STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HEALTH
SEPTEMBER 6, 2001

Mr. Chairman and Members of the Subcommittee:

On behalf of the more than one million members of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express our views on several pieces of legislation before the Subcommittee.

Today's agenda includes H.R. 2792, the Disabled Veterans Service Dog and Health Care Improvement Act of 2001, H.R. 1435, the Veterans' Emergency Telephone Service Act of 2001, and H.R. 1136, a bill to require Department of Veterans Affairs (VA) pharmacies to fill prescriptions written by private practitioners. These several bills cover a range of issues important to disabled veterans and their families. We support many of the provisions, but for the reasons we state below, we oppose or have concerns about a few.

H.R. 2792—DISABLED VETERANS SERVICE DOG AND HEALTH CARE IMPROVEMENT ACT OF 2001

Section 2 of this bill would authorize VA to provide certain hearing-impaired veterans and veterans with spinal cord injury or dysfunction, in addition to blind veterans, with service dogs to assist them.

Although DAV does not have a resolution on this issue, this provision is beneficial and will assist all enrolled veterans with certain severe disabilities. The DAV is not opposed to the favorable consideration of this section of the bill by the Subcommittee.

Section 3 of the bill pertains to maintenance of capacity for specialized treatment and rehabilitative needs of disabled veterans. It proposes to amend the definition of capacity to include each geographic service area of the VA, in relationship to the maintenance of capacity in the Department for specialized treatment and rehabilitative needs of disabled veterans. It would require VA to measure capacity by the annual amount expended for care (adjusted for inflation) in such dedicated programs. Additionally, it would extend the annual Capacity Report requirement through 2004. We suggest that section 3 of the bill further clarify the obligation to maintain capacity and include a mandate for monitoring capacity at the network level.

The VA noted in its draft annual Capacity Report for 2000 "[n]ationwide capacity appears to be maintained or improved for workload measures in seven out of eight special disability specialties…. For all disability programs except Substance Abuse, VHA can document that it has maintained or improved its workload capacity for its special disabilities programs…."

As we previously testified before this Subcommittee, we disagree with these findings and assert that VA has not met capacity in accordance with the spirit of Public Law 104-262, which mandated that,

> [T]he Secretary shall ensure that the Department maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of disabled veterans in a manner that (A) affords those veterans reasonable access to care and services for those specialized needs, and (B) ensures that the overall capacity of the department to provide such services is not reduced….

It was also mandated that capacity would be maintained at levels reported in fiscal year 1996. Interested parties argued that capacity measures should be determined by the number of veterans treated and the dollars expended for their care, and that capacity is only maintained if both components are met. We agree that both of these variables are necessary to accurately access if capacity is being met. Including both components would allow us to monitor whether the necessary reinvestment of resources from institutional to outpatient-based care is occurring in certain specialized programs. Finally, we agree that these figures are only meaningful if a reasonable adjustment for inflation is included. Maintaining acceptable capacity levels in each network is key to ensuring that veterans have timely access to specialized care in the appropriate treatment venue. It is essential that each network maintain capacity in its medical centers and community-based outpatient clinics so that veterans have access to the specialized programs they need.

We urge that additional requirements for measuring capacity be added to ensure veterans have equal access to specialized programs throughout the system. For example, the Capacity Report should include specific information about the types of programs available in each geographic service area, the number of patients treated in each program, the number of inpatient beds available, and the number of full-time employees that supports these programs. Additionally, there should be a means established by which network directors and medical center directors can be held accountable for providing this information and maintaining capacity levels of VA special disability programs as mandated by law.

Information provided in the annual Capacity Report is essential for determining the status of specialized programs within VHA. Unfortunately, there is still valid criticism about the reliability of the data contained in the report. It is imperative that uniform data collection standards be developed to ensure valid reliable data is generated for reporting purposes. Information contained in the Capacity Report is necessary for tracking the status of these important programs, and we agree there should be an extension of the annual report requirement as proposed in this section of the bill.

Section 4 of the bill would change the means test used by VA in determining whether a veteran will be placed in enrollment priority Category 5 or 7. The current placement eligibility threshold is set at about $24,000 nationwide. This legislation attempts to level the playing field to adjust the means test based on locality, thereby allowing veterans living in high-cost areas to be classified as Category 5 if they fall below the new threshold level.

DAV does not have a resolution from our membership on this issue however, its purpose appears beneficial. DAV does not oppose the favorable consideration of this section of the bill.

Section 5 of the bill would establish a pilot program designed to allow certain veterans in under-served areas to seek inpatient services in private sector hospitals utilizing their own health insurance, with VA becoming a secondary payer of any other out-of-pocket expenses. A similar measure was introduced last year with which we took exception. Despite a few new revisions in this bill, our overall objection to this concept still stands.

This measure would pay for the costs of general medical and surgical inpatient care and services not covered by any applicable health-care plan of the veteran. To be eligible, the veteran would have to be enrolled in VA to receive medical care services, have received care within a 24 month period proceeding application for enrollment in the pilot program, and require care for a non-service connected condition if services are not available from a VA facility. The proposal contains language stating that VA would coordinate care by providing case management. Additionally, any expenditure of funds shall be made from amounts in the Medical Care Collections Fund (MCCF).

We are deeply concerned that this initiative would shift medical services and veteran patients from VA to the private sector. It would encourage VA to refer patients, and the dollars used to subsidize their care outside the system. VA would lose third-party reimbursements that veterans bring to help underwrite the provision of care for all veterans using the VA health care facility. This proposal sets a dangerous precedent that, if allowed to expand, could endanger VA facilities' ability to maintain their full range of specialized inpatient services for all veterans. It would erode VHA's patient resource base, undermining VHA's ability to maintain its specialized services programs, and endanger the well being of veteran patients.

Additionally, it would allow disparate treatment of veterans depending on whether or not they have insurance, in essence creating a new eligibility category for veterans' health care based not on veteran's need, but solely on the veteran's geographic location, and to a great extent, the veteran's own health insurance. Finally, although the provision includes language for case management, we believe the VA's ability to coordinate care would be limited at best.

Clearly, other initiatives should be considered to assist veterans who reside in under-served areas. We are, however, opposed to any initiative that would turn VA into an insurer rather than a provider of health care. For the benefit of all, we feel the VA must use its resources to maintain the base of its health care services, which are provided through and by VA health care facilities and health care providers. This traditional form of VA health care has served well to offer an uninterrupted flow of services to veterans in need, and ensure the quality of those services no matter where or when they are provided.

Section 6 of the bill would establish a managed care pilot program for contract hospitalization and fee basis ambulatory care users. All fee basis and contract hospitalization provided by the Secretary in selected pilot locations would be furnished through a managed care coordinator contractor. Eligible veterans would be provided a directory to receive non-VA care or to use in health emergencies in the case of contract hospitalization. This section provides that a primary care manager would be established in each participating facility to ensure that veterans participating in the program receive appropriate care, and that they would be brought back into the VA system for followup care whenever possible and appropriate.

Of great concern to the DAV is that managed care of VA fee basis patients may create a barrier for these veterans in getting the care they need. Managed care programs frequently do not offer the kinds of specialized services that disabled veterans may need. Fee basis and contract care are provided to veterans when needed services are unavailable at a VA health care facility or when veterans would have to travel too far to a VA facility to receive the care they need. Currently, fee basis patients are able to choose the physician they want to see for fee-based health care services. As part of a managed care plan, the veteran would be required to choose one of the participating clinicians or hospitals for care. Many veterans participating in the fee basis program have long established relationships with their health care providers and are satisfied with the care they receive. We do not see that this measure would assist veterans in receiving timely, quality medical care to meet their health care needs.

Section 7 of the bill would authorize certain bereavement counseling and counseling, training, and mental health services for immediate family members of certain service and non-service connected veterans.

Although DAV does not have a resolution on these issues, this provision is beneficial and will assist veterans' family members in coping with the loss of a loved one or in coping with a serious mental health illness of a disabled veteran. The DAV is not opposed to favorable consideration of this bill by the Subcommittee.

Section 8 of this measure would extend existing MCCF authority with respect to third party collections and medication co-pays. Congress authorized VA to collect co-payments for treatment of nonservice-connected conditions as a temporary measure to achieve savings for deficit reductions. Large budget surpluses have been projected over the next decade, and, under ordinary circumstances, veterans should not have to pay for benefits accorded them by a grateful nation.

The delegates to our last National Convention in Miami Beach, Florida, July 28-August 2, 2001, passed a resolution opposing any legislation that would require the VA to increase or extend the congressional authority for collection of co-payments.

DAV strongly opposes medication co-pays.

H.R. 1435—VETERANS' EMERGENCY TELEPHONE SERVICE ACT OF 2001

This measure would authorize grants to establish a national toll-free hotline to provide information and assistance to veterans and their families, including crisis intervention counseling, general information regarding veterans' benefits under title 38, United States Code, and information about provisions of emergency shelter and food, substance abuse rehabilitation, employment training and opportunities, and small business assistance programs. The provisions of this bill limit a grant to a period of not more than two years, with payment subject to annual approval by the Secretary and subject to the availability of appropriations.

The proposed legislation would require a private, non-profit entity to contract with a carrier for use of a toll-free telephone line; employ trained and supervised personnel to answer incoming calls and provide counseling and referral service to callers on a 24-hour-a-day basis; assemble and maintain a current database of information; and publicize the hotline. The private, non-profit organization must demonstrate that it is a nationally recognized expert in the area of furnishing assistance to veterans and have a record of high quality service in furnishing such assistance, including the support from advocacy groups, such as veterans service organizations.

As written, the DAV is opposed to H.R. 1435. As stated in our July 10, 2001 testimony before the Subcommittee on Benefits, this measure attempts to take away an intrinsic part of VA's mission of service to veterans and their families.

Since about 1993, the VA has had a toll-free number whereby veterans or other VA claimants could obtain information about benefits and health care services. VA counselors also have available to them information on benefits offered by other federal departments and agencies and the states.

In March 2001, the DAV conducted a nationwide survey of VA's national toll-free hotline. The supervisory NSOs in all of our offices were asked to call the VA toll-free number and track how many times they had to call before they got through and how long they had to wait to receive the requested service. They were instructed to request the "new" Agent Orange Help Line toll-free number, which had been published by the VA the week prior to our survey.

The results of our survey were surprising and somewhat unexpected. In all but a few cases, our NSOs were able to access the help line on the first call. In one case, in Hartford, Connecticut, it took 14 tries before they were able to get through; however, very few NSOs received a busy signal when they called. For the most part, services were rendered in less than five minutes—this was total call time. In the vast majority of the calls, our NSOs received the correct toll-free Agent Orange Help Line phone number. In some cases, our NSOs were put on hold while the counselor obtained the phone number. In a few cases, our employees were referred to either the medical center or the Agent Orange registry. Overwhelmingly, we were informed that the counselors were polite and courteous. In some cases, the counselors offered to provide any additional assistance that might be needed on other matters.

The only complaint we received from a few of our supervisory NSOs dealt with the automated, recorded message they had to listen to before reaching a counselor. It was their

concern that older veterans might find it frustrating or difficult to maneuver through the automated message. However, it is difficult to imagine how a more effective system might be devised to avoid this situation and still provide a complete menu of available services.

In conclusion, it would appear that the experience from our survey confirms that the current VA toll-free number is working. As with any service, it must be continually monitored, evaluated, and improved.

If this Subcommittee believes that VA is not adequately meeting the needs of veterans or other VA claimants in providing needed information, then VA should be held accountable. If this Subcommittee also believes that 24-hour-a-day access to this information is necessary, then VA should be provided the resources to staff these toll-free telephone lines 24-hours a day.

The DAV does not believe that a private, non-profit organization would be better able to handle this function. Accordingly, we oppose this legislation.

This measure has been marked up by the Subcommittee on Benefits and amended provisions were considered by the full Committee and incorporated in H.R. 2540 as a pilot program for VA to expand its current service hours. This bill has passed the House and been referred to the Senate. DAV supports the language of section 407 of H.R. 2540.

H.R. 1136

This bill would require VA pharmacies to dispense medications to veterans for prescriptions written by private practitioners.

This measure would be beneficial to a large segment of the veteran population who do not currently receive their health care from VA. We recognize that requiring this group of veterans to use the VA system for all their health care needs just to receive prescription medications would further burden the system, cause additional delays in the delivery of health care services, and greatly increase the cost of VA health care. Indeed, VA is experiencing a large influx of veterans seeking care, apparently to obtain medication through VA. Perhaps this legislation would result in a net savings to VA. However, we foresee that, if veterans were authorized to access prescription drug benefits only, a significant number of veterans who are not currently using the system would likely choose this option and thereby cause a significant increase in overall pharmaceutical costs to VA.

Of great concern to the DAV is that, if this measure were passed and not appropriately funded to meet the presumed increased costs in pharmaceuticals, it would be extremely detrimental to the VA health care system and to currently enrolled veterans. It would place significant stress on an already overburdened system and cause a negative impact on veterans who depend on VA for all their health care needs. Additionally, we are concerned that if this mandate was not properly funded, VA may again propose to increase co-pays for medications as a way to offset rising pharmaceutical costs.

CLOSING

The DAV sincerely appreciates the Subcommittee for holding this hearing and for its interest in improving benefits and services for our Nation's veterans. The DAV deeply values the advocacy this Subcommittee has always demonstrated on behalf of America's service-connected disabled veterans and their families. Thank you for the opportunity to present our views on these important measures.