to 30 years.

The budget implications of establishing a major new entitlement program that would provide free, unlimited nursing home care to upwards of 9 million veterans and subsidize the nursing home care of other veterans and their dependents are enormous. Two options for expanding the availability of nursing home care for veterans with available funds would be to (1) adopt the cost-sharing policies of state veterans' homes or (2) implement estate recovery programs similar to those established under many states' Medicaid programs.[9]

## INACCURATE PREMIUMS COULD HAVE SIGNIFICANT COST AND ACCESS IMPLICATIONS

Insurance premiums are generally determined from data on the costs of providing individual services and the types and numbers of services used. Establishing accurate premiums will be a major challenge for VA because it does not have adequate cost or utilization data. Setting inaccurate premiums has important financial and access-to-care implications.

First, VA does not have reliable information on what it costs to provide different types of care at its medical centers. While VA established reasonable methods for medical centers to use in allocating their costs between medical services, VA officials have little confidence that the medical centers are allocating costs appropriately. As a result, VA medical centers do not have

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

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

accurate data on the costs for a day of hospital care or an outpatient visit.

Second, VA does not have adequate data on health care utilization. VA knows how many episodes of inpatient care and how many outpatient visits its current patient population uses, but several problems limit the usefulness of this data:

-- Because veterans do not enroll in the VA health care system, VA has utilization data for users, but does not know how many other veterans would have used VA if they needed care. An HMO or private health insurance plan knows how many enrollees it has and can calculate the average health care utilization across all of its enrollees, not just those who used health care services during the past year. In this way, they are able to set insurance premiums by determining the health care utilization of all policyholders; some are heavy users of services while others use no health care services.

   VA, however, has utilization data only for those veterans who used VA health care services during a given year. Without knowing how many other veterans would have relied on VA for health care services if they had needed care, VA will find that setting accurate premiums by using past VA utilization is difficult.

-- VA does not know the extent to which current users rely on VA for all of their health care services. This information is important because the Health Security Act would require each VA enrollee to use VA for all his or her health care services. Thus, VA needs to know the total health care services used by veterans under all public and private programs in order to estimate potential utilization under a managed care plan.

We found that over half of the Medicare-eligible veterans who used VA health care services in 1990 also used non-VA providers under Medicare. Without knowing the full health care utilization of those likely to enroll in VA health plans, VA will have little basis for estimating potential demand for care and setting premiums.

-- VA's complex eligibility and entitlement provisions make estimating potential utilization of health care services under a comprehensive benefit package difficult. Because most veterans are not entitled to comprehensive health care services, VA has little basis for estimating veterans' potential utilization of a comprehensive benefit package.

If VA sets its premiums too low, additional funds may need to be appropriated to cover any shortages. Otherwise, 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 benefit 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 plans--both veterans and nonveterans--by increasing the employers' share of the 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 Administration's proposal, the regional alliances could reject non-VA health plans if their premiums are out of line, but

they would be required to accept whatever premiums VA health plans propose.

VA premiums may be higher than premiums of competing health plans if their costs are higher, their enrollees are more disabled, or their enrollees are older.[10] 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. If, as discussed earlier, VA health plans offer free supplemental benefits policies to low-income and service-connected veterans, premiums for the comprehensive benefit policies would be higher because of adverse selection. Veterans anticipating the need for long-term nursing home care would likely enroll in VA health plans to avoid the high cost of nursing home care.

## CONCLUSIONS

Mr. Chairman, the veterans' health care provisions of the proposed Health Security Act address many of the current problems with the VA health care system such as the complex eligibility and entitlement provisions. However, there are significant financial implications to be taken into account. The expanded entitlement to comprehensive care and the wide discretion that would be given to the Secretary to offer supplemental benefit policies covering such services as nursing home care could require billions in appropriations.

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[10]The effects of inaccurate premiums would be increased or decreased depending on the risk adjustments made by the 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.

Because of the challenges VA would face in setting accurate premiums, there is a significant risk that premiums will not be adequate to cover the costs of services provided to VA health plan enrollees. Inadequate premiums may result in veterans being denied needed health care services unless the Congress appropriates additional funds to cover any shortages.

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Mr. Chairman, that concludes my statement. We will be glad to answer any questions that you or Members of the Committee may have.

## RELATED GAO PRODUCTS

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

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

VA Health Care: A Profile of Veterans Using VA Medical Centers in 1991 (GAO/HEHS-94-113FS, March 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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