STATEMENT OF ROSCOE BUTLER

ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

ON "A TIME FOR CHANGE:

ASSESSING THE NEED TO MODERNIZE VETERAN ELIGIBILITY FOR CARE"

DECEMBER 2, 2020

Chairman Takano, Ranking Member Roe, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on the need to modernize veterans' eligibility for health care through the Department of Veterans Affairs (VA). We believe that the current process for determining VA health care eligibility remains valid; however, if the Committee decides to move forward with a reassessment of eligibility, we believe that the Committee should once again work with stakeholders to revise the system. Access to VA health care is critically important for PVA members, who are all veterans with spinal cord injuries or disorders. We want to ensure that the VA health care system remains strong and able to fully serve these veterans in the coming years.

Background on Eligibility for VA Health Care

Initially, the veterans medical system was developed to provide needed care to veterans who were injured or ill as a result of their wartime service. Until the mid-1990s, the VA health care system was a hospital-based model with entirely different eligibility rules for hospital care than for outpatient care. In1996, after receiving testimonies from the health care community and veteran service organizations (VSOs), about the need to reform VA health care eligibility, Congress passed, and the President signed into law, H.R. 3118, the "Veterans' Health Care Eligibility Reform Act of 1996" (Public Law 104-262). This law transformed VA's health care system from a 1950s hospital-based model to one that erased distinctions between eligibility for hospital and outpatient care.[1] The House Veterans' Affairs Committee report on the legislation observed, "No longer a health care system targeted just to the service-connected veteran, the VA has also become a 'safety net' for the many lower-income veterans who have come to depend upon it."[2]

[1] Public Law 104-262 - https://www.congress.gov/104/plaws/publ262/PLAW-104publ262.pdf
[2] House Report 104-690 - https://www.congress.gov/104/crpt/hrpt690/CRPT-104hrpt690.pdf

At the time, transforming VA health care eligibility rules made sense because existing laws governing inpatient care were entirely different from outpatient care and did not provide all veterans equal access to VA outpatient care. Public Law 104-262 leveled the playing field by requiring most veterans to enroll in the VA health care system, and once enrolled, made them eligible to receive a standard medical benefits package, regardless of the basis of their eligibility for care. However, Congress established seven enrollment priority groups for health care eligibility and stipulated that VA must provide access to care to enrolled veterans based on available appropriations. VA would also be required to establish an annual patient enrollment system for care. VA published the rules implementing eligibility reform in October 1998.

On January 23, 2002, Congress passed, and the President signed into law, H.R. 3447, the "Department of Veterans Affairs Health Care Programs Enhancement Act of 2001" (Public Law 107–135). Section 202 of this legislation amended VA's priority group 7 and created a new priority group 8[3] VA provided all enrolled veterans access to VA health care until January 17, 2003, when the Department published an Interim Final Rule entitled, "Enrollment—Provision of Hospital and Outpatient Care to Veterans Subpriorities of Priority Categories 7 and 8 and Annual Enrollment Level Decision."[4] The regulation discontinued enrollment on any new priority group 8 veterans who were not in an enrolled status on January 17, 2003.

On May 15, 2009, VA published a final rule[5] that allowed priority group 8 veterans whose income exceeded current means test thresholds by 10 percent or less to enroll in VA's health care system beginning June 15, 2009. It appears this was the last time VA assessed if further changes to the eight veteran priority groups and/or subgroups were necessary.

Improving the Eligibility Process

VA's current management of the eligibility process leaves Congress, VSOs, and other stakeholders with no way of knowing whether VA's annual appropriation is sufficient to treat all veterans who want to enroll. Thus, before VA submits its annual budget request, the Department should determine how much funding is needed to open enrollment to all eligible veterans. Once that figure is determined, VA's budget request to Congress should

[3] Public Law 107-135 - https://uscode.house.gov/statutes/pl/107/135.pdf
[4] VA January 2003 Enrollment Decision - https://www.federalregister.gov/documents/2003/01/17/03-1201/enrollment-provision-of-hospital-and-outpatient-care-to-veterans-subpriorities-of-priority
[5] Final Rule Expansion of Enrollment in the VA Health Care System - https://www.federalregister.gov/documents/2009/05/15/E9-11400/expansion-of-enrollment-in-the-va-health-care-system

reflect the number of veterans it is projecting to treat and the total amount of funding it would take to do that. This is in line with 38 CFR § 17.36(c)(1), which anticipates the VA Secretary will annually consider "whether to change the categories and subcategories of veterans eligible to be enrolled."
Congress would then decide whether to fully fund the Department's request or provide a lesser amount. At the same time, VA should publish a notice in the Federal Register announcing what priority categories VA will be enrolling in the system. Because this information would need to be published well in advance, all projections should be based on the advanced appropriations. Between the VA health care system and VA's Community Care program, we are confident that Congress has provided VA enough health care delivery options to ensure all enrolled veterans have access to health care.

In 2014, Congress enacted, H.R. 3230, the "Veterans Access, Choice, and Accountability Act of 2014" (Public Law 113-146), which funded expanded access to community care to alleviate wait times; directed a comprehensive independent assessment of the Veterans Health Administration's health care delivery and management systems; and established the "Commission On Care" to review that assessment, evaluate veterans access to care, and look more expansively at how that care should be organized and delivered during the next two decades. The Commission's report, which was released in June 2016,[6] included a pair of recommendations that are relevant to today's hearing:

- Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service, and
- Establish an expert body to develop recommendations for VA care eligibility and benefit design.

While the Commission on Care recommended establishing an expert body to develop recommendations for VA health care eligibility, there are four fundamental questions that we believe must be addressed before Congress takes any action to establish another commission:

- How many enrolled veterans can the VA health care system treat?
- Are there limitations on access that are not addressed by VA's current priority groups that should be addressed?
- Are there any limitations that prevent VA from expanding enrollment to new priority group 8 veterans?

[6] Commission on Care Final Report - https://www.stripes.com/polopoly_fs/1.417785.1467828140!/menu/standard/file/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf

- What additional first- and third-party revenue would priority group 8 veterans generate if all of them were allowed access to VA health care?

Regarding opening enrollment, the Commission presented a scenario of lifting the priority group 8 enrollment suspension beginning in fiscal year 2017. In that scenario, the Commission estimated that the market share would climb steadily during a five-year phase-in period to reach 30 percent in 2021, which equates to 464,000 new priority group 8 enrollees. The report highlighted that the market share is not expected to reach the level observed among other priority categories because priority group 8 veterans have higher incomes, do not have service-connected disabilities, are more likely to have employer-sponsored coverage and individually purchased health plans, and are less likely to be uninsured relative to those in other priority groups. They further illustrated that regression analysis of market shares among veterans in census data demonstrated that higher income veterans, nondisabled veterans, and veterans with employer sponsored health insurance are all less likely to enroll.

Another significant change to VA health care eligibility was made in 2018 when Congress approved H.R. 1625, the ‘‘Consolidated Appropriations Act, 2018’’ (Public Law 115–141). Section 1712I of that law provided statutory authority for the VA Secretary to treat any former members of the Armed Forces who did not receive an honorable discharge, so long as the discharge was not a dishonorable discharge. However, this authority was limited to mental or behavioral health care services necessary to treat the mental or behavioral health care needs of veterans including those who were at risk of suicide or harming others.

PVA examined VA’s current eligibility structure which considers the following factors:

- If a veteran is 50 percent or more service connected, or is a medal of honor recipient, he or she is enrolled in priority group 1;
- If a veteran is 30 or 40 percent service connected, he or she is enrolled in priority group 2;
- If a veteran is a former POW, or was awarded a purple heart, he or she is enrolled in priority group 3;
- If a veteran is in receipt of aid and attendance or is catastrophically disabled, he or she is enrolled in priority group 4;
- If a veteran has a zero percent service-connected disability rating, is in receipt of a VA pension, or according to VA income standards is a low-income veteran, he or she is enrolled in priority group 5;
- If a veteran was exposed to an environmental hazard as defined by title 38, he or she is enrolled in priority group 6; and

- If a veteran household income according to VA's income standards is considered reasonable to require such veteran to pay a copayment for his or her health care, he or she is enrolled in either priority group 7 or 8.

Except for nursing home and dental care, hospital and outpatient care are accessible to all eligible enrolled veterans as well as veterans who received an other than honorable or general discharge, with limits. The only limitation to enrolling for VA health care, is whether the annual appropriation is sufficient to treat all enrolled veterans. We would argue that between providing health care within VA, and the Community Care program, there are sufficient health care resources to meet the needs of veterans. The only question then is whether VA has sufficient funding to care for all enrolled veterans.

Except for VA not assessing each year how many veterans can enroll in VA's health care system, the Department's current eligibility structure is working as intended. It affords all enrolled veterans access to VA hospital and outpatient care, within available appropriations. Thus, the Committee should first consider the questions set out in our testimony before advancing any changes to the current eligibility system.

We believe that Congress, VSOs, the health care community, and other stakeholders are best positioned to make any changes needed to improve access to VA's health care system. The 1996 eligibility reform process is an example of a reform that worked. As needed, we can again address any challenges and concerns Congress has with VA's current eligibility system. Unless a time comes when perceived problems with VA eligibility exceed the ability of Congress to correct, creating an independent body to review the issue should not be necessary.

Chairman Takano, Ranking Member Roe, and members of the Committee, PVA appreciates this opportunity to express our views on veterans' ability to enroll in the VA health care system. We look forward to working with the Committee and believe today's hearing can be the beginning of a process to improve access to care and ensure that those veterans who are already eligible for care are able to continue to receive the care they need and have earned.

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

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

Fiscal Year 2021

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $455,700.

Fiscal Year 2020

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $253,337.

Fiscal Year 2019

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $193,247.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.