STATEMENT OF

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BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

H.R. 2792, H.R. 1435, AND H.R. 1136

SEPTEMBER 6, 2001

Chairman Moran, Ranking Member Filner, members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA) I am pleased to present our views on H.R. 2792, the "Disabled Veterans Service Dog and Health Care Act of 2001," H.R. 1435, the "Veterans' Emergency Telephone Service Act of 2001," and H.R. 1136. PVA would like to thank you, Mr. Chairman, for including many of PVA's legislative priorities as part of H.R. 2792.

H.R. 2792, The "Disabled Veterans Service Dog and Health Care Improvement Act of 2001"

There are several provisions in H.R. 2792 that PVA supports, but there are several that we oppose at this time. I will comment on each of these provisions.

<u>Section 2: Authorization for Secretary of Veterans Affairs to Provide Service Dogs for Disabled Veterans</u>

The Department of Veterans Affairs (VA) is currently authorized to provide guide dogs to blinded veterans with service-connected disabilities only. However, there are many veterans, both service-connected and non-service connected, who suffer from certain disabilities who would benefit a great deal from having guide dogs or service dogs. These veterans include hearing-impaired veterans as well as veterans who suffer from spinal cord injury or dysfunction or other chronic impairments that severely limit mobility or function.

The Journal of the American Medical Association (JAMA) published a study in 1996 that assessed the value of service dogs for people with ambulatory disabilities. The study found "reports of paid and unpaid assistance demonstrated dramatic economic benefits of service dogs." After one year, the study found a decrease of 68 percent in paid assistance hours and a 64 percent decrease in unpaid assistance hours.

The JAMA study also detailed the many tasks that service dogs can perform, such as "open and close doors, turn switches on and off, pull a person up from a sitting position

or lying down position, assist a person in and out of baths and pools, help pull on clothing, procure and pick up objects, pull wheelchairs, and drag a person to safety in case of fire or other emergency."

PVA strongly supports Section 2 of H.R. 2792, that expands the authority of the Department of Veterans Affairs to provide guide dogs and service dogs to both service-connected and non-service connected veterans who are enrolled in the VA health care system. We believe service dogs and guide dogs are essential to creating a better quality of life for sight or hearing impaired veterans as well as those veterans who suffer from a spinal cord injury or dysfunction that substantially limits mobility or function. The dogs will give these severely disabled veterans a measure of self-confidence and independence that they would not otherwise have.

We have concerns over the language, as introduced in the Senate, that would restrict service dogs to only those veterans in receipt of disability compensation. With health care eligibility reform we moved to a uniform benefits package for veterans enrolled for VA care. By limiting service and guide dogs to those veterans who are in receipt of disability compensation, we would again start down the path of a hodgepodge system of health care benefits, an approach repudiated only a few short years ago.

The advantages provided by service dogs, both in terms of economic benefits and improvements in quality of life, should be made available to all veterans who are in need of this wonderful service. For over half-a-century, PVA has fought for the integration of

people with disabilities into the economic and social life of our Nation. Providing service dogs to veterans who need them would be a major step forward in the ultimate realization of this goal. As one participant, who has a spinal cord injury, stated in the JAMA study, "with my [dog], I feel safe and capable, and I am no longer afraid of the future. Everyone needs someone to care for, and we care for each other with dignity."

Section 3: Maintenance of Capacity for Specialized Treatment and Rehabilitative Needs of Disabled Veterans

Congress, in 1996, mandated that the Department of Veterans Affairs (VA) maintain its capacity to provide specialized services such as spinal cord injury or dysfunction (SCI/D). The VA, until last year, defied this simple statutory mandate. After much negotiation, the VA issued VHA Directive 2000-022 stipulating that all SCI centers return to mandated capacity levels by the end of the fiscal year.

PVA believes that the only way to adequately, and accurately, determine capacity is to account for the number of beds and staff. Counting the number of patients treated, waiting times, outcomes, or resources are all interesting markers determining the extent of care provided, but we have found that counting staffed beds and dedicated staff assigned to SCI/D Centers are the only ways to truly measure capacity. This is the only way to ensure that the VA is living up to its statutory requirements, and upholding its own directive.

PVA believes that Congress should address each of the VA's specialized services, in terms of capacity, separately. This approach should be tailored to the distinct

characteristics of each program, for elements that would address capacity for spinal cord injury/dysfunction care may well not adequately address the unique characteristics of mental health care, or blind rehabilitation.

Unfortunately, Section 3 of H.R. 2792 does not go far enough. Although PVA appreciates the efforts to require VA to meet the capacity requirements mandated by law, we are concerned that this language will undercut the agreement and directive we have negotiated with the VA, and it will allow the VA to default to a lesser standard. Capacity should be determined by a true count of actual staffed beds, for acute and long-term care or residential beds, and specialized, professional health care staff dedicated to providing care at SCI centers. Any other method for accounting for capacity would only establish a standard based on wishes and good intentions that does not reflect the reality faced by SCI/D veterans seeking care.

PVA also believes that there must be some accountability in the capacity reporting. Just having an individual "monitoring" the reports or data is not enough. The Veterans Integrated Service Network (VISN) directors must be held accountable for ensuring that VAMC's are meeting the capacity requirement. We propose that the maintenance of capacity of the specialized services be included in the performance plans of the VISN directors.

PVA supports the provision to extend the capacity reporting requirement for another three years. It provides a guide for enforcing the capacity requirement mandated by law and directive.

Section 4: Threshold for Veterans Health Care Eligibility Means Test to Reflect Locality Cost-of-Living Variations

PVA has argued in favor of a change to the means test used by the VA to determine whether veterans will be placed in enrollment priority Category 5 or 7 for a long time. These category placements are important because veterans enrolled in lower categories, such as 6 or 7, whose incomes are above current means test levels are required to make co-payments for most of their care. Most importantly, veterans placed in Category 7 are at a greater risk of losing access to VA health care due to budgetary constraints. Congress, in establishing Category 5, demonstrated its intention to provide health care to veterans with lower incomes, thereby serving as a safety net. Unfortunately, the current national "one-size-fits-all" means test fails to take into account the higher costs of living faced by certain veterans in different geographic locations.

As the attached white paper discusses, we have identified an established formula implemented by the Department of Housing and Urban Development (HUD) to set income limits for eligibility for low income housing benefits. The HUD formula makes adjustments in means test eligibility based on the cost-of-living experience in most every locality in the United States. As with the current VA system it also adjusts for the number of dependents in the applicant household.

PVA supports Section 4 which seeks to adjust the national means test threshold by locality to reflect the differences in geographic cost-of-living. This adjusted means test would help veterans who have incomes slightly higher than the existing threshold who have previously been designated as Category 7 but will be reclassified as Category 5. It is important to realize that the adjusted means test threshold would benefit veterans located all over the county—North, South, East, and West. The new standard based on the Department of Housing and Urban Development (HUD) Low Income Index established by the U.S. Housing Act of 1937 used to determine eligibility for low income housing assistance would realistically and equitably reflect cost-of-living variations from one locality to the next without going below the current means test threshold.

Section 5: Pilot Program for Coordination of Ambulatory Community Hospital Care

PVA opposes Section 5 that would allow non-service connected veterans in under-served areas to go to private health care inpatient facilities using their private health insurance. The VA would pay for the co-payments associated with these health care visits. PVA is not opposed to contracting for medical services when there is a demonstrable lack of availability of certain services within the VA, but we do oppose efforts that would turn the VA into an insurer of health care rather than a provider of health care. Passage of this provision would not only represent a major departure from the usual delivery of VA health care services, but would provide disparate treatment of veterans depending on whether or not they have private insurance, undermine the VA's ability to maintain its specialized services programs by eroding the VA's patient and resource base, and endanger the well-being of veterans.

PVA is concerned about the breakdown of the "hub-and-spoke" approach that the VA has used effectively in its health care system. The outpatient clinics (spokes) are supposed to feed patients into the nearest major VAMC (hub). However, under this program, patients would be sent from the outpatient clinic into the private sector. Once a veteran is sent into the private sector, the VA does not maintain any responsibility to provide follow-up care or treatment for that patient. Veteran patients would be lost to the system, as would any possible third-party payments. VA hospitals would see fewer patients. This would set a dangerous precedent that, if allowed to expand, could endanger the viability of a VA facility maintaining its full range of specialized inpatient services for all other veterans in the area as those resources go elsewhere.

There was concern in the past about funding this program from money appropriated to the Veterans Health Administration hospitals. In an attempt to overcome this problem, the bill proposes to pay for the program with funds from the Medical Care Collection Fund. Although this appears to release the pressure on hospitals to take money from their own budgets, it does not because the hospitals usually use money from the Collection Fund anyway because of the annual shortfall in appropriations for health care in the VA. With current inadequate health care appropriations, VA is finding it difficult to care for existing enrolled veterans, let alone subsidize an expansion of non-VA benefits and services.

Section 6: Pilot Program for Contract Hospitalization and Fee Basis Ambulatory Care

Currently, under 38 U.S.C. § 1703, the VA may, under certain circumstances, contract with non-VA health care facilities to furnish care for veterans if they live in an area where a VAMC is "geographically inaccessible" or because the VA is "not capable of furnishing the care or services required[.]" Under 38 U.S.C. § 1728, the VA has limited authority to reimburse veterans for health care received at non-VA facilities under certain special circumstances. Section 6, "Pilot Program for Contract Hospitalization and Fee Basis Ambulatory Care," of H.R. 2792 would force veterans in four geographic areas to receive their health care under these two statutory sections from a managed care provider. We strongly oppose this section.

People with disabilities are most at risk under a managed care regime. Forcing disabled veterans into a managed care plan would put veterans at the mercy of the health care managers who would ration their care. This could negatively effect the quality of care that a disabled veteran is receiving. A managed care program would limit the veterans' choice of health care provider. Likewise, private managed care programs do not have well-developed specialized services and direct access to specialists required by people with severe disabilities. There is no guarantee that the specialized services that the disabled veterans need will be available in the private health system. Severely disabled veterans would be forced to settle for low quality specialized care or none at all.

Section 7: Recodification of Bereavement Counseling Authority and Certain Other Health-Related Authorities

PVA supports Section 7 of the bill. For veterans who live at home, family members tend to be the primary care givers, and provide as much to the health and well-being of the veteran as a doctor or specialist. For those family members who either provide care to a severely disabled veteran or who suffer from their own severe illness or disease, they deserve assistance from the VA. They should be entitled to any bereavement counseling or support that they might need to improve their quality of life.

Section 8: Extension of Expiring Collections Authorities

PVA supports the extension of collection authorities established by Section 8 of the bill. The VA already maintains the authority to collect per diem nursing home and hospital co-payments from certain veterans, and to collect third-party payments for the treatment of non-service connected disabilities of veterans with service-connected disabilities. These collections serve as additional income for the VA on top of money that is appropriated by the government.

H.R. 1435, The "Veterans' Emergency Telephone Service Act of 2001"

As we have testified, we are unable to support H.R. 1435, the "Veterans' Emergency Telephone Service Act of 2001." As we stated before the Subcommittee on Benefits on July 10, 2001, we believe that the VA should operate any informational hotline that is created in addition to the service it currently operates. The VA has the expertise, and the

mandate, to accurately answer informational requests and to assist veterans with their benefits claims. More can be done to make the general public aware of this resource, and more can be done to improve it, but granting money to an outside entity to create a hotline without fixing the current hotline is inappropriate.

H.R. 1136, A Bill to Amend Title 38 U.S.C., to Require VA Pharmacies to Dispense Medications to Veterans for Prescriptions Written by Private Practitioners

PVA does not support H.R. 1136, a bill that requires VA pharmacies to dispense medications to veterans for prescriptions written by private practitioners. The approximate $1 billion increase for health care slated for FY 2002 does not even cover salary increases and inflation for the coming year. Moreover, it is estimated that next year the cost of pharmaceuticals will be three times the rate of inflation. The VA does not need to take on the role of the veterans' drug store. Now is not the time, when the VA does not have the resources necessary to provide sick and disabled veterans the health care they need, to further burden the VA with additional demands on these scarce resources.

Again, PVA appreciates the opportunity to share our views on these important measures with this Subcommittee. It is clear that we need to work together to reach a common ground on capacity requirements, the means test threshold, and specialized care for severely disabled veterans. The end result should be provisions that are equitable and fair and that do not diminish the quality and quantity of health care our veterans are receiving.

This concludes my testimony, Mr. Chairman. I would be happy to answer any questions that you or any of the other members of the committee might have.

ATTACHMENT

Proposal to Adjust Veterans Health Care Eligibility Means Test to More Accurately Reflect Locality Cost of Living Variations

The Paralyzed Veterans of America (PVA) is requesting legislation to change the means test used by the Department of Veterans Affairs (VA) to determine whether veterans will be placed in enrollment priority Category 5 or 7 as set forth in 38 U.S.C. § 1722. Category placement is important because veterans enrolled in lower categories (i.e., 6 and 7) whose incomes are above current means test levels are required to make co-payments for much of their care. In the "discretionary" Category 7, they could also be at greater risk of disenrollment should the VA budget require it in the future.

JUSTIFICATION

In creating Category 5, Congress demonstrated its desire to provide health care to veterans who are unable to defray the cost of care. For this reason, Category 5 veterans do not pay co-payments for health care received. Category 7 veterans do pay co-payments. In addition, VA hospitals receive reimbursement for providing care to Category 5 veterans. Hospitals do not get reimbursed for Category 7 veterans.

Currently, the VA uses a national means test income threshold of $23,688 for a veteran with no dependents and $28,430 for a veteran with one dependent. This universal threshold applies regardless of the geographic cost-of-living differences. A universal income threshold does not adequately address many individual veterans' inability to "defray the cost of care" as required by 38 U.S.C. § 1722.

RELEVANT STATUTORY AUTHORITY

38 U.S.C. § 1722 establishes the criteria by which a veteran is determined to be unable to defray necessary expenses and establishes the income thresholds to be used in making this determination.

38 U.S.C. § 1705 establishes the VA's patient enrollment system. § 1705 (a) establishes the seven categories with which the VA prioritizes the provision of care. § 1705 (a) (5) establishes the fifth priority category as " veterans not covered by paragraphs (1) through
(4) who are unable to defray the expenses of necessary care as determined under § 1722 (a) of this title". § 1705 (a) (7) establishes priority category seven as veterans described in § 1710 (a) (3) of this title.

38 U.S.C. § 1710 (a) (3) authorizes the VA to treat veterans in priority categories 6 and 7 on a "funds permitting" basis and at the Secretary's discretion.

42 U.S.C. § 1437a (b) (2) defines the term "low income families" as "…families whose incomes do not exceed 80 per centime of the median income for the area, as determined by the Secretary (of housing and urban development) with adjustments for smaller and larger families."

PROPOSAL

The most direct way to address this problem is to adjust the national means test by locality to more accurately reflect the differences in geographic cost-of-living. This locality-adjusted means test would help veterans who have incomes slightly higher than the existing threshold who have previously been designated as Category 7. They would now fall below a newly-adjusted means test threshold for their area and be classified Category 5. The individual VA Healthcare networks, otherwise known as VISNs (Veterans Integrated Service Networks), would no longer be able to collect co-payments for the care provided to these veterans but would begin to receive reimbursement for their care.

PROPOSED METHODOLOGY

We have identified the HUD Low Income Index as established through Section 3 of the U.S. Housing Act of 1937, as amended in 1998, as a viable index. The HUD index defines "low income" for families with incomes that do not exceed 80 percent of the median family income for the area in which they reside. The areas are broken down into a variety of categories including Metropolitan Statistical Areas (MSAs),

Primary Metropolitan Statistical Areas (PMSAs) and counties. This index has defined both geographic areas and cost of living within these areas and should be relatively easy for the VA to implement.

Using the low-income methodology would mean that all veterans residing in a defined locality would have a means test threshold that was adjusted to reflect the cost-of-living determined by the HUD formula for that particular defined area. This new threshold is more indicative of the veteran's ability to defray the cost of care. Furthermore, to insure that no veterans are bumped from Category 5 into Category 7 when these new thresholds are implemented, we propose to maintain the existing $24,000 threshold, regardless of the number of dependents, nationwide as the lowest figure for any means test variations even if the HUD formula determines that the low-income rate for a particular area is actually under $24,000. In other words, for any location where the low-income index indicates that the new threshold should actually be lower than $24,000, the means test figure will stay at $24,000, regardless of the number of dependents in the veterans' household. This provision guarantees that no VISN will lose any Category 5 veterans and only stand to gain category 5's from implementation of this new means test system.

The following explanation of HUD's methodology for determining the median income and subsequent income amounts is taken from HUD's own briefing book:

HUD METHODOLOGY FOR ESTIMATING FY 2000
MEDIAN FAMILY INCOMES
(ECONOMIC AND MARKET ANALYSIS DIVISION,
OFFICE OF ECONOMIC AFFAIRS, PD&R)

FY 2000 HUD estimates of median family income are based on 1990 Census data estimates updated with a combination of local Bureau of Labor Statistics (BLS) data and Census Divisional data. Separate median family income estimates (MFIs) are calculated for all Metropolitan Statistical Areas (MSAs), Primary Metropolitan Statistical Areas (PMSAs), and non-metropolitan counties.

The income adjustment factors used to update the 1990 Census-based estimates of MFIs are developed in several steps. Average wage data from the Bureau of Labor Statistics (BLS) were available for 1989 through the end of 1997 at a county level, and were aggregated to the metropolitan area level for multi-county metropolitan areas. Census Divisional level median family and household income estimates were available from the Current Population Report (CPR) March 1990-99 surveys, which measure incomes from mid-1989 through mid-1998. These data were then used to update mid-1989 income estimates from the 1990 Census to the middle of 1998. The mid-1998 estimates were trended forward to mid-FY 2000 using a factor based on past P-60 Series trends. The step-by-step normal procedures as well as the exception procedures used are as follows:

1. Estimate mid-1989 local median family incomes using 1990 Census data. (Current HUD Section 8 Fair Market Rent (FMR) program definitions are used to define metropolitan areas, which are normally the same as Office of Management and Budget metropolitan area definitions.)

2. Calculate the BLS wage change factors for each Census Division for the 1989-97 period as follows:

Census Division BLS Wages (1997)
Census Division BLS Employees (1997) = 8-year BLS wage increase factor
for Census Division
Census Division BLS Wages (1989)
Census Division BLS Employees (1989)

3. Calculate the change in median family and household incomes for the nine Census Divisions for the 1989-1998 period using Census P-60 series data, as follows:

Census Division P-60 MFI (1998) = 9-year increase factor for Census

Census Division P-60 MFI (1989) Division P-60 Median Family Income

4. Compare the BLS and P-60 series Census Divisional factors calculated in steps 2 and 3 to provide a means of adjusting local BLS wage factor changes so that they aggregate to the same change factor as P-60 changes in family incomes plus contain an added year of CPS trending.

9-year increase factor for
Census Division P-60 MFI = Ratio of Census Division P-60
8-year increase factor for MFI to ratio of Census
Census Division BLS Wages Division BLS wage changes

5. Calculate the 1989-98 increase factors for the individual metropolitan areas and nonmetropolitan counties by applying the Census Divisional index factors from step 4 to local BLS data.

Local BLS Wages (1997)
Local BLS Employees (1997) Ratio of Census 9-year income
* Division P-60 = adjustment
MFI to Census factor for
Local BLS Wages (1989) Division BLS wages MSA or County
Local BLS Employees (1989)
= 1989 to mid-
1998 MFI
Adj. factor

6. Convert 1989-98 step 5 change factor to a 1989-2000 change factor by applying an annual trending figure of 4.0 percent to update the mid-1998 estimate to mid-1999, and applying a 3.0 percent factor (3/4 of 4.0 percent) to the mid-1999 to April 1, 2000 period. (Use of a trending factor is necessary because of lags in Bureau of Labor Statistics and P-60 Series data availability; the 4.0 percent factor is based on national income change patterns in recent years.)

(Step 5 adj. factor) * 1.04 * 1.03 = 1989 to mid-FY 2000 adjustment factor

7. Calculate median family incomes for FY 2000 by multiplying the step 1 Census estimate of median family income by the income adjustment factor derived in Step 6.

1990 Census Median Family Income * Step 6 factor = FY 2000 MFI EST.

8. For American Housing Survey areas, compare the MFI estimates from step 7 with median family income estimates based on post-1989 American Housing Survey (AHS) estimates of median family income updated to 2000. Past analysis shows that there is 95 percent likelihood that the true local median family income is within 6 percent of the AHS-based estimate. For areas where an AHS-based estimate differs by more than 6 percent from the Census-based estimate, local MFI estimates are increased or decreased so that they are within 6 percent of the AHS-based estimate.

9. Compare the 2000 MFI estimate with the 1999 MFI estimate. If the 1999 estimate is higher set the 2000 estimate at the 1999 level. (This policy is applied except when estimates are revised with decennial Census data, and serves to minimize disruption in program activities due to temporary decreases in income estimates.)

In addition to the above procedures, constraints are placed on annual changes in the Census Divisional and BLS change factors based on past experience. These guidelines constrain increases for a small number of areas with unusually high increases.

VA's ABILITY TO COLLECT COPAYMENTS AND THIRD PARTY REIMBURSEMENT

Applying a regional adjustment to the means test would not affect VA's ability to charge third party health insurers for the cost of care provided to a veteran because VA's authority to collect insurance payments is not tied to the means test. However, the means test is used by VA to determine a veteran's obligation to pay co-payments for their care and adjusting the means test would therefore affect VA's ability to collect co-payments.

The means test used by the Department of Veterans Affairs is set forth at 38 U.S.C. § 1722. While this statutory provision sets forth the amount of the annual means test threshold, and prescribes the methodology for calculating whether a veteran's income exceeds this threshold, it does not state the purpose of the means test. Rather, the means test set forth in §1722 is referred to in two distinct statutes that govern eligibility for care and the obligation to pay a co-payment.

The means test threshold set forth in § 1722 is expressly referred to by the statutory provision governing VA's managed care system of enrollment. *See* 38 U.S.C. § 1705(a)(5). Under VA's enrollment system, veterans are placed in one of seven priority categories based on consideration of such factors as income, level of disability, and percentage of service-connection. *See* 38 U.S.C. § 1705. Each year, VA is required to enroll only those categories of veterans that can be treated within appropriated funding. *See* 38 U.S.C. §§ 1705, 1710(a)(4). Veterans with income under the means test threshold are placed in priority category 5, ensuring that those veterans determined to be unable to defray the cost of their care will not be among the first cut from care when appropriations are insufficient to provide care to all veterans. Regionally adjusting the means test will therefore elevate some veterans from priority category 6 and 7 to priority category 5.

The means test threshold set forth in § 1722 is also referred to in the statutory provisions governing the determination of a veteran's obligation to pay a co-payment. *See* 38 U.S.C. § 1710(a)(2)(G). Under this statutory provision, veterans with income under the annual means test threshold receive cost free care, while those with income over the means test must pay co-payments for inpatient and outpatient care. *See* 38 U.S.C. §§ 1710(a)(3), 1710(f). Veterans with income over the means test must pay an inpatient hospital co-payment of $768 per 90 days of care, plus a per diem charge of $10 per day. *See* 38 U.S.C. § 1710(f). Veterans with income over the means test must also pay an outpatient co-payment of $50.80 per visit. *See* 38 U.S.C. § 1710(g). Regionally adjusting the means test will therefore exempt some veterans from these co-payment obligations if the means test is adjusted upward in their region to an amount in excess of their current income.

The authority for VA to bill a veteran's private health insurer is set forth in 38 U.S.C. § 1729. This statute neither references the provisions of § 1722 nor utilizes the means test threshold to determine whether a veteran's private health insurer may be billed for the cost of care provided. Rather, § 1729 broadly grants VA the authority to bill the private health insurer of any nonservice-connected veteran, regardless of priority category placement or income level, for the full cost of care provided at a VA facility. *See* 38 U.S.C. § 1729(a)(2)(D)(ii). VA is even permitted to bill third party health insurers for the full cost of treatment provided for the nonservice-connected disabilities of veterans with service-connected disabilities. *See* 38 U.S.C. § 1729(a)(2)(E). Since VA 's authority to recover the cost of care from private health insurers is not related to the means test threshold set forth in § 1722, regionally adjusting the means test threshold will have no impact on insurance billing.

ESTIMATES OF NUMBER OF VETERANS AFFECTED

The following chart estimates the number of veterans in certain MSAs that would be moved form category 7 into category 5 through this proposal. These numbers are based on data obtained form the VA. The MSAs listed in the chart were chosen at random.

Please note, that while we are proposing that the bottom threshold be established at $24,000, regardless of the number of dependents per family.

MSA	1 person family	2 person family	3 person family	4 person family
Abilene (TX)	0	0	0	4
Albany-Schenectady-Troy (NY)	275	319	514	422
Albuquerque (NM)	120	150	300	315
Allentown-Bethlehem-Easton (PA)	32	49	92	82
Altoona (PA)	0	0	0	0
Anchorage (AK)	190	237	216	167
Ann Arbor (MI)	97	100	77	52
Anniston (AL)	0	0	0	0
Appleton-Oshkosh-Neenah (WI)	15	27	41	30
Atlanta (GA)	1123	1060	867	647
Baltimore (MD)	1245	1133	970	709
Bangor (ME)	0	0	0	5
Baton Rouge (LA)	9	6	9	31
Bellingham (WA)	3	1	10	10
Bergen-Passaic (NJ)	685	634	500	358
Billings (MT)	7	12	23	25
Biloxi-Gulfport-Pascagoula (MS)	0	0	0	21
Bismarck (ND)	2	6	9	25
Bloomington (IN)	2	5	10	9
Boise City (ID)	40	88	129	139
Boston-Worcester-Lawrence-Lowell-Brockton (MA-NH)	1540	1568	1366	1003
Boulder-Longmont (CO)	21	21	18	13
Burlington (VT)	23	38	37	33
Casper (WY)	2	5	12	16
Cedar Rapids (IA)	4	14	9	23
Charleston (WV)	2	0	21	24
Charlotte-Gastonia-Rock Hill (NC-SC)	245	351	350	259
Charlottesville (VA)	4	3	1	1
Chattanooga (TN-GA)	10	40	47	51
Chicago (IL)	3622	3504	2792	1876
Cleveland-Lorain-Elyria (OH)	1043	1074	957	396
Corvallis (OR)	6	5	7	6
Dover (DE)	6	20	29	38
Enid (OK)	0	0	0	0
Fayetteville (NC)	0	0	0	18
Fort Lauderdale (FL)	322	384	417	303
Hartford (CT)	694	672	574	270
Honolulu (HI)	104	108	91	63
Las Vegas (NV-AZ)	542	770	866	709
Lawrence (KS)	13	7	7	10
Lexington (KY)	98	173	216	221
Lincoln (NE)	22	37	62	52
Little Rock-North Little Rock (AR)	74	170	264	275
Los Angeles-Long Beach (CA)	1006	1146	823	1064
Minneapolis-St. Paul (MN-WI)	652	653	522	386
New York (NY)	2995	2844	3059	2093
Phoenix-Mesa (AZ)	422	559	722	602
Providence-Warwick-Pawtucket (RI)	78	157	217	211
Provo-Orem (UT)	5	9	14	27

Rapid City (SD)	7	5	22	38
St Louis (MO-IL)	198	309	434	486

CONCLUSION

Implementation of the HUD low-income rates to augment VA's single means test standard and methodology will create a system that realistically and equitably reflects cost-of-living variations from one locality to the next, reflecting a veteran's ability to defray the cost of his health care as per Congress' original intent. Leaving the existing threshold as a base level guards against harm for any veteran currently meeting existing means test criteria. While VA's health care networks will lose the ability to collect co-payments from veterans formerly enrolled in category 7 who would now be bumped into category 5, under the original statutory intent governing the eligibility category placement, where the ability to defray the cost of care is the determining factor in placement in either category 5 or 7, these veterans should never have been required to pay co-payments in the first place. Furthermore, we believe that each VA health care system will be able to recoup the loss of the moneys collected as co-payments by "drawing down" reimbursement from VA central office for these new category 5 patients.

RICHARD B. FULLER

Richard B. Fuller is the National Legislative Director of the Paralyzed Veterans of America, a non-profit veterans service organization chartered by the United States Congress to represent the interests of its members, veterans with spinal cord injury or dysfunction, and all Americans with disabilities. PVA's primary legislative focus centers on issues supporting the Department of Veterans Affairs health care system and the specialized services VA provides to PVA members. He is responsible for coordinating the organization's legislative and oversight activities on all veterans' benefits and services, as well as oversight on all federal health systems – Medicare and Medicaid – and research activities which benefit veterans as well as all Americans with disabilities.

Mr. Fuller served for eight years on the professional staff of the Committee on Veterans' Affairs of the U.S. House of Representatives with primary responsibilities in areas of veterans' health and education legislation. Since 1987, he has worked in the field of public policy and government relations, specializing in health policy for a wide variety of health advocacy, consumer health research and provider non-profit organizations in Washington, D.C.

Mr. Fuller was Director of Public Affairs of the House Committee on Veterans' Affairs from 1979 to 1981. He served on the professional staff of the Subcommittee on Education, Training and Employment, and for the Subcommittee on Hospitals and Health Care until 1987. In 1987, he joined the national government relations staff of PVA, serving first as Associate Legislative Director, and then as National Legislative Director. In 1991, he joined a Washington D.C. health care consulting firm representing the public policy and legislative interests of several national medical and research societies, including: the American Federation for Clinical Research; the American Gastroenterological Association; the American Geriatrics Society; and the National Association of Veterans Research and Education Foundations. He returned to PVA in 1993 to lead the organization's outreach efforts on national and state health-care reform.

Mr. Fuller graduated with a Bachelor of Arts degree from Duke University in 1968. He served in the United States Air Force from 1968 to 1972, stationed two and one-half years in Vietnam and Southeast Asia as an aircrew Vietnamese linguist with the Air Force Security Service.

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 2001

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $83,000 (estimated as of February 28, 2001).

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.

Fiscal Year 1999

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.

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $240,000.