H.R. 4939, THE VETERANS MEDICARE PAYMENT ACT OF 2002

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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H.R. 4939, THE VETERANS MEDICARE PAYMENT ACT OF 2002

TUESDAY, JULY 16, 2002

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

The committee met, pursuant to notice, at 11:20 a.m., in room 334, Cannon House Office Building, Hon. Christopher H. Smith (chairman of the Committee on Veterans' Affairs) presiding.

Present: Representatives Smith, Evans, Filner, Davis, and Boozman.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. Good morning. The committee will come to order. This morning we are meeting to consider a simple yet profound idea regarding the manner in which the Federal Government funds health care for veterans age 65 and above.

We will examine H.R. 4939, legislation I introduced, along with the committee's ranking member, Mr. Evans of Illinois, and Mr. Filner of California.

H.R. 4939 is a bipartisan proposal designed to address the annual funding shortfalls that have become increasingly severe in the VA health care system. It would allow Medicare-eligible veterans who choose to receive VA health care to have their Medicare part B premiums follow them through the VA health care system.

To put it another way, federal health care funds should go to the actual providers of health care services, including the VA. This would provide a stable, dependable, and recurring source of health care funding for older veterans under VA care.

With almost 2 million VA health care users eligible for Medicare, the impact of this legislation would be substantial.

As I am sure everyone in this room is aware, the demand for VA health care has significantly increased over the past decade. Record numbers of veterans are signing up because VA today provides quality health care at convenient locations.

In fact, just looking at the administration's last two budget submissions, there is an 18.5 percent increase in the number of veterans projected to use VA health care in fiscal year 2003, which is 700,000 more new veterans patients than they had projected just one year earlier.

And we have responded in the House, passing record VA health care budgets for the past 2 years, including a record $2.8 billion increase in VA discretionary health care spending for fiscal year 2003 in the House-approved budget.

Furthermore, the House has included $417 million in the supplemental appropriations bill for this year. Historically, the law establishing the Medicare program excluded care provided in the VA as a means of lowering expenses for Medicare. VA health care was adequately funded at that time, in 1965.

In the 1980s, however, the demand for VA care began to outstrip the VA's capacity to provide it. This trend accelerated in the 1990s with the VA's plan to open hundreds of community-based outpatient clinics, and to emphasize convenient ambulatory care.

Congress ratified this approach to health care by easing restrictions on outpatient care. As a safeguard, it authorized the Secretary to prioritize and limit services by a periodic review of likely demand and VA resources.

Several mechanisms were authorized in the 1980s to obtain additional funding for veterans' health care. We authorized the VA to charge copayments to some veterans who could afford them, and we required the VA to seek reimbursement from any health insurer who would otherwise be liable for a veteran's treatment.

But in taking that step, we didn't address the largest payer of health care for veterans, Medicare. Many veterans who are eligible for VA care and Medicare have other health care coverage, as well. Some are eligible for TRICARE, and a number also have employer-sponsored health coverage.

As policymakers, we have to examine how these various federal programs are working in coordination with each other to ensure that we are providing the maximum level of health care services in the most efficient manner.

Fundamentally, H.R. 4939 addresses this issue by requiring Medicare to pay for at least some of the care VA is providing to Medicare-eligible veterans. This principle is not new. VA already has the authority to collect payments from private health insurers.

Furthermore, Medicare does reimburse for care provided through the Indian Health Service, and there is a new pilot program under which Medicare would reimburse military hospitals.

Our legislation takes the next logical step, by allowing Medicare Part B premiums paid by veterans who enroll in VA health care to be paid to VA to cover the care provided for veterans.

Under H.R. 4939, Medicare-eligible veterans who enroll in VA health care would remain fully eligible for all Medicare services and benefits. I would point out that our legislation would not increase the calculation of the Medicare Part B premiums due to the enrollment of Medicare-eligible veterans in VA health care, or transfer their Part B premiums.

H.R. 4939 is simple, it is logical, equitable, and it is a proposal that would help insure that resources allocated for health care go where the patient is receiving care. It would not only affect the portion of Medicare Part B premiums paid by veterans—it would not transfer any general revenues for Medicare to the VA.

All of the federal portion allocated to Medicare Part B coverage—75 percent of the estimated cost of a Medicare patient—would remain in the Medicare system, as well as all of Part A, Medicare-allocated funding.

In addition, the Federal Government would more efficiently use their federal health care dollars because it is less expensive for

Medicare-eligible veterans to receive health care at the VA than through the Medicare system.

In fact, VA and external studies have estimated that VA health care is 25 percent to 30 percent less expensive than comparable care provided by the private sector.

H.R. 4939 could provide a new steady, dependable stream of funding for VA health care to prevent the annual funding crisis, or at least mitigate that crisis, of the past decade by merely allowing veterans to go where they go—the funds to go where veterans go for their health care.

I would like to yield to my friend and colleague, Mr. Evans, for any opening comment.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. I commend you for introducing H.R. 4939, and for your continuing efforts to adequately fund veterans health care.

For fiscal year 2003, our committee recommended an increase of $2.8 billion over current funding for veterans' medical care. This year's budget is inadequate. Veterans know it, and we all know it. As I speak, over 300,000 veterans are not receiving quality timely medical care from the VA. For years, the VA has subsidized Medicare.

I believe we must seek again Medicare funds to shore up the veterans health care system. If this legislation had been implemented at the beginning of 2002, the VA would have received approximately $1.4 billion from the Medicare system for the Medicare participants that the VA treats.

Mr. Chairman, the VA health care system should be fully funded by appropriations. That will not happen as long as appropriations mirror inadequate administration requests. In order to ensure that our veterans can access the health care that they have earned through service to this country, it's clear that we must look to other alternatives.

I hope to work closely with you, Mr. Chairman, and with other members of the committee, the Medicare and Medicaid service, the VA, and the veterans' service organizations that are helping us make this legislation better.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Evans.

[The prepared statement of Congressman Evans appears on p. 40.]

The CHAIRMAN. Any other member who is seeking recognition?

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Mr. Chairman, if I may speak out of order for 30 seconds, but I want to—we just finished what became a very emotional markup, and on the last vote we were on opposite sides.

But I want you to know that I recognize what you said in your several statements, that the bill was a very significant bill, in terms of the health care for Filipino veterans. I mean, I want you to know that this bill will be recognized for that, and we appreciate your support of that, and I just want you to know that I recognize,

really, what we did, even though we ended up on a vote on different—but I think it will be seen as that, especially in the Filipino-American community.

The CHAIRMAN. Thank you, Mr. Filner, I appreciate that.

I would like to introduce our witnesses, if members don't have any further comments. I would like to ask our first panel to be seated.

The Honorable Robert Roswell, who is the Under Secretary for Health for the Department of Veterans Affairs, is accompanied by Dr. Frances Murphy, Acting Deputy Under Secretary for Health for Policy Coordination, and Mr. Tim McClain, the general counsel. And Mr. Grissom, we also would like to thank Tom Grissom for being here.

And Dr. Roswell, if you could begin your testimony.

STATEMENTS OF ROBERT H. ROSWELL, UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY FRANCES M. MURPHY, ACTING DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY COORDINATION AND TIM S. MCCLAIN, GENERAL COUNSEL; AND TOM GRISSOM, DIRECTOR, CENTER FOR MEDICARE MANAGEMENT AT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF ROBERT H. ROSWELL

Dr. ROSWELL. Thank you. Mr. Chairman, Mr. Evans, and members of the subcommittee, I am pleased to be here this morning to present the administration's views on H.R. 4939.

This bill would direct, at the beginning of 2003, the Secretary of Health and Human Services to transfer to VA a sum of money equal to 12 times the monthly Medicare Part B premium for that year for each veteran who has enrolled in Medicare Part B, but who receives any outpatient care from the VA.

For the current year, the monthly premium is approximately $54, and would result in annual payments of approximately $650 to the Department of Veterans Affairs for each covered veteran. The bill requires that the funds be paid on a periodic basis from the federal supplemental medical insurance trust fund.

In addition, H.R. 4939 provides that even if a payment is made to VA on behalf of a veteran, the veteran does not lose eligibility to receive care under Part B from any non-VA private sector Medicare provider. If the veteran does receive such non-VA care, the Secretary of Health and Human Services must reimburse that provider.

Finally, the bill provides that beginning in 2004, VA may collect charges for Medicare Plus Choice plans for the care it provides to veterans enrolled in those plans. VA could make such collections only for care of non-service-connected conditions, and only if the care is otherwise covered under Medicare Part B.

Mr. Chairman, I strongly support the concept of federal health care coordinating benefits in ways that enhance beneficiary's care, and improves the utilization of federal health care dollars. How-

ever, I do not believe that this bill would provide a mechanism to achieve that goal completely.

As you know, the President has created a task force that is currently examining issues associated with the coordination of care between VA and the Department of Defense. I am hopeful that the presidential task force will be able to assist us in finding solutions to these vexing coordination issues and assist in increasing access to care for veterans while using federal funds in the most efficient manner.

Having said this, the administration is concerned that this transfer of funds would significantly increase mandatory spending with no identified offset. Accordingly, the administration opposes enactment of the bill. The administration estimates the bill would cost nearly $32 billion over 10 years. I have attached to my testimony a table showing how the Office of Management and Budget has calculated that estimate.

Additionally, we are also concerned that the bill would require transfer of funds to VA on behalf of veterans who receive care for service-connected disabilities. This would constitute a significant change from the historical practice of having VA shoulder the responsibility for providing and funding such care.

Finally, it should be noted that even if enacted, the bill may not actually increase VA resources, or veterans' access to care over the long term. As you know, when the department accesses new funding streams, those increased funds are typically offset against appropriations we would otherwise receive. We have no reason to believe that this would not be the case in this bill. In that event, VA would not gain permanent increased funding from the measure.

In addition, if more veterans were encouraged to use VA as a result of this bill, the cost to VA would be significantly more to cover their care than the transfer from the Medicare trust funds.

Mr. Chairman, I deeply appreciate your concern for the dilemma we face in meeting the increased and growing demand for care and VA health care services. I will be pleased to continue to work with you to find any workable solutions we can come up with, and I am delighted to answer any questions you may have.

[The prepared statement of Dr. Roswell, with attachment, appears on p. 43.]

The CHAIRMAN. Thank you very much. Dr. Roswell. Mr. Grissom.

STATEMENT OF TOM GRISSOM

Mr. GRISSOM. Thank you. Good morning, Mr. Chairman, it's a pleasure to be here, and thank you for the invitation. It's a good opportunity for the Department of Health and Human Services and the Center for Medicare and Medicaid Services to discuss with you our mutual goal, which is to strengthen and improve health care for all Americans, including Medicare beneficiaries, as well as the nation's veterans.

It is our feeling that the best way to do this is to add a comprehensive prescription drug benefit to the Medicare program, and to expand Medicare coverage for all preventive services, and to protect the long-term financial security of the program. These are three themes that I will continue to return to this morning.

Last year, the President offered a framework to the public and to Congress on ways to strengthen and improve the Medicare program.

Recently, the House of Representatives passed the Medicare Modernization and Prescription Drug Act, which takes a bold first step in providing important preventative services, as well as prescription drug benefits for all Medicare beneficiaries. We look forward to working with members of congress to ensure passage of this legislation by the Senate, and have it enacted into law this year.

By the year 2030, there will be nearly 80 million Medicare beneficiaries who are eligible for this entitlement health care program. The Medicare fund for hospital insurance will begin to have a cash flow deficit within 15 years of this date, today, and in 30 years is projected to become insolvent.

The Medicare fund for Part B services, which this legislation speaks to, will require nearly a doubling of revenues, both tax revenues and beneficiary premiums, in order to cover expenses and to remain solvent within the next 10 years. We need to remain careful stewards of the Medicare trust funds to ensure that any changes that we make today will not put at risk the health care security for older Americans in the years to come.

The concept of subvention, which is related to but not the same as this legislation, is a concept whereby Medicare would pay for care provided to Medicare beneficiaries at military veterans or federal facilities. It is a concept that has been around for some time, there has been some experimentation with the Department of Defense, and subvention of Medicare.

There are a number of complex issues surrounding subvention which we can discuss as we go through this morning's hearing, and questions as to what it really achieves, whether or not it can be carried out efficiently, and whether the coordination works best for beneficiaries and for veterans.

There is a matter of principle that is in law that, in fact, Medicare trust funds cannot be used to pay for services for which monies have already been appropriated.

We are concerned, at the Department of Health and Human Services, that subvention has the potential to undermine the long-term financial security of the Medicare trust funds.

For example, the projection offered by the VA this morning is that the legislation that we are considering could cost nearly $32 billion over 10 years, and that would not, in any way, pay for or reduce the liability that the Medicare trust fund has for providing Part B services for its beneficiaries, and no guarantee that all of those services would be cared for or provided in the VA facilities.

Again, our first priority in the Department of Health and Human Services, and with the administration is to fortify and strengthen the current Medicare program.

Real briefly, the eight principles that the President has articulated, and which the congress restated in the legislation that it passed just recently are the following. All seniors should have a subsidized prescription drug benefit as part of a modernized Medicare program.

Secondly, Medicare should provide more preventative services by reducing all copayments for those services so that care could be preventative, and to reduce the long-term cost of treating illness and disease.

Thirdly, all Medicare beneficiaries today should have the option to continue their current coverage if they so desire, with no changes for current Medicare beneficiaries.

Fourth, Medicare should provide an increasing number of health insurance options like those that are available to federal employees and other federal retirees.

Fifth, both through its operation and through legislation that Congress has considered, the operation of Medicare should increase in its efficiency so that new benefits, as they are offered, do not jeopardize the security of the trust fund.

Sixth, that the program itself, whether it is through competitive bidding, or improved management of our contractors, that the program be operationally strengthened so the care is there for the seniors when they become eligible for the program.

And that no matter how our efforts may be directed at fraud and abuse, the program's regulations and administration procedures should be updated and modernized to improve the program's operation.

And lastly, that the program should be designed and operated to guarantee and ensure high-quality care for all seniors.

It is the administration's opinion that high-quality care should be available to all seniors, and that improved service should be the true bottom line of this effort.

We support these ideas, and we are committed to meeting the challenges that they present, and learning as much as we can about how to improve these programs, and to coordinate our programs with those of the Department of Veterans Affairs.

It is critical that, as we move forth, we strengthen the Medicare program, that we provide a prescription drug benefit for our beneficiaries, that we improve the access to preventative services, and that we do so in a way that does not jeopardize the fiscal integrity of the trust funds.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Grissom appears on p. 46.]

The CHAIRMAN. Thank you very much, Mr. Grissom. I would just like to ask a couple of questions.

First of all, in your statement, Mr. Grissom, one of the principles you outlined was the patient's safety medical errors report from last year that we need to move Medicare forward on the patient safety front, and I think you are probably aware that the VA has the best—when it comes to patient safety—record out there. That is juxtaposed with average cost savings that are almost a third less for those who use the system.

You know, I start from the premise that this is all the taxpayers' money, and when we get into turf battles about whose axe is being turned in terms of a drawdown, it loses the public interest perspective.

And when the VA can provide a service that is very safe, in terms of both the private sector and the public sector, and does it for less, it almost seems to be a no brainer. I mean, you used the

word it "cost" $32 billion over 10 years. I think of it as a shift, a meaningful and prudent shift, not a cost where you say, "Oh, that money is gone, fire and forget it, it's out of there." It is money that is going to provide for that same patient base that Medicare is charged with being concerned about.

So my question, basically, is I am hoping there will be a change of attitude when it comes to looking at VA health care as these are our people, they are Medicare-eligible. How do we get the best bang for the buck? And I think we do it in the VA by shifting—not costing out, but shifting—some of those resources, we are talking about one fourth of it, towards this kind of care.

I looked at your testimony and heard you deliver it. I don't think it focuses enough—and perhaps you could provide some amplification on that—on why not. I mean, it's not a cost, it's a shift.

And you know, I have been on this committee for 22 years. Every year we go through this, and especially within the last 10 years, this white knuckle shedding of tears about not enough money available for discretionary health care.

I am very much inclined myself to think we ought to make it mandatory, and bite the bullet and say, you know, it's no longer subject to the vagaries of an appropriations process that very much puts it at risk each and every year.

But short of that, it seems to me we need to look for every meaningful and prudent way of drawing down monies that can be used wisely for our veterans.

And you know, we already have Medicare subvention within the DOD, to some extent. It seems to me we ought to be sharpening our pens and doing much more. Maybe it's not, you know, taking the premium paid by the vet who is enrolled. Maybe that's not the formula that works. I happen to think we have discussed this at length, trying to find some way of getting more money into the pipeline to help our much deserving veterans. So perhaps you can respond to that.

Mr. GRISSOM. I, in fact, did use the word "cost," and I meant by that it was a cost to the Medicare trust fund. And by that, I was merely trying to take the Part B premiums times the number of beneficiaries we thought would use it.

The bill, as it is written—and as you know, Mr. Chairman—does not require or provide that all Part B services would be delivered or provided to veterans in the VA system, nor does it relieve the Medicare trust fund or the Medicare program from providing those services.

And so, the—it is impossible for me to know whether or not the remaining dollars, the 75 percent in the Part B fund, would be sufficient to cover those.

And it is, in fact—these are taxpayers' dollars, whether they are VA appropriations or Medicare trust funds, and I did not mean to imply that it was a cost or stealing of funds. We do believe that the VA health care system is extraordinarily cost-efficient, and it does have a great safety record.

It is, as you know, a provider of health care. We are an insurer, or a payer of health care. And we have conversations with them, we continue to have those conversations, and we think that there are many opportunities for improving the coordination of that care.

The CHAIRMAN. Have either of you consulted with the President's task force on this and other proposals? Dr. Roswell, perhaps?

Dr. ROSWELL. Mr. Chairman, I haven't consulted with the President's task force formally, but I have had the opportunity to have some discussion concerning the topic with the co-chairman of the task force recently.

The CHAIRMAN. Let me just, again, Mr. Grissom, get back on the cost side, I would hope as quickly as you could, if you could provide some insight and maybe respond to us for the record on the cost benefits side.

You know, cost is one thing. I think of it as a shift, but there is also the benefit that might be accrued if we looked at this, because I do think, you know, this might be a way of, again, significantly enhancing the amount of money available for VA health care.

Dr. Roswell, two of our VSOs who will testify today, the PVA and DAV, have a deep concern about the appropriations being offset, not unlike what we saw with the medical care collections. All of the sudden the appropriators say, "Oh, another revenue stream, therefore we have to appropriate less." That certainly isn't my intent with this legislation.

And they also suggest that category sevens only ought to be put under this kind of provision or bill or model, rather than those who have a service-connected disability or indigent, or prisoners of war, the category one through six. What is your feeling on that?

Dr. ROSWELL. Well, I share the perspective of the VSOs. And first, let me acknowledge that I appreciate your stewardship for America's veterans. It is clear that your record on this committee and your actions speak volumes about how deeply you care for veterans.

Obviously, we are dealing with a very complex, thorny problem that we are all struggling to find a meaningful answer. I don't believe that non-appropriated revenues should be used to subsidize or provide care for service-connected conditions. I believe that the VSOs will echo that same opinion.

I am concerned that revenues brought into the VA from non-appropriated sources would be scored as an offset to our appropriation. And again, I believe the VSOs might echo that position.

But having said that, I think that there are ways, as a physician, as someone who has spent more than 20 years in the VA health care system, I think there are ways that we can work collaboratively to expand care to America's veterans. And I look forward to the opportunity to do that.

The CHAIRMAN. We recently received a letter from Secretary Principi showing that about 400,000 veterans are now waiting for VA health care. And without objection, I would like to put that letter into the record.

(The provided material follows:)

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

July 12, 2002

The Honorable Christopher H. Smith
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Attached is a July 1 snapshot survey conducted by the Department of Veterans Affairs (VA) to determine the number of veterans who have enrolled with VA for healthcare and who are awaiting appointments that cannot be scheduled within six months. The numbers also include existing veteran patients who have necessary clinic appointments that are not scheduled within six months, including those scheduled more than six months in the future for clinically appropriate reasons.

The recorded numbers were derived primarily from data gathered manually from multiple primary care and specialty clinics at all VA facilities. The reported totals could therefore count veterans more than once if they sought enrollment at more than one site, or are patients currently being seen at one location and have sought enrollment at a site closer to their home, or are patients waiting for more than one specialty appointment.

Conversely, the data may not include veterans who were unable to enroll and subsequently chose other healthcare options, or veterans who were removed from a wait list at their request after deciding they did not want to wait any longer for care. The data collected are only for primary care and five major specialty care areas, representing 80% of VA's workload. Data are not collected for other specialty care clinics.

Therefore, these data should be considered with caution. It must be emphasized that all veterans who require emergent care are given priority and receive the care they need. A substantial, but unknown, number of reported veterans are now receiving care from non-VA sources but have also sought VA care and pharmaceutical benefits.

2. The Honorable Christopher Smith

Veterans Integrated Service Networks (VISNs) have submitted wait list reduction plans and are ready to implement them once the supplemental funds previously requested are appropriated and distributed. Prompt enactment of the fiscal year 2002 supplemental is critically important for VA to treat veterans now waiting for care.

In addition, VA's ability to respond to veterans waiting for care will be dramatically impaired if our authority to collect and retain pharmacy co-payments is not reauthorized prior to the current September 30, 2002 expiration date. This authority was enacted in 1990 and Congress recently authorized VA to retain these collections to fund veterans' healthcare. Without the $600 million co-payment receipts from this co-payment, VA would be unable to fund 2.2 million outpatient visits. The adverse effect on our ability to treat current patients or to reduce waiting times would be severe. I strongly urge you to work for extension of our authority to collect and retain pharmacy co-payments.

Please feel free to contact me should you have questions or require further information.

Sincerely yours,

Anthony J. Principi

Enclosure

SURVEY CONDUCTED JULY 1, 2002

Data was gathered from multiple clinics at all VA facilities. The data sources included excel spreadsheets and manual lists as well as the scheduling package for those waiting 6 months or greater for an appointment. Because the survey was derived primarily from manual data collection, patients waiting at more than one site may be counted more than once; the data could also reflect the same patient waiting for multiple clinics at one specific site. Therefore, the data should be viewed as an indicator of an overall problem. We are working on automating the wait list to ensure more accurate reporting.

	A	B
Veterans Integrated Service Network	**Number of New Enrollees waiting for first clinic appointment to be scheduled**	**Number of Established Patients waiting to be scheduled for follow-up Primary Care or Specialty Care Clinic appointments AND new and established patients with appointments scheduled electronically, although the wait is 6 months or greater**
1	9,891	12,130
2	460	1,844
3	82	2,448
4	18,535	8,061
5	0	217
6	0	29,124
7	4,662	3,299
8	31,469	22,474
9	11,093	7,887
10	13	1,239
11	1,172	2,562
12	8,922	9,424
15	1,283	6,616
16	5,490	8,126
17	1,874	17,444
18	0	4,741
19	8,230	9,342
20	8,891	15,702
21	1,013	5,015
22	0	3,810
23	19,198	6,471
Totals	**132,278**	**177,976**

Col A: Number of New Enrollees waiting for first appointment where an appointment has not been scheduled.

Represents a manual count of Veterans who have enrolled and requested an appointment but the Veteran's preferred site of care cannot schedule the appointment within six months. Therefore, the Veteran is placed on a wait list. An electronic wait list is being developed that will allow for more accurate data collection.

Col B: Number of Established Patients on a wait list or new and established patients scheduled for appointments requiring a wait of 6 months or more.

Includes: 1) a manual count of established patients (patients have been seen at least once) who are on a wait list (cannot be scheduled within 6 months) for follow-up care for a Primary Care Clinic or Specialty Care Clinic visit. (Examples would include veterans waiting for reassignment to a new Primary Care Provider, or patients waiting for consults in Specialty Care clinics) Also includes 2) a count of Veterans scheduled electronically for appointments, however the wait time meets or exceeds six months. (This also includes those patients who have either voluntarily canceled their appointments or had their appointment canceled by the VA.

Note: This data includes approximately 80% of VHA's workload. All Primary Care Clinics are included and 5 major Specialty Care clinics (eye care, urology, cardiology, orthopedics, audiology). The electronic wait list capability will allow for additional clinics to be included.

The CHAIRMAN. H.R. 4939, if it became law, would move more funds into the VA health care. Wouldn't that help solve some of your problems, if we also simultaneously solved the problem of no offset from the appropriations?

Dr. ROSWELL. Certainly any additional resources would help us meet the tremendous growth and demand for VA health care services. And we are open and interested in ways that do that, although I am obliged to say that the administration, at this point, does not support Medicare subvention, per se.

The CHAIRMAN. Let me ask you, Dr. Roswell, and Mr. Grissom, if you could, what kind of collaboration do you have? Do you meet infrequently, frequently?

Because it seems to me, again, that the VA health care does provide some remedy to Medicare's problems, because it is cheaper, dollar for dollar, and it provides high-quality care for a very deserving population. Do you meet and collaborate?

Dr. ROSWELL. As you know, I am relatively new to my position, and I haven't had the opportunity to meet with Mr. Grissom before today, although we have spoken on the telephone.

However, I would point out that VA and CMS have an agreement whereby data is shared between the two agencies. More recently, Dr. Frances Murphy, the Deputy Under Secretary for health policy in VA has assumed new responsibilities in which she is involved in working with the Department of Health and Human Services across a variety of coordination issues between the two departments.

So, we are deeply committed to working across departments to solve the dilemma facing America's veterans.

Mr. GRISSOM. Administrator Scully and Secretary Principi have had a number of conversations precisely about these issues. We are aware of the dramatic increase in the number of veterans who are enrolled in and obtaining their services from the VA system.

When it—there are a number of important examples of cooperation between our agencies, as the VA attempts to collect more and more private revenue into pay for care. They have turned to Medicare for some exchange of ideas and data files on how to bill for secondary payers. We have a project ongoing with them now that will increase the private sector, private insurance revenues into VA.

And I think we always can do more than what we are doing, but that there is a good level of communication and cooperation between the two agencies.

The CHAIRMAN. Dr. Murphy, since you were referenced, if you wouldn't mind elaborating on what you are doing.

Mr. FILNER.—a chiropractor.

Dr. MURPHY. Mr. Chairman, I will respond to Mr. Filner's comment, first. Chiropractic policy development is no longer in my portfolio.

As you know, Mr. Chairman, I assumed these new responsibilities at the beginning of July. My position is a liaison position between the VA and the assistant secretary for health's office at HHS, working on a broad range of issues, including public health, health quality and patient safety, rural health programs, decreasing the disparity in health care for minority veterans, occupational

health and safety programs, IT issues, and coordination with CMS on our joint areas of collaboration.

It is a position that is crucial to our success in the future, and I am honored that Dr. Roswell and Secretary Principi asked me to take on this new challenge.

The CHAIRMAN. Has the President's task force been in contact with you, and is there any kind of touchstone between you and HHS? I mean, is everybody talking?

Dr. MURPHY. Yes. I have spoken personally with Gail Wilensky, the co-chair of the presidential task force, specifically on Medicare coordination issues, but also on the other issues that the task force is dealing with.

There are good communications and touch points between HHS, VA, DOD. We are all working together to coordinate federal health care benefits across all programs and all federal agencies.

The CHAIRMAN. Has anything that even remotely resembles what we are talking about here been discussed? I mean, Medicare subvention, in whole or in part? Dr. Roswell?

Dr. ROSWELL. Actually, it's interesting. We have had some preliminary discussions with the co-chairs of the presidential task force on an informal basis—not the whole task force—talking about the concept of the need for additional funds for VA, assuring that access to VA health care is available in an effort to move forward with VA/DOD sharing.

And one of the issues that Dr. Wilensky is quite interested in is at least the concept—which we need to explore in greater detail—of a Medicare collaboration project that might come along the lines of instead of a fee-for-service, or transfer of funds, a capitation program.

Medicare Plus Choice, as you may know, is a capitated program where Medicare providers create an HMO-like product. I believe that it is conceivable that VA could provide a capitated comprehensive health care program for veterans.

And as Mr. Grissom indicated, one of the major concerns from CMS would be to safeguard the liabilities against the trust fund. By paying a capitated rate to the VA, there would be finite liability, there wouldn't be any liability beyond that, because a veteran in such a program would have to opt for VA care, and VA would be obligated to provide the entire cost of that care, having accepted a fixed, capitated rated from CMS.

So, the concept, which I am very interested in as a physician, as a veterans' advocate, and as a veteran myself, is something that we will be exploring in greater detail.

But I think it meets the three basic elements of being good for CMS, good for veterans, and good for VA in that it does limit liabilities against the trust fund, a mechanism that is not in place in a fee-for-service or a transfer program outright.

It clearly would be beneficial for VA because veterans who were currently increasingly having difficulty deferring the cost of their care—the priority seven veterans—would now bring with them to VA an additional funding stream if they were to opt for VA care, and it would clearly be beneficial for veterans, because it would allow them to use their earned Medicare benefits, to have free access and choice to the health care provider they prefer. And should

they choose VA for that care, they would be eligible to receive the prescription benefits.

The CHAIRMAN. So the choice going to their local hospital and the VA would still be preserved, under this——

Dr. ROSWELL. It would not, Mr. Chairman.

The CHAIRMAN. So there would be exclusivity.

Dr. ROSWELL. There would have to be. And of course, I think that is the way we generate efficiencies in coordinating federal health care benefits. A Plus Choice program is an HMO.

And basically, the veteran—at least for a period of a year—would opt to receive their care through the VA, and the VA would be obligated to provide that care for a period of a year. At the end of that time, the veteran would presumably have the opportunity to go back to a traditional relationship if he or she was not satisfied with the option.

The CHAIRMAN. Mr. Evans?

Mr. EVANS. No questions.

The CHAIRMAN. Mr. Filner?

Mr. FILNER. Just a brief comment, Mr. Chairman. I am not—I find it incredible that you sit there and talk about the integrity of the Medicare trust fund representing an administration whose tax policies, whose billions of dollars of giveaways to corporate America, whose refusal to deal with corporate abuses that are undermining our whole economy, I mean, that is raiding the trust fund every single day.

And you come here and say a transfer of cost, as the chairman said in his opening question, is raiding the Medicare trust fund. I just hope you go to the President of the United States and talk about the integrity of the trust fund, instead of talking to us. We are just trying to talk about transfer of funds so we can better help our veterans. I yield back.

The CHAIRMAN. Mr. Boozman.

Mr. BOOZMAN. Yes. I guess Mr. Grissom, we all agree that if a patient goes through the regular Medicare system, you know, sees their local physician, or whatever, versus the VA system, that probably the cost is going to get rendered in a less—it's not going to cost as much in the VA system. Is that true? Would you agree with that? I mean, they seem to be——

Mr. GRISSOM. I don't have any—I do not know any—I have not seen any actuarial figures that talk about the cost of care per veteran per Medicare beneficiary. There are unquestionably certain efficiencies in the VA system because of a statutory basis for it, that we do not have in the Medicare program.

But in terms of saying the cost of care is less in one system or the other, I don't have any basis for it.

Mr. BOOZMAN. Right.

Mr. GRISSOM. They are a provider of care, and they have a very efficient system. We are, on the other hand, a payer of care, and do not provide it directly, except through agents and contractors.

Mr. BOOZMAN. With them, you know, being on salary and things, and being able to, you know, I guess determine their pay increases, you know, things like that, there is opportunity, it seems like, in that system to control costs better than, as you said, just being the payer.

But I guess what I am saying is I agree with Chairman Smith in the sense that, you know, it does seem like it is just shifting money, you know, from one section to the other. And yet also I agree that there is a problem when you are opting into both systems, you know, where you are in one system and the other.

And the comments that Dr. Roswell made about—and I know that there are some problems and it does seem like, you know, it might be good to explore how you would maybe get somebody to opt into the VA system, you know, potentially reduce costs, and maybe reward the patient by somehow reducing their costs, as far as a lower premium, or whatever.

A few hundred dollars or a hundred dollars in that regard, compared to the outlay of, you know, medical care, is really not very much money.

Mr. GRISSOM. One of the outcomes of the conversations between the two agencies is the recognition by the Medicare program that one of the causes of the dramatic increase in visits and unique users of the VA health care system is the disparity in the prescription drug benefit between the two programs.

And what I would like to leave with you as a message is that the administration acknowledges that, and that we are—that is why our efforts are committed primarily to extending and increasing prescription drug benefits in the Medicare program, acknowledging that that would improve care and modernize Medicare for all beneficiaries and eliminate part of—and I don't know what size of the fraction it is—but part of this problem of duly eligible veterans going to the VA program to obtain a drug benefit which is not available to them in the Medicare program.

And this House, this side of the Hill passed a piece of legislation in the past few weeks that is, we think, a very important first step in that direction. And that is where we believe we should spend our efforts and energies.

Mr. BOOZMAN. How about—what is the negative, as far as the VA charging secondary insurance for their part?

Mr. GRISSOM. Oh, I didn't mean—there is no negative. They absolutely should do it. They and we have been—in the Medicare program, we bill secondary payers all the time, and establish primary—who is the primary payer. We are exchanging expertise and experience and procedures with VA to enable them to do the same thing.

So, they have become more cost-conscious, and they are trying to maximize private revenues into their system, and they have been using some Medicare expertise to figure out how to do that.

Mr. BOOZMAN. Do we do that, then, Dr. Roswell?

Dr. ROSWELL. Mr. Boozman, we do that. It is not as efficient as it could be, because to bill a secondary payer or a Medigap insurer, if you will, customarily you would submit an MRA, which is a Medicare Remittance Advisory, because we are unable to bill Medicare, we don't receive an MRA. Therefore, it makes it more onerous for us to collect from the supplemental insurer.

What we also find is that sometimes, as Mr. Grissom alluded to, a veteran will use a Medicare provider for their primary care, their basic care, and then will come to the VA to augment that with the prescription drug benefits available through the VA.

That sometimes results in us duplicating the care that was already provided by the Medicare provider. So in those cases where we get past the MRA non-availability, and actually get to the secondary payer, we often find that claims are denied because of the services, the duplication of service already provided and paid for to a non-VA Medicare provider.

So it is an inefficient system, which is why I am delighted with the chairman and this committee's commitment to working towards coordinating federal health care benefits.

Mr. BOOZMAN. The MRA situation, you know, them using that to deny, how do we fix that?

Dr. ROSWELL. We are working to——

Mr. BOOZMAN. I mean, do we do that legislatively, or can that be done administratively?

Mr. GRISSOM. It can be done operationally. We do it as a matter of course. What we are learning in our conversations with the VA is they need and want and should do the same thing, and we are trying to show them our billing practices and exchange data systems so that they can do that.

Mr. BOOZMAN. And that really represents a fair amount of money that is being left on the table, doesn't it?

Dr. ROSWELL. It does, although I would point out we are really only billing the supplemental insurer for 20 percent of the total cost of care.

Mr. BOOZMAN. Right, right.

Dr. ROSWELL. But we would like to be able to collect that 20 percent.

Mr. BOOZMAN. Thank you.

Mr. FILNER. Mr. Chairman, may I have an additional chairman for Mr. Grissom?

The CHAIRMAN. Mr. Boozman, are you finished? John, are you finished?

Mr. FILNER. I'm sorry, I thought he was.

Mr. BOOZMAN. Yes.

Mr. FILNER. Thank you, Mr. Chairman. Several times you mentioned, Mr. Grissom, that the administration supports a prescription drug benefit as a part of Medicare. That's not what the bill passed did, and that's not what the administration's position is.

I don't understand how the bill—how, when you give a voucher for someone to go out into the private sector to find an insurance plan, that you call that a benefit of Medicare. How can you do that with a straight face?

We are talking about Medicare beneficiaries that are part of a Medicare program and you keep saying that that is what you support, and yet you don't.

Mr. GRISSOM. Well, we—the administration certainly supported the passage of——

Mr. FILNER. But how is that—how is it a prescription drug benefit that was passed a benefit of Medicare?

Mr. GRISSOM. Well, respectfully, we could disagree about whether—the nature of the benefit in that legislation. But if that legislation is passed in the Senate and it becomes law, it is more of a prescription drug benefit for 40 million Medicare beneficiaries than they have today.

Mr. FILNER. But it is not a prescription drug benefit of Medicare. You keep saying that, and you think everybody in the country is going to believe it, and you fooled a good part of the country up to now because you keep saying it, it's a big lie.

I mean, everybody, apparently, in the administration says the exact same words, "prescription drug benefit is a part of Medicare, prescription drug benefit is a part of Medicare." It ain't, it's a lie. It is not a benefit of Medicare, and that's why it's a horrible program, that's why it won't become law.

But you guys, you know, I don't know how you do it with a straight face. I just don't understand it.

The CHAIRMAN. Just yielding myself as much time as I may consume, first of all on the prescription drug benefits —and I think the record should be clear—it costs $350 billion, so we are paying for something.

We are paying for something that I would argue to my friend and colleague is very reasonable, and I voted for it. I believe very strongly that the administration had a reasonable idea.

After a $250 deductible, if my memory is correct, up to $1,000, 80 percent of the cost will be borne by Medicare, and then up to $2,000, 50 percent. That is a short gap. According to the CBO and others who have looked into this, and there is a consensus number, the average amount of money spent by senior citizens on prescriptions is about $1,800 and some change.

So most will fall within the area where they get a significant benefit. And then, very significantly as well, after $3,700 of out-of-pocket, we are talking about all of the cost for pharmaceuticals being borne by Medicare.

So I would beg to differ with my good friend and colleague. This is a very significant advancement. It is much more generous than that which was passed last year. And again, the price tag, according to CBO—again, speaking off the top of my head—I believe was $350 billion, not million, billion.

So I want to commend the administration and do so as publicly and as emphatically as I can, that this is a major enhancement to the Medicare program; it's not everything, and I have learned in this job over the last 22 years, everything has a cost and you do the best you can. I think it's a very good prescription plan, and I just thought the record should be clear on that.

Mr. FILNER. Mr. Chairman, if you would yield——

The CHAIRMAN. I am going to ask some additional questions, if I could.

Dr. Roswell, do you agree—and I looked at this submission that went along with your testimony—with the administration's estimate that the VA will be providing care to 10 million veterans in 2012, which seemed very high to me?

I mean, right now we have 25 million veterans. The eligible number of veterans who actually utilize health care services is far, far less than that. The submission that we got, the graph showed a progression leading up to, I think, 6 million actual enrollees.

Dr. ROSWELL. Mr. Chairman, I would acknowledge that the calculations you are referencing were prepared by the Office of Management and Budget.

I do think that probably for expediency, there were some straight-line extrapolations on percentage growth. I would fully acknowledge that 10 million users in the year 2012 is awfully high.

The CHAIRMAN. I would just like to conclude and thank our panelists, and just ask you again, for more coordination, Mr. Grissom. I just want to underscore, you know, even with the appropriators, who obviously have many veterans as constituents, the VSOs are routinely talking to our friends on the appropriations side.

The crisis within the VA is almost catastrophic. This year, Secretary Principi was almost compelled to put a moratorium on enrollees for category seven, which, thankfully, he did not do. But he certainly has the authority to do it, based on resources matching up with potential expenditures.

I have a fear that he may be in that same situation again. So we on this committee are desperately looking for revenue streams to beef up what I believe, and what we believe collectively in a bipartisan way, are the most deserving of Americans, and that is our veterans, especially those who have a service-connected disability.

And I mean, that's the spirit within which this language—and it's not perfect, if you have a better idea, we will work, you know, we will bob and weave and get the best possible language, but we need some additional revenue streams, and I would hope, Mr. Grissom, you and HHS, as I am sure you are, but even more so because of the crisis, would work with Dr. Murphy, Dr. Roswell, Mr. McClain, and the rest of the VA.

Let's come up with some answers, because we do need them. And we need more revenue. We can't rely on the appropriators. You know, they are good people, but they have a 302(b) allocation on which, you know, even now, they are deferring action, and I know that Chairman Young is deferring action because he is absolutely dissatisfied with the amount of money that would be available for our vets.

So, I just encourage you, if you could work with us more on that.

Mr. GRISSOM. We will do it.

The CHAIRMAN. I appreciate that.

Mr. FILNER. Mr. Chairman?

The CHAIRMAN. Very briefly, then we will go to our next panel.

Mr. FILNER. Thank you. You know, I think this Medicare issue is very important. And what you have outlined, Mr. Chairman, is a benefit only if an insurance company will provide it.

And there is no—you gave some costs about deductibles and premiums, et cetera. Nobody knows that. It's what the private insurance company will charge.

What is a real benefit, guaranteed benefit of Medicare, is something that, unfortunately, the leadership of this House will not even allow a vote on the Democratic plan, which had a defined benefit of Medicare. It was a premium that was paid, a $100 deductible, a 20 percent of cost paid above the deductible, and then all costs above $2,000 out-of-pocket were taken up by Medicare. That is a defined benefit of Medicare.

We didn't have a chance to vote on it. You said, you know, yours may not be perfect, but it is an advance. Well, you know, give another—you know, the leadership ought to have given another idea at least a vote, or a chance to be heard.

And so, I still dispute that this administration favors a prescription drug benefit as a defined—a prescription drug program as a defined benefit of Medicare. You allow the seniors to go out in the private market.

And Mr. Chairman, if there was a private market—if the private insurance companies could make money, they would have had these insurance policies out by now, and people would have been able to take advantage of them. The fact is, they can't make money on them, and that is why the Medicare program should have taken up on it.

The CHAIRMAN. Okay. Again, I want to thank our panelists. Your recommendations, your thoughts, we appreciate them very much. We do want to work with you, as I said, going forward. This is extremely important to all of us, I know.

And again, Mr. Grissom, I think you and HHS can play a very key role in helping to find a way to better provide additional revenues for the VA, and serve your client base of Medicare-eligible patients, as well.

Our second panel today consists of Mr. Carl Blake, the associate legislative director of the PVA, Mr. Paul Hayden, deputy director of the National Legislative Service for the VFW, Mr. Steve Robertson, director of the National Legislative Commission of the American Legion, Mr. Rick Weidman, director of government relations for the Vietnam Veterans of America, and Ms. Joy Ilem, assistant national legislative director for the Disabled American Veterans.

If we could begin with Mr. Carl Blake.

STATEMENTS OF CARL BLAKE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; PAUL A. HAYDEN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; STEVE A. ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION; RICK WEIDMAN, DIRECTOR, GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA; AND JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

STATEMENT OF CARL BLAKE

Mr. BLAKE. Mr. Chairman, ranking member Evans, members of the committee, PVA would like to thank you for the opportunity to testify today on H.R. 4939.

PVA appreciates the efforts of the committee to explore and develop methods to achieve the necessary funding levels for the VA medical system to provide health care to our nation's veterans.

As you know, PVA is a co-author, along with AMVETS, DAV, and VFW, of the independent budget, currently in its 16th year. For fiscal year 2003, the independent budget has recommended a health care appropriation increase of $3.1 billion. We were, therefore, quite disappointed that the administration only requested a $1.4 billion increase.

We were heartened by the actions of this committee and the leadership of Chairman Smith and Ranking Member Evans in forwarding to the Budget Committee recommendations to accurately address the fiscal crisis currently faced by the VA.

We note that the House of Representatives, in passing its fiscal year 2003 budget resolution, assumed an appropriated increase of $2.6 billion, an action mirrored by the Senate Budget Committee. Although this recommended increase is $500 million below the amount put forward by the independent budget, we believe that this represents a solid step in the right direction.

PVA has been in the forefront of efforts to explore alternative funding streams outside of appropriated dollars in order to enhance VA health care. Unfortunately, we have seen in the case of the medical care cost fund, that these alternative dollars are used in lieu of appropriated dollars.

Our support of these efforts has always been tempered by the basic idea that these funds should be used as a supplement to and not as a substitute for appropriated dollars. We have looked askance at efforts to shift the burden of this Federal Government obligation on to the shoulders of others.

We have found that, too often, inflated MCCF estimates are used to rationalize, not providing the VA with the funding needed to care for sick and disabled veterans. This is one of the reasons why the independent budget does not use VA collection estimates in making its recommendation for health care funding for a given fiscal year.

These estimates tend to be grossly overstated and inaccurate. Moreover, VA has historically been unable to meet its collection goals.

In the past, we have supported, in a limited manner, exploring Medicare subvention. Our support of this has been predicated on the establishment of a pilot program in order to test its feasibility, along with ensuring that this pilot only include category seven veterans, as well as making available a fee-for-service option.

We have always expressed concern that these measures brought up in previous congresses not subsidize services or care for service-connected veterans. The cost of care for service-connected conditions is a federal obligation, not to be underwritten by third parties or federal or private insurers.

We understand that H.R. 4939 is a different approach to addressing the overlap of VA health care, and the Medicare program, but our concerns still remain.

PVA feels that we need to vigorously investigate as many avenues as possible to achieve full health care funding for our veterans. We applaud this committee in introducing H.R. 4939. This may, indeed, be one effective method of achieving the end result of full funding, but we must reiterate that the VA must not be forced to rely on subsidies from veterans or their insurers to cover the cost of caring for veterans.

PVA is committed to the continuing existence of a viable, efficient, and independent VA health care system that protects the specialized services of our veterans with spinal cord injuries and disabilities, as well as other severe disabilities that lie at the heart of the VA's mission. We must ensure, as we consider H.R. 4939 and other such measures, that this vision is not compromised.

Mr. Chairman this concludes my statement, and I will be happy to answer any questions that you might have.

[The prepared statement of Mr. Blake appears on p. 53.]

The CHAIRMAN. Mr. Blake, thank you very much. Mr. Hayden.

STATEMENT OF PAUL A. HAYDEN

Mr. HAYDEN. Thank you, Mr. Chairman, members of the committee. On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States and our Ladies Auxiliary, I would like to express our deep appreciation for being included in today's important legislative forum on H.R. 4939, Veterans Medicare Payment Act of 2002.

We are pleased that this committee is focusing on what we believe to provide a viable and significant alternative funding source for VA, one that does not place the burden on the veteran, Medicare subvention, or reimbursement.

It is widely known that appropriated dollars for veterans medical care have only in recent years come close to providing adequate support. The preceding decade of flat and even deficit budgets for VA has place enormous pressure on the health care system. While at the same time, eligibility reform has meant more veterans than ever before are turning to VA health care for their medical needs.

Under current law, Medicare is prohibited from reimbursing VA for medical services it provides to Medicare-eligible veterans. This situation not only deprives Medicare-eligible veterans of their preferred choice of health care, it saddles the VA health care system with the onerous burden of covering the cost of these non-service-connected veterans health care with appropriated dollars, even though VA has possessed the authority to collect and retain, without offset, reimbursement from third-party insurers since the late 1990s.

The Veterans Medicare Payment Act of 2000 would have meant Part B of title 18 of the Social Security Act to provide for a transfer of payment to the Department of Veterans Affairs for outpatient care furnished to Medicare-eligible veterans by the Department.

While this does not provide for the VA to be reimbursed by Medicare for all health care services provided to non-service-connected Medicare-eligible veterans, it does provide for payments to VA for the largest segment of eligible VA health care users, those requiring outpatient care and services.

This represents a major step toward erasing the current inequity, and it is in agreement with VFW national resolution 622, calling for full Medicare reimbursement. Therefore, the VFW is pleased and proud to lend its full support to H.R. 4939.

Mr. Chairman, and members of the committee, once again, on behalf of the men and women of the VFW, I thank you for inviting us to present our views here today. VFW national resolution 622 is appended to the written testimony for your review, and I will be happy to respond to any questions you may have.

[The prepared statement of Veterans of Foreign Wars appears on p. 57.]

The CHAIRMAN. Thank you very much, Mr. Hayden, for your testimony, and support for the bill. Mr. Robertson.

STATEMENT OF STEVE A. ROBERTSON

Mr. ROBERTSON. Thank you, Mr. Chairman, for inviting us to participate in this long overdue hearing on Medicare subvention.

Although the American Legion fully supports the idea of figuring out a way to get Medicare reimbursements to the VA, we are not sure that your proposed legislation is the best approach.

I have a written summary here that I was going to read of our bill, but I can't pass the opportunity to talk about some of the comments in The Centers for Medicare and Medicaid Services. There are so many inaccuracies in this, that it is just overwhelming.

For example, the statement "there are many complex issues surrounding Medicare subvention, including what benefits it really achieves, and whether it can be effectively coordinated," obviously Mr. Grissom is unaware of Indian Health Services.

They have a very effective program. It was tested for 5 years before it became permanent. And the end result is the Native Americans now are in accredited hospitals and are getting better quality health care. And that is absolutely the shared vision we should all have in this room.

The next part that really—and he discusses the demonstration project, Medicare subvention demonstration project. Any time you deviate from what Medicare normally does, it becomes an aberration. That was a disaster. It was doomed from day one. I am afraid that if we take your bill and advance it, the same thing is going to happen. They are going to figure out every way to end us up on the short end of the stick, and I can give you some examples.

Another part that really bothered me was the statement that Medicare trust funds should not be used to pay for services for monies which have already been appropriated. If there is anybody in this room that believes VA is adequately appropriated to take care of all the veterans enrolled, they are smoking something illegal, and need to be tested——

The CHAIRMAN. Can we have a show of hands on that?

(Laughter.)

Mr. ROBERTSON. This is absolutely incredible. If we were asking to pay for service-connected veterans, then yes, that is a legitimate argument, because that is who the money is supposed to be taking care of, the one through six categories, the medical support people, the facilities, everything else.

But we are not asking that. We are asking to be able to bill for non-service-connected conditions. Every one of these Medicare-eligible veterans paid. They were forced to pay to participate in the Medicare program. They did not have an option.

The only option they have is where they are going to go to get their care. And right now, veterans—people can say, "Well, they are only going there to get their prescriptions." I say, "They are going where they are getting the best quality of care." You sited it yourself, the patient safety in the VA system is outstanding.

When I first came to work for the American Legion 14 years ago, we used to get calls about the quality of care. That's been fixed. Now, the calls are about accessibility, timely accessibility.

VA has this terrible, terrible problem that the rest of the for-profit world would love. Their demand is far exceeding the ability to provide the supply. This new revenue stream would enable VA to meet those additional demands by hiring additional staff that they need to provide the services that they are capable of doing.

I guess the thing that really highlighted this whole testimony was how CMS talked about strengthening Medicare. If you go through these eight steps, the VA is doing every one of them for free. For free. That's what is ridiculous.

These are paid benefits. The fact that the veteran gets to go to a VA facility to receive the benefits is because they made a personal commitment. They put their butt on the line, risking life and limb for God and country, for everything that this Congress is supposed to be standing for. That's what they were willing to die to protect. And now you are saying, "Well, we can't. You would be double-dipping."

Double-dipping what? First of all, they are paying for the benefit. And secondly, they all earned the right to go to the VA. So it's completely ludicrous. There is not a person, non-veteran, in this country that would not love to pay a $7 copayment for maintenance drugs. If they are on maintenance drugs that cost hundreds and hundreds and hundreds of dollars for them to stay alive, $7 would be a godsend. Medicare is getting that for free, they are not paying one penny for it.

When the gentleman talked about the $32 billion saved over—costing them over the next 10 years, let's go back and figure out how much money VA has saved Medicare since 1965. I don't know what comes after trillion, but it's got to be up close to it.

Mr. Chairman, the American Legion has been lobbying for over 10 years for Medicare subvention, and there is absolutely no reason why we can't get it. Congress, not CMS, determines what the rules of the game are going to be. Anybody that thinks that Medicare reimbursements should be offset against the discretionary appropriation, again, needs to go take a test.

Mr. Chairman, that concludes my comments.

[The prepared statement of Mr. Robertson appears on p. 59.]

The CHAIRMAN. Thank you very much, Mr. Robertson. Ms. Ilem.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you. Mr. Chairman and members of the committee, thank you for the opportunity to present the views of the Disabled American Veterans on H.R. 4939, The Veterans Medicare Payment Act of 2002.

This measure would authorize the transfer of a designated payment from Medicare to the VA for Medicare-eligible veterans who require VA outpatient care. DAV supports Medicare reimbursement for Medicare-eligible veterans receiving care from VA for non-service-connected disabilities.

We firmly believe that veterans should be able to see the health care provider of their choice. And when they choose VA, Medicare should reimburse the department for the cost of their care for non-service-related conditions.

Unfortunately, VA is currently required to absorb the cost of care for the treatment of Medicare-eligible veterans seeking care at its facilities for non-service-connected conditions.

Allowing Medicare-eligible veterans to apply their Medicare benefits in VA facilities makes good fiscal sense. It would reduce the government's total health care expenditures, since VA health care

costs less—at least 25 percent less—than private sector providers billing at Medicare rates.

The committee is aware of the extreme financial stress on VA at this time, due to rising health care costs, and with increased numbers of veterans seeking VA health care. As a result, VA is currently unable to provide timely health care to many of our nation's most severely disabled veterans. This bill seeks to ease the burden through collection of veterans' Medicare premiums to help cover the cost of their care at VA.

We appreciate the introduction of H.R. 4939 by the chairman and other members of the committee. However, we do have some concerns about the bill.

Initially, this measure does not distinguish between Medicare reimbursements for the treatment of service-connected versus non-service-connected conditions. Likely, this would trigger an offset in appropriations, since government funding is provided to VA for the treatment of veterans service-related disabilities.

Secondly, the measure would not cover the cost of care related to services rendered, but simply authorize the transfer of veterans' Medicare premiums as payment.

We believe VA participation in a Medicare reimbursement initiative will benefit veterans, taxpayers, and eventually, ultimately, VA, as long as Medicare reimbursement dollars are a supplement to an adequate VA appropriation.

However, we believe the reimbursement should cover the cost of their care, and be limited to paying for conditions that are non-service-connected. Although we support Medicare reimbursement, DAV believes the best solution to fully address VA's funding problems would be to shift VA health care from a discretionary funding program to a mandatory one.

We are extremely pleased that you, Mr. Chairman, have taken initial steps to explore this idea. The VA health care system is in extreme distress, and the needs of our nation's service-connected-disabled veterans are not being met. We are hopeful that a meaningful legislative remedy to this serious problem will be forthcoming.

Another way to perhaps more easily deal with the Medicare reimbursement issue is to only authorize reimbursement for Medicare-eligible group seven veterans. Under this scenario, there would less likely be an offset in appropriations.

No veteran should be denied access to veterans health care system, even veterans like those in priority group seven, who are not considered poor, have the right to take advantage of VA health care.

However, service-connected and poor veterans should not have to subsidize care for veterans who have public or private insurance coverage. Medicare reimbursement would allow Medicare-eligible priority group seven veterans to become a source of funding, rather than a drain on an already over-extended system.

While we support Medicare reimbursement, we would want Congress to insure that service-connected-disabled veterans would not be displaced, or forced to wait even longer for necessary care, and that revenue generated from Medicare reimbursement will not be used to offset federal appropriations.

In closing, if the committee chooses to pursue this initiative as the solution to ease VA health care's funding crisis, we would recommend amending H.R. 4939 to include Medicare reimbursement for services rendered, versus collection of Medicare premiums, and only for Medicare-eligible veterans in priority group seven, or only for the treatment of non-service-connected conditions, in order to avoid a potential offset in appropriations.

However, we believe the best strategy to fully address the issue of inadequate appropriations for VA health care is a shift in the funding source from discretionary to mandatory.

Thank you, Mr. Chairman. Any questions, I would be happy to answer.

[The prepared statement of Ms. Ilem appears on p. 63.]

The CHAIRMAN. Thank you very much, Ms. Ilem. Mr. Weidman.

STATEMENT OF RICK WEIDMAN

Mr. WEIDMAN. Thank you, Mr. Chairman. Thank you very much for giving Vietnam Veterans of America the opportunity to share our views here today.

The primary mission of the VA health care system is today, and has always been, to care for he or she who hath borne the battle. And therefore, those who are service-connected-disabled veterans, or if their veterans benefits administration worked better would service-connected-disabled for one condition or wound or another.

The eligibility reform passed in 1996 always envisioned that Medicare subvention would come about in order to fund those who were not service-connected, and truly not service-connected, for a physical malady. In fact, that never happened. It hasn't taken place to this date, and it needs to.

All of the folks who were non-service-connected, essentially are, in fact, an unfunded mandate on the VA, because the money and the dollars are not there. The system, therefore, is crumbling, and we have had a loss of organizational capacity that, when you couple both the expansion of who is covered by VA health care and the flat line budget and the inadequate appropriations raised each year, that we have lost 25 percent of our organizational capacity since 1996.

Stack that up against what is now running at the rate of 18 percent a year increase in non-service-connected disabled veterans and 6 percent increase per year of categories 1 through 6, and what we have is a projection out for this next year of $28 billion, and not the previously agreed upon figure among the VSOs of $25.5 billion.

We have fought this battle ever since this law came into effect. It's not that we are suggesting that we go back on that, but we have to have the funding streams attached to those individual veterans.

We would respectfully disagree with Dr. Roswell. Efficiency does not come from having a pre-determined amount. Efficiency within the greatest economy of the history of the world follows individual choice. If the money follows the individual Medicare-eligible person, and particularly on Part B, who has purchased that with their own dollars, their choice breeds efficiency.

The Legion is absolutely correct. The people come to VA because it's much better health care than they ever believed possible. And frankly, much better than it was 10 to 15 years ago.

The heart of all this problem is that we must get VA and veterans health care away from the Office of Management and Budget. These are very bright people within that permanent bureaucracy. Therefore, we can only assume that it is a conscious strategy of the permanent bureaucracy at the Office of Management and Budget to destroy the veterans health care system, therefore, offsetting any other revenues that are brought to bear, and consistently underestimating both the number of users and the amount of money that it will take to not only properly but safely care for them.

What happened at the Kansas City VA Medical Center, with infestation of rats and mice and flies and lice in the bodies of veterans also happened up at Harry Truman VA in VISN 15 as well. It was a natural consequence of cutting deep into the bone, and not having enough money to do safely what you are claiming you are doing.

Essentially, it is a "let's not, and say we did." It is time to break that, whether it is through mandatory spending or another mechanism, but to do that. This bill, Mr. Chairman, that you have introduced, is a good first step towards Medicare subvention that we also very much favor.

And in this case, it's unconscionable to limit the choice of the individual who has purchased via Part B—what's next? Are we going to say, "No, you can't use public hospitals?" Are we going to say, "No, you can't get your medical care from a Catholic hospital?" I mean, where does this end? A veteran should have the right to choose where he or she, as a citizen, wants to take the insurance coverage that he or she has purchased.

Once again, we commend your leadership, Mr. Chairman, on taking this bold step, and for introducing some additional language to essentially pry veterans health care out of the dead grasp of Office of Management and Budget. We thank you, sir, I would be happy to answer any questions.

The CHAIRMAN. Thank you very much for your testimony, for all of your testimonies, and you have been very clear, as you always are, as to where you stand, and the why of it.

I do have a couple of questions, one with regard to the President's task force on veterans health care, which probably will become a lightening rod for additional action by the Congress.

I know that you have met—the VSOs have testified, I know there was a hosting of a little cocktail or a get-together recently. But my real question is have they really asked you the way we do on this committee, in a bipartisan way, when we say, "Give us the lowdown, what are your recommendations," and then we very seriously consider everything you proffer, have they done that with you, as well?

Because my sense is that this, for the President, at least, will become his ice cutter, you know, in terms of veterans issues on health care. And you know, garbage in garbage out, if they don't get enough good information—good things in, good things come out as well—from the VSOs, we are going to be in a reactive, rather than in a proactive mode.

Are they consulting with you, sitting down, spending hours picking your brains?

Mr. ROBERTSON. Mr. Chairman, to be quite honest, we had an opportunity to testify very early in the process, and the American Legion and some of the other organizations did address the issue of Medicare reimbursement.

As you are well aware, one of the co-chairman, Ms. Lewinsky, who is Mr. Scully's predecessor, saw her views, I think, on reimbursement were pretty well made up in her mind at the beginning of the process.

However, we have talked a great deal about this, and I believe—I know—that the committee has—the task force has reviewed the idea. Whether it is going to be in the final recommendations, we don't know just yet. But I think, through the dialogue that I have heard participating or attending some of the task force hearings, it has been an active conversation, and I think that there have probably been some people that have been converted along the way.

The CHAIRMAN. Is that the——

Ms. ILEM. Yes. We had the opportunity to testify, and also open discussion with different members of the task force on this issue. And as Steve pointed out, we have sent papers to them, not only in testimony, follow-up questions and point papers, and such. So they are well aware of our position, and I think it has been brought up several times, intermittently, and is still a topic for discussion for them.

But we are unsure what their final—what they are going to come up with in their final——

The CHAIRMAN. Can I ask in the give and take, have you gotten a sense on subvention that they understand in whole or in part, because this is a part, this is obviously, as Mr. Weidman pointed out, a first step.

And also, have they conveyed back to you an interest in having a fire wall, and perhaps you could speak to this as well with regards to this legislation, to prevent an offset in the appropriations? Because it seems to me that if we give the appropriators a way out, they will take it, in providing sufficient funds.

Mr. WEIDMAN. They have moved on a number of issues. And the testimony, all five veterans' service organizations and all five military service organizations who testified before the task force agreed and made the point very strongly that you cannot consolidate the military health care system with the veterans health care system, because the military health care system is only geared towards force readiness. It's not even geared towards force health protection, it's geared towards force readiness. Whereas the VA is geared towards rehabilitation and restoration from those wounds of war, whatever they may be.

So, they backed off of that. The initial conception that some of the commissioners seemed to have, and some of the staff, was that they were going to be able to combine those two systems and save money. It is our impression at VVA that they have now backed off that, they understand the need to be separate systems.

Some things like procurement on large, common items, beginning with soap you mop the floor with, needs to be combined, in order to achieve savings in that area in order to apply it to an inad-

equately clinically-staffed system, both the medical and on the VA side.

There are some other things that we are not sure exactly where the commissioners are, but the staff has agreed with many of us who have made the point that this has to be a veterans health care system, and that has to begin with the mandatory taking of military history for every single veterans when they first come to the VA hospital, and based on when and where and what branch of service and the military occupational speciality of that veteran, test for certain conditions and heal the whole veteran.

And that would produce a profound change in how effectively we are able to accomplish health care, and stop churning people back and forth through the system, but get a good diagnosis on what is wrong with them, because they are veterans in the very beginning.

And on the Medicare subvention, we have discussed that and with staff, but I don't believe it was discussed with the commissioners.

Mr. ROBERTSON. Mr. Chairman, I think at the last meeting, Ms. Lewinsky announced that Mr. Scully was actually going to be testifying before a future hearing of the task force. So that will probably be an opportunity where all these points will be aired in great detail.

Ms. ILEM. But I think that some concern was that following the testimony when Medicare subvention was brought up about all throughout the VSO and military service organizations, the follow-up question said would we be as excited about it, or—if there was an offset.

And so I think that caused some concern about their direction, or their thinking about it. So I don't know. We all responded, but——

Mr. HAYDEN. I know for the VFW, that we definitely made the recommendation that full appropriations be left alone, and that Medicare subvention would go through without offset.

Mr. ROBERTSON. Mr. Chairman, a point of history, when Indian Health Service had the authorization to do third-party reimbursements, it was done in 1976. And their funding was basically flatlined. So when they saw the light and realized, "The only we are going to get money is if we start doing this third-party reimbursement," at that point is when they started seeking reimbursements. Their baseline never—it was never counted as an offset.

So, that is kind of where we hope that this would go, is in the same example of what happened with Indian Health Services.

The CHAIRMAN. You know, just for the record—Mr. Blake, did you want to——

Mr. BLAKE. I was just going to agree with Mr. Hayden that our biggest concern that we continue to maintain—and this is an issue that we have addressed in the information to the commission—is that the risk of offset—and I think, after hearing the testimony, the VA, I mean, they in no uncertain terms said that that's what OMB does, they offset outside funding sources against what the appropriated dollars are going to be. And I think that speaks volumes.

Mr. ROBERTSON. But I think the emphasis on treating non-service-connected conditions is what has to be at the forefront of this

whole debate. And the fact it is prepaid, that's another issue that can't be ignored.

Mr. WEIDMAN. The commission staff, when we have talked to them—and we have had several sessions both with other VSOs and a couple of sessions just with VVA that we had requested—there seems to be a common understanding, at least among the staff, that the VA health care system is, in fact, grossly underfunded, and asked to bear a burden of an expanded number of patients which is primarily in that group of non-service-connected that they never had to serve before.

In fact, the OMB's numbers—I would urge you, Mr. Chairman, to hold OMB to the higher figures projected in the worksheet that was submitted as part of VA's testimony today—they had told VA officials that they would estimate at the beginning, in preparation for the 2002 request, that they would be serving 3.9 million veterans this year, in 2002.

In fact, by their own admission, they are serving 4.775, but say it's adequately funded. Well, for that almost 900,000 veterans, if—that comes out to a 23 percent increase. If we had that additional 23 percent increase in the budget for VHA, then we wouldn't be scrambling in every direction.

But it still would make good accounting sense in order to have money for non-service-connected follow them into the VA system, if that's where they choose to go, because it conceptually is correct, as well as fiscally correct.

Mr. ROBERTSON. I would argue that they have a contractual obligation that, no matter where that veteran goes, that money is already obligated to pay for their health care, whether in the private sector, or whether they go to the moon.

And in this case, if they come into the VA the argument that they say that this is already paid for, the argument of double dipping applies if they go outside the VA. Then they are getting more money than what they were entitled to, because if they were, in fact, being funded within the VA appropriations.

The CHAIRMAN. Thank you for your comments. And you know, we want to work with you on this legislation. Mr. Blake and Ms. Ilem, consistent with your past opposition to funding especially service-connected-disabled veterans with third-party reimbursement, you are against that in this, as well.

But my sense is that this is different. We are talking about the veterans' money, not the government's money, his or her premium that they pay. I mean, it is a distinction and a difference here.

Is it something that you might take a second look at, because again, provided we can erect a sufficient fire wall to preclude an offset. And I think that's a very, very fundamental question, and we have got to either work it into the language itself, or the legislative history, or both to ensure that this is, again, not an out for OMB and for the appropriators.

Is it something that you might want to take a look at again, or would you take a look at it again? Because a service-connected-disabled veteran is also paying that Medicare Part B premium. You know, I think they might want to see their monies going to the care that they——

Ms. ILEM. Well, we could definitely think about that, and certainly submit something to you in writing about that consideration, since you are taking that view that that is not a federally-appropriated funding for that, and that's the reason behind not distinguishing——

Mr. BLAKE. I would concur. I would like to add, though, that we would still also maintain that if we are going to look at a program like this, we also have to consider the fee-for-service option for the severely disabled veterans. We have members of our organization whose severe disabilities are non-service-connected. And so they still have to have that option to gain the services they need to meet the needs of that condition.

Mr. ROBERTSON. Mr. Chairman, would it be in order for us—for the organizations who would like to, to write a rebuttal back to the CMS testimony, since we all got it today?

The CHAIRMAN. We got it right before the testimony, as well.

Mr. ROBERTSON. If we could add additional comments concerning these issues raised in their testimony, the American Legion would appreciate adding that to the record.

The CHAIRMAN. Sure. We will keep the record open for, say, an additional week to receive that testimony. And we will also make it available to CMS, so that they have the benefit. They don't necessarily read our hearing records, so——

Mr. ROBERTSON. We could give you some questions to ask them.

The CHAIRMAN. Well, that would be helpful as well, because my sense is that—and we found this afresh when we dealt with the issue of terrorism—that many had no clue within the government as to the VA's mandate, its responsibilities and capabilities, and that was HHS primarily.

It was an eye-opener to me. So I would welcome those questions. We can be the transmitter of those questions for a response on the record from CMS.

One last thing before yielding to Mr. Filner—we did invite the President's task force to testify today. They declined. My sense is that they may feel they are not ready yet because they are close to producing their product, but I would have hoped, especially since once it is in concrete, so to speak, and the ink is dry, everyone then rallies around it, or at least most people, and says, "This is the proposal." that is why I was asking you about your input and whether or not it is real, and whether or not it is being listened to with attentive ears.

We wanted them here, right where you are, as panel members, too. Mr. Filner?

Mr. FILNER. I just wanted to join with the chairman and thank you for your testimony. It really helps us understand what is going on, and gives us ideas.

Mr. Weidman, you mentioned the Kansas City situation. We had a hearing there. Mr. Boozman and I were there with Mr. Moran, and some—I think there was some sense—it was not a consensus, but that there was something going on more than just needing more money to rectify those situations. That is, severe management problems and structural situations.

For example, everybody knew about the rats, but the medical director kept receiving high evaluations, as an example. I mean, the whole evaluation system came under some question.

And the VISN director, she—and not being evaluated either, because of what was going on. I mean, there were severe, it seemed to me, systematic problems that I ask Dr. Roswell, he might look at those for the rest of the system also. That is, and the employees that we talked to did not believe any more money would help them, because the director would have wasted it all anyway.

Mr. WEIDMAN. May I comment back on that, Mr. Filner, why we feel that way?

Mr. FILNER. Sure.

Mr. WEIDMAN. The——

Mr. FILNER. Not that I—I mean, you know, they got more money and they rectified stuff that we saw. Money is always helpful. But if there is a real inefficient management system, it's not going to be put to the best use, that's all.

Mr. WEIDMAN. What has happened is because of starving the system, we put very good people at the VA into doing a "let's not and say we did" pretend situation. The situation in the State of Missouri in particular, but in VISN 15, VVA for three years was working with our state president there, trying to bring that to the attention of the VHA hierarchy, up to and including then-under secretary.

Also, we had been to Senator Bond repeatedly. We had tried to deal with the VISN director. It was slash and burn, slash and burn, right across the board. The reason why the hospital director wanted to move it to clinical services is because they were so grossly understaffed because what was happening is that the rewards system was based on—the ratings of the VISN directors and the VISN hospital directors was based on how much money they could save. That was the number one.

So, the VISN director got the maximum bonus of over $12,000 each year, and so did the hospital director. And the hospital director has been allowed to retire with no repercussions. And the VISN director is now reassigned, but is still drawing full salary. And the criteria for VISN directors has not been changed, to our knowledge. And the criteria for hospital directors has not been changed.

So, there were two things operating here. One is a lack of proper accountability through the management structure, which we testified before this committee repeatedly, having to do with excessive bonuses and poor accountability within the system.

And the second thing, sir, was it was accentuated, just simply because there flat wasn't enough money in the system.

Mr. FILNER. I think we agree on that. We have just got to look at both the accountability and the money.

Mr. WEIDMAN. I agree with you, sir.

The CHAIRMAN. Mr. Boozman?

Mr. BOOZMAN. I just wanted to thank the testimony—I thought that your testimony was very thoughtful and very helpful in really discussing a very important issue, and I think your suggestion, you know, of writing a reply, you know, additional, would also be very helpful. So, thank you.

The CHAIRMAN. Mr. Boozman, thank you very much. I want to thank our very distinguished panel. We always value your opinions, and as we look to tweak and change, and you know, work on this issue of this legislation particularly, or any other, we will invite your maximum input.

And Mr. Robertson, if you could, and all of you, if you would like to, I would invite your commentary on CMS's testimony, and any questions you would like for us to ask.

Mr. WEIDMAN. Can we also comment on the OMB that Dr. Roswell was forced to deliver?

The CHAIRMAN. Absolutely.

Mr. WEIDMAN. Thank you.

The CHAIRMAN. And again, if there is some questions to be posed from the minority, absolutely, and from the majority, as well.

Thank you. The hearing is adjourned.

[Whereupon, at 12:55 p.m., the committee was adjourned.]

APPENDIX

I

107TH CONGRESS
2D SESSION

H. R. 4939

To amend title XVIII of the Social Security Act to provide for a transfer of payment to the Department of Veterans Affairs for outpatient care furnished to Medicare-eligible veterans by the Department.

IN THE HOUSE OF REPRESENTATIVES

JUNE 13, 2002

Mr. SMITH of New Jersey (for himself, Mr. EVANS, and Mr. FILNER) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and Veterans' Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to provide for a transfer of payment to the Department of Veterans Affairs for outpatient care furnished to Medicare-eligible veterans by the Department.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Medicare Payment Act of 2002".

SEC. 2. TRANSFER OF PAYMENT FOR MEDICARE-ELIGIBLE VETERANS WHO RECEIVE OUTPATIENT SERVICES FROM THE DEPARTMENT OF VETERANS AFFAIRS.

(a) MEDICARE PROGRAM.—Part B of title XVIII of the Social Security Act (42 U.S.C. 1395j) is amended by inserting after section 1841 the following new section:

"TRANSFER OF PAYMENT FOR MEDICARE-ELIGIBLE VETERANS WHO RECEIVE OUTPATIENT CARE FROM THE DEPARTMENT OF VETERANS AFFAIRS

"SEC. 1841A. (a) PAYMENT TO SECRETARY OF VETERANS AFFAIRS.—

"(1) IN GENERAL.—If a medicare-eligible veteran receives outpatient care from the Department of Veterans Affairs during a year (beginning with 2003) that the veteran is otherwise eligible to receive under chapter 17 of title 38, United States Code, the Secretary shall transfer to the Secretary of Veterans Affairs for that veteran for that year an aggregate amount equal to 12 times the monthly premium rate applicable to an individual enrolled under this part for that year, as determined by the Secretary under section 1839(a)(3).

"(2) PERIODIC PAYMENTS.—Payments under this subsection shall be made from the Federal Supplementary Medical Insurance Trust Fund estab-

lished in section 1841 on a periodic basis upon receipt of a certification from the Secretary of Veterans Affairs that a medicare-eligible veteran was provided such outpatient care during the year involved in a facility of the Department of Veterans Affairs.

"(3) DOCUMENTATION OF CARE PROVIDED.—The Secretary and the Secretary of Veterans Affairs shall establish a mechanism under which the Secretary may verify that a medicare-eligible veteran received outpatient care from the Department of Veterans Affairs.

"(b) EFFECT ON ENROLLMENT UNDER THIS PART.—The receipt of outpatient care from the Department of Veterans Affairs during a year by a medicare-eligible veteran shall not affect—

"(1) the enrollment of the veteran under this part; and

"(2) the ability of the veteran to receive items and services from participating physicians, health care practitioners, providers of services, and suppliers under this part and to have payment made for such services under this part during the year.

"(c) EFFECT ON CALCULATION OF PART B PREMIUMS.—In determining a monthly actuarial rate for en-

rollees under section 1839 for determining the amounts of premiums charged to such enrollees for months in a year, the Secretary shall not, for months in the year involved, take into account payments transferred to the Secretary of Veterans Affairs under subsection (a), or the costs incurred by the Secretary of Veterans Affairs in furnishing care to the medicare-eligible veteran.

"(d) PAYMENT OF PREMIUMS.—The receipt of outpatient care from the Department of Veterans Affairs during a year by a medicare-eligible veteran shall not result in a reduction in the amount of premium otherwise collected from the veteran under section 1840(a)(1).

"(e) WAIVER OF CERTAIN CONDITIONS OF PARTICIPATION.—The prohibition of payments to Federal providers of services under sections 1814(c) and 1835(d), and paragraphs (2) and (3) of section 1862(a) shall not apply to payments made under subsection (a). The Secretary shall waive such provisions of this title that the Secretary of Veterans Affairs demonstrates to the satisfaction of the Secretary should not apply to the provision of health care services furnished by the Department of Veterans Affairs.

"(f) DEFINITIONS.—In this section:

"(1) VETERAN.—The term 'veteran' has the meaning given that term in section 101(2) of title 38, United States Code.

"(2) MEDICARE-ELIGIBLE.—The term 'medicare-eligible' means, with respect to a veteran, an individual who is enrolled under this part.

"(3) OUTPATIENT CARE.—The term 'outpatient care' means those items and services for which payment may be made under this part.".

(b) CONFORMING AMENDMENT.—Section 1857(e) of such Act (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

"(3) REIMBURSEMENT FOR CERTAIN CARE PROVIDED BY THE DEPARTMENT OF VETERANS AFFAIRS.—With respect to contract years beginning after 2003, the right of the United States under section 1729 of title 38, United States Code, to recover or collect charges for health care items or services from a third party, with respect to which payment may be made under part B, shall apply to Medicare+Choice organizations offering a Medicare+Choice plan in which a veteran is enrolled.".

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Statement of Honorable Lane Evans
Ranking Democratic Member

Hearing on H.R. 4939
Veterans Medicare Payment Act of 2002
July 16, 2002

Good morning, Mr. Chairman. Thank you for holding this hearing.

This year, on a bipartisan basis, this Committee recommended to our Budget Committee an increase of $2.8 billion over the fiscal year 2002 budget for the Veterans Health Administration. Ostensibly, the Budget Committee agreed to many of our funding recommendations. Unfortunately, however, it is appropriations that count and appropriators are once again dealing with funding limitations that make it highly unlikely this increase will occur. As a matter of fact, the Appropriations Committee allocated $677 million less to its VA, HUD, Independent Agencies Subcommittee than the Bush Administration requested for those programs. This will make it difficult, if not impossible, for appropriators to make any significant addition to the VA's medical care budget again in fiscal year 2003.

Assuming that the House GOP leadership will once again lack the willingness to allow adequate funding for the VA's struggling health care system, we must seek other means. While I believe this Committee, under your leadership, Mr. Chairman, has repeatedly demonstrated its willingness to provide adequate funding for veterans' health care, it is disappointing to be continually foiled "where the rubber hits the road". Indeed, there is much at stake if the GOP fails to produce an adequate budget for our veterans.

We, on this Committee, have strongly opposed a very controversial Bush Administration proposal to charge many middle class and near-poor veterans $1500 to access their health care system. The Administration's budget estimates $1.1 billion will come from implementation of this proposal. Yet if it is not implemented and the appropriators don't find funds to compensate for it, VA's request is significantly deficient, even by its own inadequate reckoning. In addition to having to compensate for that funding, many of us are hearing continuing problems with waiting times for health care and confronting growing numbers of veterans who cannot access *any* VA care.

It is in response to this increasingly worrisome situation, that I believe we must seek Medicare funds to shore up the veterans' health care system. Medicare Subvention for VA has a long history in Congress. At one time, this Committee considered Medicare Subvention authority to allow VA to use its excess capacity to treat more veterans who wanted access to VA health care. VA began enrolling and treating *all* veterans some time ago. The White House has since affirmed this policy, yet it has not been willing to request all of the funding necessary to treat the thousands of veterans who are now waiting to be enrolled in the system. In a survey conducted at my request on July 1, 2002, there were 132,278 veterans who have been waiting more than six months for their first VA health care appointment; another 177,976 veterans have been waiting at least 6 months for follow-up care. The Bush Administration wants it both ways—it demands VA continue to treat every veteran who wants care, but refuses to request adequate funding to allow it to do so. Many of these veterans have multiple eligibilities for federal and private sector benefits including Medicare.

According to VA, 2.2 million or about 52% of the veterans it treats are eligible to participate in Medicare. As the population ages, this number will grow. I believe the trust fund should be at least partially responsible for veterans who are eligible for and participate in the Medicare Part B program and choose to use the VA for at least part of their outpatient health care. If this legislation had been implemented at the beginning of 2002, VA would have collected $648 for each of the Medicare participants it treats or approximately $1.4 billion. I strongly believe that, should this body approve this legislation, Congress should take steps to assure these funds are made available to the Department of Veterans Affairs without offsetting appropriations that would normally be available through appropriations. As the VSOs will be unanimous in saying today, these funds should supplement not substitute for appropriated dollars.

In most cases, $648 will not cover the cost of treating these individuals. In 2001, VA allocated (using VERA) $3,126 for each veteran receiving basic care and $42,765 for each veteran receiving complex care. That means that for most of the patients VA treats, this proposal will cover about one-fifth of the allocated cost of care. This is roughly the percentage many individuals pay out-of-pocket for their private insurance coverage. Allowing VA to collect these funds, fairly acknowledges the veterans' preference in obtaining his care from VA as opposed to another non-governmental medical care facility or provider. This proposal also seems a fitting acknowledgement of the responsibility VA shares with Medicare to ensure these dual-eligibles are able to obtain the benefits they have earned from both systems.

I also advocate this approach to capturing VA's share of Medicare revenues as opposed to other approaches. One approach modeled after the military health system's experience with Medicare Subvention has had, at best, mixed results. This approach required the Department of Defense to determine a "level of effort" before funds flow from the trust fund. The Medicare participants enjoyed the new or regained access to military treatment facilities.

But, if the goal was to create new funding streams for military health care, in the final analysis, its demonstration must be deemed a failure. Participating military hospitals lost money treating Medicare beneficiaries who had not previously had access to the military's treatment facilities. Documenting all of the health care costs the military facilities had previously spent for Medicare beneficiaries, in comparison to what they spent for the new enrollees' services proved to be administratively burdensome. In addition, the reimbursement Medicare offered on a per-capita basis was insufficient to cover the costs of the military retirees and their dependents' care. Mostly the deficit was due to the fact that these new patients required a mix of services for which the facilities had to contract. I believe the proposal we have before us offers a far less burdensome means of sharing a small portion of the costs VA bears on behalf of dual-eligibles.

Mr. Chairman, I wish we could count on appropriations to address the increasing needs of the VA health care system, but time and time again, the appropriations process has failed to provide the requisite resources. In order to assure that our veterans can access the health care they have earned through service to their nation, however, it is abundantly clear we must look to other alternatives. I hope to work closely with you, the other members of this Committee, VA, the Center for Medicare and Medicaid Services and the veterans organizations in perfecting this legislation. I commend your good efforts to assist our nation's veterans.

STATEMENT OF
ROBERT H. ROSWELL, M.D.
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

July 16, 2002

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here this morning to present the Administration's views on H.R. 4939, the "Veterans Medicare Payment Act of 2002." This bill would direct that beginning in 2003, the Secretary of Health and Human Services must transfer to VA, a sum of money equal to twelve times the monthly Medicare Part B premium for that year for each veteran who has enrolled in Medicare Part B, but who receives any outpatient care from VA. For the current year, the monthly premium is approximately $54 and would result in annual payments of approximately $650 for each covered veteran. The bill requires that the funds be paid on a periodic basis from the Federal Supplementary Medical Insurance Trust Fund.

In addition, H.R. 4939 provides that even if a payment is made to VA on behalf of a veteran, that veteran does not lose eligibility to receive care under Part B from any non-VA private-sector provider. If the veteran does receive such non-VA care, the Secretary of HHS must reimburse that provider. Finally, the bill provides that beginning in 2004, VA may collect charges from Medicare + Choice plans for the care it provides to veterans enrolled in those plans. VA could make such collections only for care of nonservice-connected conditions and only if the care is otherwise covered under Medicare Part B.

Mr. Chairman, I strongly support the concept of federal healthcare coordinating benefits in ways that enhance beneficiaries' care and improve the utilization of federal healthcare dollars. However, I do not believe that this bill would provide a mechanism to achieve that goal. As you know, the President has created a task force that is

currently examining issues associated with the coordination of care between VA and the Department of Defense. I am hopeful that the Presidential Task Force will be able to assist us in finding solutions to these vexing coordination issues, and assist in increasing access to care for veterans, while using federal funds in the most efficient manner.

Having said this, the Administration is concerned that this transfer of funds would significantly increase mandatory spending with no identified offset. Accordingly, the Administration opposes enactment of the bill. The Administration estimates that the bill could cost nearly $32 billion over 10 years. Attached is a table showing how OMB reached that estimate.

Additionally, we are also concerned that the bill would require transfers of funds to VA on behalf of veterans who receive care for a service-connected disability. This would constitute a significant change from the historic practice of having VA shoulder the responsibility for providing and funding such care.

Finally, it should be noted that, even if enacted, this bill may not actually increase VA resources or the veterans' access to care over the long term. As you know, when the Department accesses new funding streams, those increased funds are typically offset against the appropriations we would otherwise receive. We have no reason to believe that would not be the case with this bill. In that event, VA would not gain permanent increased funding from the measure. In addition, if more veterans were encouraged to use VA as a result of this bill, the cost to VA would likely be significantly more than the transfer from the Medicare Trust Funds.

Mr. Chairman, I appreciate your concern for the dilemma we face in meeting the increasing growth in demand for VA healthcare services. I will be pleased to continue to work with you to find workable solutions to these problems. I am pleased to answer any questions you may have.

Medicare Subvention -- HR 4939

FY 2002 VA Data	FY 2002	FY 2003	FY 2004	FY 2005	
Projected Users SOY	4,637,122				
Expected Increase	3%				
Projected Users Current	4,775,400	5,252,940	5,646,910	6,070,428	
Percent over 65	50%	50%	50%		50%
Projected Users over 65	2,387,700	2,626,470	2,823,455	3,035,214	
Percent of Users with Part B	2,244,438	2,468,882	2,654,048	2,853,101	
Annual Part B Premium	$ 648.00	$ 682.80	$ 716.40	$ 758.40	
Total Transfer to VA (PAYGO)	$1,454,395,694	$1,685,752,342	$1,901,359,771	$2,163,792,007	

FY 2006	FY 2007	FY 2008	FY 2009
6,525,710	7,015,139	7,541,274	8,106,870
50%	50%	50%	50%
3,262,855	3,507,569	3,770,637	4,053,435
3,067,084	3,297,115	3,544,399	3,810,229
$ 801.60	$ 847.20	$ 897.60	$ 949.20
$2,458,574,431	$2,793,315,965	$3,181,452,361	$3,616,669,090

FY 2010	FY 2011	FY 2012
8,714,885	9,368,501	10,071,139
50%	50%	50%
4,357,442	4,684,251	5,035,569
4,095,996	4,403,196	4,733,435
$ 1,005.60	$ 1,071.60	$ 1,126.80
$4,118,933,438	$4,718,464,352	$5,333,634,803

Total PAYGO Cost 10 years (FY 03 - FY 12):

TESTIMONY of
TOM GRISSOM
DIRECTOR, CENTER FOR MEDICARE MANAGEMENT
CENTERS FOR MEDICARE & MEDICAID SERVICES
on
VETERANS' MEDICARE PAYMENT ACT OF 2002 (H.R. 4939)
before the
HOUSE VETERANS' AFFAIRS COMMITTEE

July 16, 2002

Good morning, Chairman Smith, Congressman Evans, and members of the Committee. Thank you for inviting us to discuss the Veterans Medicare Payment Act of 2002, and the importance of ensuring that America's veterans have access to the health care they need. One of the best ways we can do this is by strengthening and improving the Medicare program for all Americans. This includes adding a comprehensive prescription drug benefit, expanding Medicare coverage of preventive services, and protecting the long-term financial security of the program.

In recent months, we have been reminded once again of the contributions that members of America's armed forces, including veterans, have made and continue to make to our country. This Administration strongly supports providing all Medicare beneficiaries, including our nation's veterans, with a wide range of choices. To that end, last year, the President proposed a framework for strengthening and improving the Medicare program. We are pleased that the House of Representatives recently passed H.R. 4954, the Medicare Modernization and Prescription Drug Act, which takes a bold first step toward providing a long-overdue prescription drug benefit in Medicare and toward implementing many of the President's principles. We look forward to working with the Congress to ensure these measures become law this year.

BACKGROUND

When Medicare was created in 1965, President Johnson said, "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime."

Thirty-six years later, President Bush believes it is time for our nation to come together and renew that commitment to all seniors, including those who have made sacrifices for all Americans by serving in our armed forces. I share the President's view that we have a moral obligation to fulfill Medicare's promise of health care security for America's seniors and people with disabilities.

The 77 million Americans who will be entitled to Medicare in 2030 are counting on Medicare's promised benefits. Yet even Medicare's current benefits are not secure for the retirement of the Baby Boom generation. Medicare's fund for hospital insurance will face cash flow deficits beginning in about 15 years and is projected to become insolvent within 30 years. Medicare's fund for its other benefits will require nearly a doubling of beneficiary premiums and infusions of general revenues to remain solvent over the next 10 years. Consequently, we need to be careful stewards of the Medicare Trust Fund and ensure that any changes we make will not put at risk the health care security that older Americans now and in the future deserve.

The concept of "subvention," whereby Medicare would pay for care provided to Medicare beneficiaries at military, veterans', or other federal facilities, is a concept that has been around for a long time. There are many complex issues surrounding subvention including what benefits it really achieves, and whether care can be efficiently coordinated. Foremost, as a matter of principle and by law, the Medicare Trust Funds cannot, and should not, be used to pay for services for which monies have already been appropriated. This has always been a most difficult issue, and is even more so today given the current financing issues associated with the Medicare Trust Funds. We are concerned that subvention has the potential to undermine the long-term financial security of the Trust Funds. For example, the Administration's preliminary estimates are that H.R. 4939 could cost the Medicare program nearly $32 billion over the next 10 years. As you know, the President is dedicated to strengthening and improving health care for all Medicare beneficiaries, including America's veterans. However, our first priority must be to fortify the current Medicare program.

STRENGTHENING MEDICARE

Medicare has provided health care security to millions of Americans since 1965. But its lack of prescription drug coverage demonstrates that Medicare is not keeping up with the rapid advances in medical care. Last week, the Department of Health and Human Services (HHS) released a report presenting evidence on significant improvements in the health of older Americans that have occurred because of recent breakthroughs in drug treatments -- enabling millions of seniors to live longer, more enjoyable and productive lives. The HHS report includes a detailed review of the drug breakthroughs for the following diseases: cancer, osteoporosis and hip fractures, asthma, arthritis, high cholesterol, heart disease, stroke, enlarged prostate, depression, Alzheimer's disease, diabetes, and migraines. With the wonderful medicines currently available, as well as all of the new breakthrough drugs in the pipeline, now is the time to create a Medicare drug benefit that will expand coverage and availability for all beneficiaries.

Recognizing the important benefits that advances in prescription drugs offer, President Bush worked with members of Congress across party lines to develop a framework for a modernized Medicare program and for keeping Medicare's benefits secure. The President's framework includes the following eight principles:

First, all seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare. The design of the drug benefit in H.R. 4954 will continue to encourage the valuable innovation in prescription drugs that holds so much promise for improving the health of seniors in the 21st century. This design is far preferable to some alternative proposals to create a very costly, government-run drug plan that would determine which drugs were "on formulary," impede innovation, increase drug prices, and impose trillions of dollars in new obligations on a Medicare program that already faces a funding shortfall for the Baby Boom generation, threatening all of Medicare's benefits.

The Administration also strongly supports provisions in H.R. 4954 that will help Medicare provide affordable coverage options that keep pace with modern medicine. The bill begins to address the chronic underfunding of private plans in Medicare and

takes important steps toward creating an effective system of private plan competition in Medicare. I might add that in allowing the VA to seek reimbursement from these plans, H.R. 4939 undermines these efforts. The bill creates more affordable Medigap options, provides regulatory relief and simplification, encourages innovative coverage options that will help beneficiaries with chronic diseases and special needs, improves the quality and reduces the costs of durable medical equipment and Medicare claims processing through competitive bidding, improves preventive coverage, and improves access to valuable new treatments. All of these steps will help beneficiaries get more value in terms of health improvements from the new drug benefit and all other Medicare benefits, and will enable them to do so at a lower cost.

The Administration is particularly pleased with the provisions included in H.R. 4954 that will provide immediate relief for seniors who have already waited far too long for prescription drug assistance. This includes the bill's authorization of a Medicare-endorsed prescription drug card and temporary assistance for low-income seniors until a full drug benefit is available. These provisions will allow seniors to start receiving help with drug costs beginning next year, not two years from now or longer, and they will help the Medicare program work with seniors and drug benefit providers to implement the Medicare drug benefit effectively.

Second, modernized Medicare should provide better coverage for preventive care and serious illnesses. Medicare's current cost-sharing often imposes the highest costs on those who need the most care. Individuals who need hospital care currently face a payment of more than $800 for each spell -- and they can have several spells in a year -- and Medicare's coverage for hospitalizations can eventually run out. And unlike most private insurance, Medicare does not provide "stop-loss" protection to limit the financial obligations imposed on beneficiaries. At the same time, whether in Medicare itself -- or in the Medigap plans that seniors buy to fill in Medicare's coverage gaps -- first-dollar coverage often drives up costs and premiums for beneficiaries without yielding noticeable improvements in health. Thus we believe Medicare's coverage should be improved so that it provides better protection when serious illnesses occur and better coverage to help prevent these illnesses in the first place -- like having zero co-payments

on Medicare's preventive benefits while still encouraging prudent use of services and beneficiary involvement in health care decisions. Because they will encourage better use of preventive care and other services, better Medicare benefits will also help seniors and the Medicare program get the best value from the new drug benefit.

Third, today's beneficiaries and those approaching retirement should have the option of keeping the traditional Medicare plan with no changes. For us, this is obvious -- no one should be forced to accept significant changes they do not like and are not prepared for. Although we believe that a modernized Medicare program will be attractive to many current beneficiaries, we believe the choice rightly rests with them on whether to move from the existing program to the modernized one.

Fourth, Medicare should provide better health insurance options, like those available to all Federal employees and retirees. For too long, Medicare has been a "one size fits all" program, and we should offer options appropriate to the unique challenges various seniors face -- including the kind of innovative disease management programs that are threatened by chronic underpayments to private plans today. Private plans have been a critical source of drug coverage and other innovative benefits for seniors, and should remain so.

Fifth, Medicare legislation should strengthen the program's long-term financial security. Without strong measures to make the program more efficient being incorporated along with new benefits, all of Medicare's benefits will become less secure. Some might want to exploit the accounting gimmicks that Medicare's bifurcated Trust Fund system encourages and leave it to future generations to figure out how to pay for it. We cannot hide the fact that Medicare's financial security would be compromised should it have to pay Veterans' facilities for care that is already financed through an appropriation.

We want to work to make sure that the benefits we promise today will be there for beneficiaries tomorrow. This is why we must be prudent stewards of the Medicare Trust Fund, and why we must be vigilant in ensuring we do not take steps that could put the

long-term financial security of the Medicare program at risk. This is also why we support changes in Medicare's Trust Fund accounting to provide a clear picture of Medicare's financial outlook. We have all seen examples of how poor accounting practices can lead to poor planning, with devastating consequences for many Americans. It is critically important that we avoid such practices in a program that is so important to all Americans.

Sixth, the management of the government Medicare plan should be strengthened so that it can provide better care for seniors. We're working to do that now at CMS where we are able, but we also need legislation to proceed with such steps as competitive bidding so that Medicare and its beneficiaries can get better, market-based prices for the items it buys while ensuring high quality. We are pleased that H.R. 4954 takes steps to improve the quality and reduce the costs of durable medical equipment and Medicare claims processing through competitive bidding. However, we also want to ensure that competitive bidding can be implemented in a timely fashion.

Seventh, Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced. Here, too, we have moved aggressively but we need help from Congress and want to work with Congress to enact into law. Regulatory reforms and simplifications are needed to reduce burdens on providers and on CMS at a time when we are implementing new benefits into the Medicare program.

Eighth, Medicare should encourage high-quality health care for all seniors. Recent reports from the Institute of Medicine and others have made clear the widespread opportunities for improving patient care that exist -- which are likely to benefit seniors more because they use more care. These studies have also shown that these problems are not the result of malfeasance, and made it clear that we need to change the environment for medical practice to one that encourages systematic and continuous improvements in care, not endless and costly litigation.

CONCLUSION

Beneficiaries eligible for both Medicare and veterans' health care benefits should enjoy a wide range of choices, and improved service, which is the true "bottom line" in this effort. The President strongly supports these ideas, and we are committed to meeting the challenges they present and learning as much as we can about how to continually improve such programs. We look forward to working with this Committee and Congress and as we strive to improve health care services available to our nation's Medicare beneficiaries and veterans. While we recognize the importance of ensuring that veterans have access to top quality health care, the issue of subvention has always been a difficult one. It is critical as we move forward in strengthening and improving the Medicare program that we ensure that any changes to the program do not harm the financial integrity of the Medicare Trust Funds. Thank you for the opportunity to discuss this with you today. I look forward to answering any questions you may have.

STATEMENT OF

CARL BLAKE, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

H.R. 4939, THE "VETERANS MEDICARE

PAYMENT ACT OF 2002"

JULY 16, 2002

Chairman Smith, Ranking Democratic Member Evans, members of the Committee, PVA would like to thank you for the opportunity to testify today on H.R. 4939, the "Veterans Medicare Payment Act of 2002." PVA appreciates the efforts of the Committee to explore and develop methods to achieve the necessary funding levels for the Department of Veterans Affairs (VA) medical system to provide health care to our Nation's veterans.

An issue of the gravest concern to PVA is to ensure the adequate funding of the VA health care system. VA health care is a proper federal obligation, an obligation undertaken in recognition of the service and sacrifice of veterans. PVA is a co-author, along with AMVETS, the Disabled American Veterans, and the Veterans of Foreign Wars of *The Independent Budget*, currently in its 16th year. For fiscal year (FY) 2003, *The Independent Budget* has recommended a health care appropriation increase of $3.1 billion. We were therefore quite disappointed that the Administration only requested a $1.4 billion increase. We were heartened by the actions of this Committee and the leadership of Chairman Smith and Ranking Member Evans in forwarding to the Budget Committee recommendations that accurately addressed the fiscal crisis currently faced by the VA. We note that the House of Representatives, in passing its FY 2003 budget resolution assumed an appropriated increase of $2.6 billion, an action mirrored by the Senate Budget Committee. Although this recommended increase is $500 million below the amount put forward by *The Independent Budget*, we believe that this represents a solid step in the right direction.

PVA has been in the forefront of efforts to explore alternative funding streams, outside of appropriated dollars, in order to enhance VA health care. Unfortunately we have seen, in the case of the Medical Care Cost Fund (MCCF), that these alternative dollars are used in lieu of appropriated dollars. Our support of these efforts has always been tempered by the basic idea that these funds should be used as a supplement to, and not as a substitute for, appropriated dollars. We have looked askance at efforts to shift the burden of this federal government obligation onto the shoulders of others. We have found that too often inflated MCCF estimates are used to rationalize not providing the VA with the funding needed to care for sick and disabled veterans. This is one reason why *The Independent Budget* does not use VA collection estimates in making its recommendation for health care funding for a given fiscal year. These estimates tend to be grossly overstated and inaccurate. Moreover, VA has historically been unable to meet its collection goals.

In the past we have supported, in a limited manner, exploring Medicare subvention. Our support of this has been predicated on the establishment of a pilot program in order to test

its feasibility, along with ensuring that this pilot only include Category 7 veterans, as well as making available a fee-for-service option. We have always expressed concern that these measures, brought up in previous Congresses, not subsidize services or care for service-connected veterans. The cost of care for service-connected conditions is a federal obligation not to be underwritten by third parties or federal or private insurers. We understand that H.R. 4939 is a different approach to addressing the overlap of VA health care and the Medicare program, but our concerns still remain. We believe that this Committee must be fully cognizant of any adverse precedents and policy repercussions that might occur if this measure moves forward.

PVA feels that we need to vigorously investigate as many avenues as possible to achieve full health care funding for our veterans. We applaud this Committee in introducing H.R. 4939. This may indeed be one effective method of achieving the end result of full funding. But we must reiterate that the VA must not be forced to rely on subsidies from veterans or their insurers to cover the costs of caring for veterans.

PVA is committed to the continuing existence of a viable, efficient, and independent VA health care system that protects the specialized services such as care for veterans with spinal cord dysfunction that lie at the heart of the VA's mission. We must ensure, as we consider H.R. 4939 and other such measures, that this vision is not compromised.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2002

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program—$179,000 (estimated).

Fiscal Year 2001

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program—$242,000.

Fiscal Year 2000

General Services Administration—Preparation and presentation of seminars regarding implementation of the Americans With Disabilities Act, 42 U.S.C. §12101, and requirements of the Uniform Federal Accessibility Standards—$30,000.

Federal Aviation Administration—Accessibility consultation--$12,500.

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program—$200,000.

STATEMENT OF

DENNIS M. CULLINAN, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

H.R.4939 -- ***Veterans Medicare Payment Act of 2002***

WASHINGTON, D.C. JULY 16, 2002

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.7 million men and women of the Veterans of Foreign Wars of the U.S. and our Ladies Auxiliary, I would express our deep appreciation for being included in today's important legislative forum to discuss a bill to provide much needed additional funding for the Department of Veterans Affairs' Medical Care System.

Introduced by Chairman Christopher Smith of this committee and enjoying seventeen cosponsors at this writing, this legislation, the *Veterans Medicare Payment Act of 2002*, amends Part B of Title 18 of the Social Security Act to provide for a transfer of payment to the Department of Veterans Affairs for ***outpatient*** care furnished to Medicare-eligible veterans by the Department. In consonance with current VFW National Resolution 622 calling for the enactment of legislation authorizing VA to collect and retain Medicare dollars, the VFW is pleased and proud to lend its support to H.R. 4939.

While this bill does not, as called for in VFW Resolution 622, provide for the Department to be reimbursed by Medicare for ***all*** health care services provided to Medicare eligible veterans, it does provide for payments to VA for the largest segment of eligible VA health care users: those requiring outpatient care and services. The VFW emphasizes that this bill, in affording much needed additional non-appropriated dollars to the Veterans Health Administration, increases access to veterans throughout the nation, particularly in certain underserved and rural areas. The provision of timely, accessible and top-quality health care by VA to all veterans requiring such is a key priority of the Veterans of Foreign Wars.

In this vein, we believe VA must be provided with a viable and significant alternative-funding source to augment appropriated dollars. Full Medicare Reimbursement to VA for care provided eligible veterans is just such a funding stream. Also known as Medicare Subvention, implementing this concept would allow VA to collect and retain Medicare dollars thereby bolstering the system while at the same time providing Medicare-eligible veterans with the option of having VA provide for their non-service connected health care needs. The enactment of H.R. 4939 would represent a major step toward realizing this vital objective.

It is our view that many veterans, particularly among our military retirees, would prefer to use their earned Medicare entitlement at VA as opposed to private sector providers. Unfortunately, current law prohibits Medicare from reimbursing VA for medical services it provides to eligible veterans even though the Medicare Trust Fund would potentially save money in the process because VA is known to provide more cost-effective care than the private sector. This situation deprives veterans of health care they need and desire while denying the VA health care system desperately needed additional funding.

Standing in strong support of H.R. 4939, I would now articulate the VFW's vision in support of full VA Medicare Subvention or Reimbursement. To achieve the desired result of shoring up the VA Medical Care System and providing enhanced care and services to veterans:

- Subvention must be implemented uniformly nation-wide so that the outcome is not distorted by regional variations in sick vs. healthy populations. This is also an issue of equity in that it would avoid discriminating between otherwise eligible veterans based solely on geographical location.
- There must be **no** annual cap on Medicare payments to VA. As was demonstrated with the DOD pilot, such an arbitrary upper limit would only place VA in a position to lose dollars relative to CMS with no reasonable expectation of recouping even a modest portion of the cost of providing care to an expanded Medicare eligible veteran patient workload.
- The Level of Effort (LOE) requirement must be eliminated. While the Trust Fund may be technically comprised of "federal" dollars, it is separate and discreet from the General Treasury from which VA appropriations properly flow as directed by the Congress and Administration. With respect to the provision of health care, VA should be treated no differently than any other provider. In the extremely unlikely event that VA becomes "over funded" under subvention, Congress is appropriate entity to take corrective action.
- The CMS capitation or payment formula must be adjusted to accommodate medical services ***actually*** provided by VA as opposed to only those currently covered under Medicare. As has been documented by the DOD pilot as well as the current situation in the private health care market, this is particularly urgent with respect to the provision of Managed Care which is the primary VA modality. Ancillary to this, payments to VA must be at a 100% rate and not at a reduced or discounted rate relative to other providers as has been proposed in earlier legislation.
- Full appropriation support must be maintained with absolutely no reduction in funding as a consequence of subvention funding. These dollars are to be applied to remedying over a decade of under funding of VA Medical Care and to cover the cost of providing for an expanded Medicare eligible patent workload.

Mr. Chairman and members of the committee, once again on behalf of the men and women of the Veterans of Foreign Wars I thank you for inviting us to present our views here today. Germane VFW Resolution 622 is appended to this testimony for your review, and I will be happy to respond to any questions you may have. Thank you.

STATEMENT OF
STEVE ROBERTSON, DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ON
H.R. 4939, VETERANS MEDICARE PAYMENT ACT OF 2002

JULY 16, 2002

Mr. Chairman and Members of the Committee:

Once again, The American Legion applauds the bold leadership of this Committee. Thank you for including The American Legion in this hearing.

The American Legion continues to actively advocate authorizing the Department of Veterans Affairs (VA) to be a Medicare provider for the treatment of Medicare-eligible veterans' nonservice-connected medical conditions. The American Legion fully supported the enactment of Public Law (P.L.) 104-262 that authorized eligibility reform and opened enrollment in VA's health care system within existing appropriations. Clearly, millions of veterans -- previously locked out of the system -- have enthusiastically enrolled to meet their unique health care needs for many legitimate reasons:

- VA's quality of care,
- VA's holistic approach to health care,
- VA's full continuum of care to include specialized services,
- VA's medical and prosthetics research,
- VA's affiliation with over 100 medical schools,
- VA's renown patient safety record,
- VA's numerous health care facilities,
- Affordability of care, and
- Camaraderie.

In order for more veterans to access VA health care, additional revenue streams must be generated to supplement (not offset) annual discretionary appropriations. Annual discretionary appropriations for medical care are primarily designed to provide funding for the care of veterans assigned to Priority Groups 1-6, medical and support personnel, research, medical affiliations, its infrastructure and capital assets. The annual discretionary appropriations are distributed throughout the system via the Veterans Equitable Resource Allocation (VERA) formula which takes into account numerous factors; however, the number of enrolled Priority Group 7 veterans or Medicare-eligible veterans are not funding components.

Wisely, Congress authorized VA to bill, collect, retain, and reinvest all co-payments, deductibles, and third-party reimbursements. This provides VA with much needed additional resources; however, these funds are scored as an offset against the annual discretionary appropriations. When VA does not meet its projected collection goals, the health care system experiences a budgetary shortfall. Such shortfalls result in limited health care services and timeliness of access. Third-party reimbursements primarily come from private health insurance providers. Unfortunately, under current law, VA is prohibited by Federal statute from billing the country's largest Federally-mandated, pre-paid health insurance provider – Medicare.

A large number of veterans seeking health care services in VA are Medicare-eligible and list Medicare as their health insurance provider. Others list health maintenance organizations (HMO) that traditionally refuse to reimburse VA for treatment of their health care beneficiaries. Others list preferred providers organization (PPO); however, VA is not listed as a preferred provider – therefore, will not be reimbursed for care. Finally, many veterans list no private health care coverage at all.

The American Legion strongly advocates Congress reconsider authorizing VA to bill, collect, and retain third-party reimbursements from the Centers for Medicare and Medicaid Services

(CMS) for treatment of Medicare-allowable, nonservice-connected medical conditions of Medicare-eligible veterans. Since Medicare is a Federally-mandated, pre-paid health insurance program, The American Legion believes Medicare-eligible veterans should be allowed to choose their health care provider. If VA is a Medicare-eligible veteran's health care provider of choice, then VA should be reimbursed for providing quality health care services.

Since VA is a Federal health care system, Congress should expect fewer incidents of the fraud, waste, and abuse which frequently occurs throughout the private health care industry. Additionally, VA billing should be well within the limits of Medicare allowable rates for authorized services. Finally, unlike the private health care industry, VA – as a Medicare provider -- would be completely under the governmental oversight of Congress.

Turning to H.R. 4939, Veterans Medicare Payment Act of 2002, The American Legion is deeply concerned with this approach to the Medicare reimbursement issue. This legislation would seek to provide a transfer of the veteran's Part B premium as a payment to VA for outpatient care furnished to Medicare-eligible veterans from CMS. Although this would represent a small step in the right direction, it would continue to discriminate against Medicare-eligible veterans by prohibiting them from receiving the full benefit of their financial investment. It would also prohibit VA from having the much-needed resources to meet the growing demand for providing quality health care to America's veterans, especially those commonly referred to as the Greatest Generation.

Allowing VA to receive the Part B Premium is not how Medicare reimbursement works in the private sector or any other Federal health care system. The DoD Medicare demonstration project was a clear example of how dramatic deviation from the normal process is destined for failure. Under this "special arrangement" DoD experienced two unique Medicare rules – maintenance of effort and reduced reimbursement. No other Medicare provider, public or private, faced these unique Medicare reimbursement provisions.

Maintenance of effort or level of effort required DoD to treat a pre-determined number of Medicare-eligible patients before it could bill Medicare for treating a Medicare-eligible DoD beneficiary. The fact that DoD beneficiaries were also Medicare-eligible had absolutely no relevance to their access to care. The logic of this requirement is beyond plausible rationale since eligibility for treatment within DoD is based on honorable military service and has absolutely nothing to do with Medicare-eligibility.

The reduced reimbursement was clearly another aberration unique to DoD. No other public or private Medicare provider faced reduced reimbursements. Clearly, this was a premeditated initiative to financially discourage the project; however, Congress enacted TRICARE for Life. TRICARE for Life is an extremely effective version of Medicare reimbursement for Medicare-eligible retired military personnel and their dependents.

Medicare provides health care financial assistance for nearly 40 million Americans. Generally, an individual is eligible for Medicare if they or their spouse worked for at least 10 years in Medicare-covered employment, is 65 years of age or older, and a citizen or permanent resident of the United States. Others may qualify for coverage if they are under age 65 with severe disabilities or with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant). However, nearly every working person in the United States is mandated to make monthly contributions to Medicare throughout their career. Veterans are no exception. As members of the U.S. workforce, they have paid into the Medicare system, yet they are denied this entitlement if they chose to seek treatment at VA because VA is prohibited from billing and collecting Medicare reimbursements for the treatment of nonservice-connected medical conditions of enrolled Medicare eligible veterans.

Mr. Chairman, your legislation would amend part B (Supplementary Medical Insurance) of title XVIII (Medicare) of the Social Security Act to provide for a transfer of payment to the VA for outpatient care furnished to Medicare-eligible veterans by the Department. Granted, this bill would ensure that the Part B Medicare premium, paid by veterans to the Federal government, would be reinvested in VA. However, The American Legion would rather see legislation similar to that which authorized Indian Health Services (IHS) to become a Medicare and Medicaid provider. IHS was not faced with either maintenance of effort or reduced reimbursements

provisions. Why should VA be denied full reimbursement for the treatment of nonservice-connected medical conditions of Medicare-eligible veterans?

Authorizing CMS to transfer the monthly Part B payment in lieu of the entire allowable reimbursement would be an option private health insurance providers would rather pay to VA as well. IHS does not receive a transfer of the monthly Part B payment. No private health care provider receives a transfer of the monthly Part B payment. Why should VA have to settle for this unique provision?

Clearly, IHS serves as an excellent example of how the quality, accessibility, and timeliness of health care can dramatically improve with new revenue streams that supplement rather than offset annual discretionary funding. Working closely with CMS, IHS successfully developed an effective and efficient third-party billing and collection system. Using IHS as a model, VA and CMS can emulate this achievement.

Opponents of allowing VA to receive Medicare reimbursements have argued that it would constitute "double-dipping" by veterans because Congress provides VA with annual discretionary funding for medical care. This is absolutely illogical. Access to VA health care is based purely on honorable military service – an earned benefit. Access to Medicare is Federally mandated and pre-paid by each beneficiary from automatic payroll deductions from personal wages. If VA were to bill CMS for treatment of service-connected health care, "double-dipping" allegations would be understandable; however, The American Legion believes Medicare reimbursements are justifiable for only nonservice-connected medical conditions. Furthermore, if the Federal government believes private health insurance companies should pay for the cost of treatment of nonservice-connected conditions, then the Federal government should be willing to set the example.

The American Legion is impressed by the entire IHS third-party reimbursement cycle. Comparing IHS' and VA's third-party reimbursement cycles, The American Legion noticed three major differences: leadership's focus on the coordinated effort throughout the entire cycle, more emphasis on accounts receivable than billing, and the training and use of certified coders.

- The leadership within IHS recognized that the effectiveness of third-party reimbursement collections had a direct impact on the quality of care provided by the system. With flat-lined annual discretionary funding levels, third-party reimbursements were the only means of generating additional, much needed health care dollars. IHS has successfully convinced everyone in the reimbursement cycle how critical each element is in the cycle. Every component plays an interdependent role, from administrative staff to health care providers to certified coders to collections, it is a team effort.
- Initially, IHS' primary focus was on billing rather than collections. Although the billing was working extremely well, accounts receivable were receiving less attention. Much needed revenue was slipping through their fingers because billing questions were not being effectively answered in a timely manner resulting in claims exceeding billing deadlines.
- Certified coders also proved to be a critical factor. Yet, the Office of Personnel Management (OPM) does not authorize VA or IHS to have full time employees (FTE) as certified coders. The American Legion finds this disturbing and an unsound business practice. Certified coders in the private sector are paid wages compatible to their skill level, yet OPM fails to recognize their value within the Federal government performing the same function as in the private sector.

Congress -- not CMS -- prohibited VA from receiving third-party reimbursements from Medicare; therefore, it is Congress – not CMS – that can modify this mandate and allow VA to bill CMS for allowable nonservice-connected medical conditions. If a Medicare-eligible veteran goes to a private health care provider and is treated for a service-connected or nonservice-connected medical condition and Medicare covers the entire cost of care; then that veteran should enjoy the same benefit within VA. If one Federal health care provider can receive Medicare reimbursements with superficial provisions, then all Federal health care providers should be treated equally. Since the enactment of TRICARE for Life, the Medicare reimbursement disconnect between VA and TRICARE jeopardizes close coordination of health care delivery for Medicare-eligible TRICARE beneficiaries in VA facilities.

Mr. Chairman, H.R. 4939 offers an untested approach to allowing VA to serve as a Medicare provider and seek reimbursements from CMS. There is a good chance that the actual cost of care and collecting of the Part B premium could exceed the total amount of the premium – resulting in a zero sum (or more likely an overall deficit) episode – similar to the failed DoD demonstration program. IHS conducted a five-year demonstration project that became permanent because of its overwhelming success in achieving it primary goal – improve the quality of care for its beneficiaries. The American Legion shares that goal and vision for VA.

The American Legion strongly encourages this Committee to consider legislation that emulates the IHS or TRICARE for Life approach in lieu of H.R. 4939.

Mr. Chairman, that concludes my testimony. I welcome your questions. Thank you.

STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
JULY 16, 2002

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to present the views of the Disabled American Veterans (DAV) on H.R. 4939, the Veterans Medicare Payment Act of 2002. As an organization of more than one million service-connected disabled veterans, DAV is especially concerned about maintaining a viable Department of Veterans Affairs (VA) health care system that can meet the unique health care needs of our nation's service-connected veterans. The health and well being of many severely disabled veterans is dependent upon sufficient resources for VA's specialized programs and services to allow for their timely, efficient delivery.

The Veterans Medicare Payment Act of 2002, H.R. 4939, would authorize a transfer of payment from Centers for Medicare & Medicaid Services (CMS) to the VA for Medicare-eligible veterans who receive outpatient care from VA. This measure would allow VA to collect a total amount equal to 12 times the monthly premium rate paid by an individual enrolled in the Medicare program under Part B of title XVIII of the Social Security Act (42 United States Code 1395j). H.R. 4939 would not prohibit Medicare-eligible veterans from receiving health care from other providers outside the VA system.

The Disabled American Veterans (DAV) supports Medicare reimbursement for Medicare-eligible veterans receiving care from VA for non service-connected disabilities. We firmly believe that veterans should be able to see the health care provider of their choice, and when they choose VA, Medicare should reimburse the Department for the cost of the care for their non service-connected disabilities. Unfortunately, VA is currently required to absorb the cost of care for treatment of Medicare-eligible veterans seeking care at its facilities for non-service-connected conditions. The Committee is aware of the extreme financial stress on VA at this time due to rising costs for health care and increased numbers of veterans seeking VA health care. As a result, VA is currently unable to provide timely health care to many of our nation's most severely disabled veterans. This bill seeks to ease that burden through collection of veterans Medicare premiums to help cover the cost of their care at VA. We appreciate the introduction of H.R. 4939 by the Chairman and other Members of the Committee. Introduction of this legislation is an initial step in the right direction, however; we do have some concerns about the bill.

Initially, this legislation does not distinguish between Medicare reimbursements for the treatment of service-connected versus non service-connected conditions. Likely, this would trigger an offset in appropriations since government funding is provided to VA for the treatment of service related disabilities. Secondly, this measure would not cover the cost for care as related to services rendered but simply authorize the transfer of veteran's Medicare premiums as payment. We believe VA participation in a Medicare reimbursement initiative will benefit veterans, taxpayers, and ultimately VA as long as Medicare reimbursement dollars are a supplement to an adequate VA appropriation. However, we believe the reimbursement should cover the cost of their care and be limited to paying for conditions that are not service-connected. VA is currently receiving appropriations from the government to cover the cost of health care for veterans' service-related conditions. To offset federal appropriations for VA health care by revenue from Medicare makes no sense and benefits no one, not veterans, not the VA, not the Medicare Trust Fund, and not American taxpayers.

Although we support Medicare reimbursement, DAV believes a better solution to fully address VA's funding problems would be to shift VA health care from a discretionary funding program to a mandatory program. We are extremely pleased that the Chairman has taken initial steps to explore this solution. The VA health care system is in real distress. The needs of our nation's service-connected disabled veterans are not being met. We are hopeful that a meaningful legislative remedy will be forthcoming.

To receive VA health care, most veterans must enroll, with the exception of veterans with a service-connected disability of 50 percent or more, veterans who were discharged from the military within one year but have not yet been rated for a VA disability benefit, and veterans seeking care for only a service-connected disability. Although access to health care is an earned benefit, based on honorable military service, it is not considered an entitlement; therefore, it is subject to annual discretionary appropriations. Priority level funding may change from year to year, depending on congressional appropriations. Seven priority groups were established to help ensure that VA resources are allocated to veterans with the highest priority for care. Priority Group 1, made up of veterans with service-connected disabilities rated 50 percent or greater have the highest priority to care; although, once in the VA health care system, there is no priority to receive care. Priority Group 7 veterans are nonservice-connected veterans and noncompensable service-connected veterans with incomes and net worth above the established thresholds, who agree to pay specified copayments for medical care and prescription medication. Currently, VHA is authorized to retain all copayments collected from veterans and third-party reimbursements collected from their private insurance companies. However, VHA is prohibited from billing Medicare for services rendered to Medicare-eligible veterans.

Medicare-eligible veterans have earned the right to use VA health care services. We strongly believe that Congress should pass legislation that permits Medicare-eligible veterans the option of choosing VA health care and using their Medicare coverage. Citizens purchase Medicare coverage through payroll deductions and should have the right to use those benefits to receive care from the provider of their choice. The VA health care system is well known for its specialized programs in areas such as blind rehabilitation, spinal cord injury, amputations, post-traumatic stress disorder, traumatic brain injury and mental health. Medicare reimbursement would give veterans, who are seeking treatment for a non service-connected disability and, who currently cannot use their Medicare coverage at VA facilities, but who need specialized care, the option of choosing the VA system and using their Medicare coverage, i.e., allowing VA to collect from Medicare for the cost of care provided. Additionally, VA believes it can deliver care to Medicare beneficiaries at a discounted rate, which would save money for the Medicare Trust Fund and stretch taxpayer dollars. Allowing Medicare-eligible veterans to apply their Medicare benefits in VA facilities would reduce the government's total health care expenditures for the treatment of non service-connected disabilities. VA health care costs less, at least 25 percent less, than private-sector providers billing at Medicare rates. The savings could be realized by reduced cost to patients, through low or no copayments, or passed on to taxpayers by setting reimbursement rates discounted from standard CMS rates, or by a combination.

In previous testimony before the President's Task Force To Improve Health Care Delivery For Our Nation's Veterans, DAV discussed the growing number of Priority Group 7 Medicare-eligible veterans seeking care at VA and support for Medicare reimbursement for their care. One way to more easily deal with the Medicare reimbursement issue for Medicare eligible veterans is to only include Priority Group 7 veterans for reimbursement. This way there would less likely be an offset in appropriations.

The VA Secretary determines Priority Group 7 veterans' access to VA health care on an annual basis. VA's ability to provide their care largely depends on if it receives an adequate appropriation for health care. From one year to the next, this group of veterans is not sure if they will be able to continue to use VA health care services. VA Secretary Principi was prepared to announce his decision to limit enrollment of new Priority Group 7 veterans for this year. At the last minute he reversed his decision based on a promise from the Administration to provide supplemental funding to VA to continue open enrollment for all priority groups in 2002. The potential closure of enrollment for new Priority Group 7 veterans demonstrates that appropriations cover only Priority Groups 1-6. Medicare reimbursement would obviate the need to deny access to Priority Group 7 users.

The cost of care for this growing population of enrolled Priority Group 7 veterans exceeds medical care cost recovery (MCCR) from these patients and their secondary insurers. The DAV along with the *Independent Budget* (*IB*) group has consistently opposed the offset of MCCR collections. We believe that it is the responsibility of the Federal government to fund the cost of veterans care; therefore, we do not include any cost projections for MCCR in the *IB* budget development. VA's historical inability to meet its collection goals has eroded our confidence in VA estimates. We have urged the Administration and Congress to drop this

budget gimmick and address the veterans' medical care appropriations in a straightforward manner by providing a realistic budget fully funded by appropriations. We strongly believe monies collected through MCCR should be a supplement to, not a substitute for, discretionary appropriations. Collections from Medicare-eligible Priority Group 7 veterans do not cover the cost of their care, and since appropriations are not sufficient, these funds are redirected away from service-connected and poor veterans to subsidize the Medicare trust fund. Additionally, because of the shortfall in appropriated funds, services provided for the care of service-connected and poor veterans are delayed, and those veterans particularly must wait much too long to receive necessary care.

While we support Medicare reimbursement, we would want Congress to ensure that service-connected disabled veterans would not be displaced or forced to wait even longer for necessary care and that revenue generated from Medicare reimbursement will not be used to offset federal appropriations. It doesn't make any sense to replace appropriated funds with Medicare funds. There is no benefit to VA, Medicare, or taxpayers if VA appropriations were offset by Medicare revenues.

The assumption that Medicare reimbursement dollars should necessarily be offset by VA appropriation reductions is invalid because it is based on the incorrect belief that current appropriations are sufficient to provide services to service-connected, poor, and Priority Group 7 Medicare-eligible veterans. While VA sets standards for quality and efficiency, veterans' access to health care is constrained. Consistently inadequate appropriations have forced VA to ration care by lengthening waiting times. Last year appropriations were barley sufficient to cover the cost of care for Priority Groups 1-6. Appropriations over the last several years have been insufficient to provide services to service-connected, poor, and Priority Group 7 Medicare eligible-veterans. By VA estimates, there are over 1 million Priority Group 7 users, with 50-65 percent of them being Medicare eligible. Only 15 percent of Priority Group 7 Medicare-eligible users have billable Medigap insurance, leaving 85 percent where VA receives no insurance reimbursement. The average collections from Medigap insurance for Priority Group 7 Medicare-eligible veterans is estimated at only 12-13 percent of the possible total billable portion. Obviously, VA spends a significant amount of resources on providing health care services for Priority Group 7 Medicare-eligible veterans with little reimbursement. We strongly believe their health care costs should be covered by Medicare funds.

The director of CMS has stated that veterans' care should be covered by VA appropriations and that Medicare reimbursement would represent a double payment by the government. This is a spurious argument; actually, the current situation represents "reverse subvention" with VA appropriations used to pay for care that has already been funded by contributions to the Medicare Trust Fund.

No veteran should be denied access to the veterans health care system. Veterans, even veterans like those in Priority Group 7, who are not poor, have the right to take advantage of VA health care. However, service-connected and poor veterans should not have to subsidize care for veterans who have public or private insurance coverage. Medicare reimbursement would allow Medicare-eligible Priority Group 7 veterans to become a source of funding rather than a drain on an already over-extended system.

In closing, if the Committee chooses to pursue this initiative we recommend amending H.R. 4939 to include Medicare reimbursement for services rendered versus collection of Medicare premiums, and only for veterans in Priority Group 7 or only for the treatment of non service-connected conditions; to avoid a potential offset in appropriations. However, we believe the best strategy to fully address the issue of inadequate appropriations for VA health care, is a shift in the funding source from discretionary to mandatory. We thank the Committee for holding this hearing and for its consideration of this important issue.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

Post-Hearing Questions for
Robert H. Roswell, M.D.
From the Honorable Christopher H. Smith
Regarding the July 16, 2002, Hearing
On H.R. 4939

Question 1. The Committee received a report dated July 12, 2002, from Secretary Principi revealing that about 300,000 veterans are now waiting for VA primary care appointments for six months or more. If H.R. 4939 were to become law and begin to move funds into VA care, to what extent would these funds enable VA to reduce the current backlog of veterans waiting for VA health care services?

Response: The Administration feels that H.R. 4939 may not actually increase VA resources or veterans' access to care. When the Department acquires new funding streams, those increased funds are typically offset against the appropriations that VA would otherwise receive. In that event, VA would not gain permanent increased funding from the measure. In addition, if more veterans were encouraged to use VA as a result of this bill, the cost to VA would possibly be significantly more than the transfer from the Medicare Trust Funds, since the Part B premium finances only a portion of Part B costs. We believe that if the VA needs additional funding to pay for the care they provide, the best way to seek this funding is through the Federal Budget.

In addition, the Administration has not proposed and does not support VA-Medicare subvention as a pilot or on a permanent basis. It is important to recognize that, first and foremost, VA-Medicare subvention is primarily a means for the Medicare Trust Funds to augment VA appropriations.

Question 2. We understand that one of the options for the Priority 7 Medicare eligible veteran might be for VA to cease providing pharmaceutical services, but continue providing other necessary care. What would be the policy basis for this view, and what would its intended result be in your estimation?

Response: VHA is not currently considering this option. Presumably, the policy basis to support a change in law to allow this would be cost savings and to place these veterans on an equal footing with other Medicare-eligible individuals who are not veterans.

Question 3. Last year, our Health Subcommittee Chairman introduced H.R. 2792, a bill that would have established a pilot program to coordinate benefits involving veterans who are eligible for both VA and Medicare benefits. With that pilot, participating veterans would have received inpatient care under Medicare, with coordination by VA for continuing and follow-up services. VA opposed this

idea at that time. Now, considering that VA is nearly overwhelmed with Medicare-eligible veterans, has the VA's view of this proposal changed?

Response: VA still opposes this proposal. The proposal would create a disparate eligibility status based on a veteran's third party coverage and priority group. We remain concerned that the program would undermine our ability to maintain existing services, especially specialized medical services and programs for veterans. Limiting care to VA general medical and surgical services would mean that veterans needing specialty health services would still need to come to VA for such care, but they would not have access to VA's comprehensive continuum of care, needed for their complex care needs. The health care covered by this proposal would be inpatient care for non-service-connected conditions. A veteran currently receiving care for a service-connected condition, for which VA does not or cannot contract locally, would also be forced to receive care in multiple locations. These types of disparities are not consistent with our goals and strategies of improving access, convenience, and timeliness of VA health care to all eligible veterans.

Question 4. Please give the Committee a general description of the pilot plan that was authorized by a prior Appropriations Acts and implemented in the Viera clinic in Representative Dave Weldon's district? How did that pilot project differ from the proposal made in H.R. 2792?

Response: Please see the Attachment to this set of responses.

Question 5. With all the pressure now on VA, with thousands of veterans waiting for outpatient appointments in Florida, and with nearly 300,000 nationwide who are waiting, according to your own report, have VA's views on this coordination idea changed any in the last year, and if so, what do you support?

Response: We have not changed our view with respect to the coordination idea proposed in H.R. 2792. We do not believe that improvements to coordination of care can be achieved by the approach presented within the bill.

Question 6. If the bill, H.R. 4939, were enacted, and Part B eligible veterans enrolled in VA became more aware that their personal funds were supporting the system they had chosen to deliver their care, do you believe that these veterans might stay with VA and reduce their joint reliance on VA and private providers under Medicare, or would their joint use of both public and private systems continue as under the current system?

Response: H.R. 4939 would require a transfer to VA from Medicare of twelve times the monthly Medicare Part B premium for each veteran enrolled in Medicare Part B who receives any outpatient care from VA. These veterans do not lose eligibility to receive care under Part B from any non-VA private-sector

provider. This bill would simply establish a mechanism whereby VA would receive from Medicare limited reimbursement for care provided to Medicare-eligible veterans. We do not believe that H.R. 4939 would provide sufficient incentive for veterans to change their current arrangements for receiving health care, whether from VA or from non-VA providers, which would be based on numerous other factors in addition to third-party reimbursement considerations.

Question 7. The Disabled American Veterans (DAV) has recommended to the Committee that, for Congress to more fully address VA's funding problems, the VA should shift VA health care from a discretionary funding program to a mandatory program. The Ranking Member and I introduced H.R. 5250 on July 26, 2002, that would achieve this goal (bill attached).

Response: Not a question, but rather a lead-in to question 8.

Question 8. What would be the effect of a mandatory funding formula on the VA health care system?

Response: Depending upon its construction and methodology, a mandatory funding formula would provide predictable, but not necessarily adequate, funding for VA health care. The specific formula proposed in H.R. 5250 might have little impact on the VA health care system. We question whether the proposed formula would be considered an appropriation from the Treasury. Section 1301(d) of title 31, United States Code, provides that a law may be construed to make an appropriation out of the Treasury only if the law specifically states that an appropriation is made. Even if it were considered an appropriation, the next appropriation for VA medical care would probably supersede it.

Question 9. DAV testified that Medicare eligible veterans should retain the option under H.R. 4939 to choose VA health care and continue their private sector Medicare coverage as well. What, if any, problems might occur from an open-choice option such as this?

Response: The largest problem that may occur from an open-choice option would be negative outcomes from a lack of coordinated care. If veterans choose to receive some of their care from non-VA providers and the rest from VA providers, the current problems of duplicated care and the provision of unnecessary services may be exacerbated, with significant cost to both programs. In addition, the Medicare Trust Fund may be depleted of needed funds should individuals continue to receive care from Medicare, as expected.

Question 10. In order to decrease the likelihood of appropriations offsets for H.R. 4939, DAV suggested that only Priority Group 7 veterans be subjected to any Medicare participation plan with VA. Do you generally agree with this view, and why or why not?

Response: We do not believe that subjecting only priority group 7 veterans to a Medicare participation plan with VA would decrease the likelihood of appropriations offsets for H.R. 4939. Medical care appropriations are available for the care of priority group 7 veterans. So, should Medicare funds become available for their care, we would expect Congress to propose an appropriation offset.

Question 11. The American Legion suggested that VA use the Indian Health Service (IHS) as a model for becoming a Medicare provider. IHS does not receive a transfer of the monthly Part B premium, but instead bills Medicare directly on a case-by-case basis for services rendered, or works within current Medicare managed-care plans. Would the IHS model work better for VA than my proposal under H.R. 4939, and why?

Response: The Administration does not support VA-Medicare subvention as a pilot or on a permanent basis, including subvention models based on the Indian Health Service. Adopting such a model would cost Medicare even more than what has been proposed under H.R. 4939.

Question 12. How many veterans enrolled in VA health care are currently Medicare eligible? If these veterans received all of their care from Medicare, what would the cost be to the Medicare program to provide the same level of health care to them?

Response: For FY 2002, VA is projecting approximately 3 million Medicare-eligible veteran enrollees (proxy = age 65 and over). Assuming VA service utilization rates and applying Medicare allowable charges, we estimate VA expenditures of $7 billion for Medicare covered services. By 2012, this group is estimated to increase to 4.35 million enrollees with estimated VA expenditures of $12.7 billion for Medicare covered services. We are unable to estimate costs to Medicare if these veterans were to receive all their health care under Medicare rather than receiving some or all through the VA health care system.

Question 13. Given the aging of the veteran population, within another few years, a likely majority of VA's patients will be eligible for Medicare. As time goes by, do you believe that VA-Medicare coordination will be seen as a more realistic possibility, or do you see VA and CMS maintaining separate programs for the foreseeable future?

Response: The mission of the Veterans Health Administration is to provide high quality, accessible healthcare to eligible veterans. In order to maximize the medical care benefits and services provided to veterans, VA strongly supports coordination of benefits with other federal programs, including Medicare. Medicare and VA are separate programs, however, with different purposes. A substantial number of veterans are under 65 years old or have service-connected and special disabilities requiring services not readily available outside VA.

Therefore, there will be a continued need for a separate veterans healthcare system in the foreseeable future. Over time, I believe that opportunities for health care coordination with the Department of Health and Human Services will emerge. To this end, VA has established the position of Deputy Under Secretary for Health Policy Coordination, who will explore and oversee such opportunities for coordination.

Question 14. Have you consulted with the President's Task Force on Veterans Health Care on Medicare-VA relationships? What was the nature of any consultations?

Response: Executive Order 13214, which created the Presidential Task Force and outlined its three missions, does not specifically mention Medicare subvention. However, in its interim report, the Task Force discusses Medicare reimbursement in chapters 3 and 4 and indicates that its Final Report will also address this issue. I have had informal discussions with the co-chairs and discussed the concept of Medicare collaboration.

Question 15. VA has been working on various planning scenarios this year to deal with the burgeoning demands on the system. Can you review for the Committee some of the options VA may be considering in respect to dealing with this growth in demand, including their expected advantages to the system?

Response: VA is currently reviewing several different scenarios as we develop the FY 2004 budget and the FY 2003 VERA allocation methodology. However, all of these scenarios are pre-decisional and it would be premature to release them at this time.

Question 16. The VFW alluded to several primary factors in its testimony that the VHA believes may have undermined the success of DoD's Medicare Subvention pilot program, authorized under the Balanced Budget Act of 1997. VFW proposes that there be no annual cap on Medicare payments to VA; that the level of effort requirement be eliminated; and that VA in effect be treated no differently than any other Medicare health care provider. Should we consider some of these points as we develop future legislation to authorize a Medicare subvention pilot program?

Response: The Administration has not proposed and does not support VA-Medicare subvention as a pilot or on a permanent basis. It is important to recognize that, first and foremost, VA-Medicare subvention is primarily a means for the Medicare Trust Funds to augment VA appropriations. We believe that if the VA needs additional funding to pay for the care they provide, the best way to seek this funding is through the Federal Budget. Lessons learned from the DoD subvention pilot cannot be ignored in better understanding the implications of such a Medicare subvention program.

Question 17. Beyond the specifics of H.R. 4939 or of other Medicare subvention measures now before Congress, should a relationship between VA and CMS regarding dual eligible veterans be stimulated between these institutions, and why or why not?

Response: Coordination of the federal health care benefits provided by VA, DoD and HHS programs should be aggressively pursued to ensure efficient and maximal delivery of healthcare services with the minimum federal budget appropriations and strongest protections for the Medicare Trust Funds. Furthermore, coordination of benefits for dual eligible beneficiaries could reduce duplication of services, and improve healthcare quality and safety.

Question 18. Title 38, United States Code, Section 111 authorizes some veterans to be reimbursed for travel costs, but the mileage allowance is inadequate at only 11 cents per mile. What are your views on the role of VA's beneficiary travel program as a means of promoting access to VA health care?

Response: The beneficiary travel program serves as a means to assist in defraying the cost of travel expenses for veterans with special eligibility or those with low incomes when the travel is in conjunction with scheduled appointments. Currently, demand for VA health care is at an all time high. The number of veterans enrolled in the VA health care system currently exceeds the Department's available resources to provide timely access to quality health care. Due to the current demand for VA health care benefits, the Department cannot endorse any proposal that would divert funding away from medical care for veterans. Therefore, utilizing the beneficiary travel program as a means of promoting access to VA health care would create a false impression of system capacity and further compound VA's access problem.

Question 19. Would VA support increased beneficiary travel mileage allowance for service-disabled veterans in rural areas, or for those who are poor?

Response: The current VA beneficiary travel policy provides travel reimbursement benefits for service-disabled veterans and those with low incomes, regardless of geographic residence. The increase in demand for VA health care benefits and subsequent pressures on the medical care appropriation preclude the Department from endorsing any additional health care benefit expenditures at this time.

Attachment: Response to Question 4

Issue: Question #4 from the subject post hearing questions asks for a general description of the East Central Florida contracting pilot program and for a comparison of that pilot to the one in current legislation.

Discussion: In the VA's 2000 Appropriations Act, Congress directed VA to continue an inpatient hospitalization program (ECF Pilot Program), which had been piloted between June 1998 and September 1998. The pilot program participants consisted of a small group of veterans determined not to have specialty needs who were enrolled and actively receiving their primary care from the VA interim clinic in Palm Bay (Brevard County), Florida. Findings from the pilot program concluded that contracting with the private sector could be cost-effective under appropriate conditions.

On August 1, 2000, the ECF Hospitalization Program, Phase II was initiated. A large multi-specialty outpatient clinic (Viera OPC) was activated in July 1999 to replace the small interim Palm Bay primary care clinic. The Viera OPC activation significantly increased clinic capacity and, therefore, the number of veterans accessing VA outpatient health care services in ECF, as well as those potentially eligible for hospitalization. During the pilot program veterans who were enrolled to receive primary care at the Palm Bay clinic were eligible to receive inpatient services in the community via contract. When Phase II was initiated, veterans enrolled and actively receiving care at the Viera OPC were given options of where they could receive needed hospitalization (as determined by their VA primary care physician) as part of the ECF Hospitalization Program, Phase II.

Veterans seeking care for their service-connected conditions could elect inpatient hospitalization either at a VA hospital or through VA contracts with local non-VA hospitals at VA expense. In addition, veterans with no other form of health coverage (Medicare, Insurance, HMO) were eligible to receive care with VA contract hospitals in the community. Veterans with other inpatient hospitalization options (Medicare, Insurance, HMO) could select care at a VA facility, or could elect to use their other health coverage and self refer to hospitals in the community.

For both the original ECF Pilot and the Phase II Hospitalization Programs, patient demographics, unit costs, patient satisfaction, and program utilization were compared with patients receiving equivalent care at the parent VA facility at Tampa.

Results: Costs to operate the ECF Phase II Hospitalization Program were significantly higher than the costs reported for the ECF Pilot Program. While contracted hospital costs in the ECF Pilot Program were only approximately 85.5 percent of what might have been expended for hospitalization at existing VA facilities, contract costs during the Phase II program were approximately 33

percent higher than the cost of equivalent VA care. A number of factors are believed to have contributed to these differences.

Demographics and the health status between the two eligible populations were significantly different. During the Pilot Program, only primary care patients treated at the interim Palm Bay Clinic were included in the pilot. This likely excluded the more complex patients with multiple diagnoses. With the opening of the Viera multi-specialty clinic, access to a range of specialty care services greatly expanded. This increased the total of number of veterans seeking care in the ECF area as well as the complexity of the patient care base. A 'case mix' comparison was performed to evaluate the complexity/ degree of sickness between those admitted under the Pilot Program and those that were admitted as part of the Phase II Program. The patients admitted during the Pilot Program had a case mix of 1.10. Those admitted during the Phase II Program had a case mix of 1.29, i.e., were more complex. Another very significant difference was age. During the Pilot Program, the average patient admitted was 65 years. In contrast, during the Phase II Program, the age of the veterans admitted to a private sector contract hospital was 57 years of age. This leads us to conclude that the patients that were admitted during the Phase II program, although younger, represented a sicker/ more complex population.

Other factors contributing to the increase in contracted costs in the Phase II program might be attributed to private sector billing practices as well as methods used to determine VA inpatient costs for comparable care. Lessons learned from the ECF Pilot Program (phase I) resulted in an improved cost accounting methodology for the Phase II program. For instance, it was not unusual to receive bills from private sector hospitals six (6) months to one year after the results of the pilot program report had been published. For costing purposes during the ECF Phase II reporting period, we elected to include only the costs of patients that had been admitted through June 2001, and that we felt represented a 'completed' bill. In this way, we hoped to represent a truer cost than during the pilot.

In addition, the methodology used to calculate VA inpatients costs changed between the Pilot program and the Phase II Program. During the pilot program, we had no VA method for comparing VA inpatient costs with private sector costs using Diagnostic Related Grouping (DRG). DRG costs were approximated using a detailed mathematical formula based on Medicare Costs. Between the Pilot Program and the Phase II Program, VA implemented the Decisions Support System (DSS). This enabled us to extract the specific VA costs of treating patients by DRG category.

SUMMARY OF KEY FINDINGS: Results of the ECF Phase II Program did not support the premise that contracting with hospitals in the private sector was more cost-effective than admitting the veteran to an available VA facility. While the ECF Pilot Program experienced private sector costs that were 85.5 percent of VA

costs, the cost of an inpatient admission during the ECF Phase II Program was approximately 33 percent higher than admission to an existing VA facility. While this conclusion is inconsistent with previous findings of the ECF Pilot Program, we believe there are specific instances where contracting for private sector care would be a more cost-effective alternative. For example, this would be the case when the capital investment costs to renovate existing facilities or to build new facilities are factored into the equation. VHA has been cited by GAO studies and others for expending millions of dollars maintaining old, under-used facilities that do not meet basic life safety requirements. In making decisions about whether to continue to maintain these facilities and invest the capital required to bring them up to current standards, the cost-effectiveness of contracting should be thoroughly analyzed especially in light of an overall declining veteran population. The cost of contracting out the inpatient portion of care may well be more cost-effective in instances when VA construction or a major renovation is required to accommodate inpatient care.

NEXT STEPS: Effective December 1, 2001, modifications were made to the inpatient hospitalization program, ECF Phase III, due to budget constraints. Changes will help offset the increasing total costs of operating the program. Contracts were awarded to one medical/surgical provider and one mental health care provider in Brevard County for non-emergent inpatient care only. Veterans without alternate health care coverage (i.e., Medicare, Insurance, HMO) will be referred by primary care providers at the Viera OPC to these facilities for non-emergent hospitalization. Emergency admissions for service connected conditions will be covered by the existing fee basis program, or through emergency care provisions as outlined in the Millennium Bill for veterans with no other form of health care. Although the Phase III Program was only recently initiated, we believe the number of veterans using this program will be significantly reduced and, therefore, the total cost of operating the program will be manageable.

Comparison of the ECF Pilot to H.R. 2792.

Comparisons with the ECF pilot are noted in bold.

SEC. 5. PILOT PROGRAM FOR COORDINATION OF AMBULATORY COMMUNITY HOSPITAL CARE.

(a) IN GENERAL- Chapter 17 of title 38, United States Code, is amended by inserting after section 1725 the following new section:

`Sec. 1725A. Coordination of hospital benefits: pilot program

`(a) PILOT PROGRAM- Subject to the availability of funds specified in subsection (g), the Secretary shall carry out a pilot program in not more than four geographic areas of the United States to improve access to, and coordination of, inpatient care of eligible veterans. Under the pilot program, the Secretary, subject to subsection (b), shall pay certain costs described in subsection (b) for which an eligible veteran would otherwise be personally liable. The authority to carry out the pilot program shall expire on September 30, 2006.

`(b) PAYMENT OF COSTS- In carrying out the program described in subsection (a), the Secretary may pay the costs authorized under this section for hospital care and medical services furnished on an inpatient basis in a non-Department hospital to an eligible veteran participating in the program. Such payment may cover the costs for applicable plan deductibles and coinsurance and the reasonable costs of such inpatient care and medical services not covered by any applicable health-care plan of the veteran, but only to the extent such care and services are of the kind authorized under this chapter.

East Central Florida Hospitalization Program (ECF) pays cost of care for eligible patients at contract facilities. Contract is based on discounted Medicare rate. VA does not pay any patient co-payments or deductibles. Non service connected and service connected veterans treated for non-service connected conditions who have health plans (i.e. HMO, Medicare and/or private insurance) are not eligible under the program.

***Eligible patients*: those veterans enrolled and receiving care at the Brevard/Viera OPC during the past 24 months who**

- **are not covered by a health care plan and need admission for a *non*-emergent condition or**
- **service-connected veterans being treated for a *non*-emergent service connected condition**

The Secretary shall limit the care and services for which payment may be made under the program to general medical and surgical services and shall require that such services may be provided only upon preauthorization by the Secretary.

ECF covers medical, surgical and psychiatric *non-emergent* admissions. Emergent admissions are covered under provisions of Millenium Bill or fee basis authority

`(c) ELIGIBLE VETERANS- (1) A veteran described in paragraph (1) or (2) of section 1710(a) of this title is eligible to participate in the pilot program if the veteran--

`(A) is enrolled to receive medical services from an outpatient clinic operated by the Secretary which is (i) within reasonable proximity to the principal residence of the veteran, and (ii) located within the geographic area in which the Secretary is carrying out the program described in subsection (a);

`(B) has received care under this chapter within the 24-month period preceding the veteran's application for enrollment in the pilot program;

ECF same

`(C) as determined by the Secretary before the hospitalization of the veteran (i) requires such hospital care and services for a non-service-connected condition, and (ii) could not receive such services from a clinic operated by the Secretary; and

`(D) elects to receive such care under a health-care plan (other than under this title) under which the veteran is entitled to receive such care.

`(2) Nothing in this section shall be construed to reduce the authority of the Secretary to contract with non-Department facilities for care of a service-connected disability of a veteran.

ECF –Service Connected veterans are included in ECF program and can elect hospitalization at either a VA hospital or contract non-VA facility for a non-emergent service connected condition

`(3) Notwithstanding subparagraph (D) of paragraph (1), the Secretary shall ensure that not less than 15 percent of the veterans participating in the program are veterans who do not have a health-care plan.

ECF- approximately 80 % of veterans currently participating in program have no health plan.

`(d) CASE MANAGEMENT- As part of the program under this section, the Secretary shall, through provision of case-management, coordinate the care being furnished directly by the Secretary and care furnished under the program in non-Department hospitals to veterans participating in the program.

ECF – has a full time RN who case manages every patient approved for hospitalization at a contract non-VA facility

`(e) DESIGNATION OF PARTICIPATING SITES- (1) In designating geographic areas in which to establish the program under subsection (a), the Secretary shall ensure that--

`(A) the areas designated are geographically dispersed;

`(B) at least 70 percent of the veterans who reside in a designated area reside at least two hours driving distance from the closest

medical center operated by the Secretary which provides medical and surgical hospital care; and

ECF – Brevard/Viera Clinic is located 115 miles (2.25 hours) from West Palm Beach VA, 131 miles (2.5 hours) from Tampa VA and 169 miles (3 hours) from Gainesville VA. At least 70% of current patients reside 2 or more hours from a VA inpatient facility

`(C) the establishment of the program in any such area would not result in jeopardizing the critical mass of patients needed to maintain a Department medical center that serves that area.

`(2) Notwithstanding paragraph (1)(B), the Secretary may designate for participation in the program at least one area which is in proximity to a Department medical center which, as a result of a change in mission of that center, does not provide hospital care.

`(f) REPORTS- (1) Not later than September 30, 2003, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience in implementing the pilot program under subsection (a).

`(2) Not later than September 30, 2005, the Secretary shall submit to those committees a report on the experience in operating the pilot program during the first two full fiscal years during which the pilot program is conducted. That report shall include--

`(A) a comparison of the costs incurred by the Secretary under the program and the cost experience for the calendar year preceding establishment of the program at each site at which the program is operated;

The methodology for this should be determined well before the pilot programs begin. This process is much more complex than it may seem. ECF admissions for FY 2001 reflected inpatient costs at contract facilities to be approximately 33% higher than at a VA facility.

`(B) an assessment of the satisfaction of the participants in the program; and

ECF-92% of participants rate overall satisfaction with ECF program as good or excellent.

`(C) an analysis of the effect of the program on access and quality of care for veterans.

`(g) FUNDING LIMITATIONS- (1) The total amount expended for the pilot program in any fiscal year (including amounts for administrative costs) may not exceed $50,000,000.

`(2) Any expenditure of funds for the pilot program shall be made from amounts in the Medical Care Collections Fund attributable to collections under section 1729 of this title. No funds may be expended to support the purposes of this section from any other funds available to the Secretary for the delivery of health care services to veterans, including funds

appropriated or otherwise available for the care and treatment of veterans who require specialized care and resources.
`(h) HEALTH-CARE PLAN DEFINED- For purposes of this section, the term `health-care plan' has the meaning given that term in section 1725(f)(3) of this title.'.
(b) CLERICAL AMENDMENT- The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1725 the following new item:
`1725A. Coordination of hospital benefits: pilot program.'.

Post-Hearing Questions for
Robert H. Roswell, M.D.
From the Honorable Lane Evans
Regarding the July 16, 2002, Hearing
On H.R. 4939

Question 1. Do you believe that, by providing "free" care to Medicare-eligible veterans, VA is subsidizing the Medicare trust fund, particularly for non service-connected care? Why or why not?

Response: The Administration does not consider there to be a subsidy involved. In enacting VA's appropriations, Congress takes into account the fact that current law prohibits VA from obtaining reimbursement from Medicare for care provided to Medicare-eligible veterans. So, VA is not penalized for providing care to veterans who choose not to go to Medicare providers.

Question 2. Previous administrations have supported some legislative proposals to allow Medicare funds to transfer to VA. What are the components of a legislative proposal that this Administration would require? Would any previously considered provisions be acceptable and under what circumstances?

Response: The Administration does not support VA-Medicare subvention as either a pilot or a permanent program. The Administration sees VA-Medicare subvention as primarily a means for the Medicare Trust Funds to augment VA appropriations and does not believe that this would serve either program well.

- The Administration has found that Medicare subvention has not proven to be cost-effective. The DoD-Medicare subvention pilot was found to be very costly and did not accomplish all of its goals. The lessons learned from this experience must be closely examined to better understand the implications of such a Medicare subvention program.
- The Administration believes that Medicare subvention would not enhance veterans' access to health care. All dual eligible veterans may receive all covered services from either program. Subvention would do nothing to change this.
- The Administration believes that by requiring Medicare to pay for services already financed by a separate VA appropriation, Medicare subvention decreases the financial security of the Medicare program and the assurance that over 40 million aged and disabled Americans will have access to health care when they need it. This is contrary to the President's Framework to Strengthen Medicare, which, among other things, states that Medicare legislation should strengthen the program's long-term financial security.
- Medicare subvention runs counter to the Administration's efforts to modernize Medicare, which seeks program efficiencies and benefit enhancements through a greater reliance on the private rather than public sector.

The Administration is committed to coordinating care provided by VA, DOD, and Medicare programs. However, VA must ensure that these programs and their beneficiaries are protected, while making changes that will improve program efficiency and efficacy.

Question 3. Is VA funded to provide care to Priority 7 vets? If not, for whom is it funded to provide care? Please explain your answer.

Response: VA is funded to provide care for all veterans who are enrolled and seek care. In this regard, revenues obtained from sharing agreements, co-payments, and third-party collections (health insurance providers) supplement VA's appropriated funds.

VA's budget request for FY 2002 did not anticipate the unprecedented workload experienced to date. In order to improve our workload projection capability, VA enlisted the support of a well-known actuarial firm, Milliman USA, to provide assistance in making forecasts of the patient population. This has placed VA staff in a much stronger position to evaluate and account for the impact of a variety of different factors on the size and distribution of our future patient population. The Department's FY 2003 budget is the first to present workload projections that reflect the assistance of this actuarial firm.

Question 4. DOD was not able to deliver care to the new Medicare beneficiaries it served in the TRICARE Senior Prime demonstration within the discounted reimbursement rate Medicare provided; what makes VA think it can?

Response: The DOD-Medicare subvention pilot was found to be very costly and did not accomplish all of its goals. It is important that the lessons learned from this experience be closely examined to better understand the implications of similar Medicare subvention programs. As stated above, the Administration does not support a VA-Medicare subvention program.

Question 5. To your knowledge, is the Presidential Task Force specifically charged to review Medicare subvention and the coordination of a federal health benefit?

Response: Executive Order 13214, which created the Presidential Task Force (PTF) and outlined its three missions, does not specifically mention Medicare subvention. In its interim report, the PTF discusses Medicare reimbursement in chapters 3 and 4 and indicates that its final report will also address this issue.

Question 6. Dr. Roswell, your statement says, "...when the Department accesses new funding streams, those increased funds are typically offset against the appropriations we would otherwise receive. We have no reason to believe that would not be the case with this bill." Does this mean the Administration will

no longer support legislation that creates non-appropriated revenue streams for the Department? Are there any legislative means of safeguarding new revenue streams from offset?

Response: VA would support legislation creating non-appropriated revenue streams that are beneficial to both veterans and VA and that are consistent with Administration policy. Measures that will provide additional funds or decrease demand of enrollees other than our core constituency (service-connected veterans and indigent and special-needs veterans) are options that are reviewed during each budget cycle. The budgets of all agencies are developed with a full understanding of total resource needs and total revenue streams.

CHAIRMAN SMITH TO CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Smith's Follow-up Questions to the July 16, 2002 Hearing on H.R. 4939, the Veterans Medicare Payment Act of 2002:

Q: Medicare subvention is underway in the Department of Defense, based on the original mandate in the Balanced Budget Act of 1997. VA Medicare subvention was discussed in that same Act as well, but was not authorized as a pilot plan for VA until further experience was gained in the DoD ten-site pilot program. Now that the DoD experience is well documented, would Secretary Thompson support the step contemplated in the 1997 Act, or would you oppose it, and why?

A: The Administration has not proposed and does not support VA-Medicare subvention as a pilot or on a permanent basis. It is important to recognize that, first and foremost, VA-Medicare subvention is primarily a means for the Medicare Trust Funds to augment VA appropriations. The Administration does not believe that this would serve either program well.

- Medicare subvention has not proven to be cost-effective. Rather, the DoD-Medicare subvention pilot, authorized by the Balanced Budget Act of 1997, was found to be very costly and did not accomplish all of its goals. The later passage of TRICARE for Life eventually obviated the DoD subvention program, but the lessons learned from this experience must be closely examined to better understand the implications of such a Medicare subvention program.

- Medicare subvention would not necessarily enhance veterans' access to healthcare. There is no longer a justification for a subvention program based on its ability to increase access to care at VA for veterans. Today, veterans who decide to enroll with VA are eligible to receive care from VA. In addition, all dual eligible veterans (both entitled to VA care and care under Medicare) may receive all covered services from either program. Subvention would do nothing to change this.

- By requiring Medicare to pay for services already financed by a separate VA appropriation, Medicare subvention decreases the financial security of the Medicare program and the assurance that over 40 million aged and disabled Americans will have access to health care when they need it. This is contrary to the President's Framework to Strengthen Medicare, which among other things, states that Medicare legislation should strengthen (not weaken) the program's long-term financial security.

Finally, Medicare subvention runs counter to the Administration's efforts to modernize Medicare, which seeks program efficiencies and benefit enhancements through a greater reliance on the private rather than public sector. We believe that if the VA needs additional funding to pay for the care they provide, the best way to seek compensation is through the Federal Budget.

Q: What are the reasons that DoD, in its relationship with Medicare, has received no reimbursement, despite the fact that DoD officials have informed this Committee that over $200 million is in dispute in DoD's ten-site pilot program, and what are the bases for CMS's opposition to reimbursing DoD?

A: Under Senior Prime, the Medicare subvention demonstration for the Department of Defense, CMS (formerly HCFA) made monthly interim payments to DOD if the calculated capitation payment exceeded a specified threshold at each individual demonstration site. However, the Memorandum of Agreement between DOD and CMS itemized several requirements that had to be met in order for DOD to retain the interim payments after the end of the year. If the DOD did not meet all of these requirements (also referred to as "tests") set up to determine what they should keep, they had to return the excess portion of the payment.

Specifically, in 1998, interim payments from CMS to DOD totaled $2,401,345*. In accordance with the MOA between CMS and DOD, DOD could not retain the payments and netted $0. In 1999, interim payments from CMS to DOD totaled $42,811,591. After the reconciliation had been completed, DOD netted $0. For CY2000, DOD is projected to retain $15,022,784. For CY 2001, projections for net payments retained by DOD are $34,757,479.

*The first Senior Prime demonstration site became operational in September 1998. All six sites were operational by January 1999 and the demonstration ended on December 31, 2001.

Q: Does Medicare provide any long-term care? Are you aware that VA has a comprehensive long-term care benefit, including nursing home, rehabilitation, prosthetics and sensory aids, home care, respite, and hospice services?

A: Medicare does not cover long-term custodial care. Under the traditional Medicare fee-for-service program, Medicare covers skilled nursing services when provided in a nursing home facility (up to 100 days per year) or in a beneficiary's home. In addition, outpatient physical, occupational, cardiac, and speech and language rehabilitation therapy are covered. Medicare also pays for certain durable medical equipment and prosthetic and orthotic supplies prescribed by a physician in accordance with specified Medicare coverage rules. However, the VA and Medicare do not cover all of the same items. For example, Medicare does not cover hearing aids or eyeglasses, with the exception of post-cataract surgery lenses.

Additionally, Medicare beneficiaries suffering from a terminal illness may elect to receive a hospice benefit that includes respite services.

Q: How many of these VA services in long-term and extended care are available to veterans in the private sector under Medicare?

A: Veterans eligible for Medicare may receive the same Medicare-covered services in the private sector as any other Medicare beneficiary. However, benefits such as long-term custodial care, hearing aids, and several other VA benefits are only available through the VA, unless the beneficiary wishes to pay for it him/herself or has other insurance that specifically covers it.

Q: There are studies showing that VA provides care at considerably less cost on average than private facilities for the same kinds of patients. Do you agree that VA costs are lower than private care of Medicare beneficiaries?

A: CMS does not have the data to make this determination.

Q: Has CMS or other offices at the Department of Health and Human Services consulted with the President's Task Force on Veterans Health Care on Medicare-VA relationships? What was the nature of those consultations?

A: CMS met with consultants and staff to The President's Task Force in order to give them general feedback on the DoD subvention demonstration, Senior Prime.

Q: Please respond to each of the points directed at CMS and raised in the attached letter from The American Legion, dated July 17, 2002 (letter attached).

A:

- The American Legion is aware of the current activities of the Indian Health Services (IHS) involving Medicare and Medicaid subvention. The American Legion understands that Medicare and Medicaid subvention enabled IHS to supplement their frozen annual discretionary appropriations with reimbursements for treating CMS-eligible beneficiaries. This additional revenue stream and the CMS requirements helped IHS improve the quality of care, the accessibility to care, and the timeliness of care throughout its health care delivery system. Clearly, both benefits were achieved and care was effectively coordinated. Why does Director Grissom feel that the Veterans Health Administration (VHA) is incapable of similar results?

  CMS has not made any such judgments regarding the VA. In general, Medicare subvention has not proven to be cost-effective. The Administration does not support subvention as a pilot or on a permanent basis. For example, The DoD-Medicare subvention pilot, authorized by the Balanced Budget Act of 1997, was found to be very costly and did not accomplish all of its goals. The lessons learned from this experience must be closely examined to better understand the implications of such a Medicare subvention program.

  Additionally, Medicare subvention would not necessarily enhance veterans' access to healthcare. There is no longer a justification for a subvention program based on its ability to increase access to care at VA for veterans. Today, veterans who decide to enroll with VA are eligible to receive care from VA. In addition, all dual eligible veterans (both entitled to VA care and care under Medicare) may receive all covered services from either program. Subvention would do nothing to change this.

- Why does Director Grissom believe that the VHA is fully funded to take care of all veterans eligible for enrollment?

  CMS and the VA face very similar challenges. Both of us face limited budgets from which to provide a very large group of beneficiaries with a comprehensive set of benefits. Neither of us feels that it is fully equipped to meet the challenge.

- Since Medicare eligibility is not a criterion of mandatory care within VHA, would Director Grissom recommend prohibiting the enrollment of all Priority Group 7 Medicare-eligible veterans, thus forcing them into the private sector?

  CMS does not believe it is equipped to make any such recommendation.

- Why does Director Grissom oppose reimbursing VHA only for treatment of a Medicare-eligible veteran's non-service connected medical conditions?

  This Administration is dedicated to strengthening and improving Medicare for all beneficiaries, including America's veterans. First and foremost, that means fortifying the current Medicare program. This includes adding a comprehensive prescription drug benefit, expanding Medicare's coverage of preventive services, and protecting the long-term financial security of Medicare. Given the current financing issues associated with the Medicare Trust Funds, we are concerned that subvention has the potential to further undermine the financial security of the program.

- Does Director Grissom know how many Medicare-eligible veterans have access to VA's pharmacy for treatment of non-service connected medical conditions?

  CMS does not have the number of Medicare beneficiaries who are eligible to receive pharmacy services. We believe that the VA has access to estimates of this figure.

- Does Director Grissom, believe the Secretary of VA's ability to reassign a Medicare-eligible veteran from Priority Group 7 to Priority Group 4 is a bad policy?

  CMS does not believe it is equipped to make this kind of judgment about VA policies.

- Does Director Grissom believe veterans should be Federally mandated to enroll in Medicare, especially if VHA cannot be reimbursed for treatment?

  It is unnecessary to mandate veterans to enroll in Medicare. Medicare is available, in general, for people age 65 or older, younger people with disabilities and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or transplant) without regard to veteran status.

- Does Director Grissom anticipate the modernized Medicare providing access to all of these special services for Medicare beneficiaries?

  This Administration strongly supports providing Medicare beneficiaries with a wide range of choices. This includes adding a comprehensive prescription drug benefit, expanding Medicare coverage of preventive services, all while protecting the long-term security of the program. Although we cannot be certain, unfortunately, in the current round of priority-setting and reforms, there are some services available to veterans that may not be made available to Medicare beneficiaries.

- Does Director Grissom believe VHA would "exploit the accounting gimmicks that Medicare's bifurcated Trust Fund system encourages," especially since VHA is subject to the same congressional oversight as CMS?

  No. We are certain that CMS and VHA are equally committed to the long-term financial security of Federal health programs.

- Why does Director Grissom believe the DoD Medicare Subvention Demonstration Program was a failure?

  By no means was the Medicare DoD subvention demonstration a failure. CMS strongly believes that any demonstration from which lessons are learned for future action must be deemed a success. Unfortunately, the DoD-Medicare subvention pilot was found to be very costly and did not accomplish all of its goals. The lessons learned from this experience must be closely examined to better understand the implications of Medicare subvention.

- What other Medicare providers (public or private) are faced with a maintenance or level of effort criteria?

  The purpose of a "Level of Effort" (LOE) measure is to ensure that Medicare does not double pay for services that are already paid for under Congressional appropriations. There are no other traditional Medicare providers who receive similar funding through budgetary appropriations and, therefore, a LOE is not needed.

- What other participating Medicare+Choice (M+C) health maintenance organizations receive reduced reimbursements for enrolled Medicare beneficiaries?

  Under the DoD MOA, certain components of the standard M+C capitation were excluded from DoD payments as they were felt to either:
  - Represent double payment for services that were separately funded by Congress (i.e., graduate medical education and a proportion of capital); or
  - Be irrelevant to the DoD health care system (i.e., disproportionate share payments).

- Why have so many HMOs refused to participate in Medicare+Choice?

  With enactment of the Balanced Budget Act of 1997 (BBA) came the expectation and intent that the Medicare+Choice program would continue to grow and offer additional choices to beneficiaries. Unfortunately, the number of plans and percentage of beneficiaries enrolled have declined steadily from a high of 18% in 1999. Insufficient payment rates as a result of a change in how the monthly capitation rates are calculated, and a failure of M+C rates to keep up with medical inflation have been cited as the primary reasons for plans dropping out of or not entering the M+C program.

Administrative and regulatory barriers have also been cited. The Administration is actively working to make changes in the M+C program and offer alternative options to encourage participation by a variety of M+C plans and increase private sector options for Medicare beneficiaries.

- Under current law, does Director Grissom feel Medicare-eligible veterans would receive better care and services in VHA or in the private sector?

  This Administration strongly supports providing all Medicare beneficiaries, including veterans, with a wide range of choices. We believe that each veteran is best able to determine where s/he should obtain his/her health care.

- Does Director Grissom feel VA, the nation's largest health care system, is incapable of billing CMS properly?

  While it is CMS' understanding that the VA is working toward enhancing its systems' capabilities, we believe that currently the VA does not have the mechanisms in place to meet certain procedure and diagnostic coding specifications.

- Does Director Grissom believe the VHA health care system's ability to serve the older veterans' population is lacking or questionable?

  CMS strongly believes in the ability of the Veterans Health Administration to provide a broad spectrum of medical, surgical, and rehabilitative care to its customers.

Q: What is the current balance in the Federal Supplemental Medicare Insurance Trust Fund? Assuming one million Part B eligible veterans' annual health insurance premiums were paid from this Fund, by what percentage would the current Fund balance be reduced?

A: As of December 31, 2001, the Supplemental Medicare Insurance Trust Fund had a balance of $41.3 billion. If one million Part B eligible veterans' annual health insurance premiums were paid from this Fund*, the current Fund balance would be reduced by 1.6 percent

**The Part B premium is $55 per month in 2002. It would cost $660,000,000 to cover one million Part B eligible veterans' premiums for one year, reducing the SMI Trust Fund to $40.64 billion.*

CONGRESSMAN EVANS TO CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Evans's Follow-up Questions to the July 16, 2002 Hearing on H.R. 4939, the Veterans Medicare Payment Act of 2002:

Q: Do you believe that, by providing "free" care to Medicare-eligible veterans, VA is subsidizing the Medicare Trust Fund? Why or why not?

A: Medicare and VA financing are completely independent of each other. Medicare is comprised of two parts: Hospital Insurance (HI) and Supplementary Medical Insurance (SMI). HI is financed primarily by payroll taxes paid by workers and employers. SMI is primarily financed by transfers from the general fund of the U.S. Treasury, and monthly premiums paid by beneficiaries. Income not currently needed to pay benefits and related expenses is held in the HI and SMI trust funds and invested in U.S. Treasury securities. In contrast, VA pays for the care they provide to eligible beneficiaries though funding that is financed by a discretionary Federal Budget appropriation. Moreover, by law, the Medicare Trust Fund cannot pay for care that is provided by the Department of Veterans Affairs. To the extent that the VA needs more money to appropriately pay for the care they provide, we believe that the best way to seek compensation is through the Federal Budget.

Q: How much funding was transferred from the Medicare Trust Fund to the Department of Defense under the Medicare Subvention demonstration – TRICARE Senior Prime?

A: The first Senior Prime demonstration site became operational in September 1998. All six sites were operational by January 1999 and the demonstration ended on December 31, 2001.

- In 1998, interim payments from CMS (then HCFA) to DOD totaled $2,401,345. However, in accordance with the MOA between CMS and DOD, DOD could not retain the payments and netted $0*.
- In 1999, interim payments from CMS to DOD totaled $42,811,591; DOD netted $0.
- In CY2000, interim payments totaled $52,514,821; projections for net payments retained by DOD are $15,022,784.
- In CY2001, interim payments totaled $74,864,479; projections for net payments retained by DOD are $34,757,479.

***Background:**
The BBA of 1997, which authorized the Senior Prime required that all of the DOD demonstration sites spend the amount they would have spent without the demonstration on Medicare-eligible retirees' care. Since the DOD already received some money to cover health care for retirees as part of its annual appropriation (level of effort), this provision was made in order to insure that Medicare did not "double pay" for what was already part of DOD's existing appropriation. In addition, in order to encourage efficient utilization of services and protect the Medicare Trust funds, the Memorandum of Agreement (MOA) further specified that CMS would not adjust for "underpayments" or "overpayments" that result from inefficiency or efficiency.

Under Senior Prime, CMS made monthly interim payments to DOD if the calculated capitation payment exceeded a specified threshold at each individual demonstration site. The MOA between DOD and CMS itemized several tests that had to be met in order for DOD to retain interim payments after the end of the year. If the DOD did not meet all of these requirements (also referred to as "tests") set up to determine what they should keep, they had to return the excess portion of the payment.

The four tests, which comprise the annual level of effort reconciliation process, were developed to insure that the above stated objectives were met. The first test compares total spending at all demonstration sites to the total base year level of effort. The second test makes sure that a minimum percentage of DOD spending at each of the sites is for beneficiaries enrolled in the demonstration. The third test is demonstration site specific and insures that no payments are made to any site that did not enroll the minimum number of beneficiaries in the demonstration. The fourth, and last test, insures that DOD is not rewarded for inefficiencies in the care provided. In this test, DOD is only given "credit" towards meeting the level of effort for enrollee care to the extent Medicare would have paid a private M+C plan.

Q: Previous administrations have supported some legislative proposals to allow Medicare funds to transfer to VA. What are the components of a legislative proposal that this Administration would require? Would any previously considered provisions be acceptable and under what circumstances?

A: The Administration has not proposed and does not support VA-Medicare subvention as a pilot or on a permanent basis. It is important to recognize that, first and foremost, VA-Medicare subvention is primarily a means for the Medicare Trust Funds to augment VA appropriations. The Administration does not believe that this would serve either program well.

- Medicare subvention has not proven to be cost-effective. Rather, the DoD-Medicare subvention pilot, authorized by the Balanced Budget Act of 1997, was found to be very costly and did not accomplish all of its goals. The later passage of TRICARE for Life eventually obviated the DoD subvention program, but the lessons learned from this experience cannot be ignored in order to better understand the implications of such a Medicare subvention program.

- Medicare subvention would not enhance veterans' access to healthcare. Today, veterans who decide to enroll with VA are eligible to receive care from VA. In addition, all dual eligible veterans (both entitled to VA care and care under Medicare) may receive all covered services from either program. Subvention would do nothing to change this.

- By requiring Medicare to pay for services already financed by a separate VA appropriation, Medicare subvention decreases the financial security of the Medicare program and the assurance that over 40 million aged and disabled Americans will have access to health care when they need it. This is contrary to the President's Framework to Strengthen Medicare, which among other things, states that Medicare legislation should strengthen (not weaken) the program's long-term financial security.

Finally, Medicare subvention runs counter to the Administration's efforts to modernize Medicare, which seeks program efficiencies and benefit enhancements through a greater reliance on the private rather than public sector. We believe that if the VA needs additional funding to pay for the care they provide, the best way to seek compensation is through the Federal Budget

Q: Is the VA funded to provide care to Priority 7 vets? Please explain your answer.

A: We believe the VA can more appropriately answer this question.

CHAIRMAN SMITH TO PARALYZED VETERANS OF AMERICA

Question 1 – Some veterans' organizations have recommended to the Committee that, for Congress to more fully address VA's funding problems, the funding mechanisms for VA health care shift from a discretionary funding program to a mandatory program. The Ranking Member and I introduced H.R. 5250 on July 26, 2002, a bill that if enacted, we believe would achieve this goal.

> Could you predict the effects of a mandatory funding formula on the VA health care system, and advise the Committee whether such a system of funding would make Medicare coordination unnecessary for VA health care?

Answer: PVA is continually concerned with the uncertainty and unreliability of the current budget and appropriation processes' lack of responsiveness in providing funding levels that adequately meet the health care demands of the veterans' population. Far too many intervening factors, including political and budgetary influences, can affect VA health care funding levels throughout the annual budget and appropriations debate over discretionary dollars that have little relationship to the number of veterans seeking health care and the cost of providing those services to them. H.R. 5250, introduced by Chairman Smith and Ranking Democratic Member Evans, seeks to resolve this uncertainty by establishing certain formulas to assess yearly patient demand and establish annual funding levels from mandatory spending that would meet the funding needs of the VA health care system. We believe this to be an innovative approach to tackle what has been a very vexing problem facing VA health care. We look forward to working with the Committee in analyzing this legislation to see exactly what protections the bill will provide to make certain funding meets potential rising costs, patient demand fluctuations and health benefit levels.

The Chairman's question asks PVA to "advise the Committee whether such a system of funding would make Medicare coordination unnecessary for VA health care. We believe it would. Even under the current discretionary funding scenario we have not been totally convinced that Medicare subvention was the panacea some people think it could be in providing alternative funding sources to augment insufficient budget requests and appropriations. We have concerns that VA might not be reimbursed adequately for the care it provides Medicare eligible veterans. We also believe that Medicare reimbursements, instead of being used to augment VA budgets, could be used by budget analysts at the Office of Management and Budget and elsewhere to offset needed health care funding level increases. We can think of no legislative directive that could prohibit this offset from taking place.

Ideally, if VA funding did flow from mandatory sources, and those funding levels were adequate to meet the demands on the system and the cost of that care, there would be no need to submit the VA to the potential budget offset situation by trying to underwrite budgets from other public or private funding sources.

Question 2 – What kind of funding relationship between VA and HHS would your organizations support, or is there no such relationship that would be acceptable to you?

Answer: Funding and cooperative relationships currently exist between the VA and HHS, including interactions between VA research and the National Institutes of Health (NIH). Further cooperative efforts have been mandated by the recently enacted P.L. 107-188, including accumulating and managing the Strategic National Stockpile. PVA has expressed support in further examining many proposals that would create new funding streams for VA health care in order to protect veterans from the effects of inadequate fiscal resources. In the past, PVA has supported the creation of a pilot project to test the feasibility of Medicare subvention. Our support has been based on the inclusion of a fee-for-service component and the assurances of the VA that it could provide health care for fewer dollars, thereby protecting the Medicare Trust Funds and providing additional resources to the VA. We have also stressed that this pilot be limited to veterans seeking care for non-service-connected conditions. We have, in the past, expressed concerns that if this indeed prove feasible, that these additional resources not be substituted for adequate appropriated dollars, and we have recently, before the Committee in testimony regarding another Medicare plan, reiterated these same concerns.

Question 3 – The DAV discusses in its statement the need to convert funding from a discretionary to a mandatory basis. Why would mandatory funding, even if a "perfect" formula were to be developed for VA, be better than Medicare funding for VA, or should they be considered in tandem?

Answer: If the choice is between mandatory funding and Medicare reimbursement, PVA would opt for mandatory funding. PVA's concern continues to be ensuring that adequate and sufficient funding is made available to provide health to sick and disabled veterans.

As we continue to emphasize, PVA believes that any estimates that the VA makes for Medicare funding as a resource mechanism for VA health care services opens up the possibility of offsets that have been the norm in determining appropriations for the VA in the past. The Office of Management and Budget (OMB) has shown time and again that it will offset appropriated dollars against any estimates made by the VA for the Medical Care Cost Fund (MCCF). This problem is compounded by the fact that inflated MCCF estimates tend to be grossly overstated and inaccurate. There is no way to prevent this same thing from happening with Medicare fund transfers.

Question 4 – Has your organization consulted with the President's Task Force on Veterans Health Care for their views on Medicare-VA relationships? What was the nature of those consultations, and do you expect recommendations from the Task Force dealing with the Medicare dual-eligibility question?

Answer: PVA has testified before the President's Task Force on Veterans Health Care and participated in meetings concerning VA health care and the possibility of Medicare subvention. We emphasized that any form of subvention should be conducted only on a

limited basis for Category 7 veterans receiving care for non service-connected conditions. We also explained that we would only support the idea if there is a fee-for-service option that would allow PVA members, veterans with spinal cord injury, or other severely disabled veterans to receive quality care. PVA cannot speak to the views of the President's Task Force on Veterans Health Care concerning the Medicare-VA relationship. Depending on the thoroughness and scope of the Task Force's final recommendations, we anticipate some form of recommendation regarding the Medicare-VA relationship.

PVA also voiced concern before the Task Force about the possibility that OMB would offset appropriated dollars if Medicare funds were added to the pool of VA health care resources. PVA does not see the point of having Medicare subvention if OMB will continue to place an offset on VA's funding.

PAUL A. HAYDEN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

RESPONSE TO

POST-HEARING QUESTIONS SUBMITTED BY
CHAIRMAN CHRIS SMITH
HOUSE COMMITTEE ON VETERANS' AFFAIRS
REGARDING THE HEARING ON

H.R. 4939, *VETERANS MEDICARE PAYMENT ACT OF 2002*
JULY 16, 2002

Question 1: Some veterans' organizations have recommended to the Committee that, for Congress to more fully address VA's funding problems, the funding mechanisms for VA health care shift from a discretionary funding program to a mandatory program. The Ranking Member and I introduced H.R. 5250 on July 26, 2002, a bill that if enacted, we believe would achieve this goal (bill attached).

> Could you predict the effects of a mandatory funding formula on the VA health care system, and advise the Committee whether such a system of funding would make Medicare coordination unnecessary for VA health care?

Response: Recognizing that mandatory funding still will not guarantee adequate funding every year for VA, it possesses the potential to end the years of inadequate and inconsistent funding associated with the Budget/Appropriations process that has resulted in the actual denial of mandated VA health care. A mandatory funding stream could potentially allow VA to meet actual demand for services versus tailoring services to meet the budget. Given the assumption that a mandatory funding formula would be based on those currently eligible to enroll in the VA health care system, we believe that Medicare coordination would remain necessary in the event that mandatory funding was enacted. It is only equitable that Category 7 veterans and military retirees who have TRICARE for Life should be allowed to have Medicare billed for their co-payments to VA.

Question 2: What kind of funding relationship between VA and HHS would your organizations support, or is there no such relationship that would be acceptable to you?

Response: Given the restraints that were placed on the DOD Medicare Subvention pilot program, the VFW would support a relationship that incorporates the following five points articulated in our written testimony:

- Subvention must be implemented uniformly nation-wide so that the outcome is not distorted by regional variations in sick vs. healthy populations. This is also an issue of equity in that it would avoid discriminating between otherwise eligible veterans based solely on geographical location.
- There must be **no** annual cap on Medicare payments to VA. As was demonstrated with the DOD pilot, such an arbitrary upper limit would only place VA in a position to lose dollars relative to CMS with no reasonable expectation of recouping even a modest portion of the cost of providing care to an expanded Medicare eligible veteran patient workload.
- The Level of Effort (LOE) requirement must be eliminated. We believe that this requirement is one of the main reasons the DOD study failed and we want to prevent the same thing from happening to VA. VA is currently fronting the cost of care for Medicare-eligible veterans without reimbursement. For them to continue to front the costs for an established population of current and future enrolled Medicare-eligible veterans before being able to receive reimbursement from CMS circumvents the purpose of Medicare reimbursement altogether.
- The CMS capitation or payment formula must be adjusted to accommodate medical services ***actually*** provided by VA as opposed to only those currently covered under Medicare. As has been documented by the DOD pilot as well as the current situation in the private health care market, this is particularly urgent with respect

to the provision of Managed Care which is the primary VA modality. Ancillary to this, payments to VA must be at a 100% rate and not at a reduced or discounted rate relative to other providers as has been proposed in earlier legislation.

- Full appropriation support must be maintained with absolutely no reduction in funding as a consequence of subvention funding. These dollars are to be applied to remedying over a decade of under funding of VA Medical Care and to cover the cost of providing for an expanded Medicare eligible patent workload.

Question 3: The DAV discusses in its statement the need to convert funding from a discretionary to a mandatory basis. Why would mandatory funding, even if a "perfect" formula were to be developed for VA, be better than Medicare funding for VA, or should they be considered in tandem?

Response: We believe that mandatory funding and Medicare subvention should be considered in tandem. See question 1.

Question 4: Has your organization consulted with the President's Task Force on Veterans Health Care for their views on Medicare-VA relationships? What was the nature of those consultations, and do you expect recommendations from the Task Force dealing with the Medicare dual-eligibility question?

Response: Yes, we testified before the President's Task Force on January 15, 2002. I have attached a copy for your information. In reviewing the Task Force's Interim Report released on July 31, 2002, it is apparent that the Task Force is interested in the issue of VA funding and Medicare reimbursement is discussed as an option, however, no specific recommendations were offered.

Paul Hayden, Deputy Director
National Legislative Service
Veterans of Foreign Wars of the United States

RESPONSE TO

POST-HEARING QUESTIONS SUBMITTED BY REPRESENTATIVE LANE EVANS HOUSE COMMITTEE ON VETERANS' AFFAIRS REGARDING THE HEARING ON

H.R. 4939, *Veterans' Medicare Payment Act of 2002*
July 16, 2002

Question 1: In the past, many bills that shift funding from Medicare to VA have required VA to meet a "level of effort". In the Department of Defense's demonstration project, this was never done to the Center of Medicare and Medicaid's (CMS) satisfaction, so funds were never transferred. Assuming that our efforts in this Committee lead us back down that path, are you still willing to support a bill that transfers funds between agencies?

Response: No, it is our position that the Level of Effort (LOE) requirement must be eliminated. We believe that this requirement is one of the main reasons the DOD study failed and we want to prevent the same thing from happening to VA. VA is currently fronting the cost of care for Medicare-eligible veterans without reimbursement. For them to continue to front the costs for an established population of current and future enrolled Medicare-eligible veterans before being able to receive reimbursement from CMS circumvents the purpose of Medicare reimbursement altogether. In addition, it denies those veterans the right to use their earned Medicare entitlement at the provider of their choice. Veterans are unique in that they possess access to two, or in some cases three, different federal health care systems. They have earned the right to VA care by virtue of their service to the Nation and they also have an entitlement to Medicare. Medicare should reimburse VA for care provided to non-service connected Medicare-eligible veterans. Given this scenario, the VA would continue to meet a de facto "level of effort" as it pertains to service-connected Medicare eligible veterans. See question #2.

Question 2: Do you all agree with DAV's position that Medicare funds should only cover non-service connected care?

Response: Yes, we agree that Medicare should not reimburse VA for service-connected care. We believe that VA has an obligation to meet the needs of service-connected care, even if that service-connected veteran is also Medicare-eligible. Further, since VA already has the authority to bill and retain all collections from third-party insurers for any health care it provides to veterans for *non-service-connected* conditions we view Medicare reimbursement as a natural extension of this preexisting authority.

Question 3: I think the Committee agrees with the VSOs that we should use Medicare transfer payments to augment the VA's funding stream. If we enact Medicare funding transfers for VA, how do you believe we can best assure that funds are used to supplement, but not substitute for appropriated funds?

Response: Currently, when veterans receive care from VA for non-service connected conditions, the law (Public Law 105-33) allows VA to bill the veterans' private health insurers and retain these third-party collections in the Medical Care Collections Fund (MCCF) to supplement its appropriations for healthcare. Prior to the creation of the MCCF, these collections were returned to the Department of Treasury. We believe that any Medicare funds transferred to VA would need to be deposited in the MCCF or have a similar type of fund created that would allow VA to retain, without offset from appropriations, and reallocate those funds to provide additional health care resources for our nation's veterans.

THE AMERICAN LEGION
1608 K Street, NW
Washington, DC 20006

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

August 6, 2002

Dear Mr. Chairman:

Thank you, Mr. Chairman, for allowing The American Legion to testify on July 16, 2002, regarding H.R. 4939, the Veterans Medicare Payment Act of 2002.

Per your request, The American Legion welcomes the opportunity to respond to your follow-up questions:

1. **Some veterans' organizations have recommended to the Committee that, for Congress to more fully address VA's funding problems, the funding mechanisms for VA health care shift from a discretionary funding program to a mandatory program. The Ranking Member and I introduced H.R. 5250 on July 26, 2002, a bill that if enacted, we believe would achieve this goal (bill attached).**

   Could you predict the effects of a mandatory funding formula on the VA health care system, and advise the Committee whether such a system of funding would make Medicare coordination unnecessary for VA health care?

The American Legion recognizes the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) as a national resource. Over the years, Congress has invested a great deal to establish an integrated health care delivery network to care for America's veterans. The only tragedy is the constant threat of financial uncertainty. The American Legion believes improved financial stability would reap tremendous rewards that would result in improved quality of care, more timely access to care, and greater accessibility to more veterans.

Currently, all of the Federal health care delivery systems are funded by annual discretionary appropriations; therefore, there is no existing model for mandatory funding. Although Medicare and Medicaid receive mandatory funding, they are Federal health insurance programs. Their mandatory funding formulas are very straightforward; however, their allowable treatments and services are extremely limited. Additionally, many private health care providers consider Centers for Medicare and Medicaid Services' (CMS) reimbursement rates inadequate. One specific Medicare program (Medicare+Choice) is a health maintenance organization (HMO) option. Due to inadequate reimbursement rates for enrolled beneficiaries, many HMOs have refused to participate in the program leaving hundreds of thousands of Medicare beneficiaries with few other health care options.

Even TRICARE for Life presents challenges for its beneficiaries. Under this new Medicare option for Medicare-eligible military retirees and their Medicare-eligible dependents, beneficiaries must purchase Medicare Part B coverage and TRICARE serves as their supplemental insurance provider. Should a TRICARE for Life military retiree choose to go to VA for treatment of a nonservice-connected medical condition, the billing and collection process becomes extremely complex. Under current law, VA cannot bill Medicare Part A or Part B, but is authorized to bill the supplemental insurance provider – TRICARE. This deters TRICARE from referring TRICARE for Life beneficiaries to VHA for treatment. TRICARE may not reimburse VHA for enrolled dual-eligible veterans listing TRICARE for Life as their third-party insurance provider.

Clearly, the accuracy of a mandatory funding formula is an absolutely critical factor. The American Legion believes this fiscal stability (as in the private health care industry) can be achieved through a coordinated, combination of revenue streams:

- Mandatory funding is to cover the cost of health care delivered to veterans identified in title 38, United States Code (USC), as entitled to care.
- Discretionary funding to maintain the physical infrastructure, future construction (major and minor), research, general operating expenses, and state grants programs.
- Co-payments or deductibles paid by certain enrolled veterans for the treatment of nonservice-connected medical conditions.
- Premiums paid directly to VHA for health coverage (basic care, comprehensive care, or specialized services) based upon individual needs by veterans with inadequate health care coverage.
- Third-party reimbursements for the treatment of nonservice-connected medical conditions from health insurance providers (including TRICARE and Medicare).

It is important to emphasize that VHA will continue to compliment, rather than compete, with the private health care industry. VHA's medical education mission will continue to help produce future generations of health care providers. VHA will continue to collaborate with the entire health care industry in the area of medical and prosthetics research. VHA will continue to serve as a backup to the Department of Defense's (DoD) medical services and the National Disaster Medical System during national emergencies. VHA stands ready to assume an additional mission in support of Homeland Security. However, without fiscal stability, VHA's ability to attract and retain quality health care personnel to meet these missions will continue to be a challenge.

2. What kind of funding relationship between VA and HHS would your organizations support, or is there no such relationship that would be acceptable to you?

The American Legion believes VA and the Department of Health and Human Services (HHS) could and should engage in a meaningful, mutually beneficial relationship. By law, VHA is not authorized to bill CMS for the treatment of any enrolled Medicare-eligible veteran. Medicare-eligibility is not a criterion for enrollment in VHA. Medicare is a Federally mandated, pre-paid health insurance program for most Medicare-eligible veterans. Unlike private health insurance options, Federal law requires enrollment and payment – whether the benefit is wanted, used or not – in Medicare. Medicare receives mandatory appropriations and VHA receives discretionary funding. VA is forced to subsidize Medicare's mandatory funding with its scarce discretionary funds for the treatment of all enrolled Medicare-eligible veterans regardless of whether the medical condition is service-connected or nonservice-connected.

During this hearing, Director Tom Grissom from CMS stated *"Foremost, as a matter of principle and by law, the Medicare Trust Funds cannot, and should not, be used to pay for services for which monies have already been appropriated."* Congress does not appropriate funding to pay for health care services for the entire enrolled VHA patient population – the current long waiting periods for appointments is evidence enough to dispel that assumption. Without question, VHA is obligated to treat all service-connected disabled veterans for their service-connected medical conditions. Whether these veterans are Medicare-eligible or not – VHA is obligated to treat them and The American Legion believes be fully funded to meet that obligation. The American Legion sees this as a national obligation for their "**lifetime premiums were paid in full**" and would not expect Medicare or any other insurance provider to be billed for the treatment of service-connected medical conditions.

However, title 38, USC, clearly authorizes all eligible veterans to enroll in VHA within existing appropriations. A great number of these veterans are expected to pay for the quality health care they receive through co-payments and third-party reimbursements specifically for the treatment of nonservice-connected medical conditions. Many of these enrolled veterans identify Medicare as their third-party insurance provider. Clearly, VHA is meeting the health care needs of many Medicare beneficiaries and should be reimbursed for allowable services. As previously mentioned, CMS is fully funded to pay for the medical care of Medicare-eligible beneficiaries.

Both Medicare and VHA are Federal agencies and subject to congressional oversight. This should protect both agencies from incidents of fraud, waste, or abuse in billing or treatment provided. VHA has no profit motive; therefore, medical treatment of America's veterans should be based solely on medical needs rather than budgetary concerns. Both CMS and VA would be achieving their primary goals – delivery of affordable, quality health care to their beneficiaries.

In Director Grissom's testimony, he identified eight principles for a modernized Medicare program – VHA is currently accomplishing all eight principles for enrolled veterans whether they are Medicare-eligible or not. It is clearly obvious to America's veterans, especially those Medicare-eligible, VHA is often their best health care option. However, fiscal instability creates budget-driven problems in timeliness of access of care, accessibility to services, and limited enrollment.

3. **The DAV discusses in its statement the need to convert funding from a discretionary to a mandatory basis. Why would mandatory funding, even if a "perfect" formula were to be developed for VA, be better than Medicare funding for VA, or should they be considered in tandem?**

The American Legion believes, as stated previously, VHA fiscal stability depends on a coordinated combination of revenue streams. Title 38, USC, defines those veterans entitled to health care (whether enrolled in VHA or not) and those veterans eligible to enroll and receive health care within VHA. Clearly, The American Legion believes there are times when Medicare should not be billed for any treatment of medical conditions; however, there are times when Medicare should reimburse VHA for treating certain medical conditions of Medicare-eligible veterans.

4. **Has your organization consulted with the President's Task Force on Veterans Health Care for their views on Medicare-VA relationships? What was the nature of those consultations, and do you expect recommendations from the Task Force dealing with the Medicare dual-eligibility question?**

The American Legion is fully engaged with the ***President's Task Force To Improve Health Care Delivery For Our Nation's Veterans***. The collaboration between The American Legion, the Task Force Members, and the Task Force's professional staff is ongoing. In testimony before the Task Force, The American Legion raised the issue of Medicare reimbursement among many other issues. The American Legion also submitted to the Task Force "white papers" on Medicare Reimbursement for VA, Medicare Reimbursement for Indian Health Service, and the DoD's Medicare Subvention Demonstration Project.

In the "white paper" on Medicare Reimbursement for VA, The American Legion addressed many of the same points covered in this letter.

In the "white paper" on Medicare Reimbursement for Indian Health Service (IHS), The American Legion shared its findings on the successful IHS third-party reimbursement efforts, to include Medicare and Medicaid. The American Legion cited the efforts of CMS to help IHS improve its billing and collection efforts.

In the "white paper" on DoD's Medicare Subvention Demonstration Project, The American Legion identified the unique design flaws (not required of IHS) that destined this well-intended project to nearly immediate financial failure.

On July 31, the Task Force released its Interim Report to President Bush. In Chapter 4, under General Finding 3, Lack *of coordinated benefits between VA and both DoD and Medicare continues to reduce access to care by both VA and DoD beneficiaries*, addresses the current situation. The Task Force will continue to explore this issue in future sessions. The American Legion has every reason to believe the Task Force will address this critical issues concerning dual-eligible (VA and CMS) and tri-eligible (TRICARE, VA, and CMS) veterans.

Other comments:

Thank you again for the opportunity to participate in the hearing and answering additional questions.

The American Legion sees a great deal of difference in VHA and the rest of the health care industry. The private health care industry appears focused on the "bottom-line" and "profit margins" in leadership, managerial, and operational decisions. Congressional oversight and appropriations have forced VHA to exercise fiscal constraint, while improving quality of care,

improving patient safety, shifting emphasis from inpatient to outpatient care, and expanding enrollment eligibility.

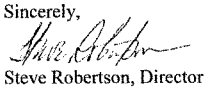
Within VHA, there is an obvious disproportionate growth in the patient to health care provider ratio. Hundreds of thousands of eligible veterans are waiting for an opportunity to enroll in VHA. Once enrolled, newly enrolled veterans are waiting five to six months for their initial appointments. Veterans already enrolled are experiencing unacceptable waiting periods for primary care appointments and specialty care referrals that exceed VA's own acceptable access standards. Current discretionary appropriations is offset by seldom achieved, third-party reimbursements. An inability to bill Medicare for treatment of nonservice-connected medical conditions and VHA's inability to effectively bill and collect from third-party insurance companies further hamper third-party reimbursements.

More and more veterans are turning to VHA than ever before for an array of reasons:

- VHA continues *Putting Veterans First*;
- VHA's quality of care is outstanding across the board;
- VHA's specialized services continue to rank among the nation's best;
- Within VHA, a patient's ability to pay does not directly impact the quality of care received;
- Access to VHA's pharmacy, especially for veterans on maintenance medications, is cost-effective;
- VHA continues to examine the whole-veteran, not just the complaint (preventive medicine);
- Collapse of other health care coverage options; and
- Access is an earned benefit for honorable military service from a grateful nation.

The American Legion stands ready to continue to work with you and your staff to meet the nation's obligation to its veterans and their families.

Sincerely,



Steve Robertson, Director
National Legislative Commission

RESPONSE TO FOLLOW-UP QUESTIONS FOR
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
FROM THE HONORABLE CHRISTOPHER H. SMITH, CHAIRMAN
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
JULY 16, 2002 HEARING

Question: Some veterans' organizations have recommended to the Committee that, for Congress to more fully address VA's funding problems, the funding mechanisms for VA health care shift from a discretionary funding program to a mandatory program. The Ranking Member and I introduced H.R. 5250 on July 26, 2002, a bill that if enacted, we believe would achieve this goal (bill attached).

> Could you predict the effects of a mandatory funding formula on the VA health care system, and advise the Committee whether such a system of funding would make Medicare coordination unnecessary for VA health care?

Answer: The Disabled American Veterans (DAV) believes that shifting Department of Veterans Affairs (VA) health care from a discretionary to a mandatory funding program will bring stability to the system and eliminate the year-to-year uncertainty about funding levels that have prevented VA from being able to adequately plan for and meet the growing needs of veterans seeking treatment. We also believe it will help end the rationing of care due to inadequate appropriations. Mandatory funding for VA health care, coupled with mandated access standards will allow VA to provide quality health care in a timely manner to our nation's sick and disabled veterans.

DAV believes the provisions and base formula for calculating the cost of care per patient included in H.R. 5250 allows for sufficient funding for VA health care for current enrollees therefore; it would not be necessary to pursue Medicare reimbursement as a funding alternative.

Question: What kind of funding relationship between VA and Health and Human Services (HHS) would your organizations support, or is there no such relationship that would be acceptable to you?

Answer: In the absence of mandatory health care funding for VA, Medicare should reimburse the Department for the cost of the care for treatment of Medicare-eligible veterans non service-connected disabilities. We would support a relationship between VA and HHS that included:

- Reimbursement for Medicare-eligible veterans receiving care from VA for non service-connected disabilities only.
- A fee for service contract with the Centers for Medicare and Medicaid Services (CMS) to cover the cost for VA care relative to services rendered.

- A reasonable and appropriate Level of Effort requirement (the number of Medicare-eligible veterans VA would have to cover the cost of care for prior to CMS reimbursement).
- No offset in appropriations as a consequence of Medicare reimbursement.

DAV believes VA participation in a Medicare reimbursement initiative for Medicare-eligible veterans receiving care from VA for non service-connected disabilities will benefit veterans, taxpayers, and ultimately VA as long as Medicare reimbursement dollars are a supplement to an adequate VA appropriation. There should be no offset in appropriations as a consequence of Medicare Reimbursement. Again, we believe the reimbursement should cover the cost of their care and be limited to paying for conditions that are not service-connected since VA is currently receiving appropriations from the government to cover the cost of health care for veterans' service-related conditions.

Although we support Medicare reimbursement, DAV believes a better solution to fully address VA's funding problems would be to shift VA health care from a discretionary funding program to a mandatory program.

Question: The DAV discusses in its statement the need to convert funding from a discretionary to a mandatory basis. Why would mandatory funding, even if a "perfect" formula were to be developed for VA, be better than Medicare funding for VA, or should they be considered in tandem?

Answer: DAV believes that pursuing mandatory health care funding for VA is a more comprehensive approach to solving VA's overall funding problems.

In the absence of mandatory health care funding for VA, we would support Medicare reimbursement for Medicare-eligible veterans receiving care for non service-connected conditions. However, we do not believe that Medicare reimbursement would fully solve VA's funding problems, which stem from years of inadequate appropriations. Additionally, there has been much resistance to Medicare reimbursement for VA. Although we do not believe that Medicare reimbursement for Medicare-eligible veterans seeking care for non-service connected conditions represents a "double payment" from the government for such care, it is complicated and could potentially have a negative impact on VA if not developed properly.

The Department of Defense (DoD) Medicare Subvention pilot program has highlighted numerous problems that can occur as a result of poor contract development and has not proven to be entirely beneficial for DoD. Likewise, factors such as Level of Effort requirements, CMS capitation and payment formulas, and the possibility of an offset of appropriations are all potential pitfalls for a Medicare reimbursement program for VA. Consideration of the specific elements unique to VA's patient population and development of an appropriate CMS contract would be essential for a beneficial VA Medicare reimbursement initiative.

Question: Has your organization consulted with the President's Task Force on Veterans Health Care for their views on Medicare-VA relationships? What was the nature of those consultations,

and do you expect recommendations from the Task Force dealing with the Medicare dual-eligible question?

Answer: DAV presented testimony in support of Medicare reimbursement for VA to the President's Task Force To Improve Health Care Delivery For Our Nation's Veterans (PTF) on January 15, 2002 (see attachment). Since that time we have met formally and informally with members of the PTF, along with other veterans service organizations, on this issue and discussed the question of dual-eligibility on several occasions. However, we do not know if it will be the consensus of the PTF to include the issue of Medicare reimbursement in its final report or if it will recommend support or rejection of the concept. Of course, there is also a possibility the PTF may recommend mandatory health care funding for VA.

RESPONSE TO FOLLOW-UP QUESTION FOR
JOSEPH A. VIOLANTE
NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
FROM THE PRESIDENT'S TASK FORCE TO
IMPROVE HEALTH CARE FOR OUR NATION'S VETERANS
JANUARY 15, 2002 MEETING

QUESTION:

Would Veterans Service Organizations support Medicare subvention, if funds collected were used to offset federal appropriations for VA health care?

RESPONSE:

The Disabled American Veterans (DAV) supports Medicare subvention. We believe VA participation in this initiative will benefit veterans, taxpayers, and ultimately VA as long as Medicare subvention dollars are a supplement to an adequate VA appropriation. To offset federal appropriations for VA health care by revenue from Medicare makes no sense and benefits no one, not veterans, not the VA, not the Medicare Trust Fund, and not American taxpayers.

The Veterans Health Administration (VHA) is the largest health care delivery system in the United States, providing care to more than 4 million veterans at more than 1,300 sites. Following enactment of Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, a standardized Medical Benefits Package became available to all enrolled veterans. To receive VA health care, most veterans must enroll, with the exception of veterans with a service-connected disability of 50 percent or more, veterans who were discharged from the military within one year but have not yet been rated for a VA disability benefit, and veterans seeking care for only a service-connected disability. Although access to health care is an earned benefit, based on honorable military service, it is not considered an entitlement; therefore, it is subject to annual discretionary appropriations. Priority level funding may change from year to year, depending on congressional appropriations. Seven priority groups were established to help ensure that VA resources are allocated to veterans with the highest priority for care. Priority Group 1, made up of veterans with service-connected disabilities rated 50 percent or greater have the highest priority to care. Priority Group 7 veterans are nonservice-connected veterans and noncompensable service-connected veterans with incomes and net worth above the established thresholds, who agree to pay specified copayments for medical care and prescription medication. Currently, VHA is authorized to retain all copayments collected from Priority Group 7 veterans and third-party reimbursements collected from their private insurance companies. However, VHA is prohibited from billing Medicare for services rendered to Priority Group 7 Medicare-eligible veterans.

Medicare-eligible Priority Group 7 veterans have earned the right to use VA health care services. We strongly believe that Congress should pass legislation that permits Medicare-eligible Priority Group 7 veterans the option of choosing VA health care and using their Medicare coverage. Citizens purchase Medicare coverage through payroll deductions and should

have the right to use those benefits to receive care from the provider of their choice. The VA health care system is well known for its specialized programs in areas such as blind rehabilitation, spinal cord injury, post-traumatic stress disorder, traumatic brain injury and mental health. Medicare subvention would give veterans who currently cannot use their Medicare coverage at VA facilities, but who need specialized care, the option of choosing the VA system and using their Medicare coverage. Additionally, VA believes it can deliver care to Medicare beneficiaries at a discounted rate, which would save money for the Medicare Trust Fund and stretch taxpayer dollars. Allowing Medicare-eligible Priority Group 7 veterans to apply their Medicare benefits in VA facilities would reduce the government's total health care expenditures. VA health care costs less, at least 25% less, than private-sector providers billing at Medicare rates. The savings could be realized by reduced cost to patients, through low or no copayments, or passed on to taxpayers by setting subvention rates discounted from standard Centers for Medicare & Medicaid Services (CMS) rates, or by a combination. A large number of Priority Group 7 veterans bring diversity to the case mix and lower average costs. Finally, this group comprises a body of users that could be directed to other Medicare providers outside the VA system in case VA is needed to fulfill its fourth mission as backup to the Department of Defense in time of War or domestic emergency.

The VA Secretary determines Priority Group 7 veterans' access to VA health care on an annual basis. VA's ability to provide their care largely depends on if it receives an adequate appropriation for health care. From one year to the next, this group of veterans is not sure if they will be able to continue to use VA health care services. Secretary Principi was prepared to announce his decision to limit enrollment of new Priority Group 7 veterans for this year. At the last minute he reversed his decision based on a promise from the Administration to provide supplemental funding to VA to continue open enrollment for all priority groups in 2002. The potential closure of enrollment for new Priority Group 7 veterans demonstrates that appropriations cover only Priority Groups 1-6. Medicare Subvention would obviate the need to deny access to Priority Group 7 users.

The cost of care for this growing population of enrolled Priority Group 7 veterans exceeds medical care cost recovery (MCCR) from these patients and their secondary insurers. The DAV along with the *Independent Budget* (*IB*) group has consistently opposed the offset of MCCR collections. We believe that it is the responsibility of the Federal government to fund the cost of veterans care; therefore, we do not include any cost projections for MCCR in the *IB* budget development. VA's historical inability to meets its collection goals has eroded our confidence in VA estimates. We have urged the Administration and Congress to drop this budget gimmick and address the veterans' medical care appropriations in a straightforward manner by providing a realistic budget fully funded by appropriations. We strongly believe monies collected through MCCR should be a supplement to, not a substitute for, appropriations. Collections from Medicare-eligible Priority Group 7 veterans do not cover the cost of their care, and since appropriations are not sufficient, these funds are redirected away from service-connected and poor veterans to subsidize the Medicare trust fund. Additionally, because of the shortfall in appropriated funds, services provided for the care of service-connected and poor veterans are delayed, and those veterans particularly must wait much too long to receive necessary care.

While we support Medicare subvention, we would want Congress to ensure that service-connected disabled veterans would not be displaced or forced to wait even longer for necessary care and that revenue generated from Medicare subvention will not be used to offset federal appropriations. It doesn't make any sense to replace appropriated funds with Medicare funds. There is no benefit to VA, Medicare, or taxpayers if VA appropriations were offset by Medicare revenues.

The assumption that subvention dollars should necessarily be offset by VA appropriation reductions is invalid because it is based on the incorrect belief that current appropriations are sufficient to provide services to service-connected, poor, and Priority Group 7 Medicare-eligible veterans. While VHA sets standards for quality and efficiency, veterans' access to health care is constrained. Consistently inadequate appropriations have forced VA to ration care by lengthening waiting times. Last year appropriations were barley sufficient to cover the cost of care for Priority Groups 1-6. Appropriations over the last several years have been insufficient to provide services to service-connected, poor, and Priority Group 7 Medicare eligible-veterans. By VA estimates, there are approximately 1 million Priority Group 7 users with 50-65 percent Medicare eligible. Only 15 percent of Priority Group 7 Medicare-eligible users have billable Medigap insurance, leaving 85 percent where VA receives no insurance reimbursement. The average collections from Medigap insurance for Priority Group 7 Medicare-eligible veterans is estimated at only 12-13 percent of the possible total billable portion. Obviously, VA spends a significant amount of resources on providing health care services for Priority Group 7 Medicare-eligible veterans with little reimbursement. We strongly believe their health care costs should be covered by Medicare funds.

The director of CMS has stated that veterans' care should be covered by VA appropriations and that subvention would represent a double payment by the government. This is a spurious argument; actually, the current situation represents "reverse subvention" with VA appropriations used to pay for care that has already been funded by contributions to the Medicare Trust Fund. We estimate that $600 million of the veterans medical care appropriations is used to subsidize Medicare.

No veteran should be denied access to the veterans health care system. Veterans, even veterans like those in Priority Group 7, who are not poor, have the right to take advantage of VA health care. However, service-connected and poor veterans should not have to subsidize care for veterans who have public or private insurance coverage. Medicare subvention would allow Medicare-eligible Priority Group 7 veterans to become a source of funding rather than a drain on an already over-extended system. We strongly urge the President's Task Force to recommend to the administration's support of Medicare subvention without offset to the annual appropriation.

RESPONSE TO FOLLOW-UP QUESTIONS FOR
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
FROM THE HONORABLE LANE EVANS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
JULY 16, 2002 HEARING

Question One: In the past, many bills that shift funding from Medicare to VA have required VA to meet a "level of effort." In the Department of Defense's demonstration project, this was never done to the Center of Medicare and Medicaid's (CMS) satisfaction, so funds were never transferred. Assuming that our efforts in this Committee lead us back down that path, are you still willing to support a bill that transfers funds between agencies?

Answer:

Initially, Disabled American Veterans (DAV) believes a better solution to fully address the funding problems of the Department of Veterans Affairs (VA) would be to shift VA health care funding from discretionary appropriations to a mandatory program. In the absence of mandatory health care funding for VA, we believe Medicare should reimburse the Department for the cost of the care for treatment of Medicare-eligible veterans for nonservice-connected disabilities. However, DAV could not support a Medicare reimbursement project for VA that does not ensure a fair and reasonable Level of Effort requirement (the number of Medicare-eligible veterans for whom the VA would have to cover the cost of care prior to CMS providing reimbursement.)

As you pointed out, the Department of Defense (DoD) Medicare Subvention pilot program has highlighted numerous problems that can occur as a result of poor contract development and has not proven to be entirely beneficial for DoD. Likewise, factors such as Level of Effort requirements, CMS capitation and payment formulas, and the possibility of an offset in appropriations are all potential pitfalls for a Medicare reimbursement program for VA. An appropriate CMS contract, reflecting specific elements unique to VA's patient population, would be essential for a beneficial VA Medicare reimbursement initiative.

DAV would support a contract between VA and CMS for Medicare reimbursement that included:

- Reimbursement for Medicare-eligible veterans receiving care from VA for nonservice-connected disabilities only
- A fee-for-service contract with CMS to cover the cost for VA care relative to services rendered
- A reasonable and appropriate Level of Effort requirement
- No offset in appropriations as a consequence of Medicare reimbursement.

We believe VA participation in a Medicare reimbursement initiative for Medicare-eligible veterans receiving care from VA for nonservice-connected disabilities will benefit veterans,

taxpayers, and ultimately VA as long as Medicare reimbursement dollars are a supplement to an adequate VA appropriation. There should be no offset in appropriations as a consequence of Medicare reimbursement. Again, we believe reimbursement should cover the cost of their care and be limited to paying for conditions that are not service-connected since VA is currently receiving appropriations from the government to cover the cost of health care for veterans' service-related conditions.

Question Two: Do you all agree with DAV's position that Medicare funds should only cover nonservice-connected care?

Answer:

N/A

Question Three: I think the Committee agrees with the VSOs that we should use Medicare transfer payments to augment the VA's funding stream. If we enact Medicare funding transfers for VA, how do you believe we can best assure that funds are used to supplement, but not substitute for appropriated funds?

Answer:

Again, in the absence of mandatory health care funding for VA, Medicare should reimburse the Department for the cost of the care for treatment of Medicare-eligible veterans for nonservice-connected disabilities. We believe VA participation in a Medicare reimbursement initiative will be beneficial to VA as long as Medicare subvention dollars are a supplement to an adequate VA appropriation. To offset federal appropriations for VA health care by revenue from Medicare makes no sense and benefits no one, not veterans, not the VA, not the Medicare Trust Fund, and not American taxpayers.

We clearly object to any offset of appropriations as a consequence of Medicare reimbursement for VA; however, there is no way to guarantee an offset would not occur. VA forwards its annual budget proposal to the Office of Management and Budget (OMB) for approval and it is possible that OMB would direct VA to make the offset and deduct an equal amount of funds projected to be collected from Medicare from the overall VA medical care appropriation. Even if Congress passed legislation that specifically prohibited an offset, budget gimmicks or manipulation of budget figures could be utilized to create an offset.

As we indicated in our testimony, the assumption that subvention dollars should necessarily be offset by VA appropriation reductions is invalid because it is based on the incorrect belief that current appropriations are sufficient to provide services to service-connected, poor, *and* Priority Group 7 Medicare-eligible veterans (nonservice-connected veterans and noncompensable service-connected veterans with incomes and net worth above the established thresholds, who agree to pay specified copayments for medical care and prescription medication). The director of CMS has stated that veterans' care should be covered by VA appropriations and that subvention would represent a "double payment" by the government. This too is a spurious argument; actually, the current situation represents "reverse subvention" with VA appropriations used to pay for care that has already been funded by contributions to the Medicare Trust Fund.

If Congress pursues Medicare reimbursement for VA, we urge the Committee to do everything possible to ensure a fair and equitable VA Medicare reimbursement program is developed without an offset in appropriations.