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BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS

December 2, 2020

Chairman Takano, Ranking Member Dr. Roe and Members of the Committee. Thank you for inviting us here today to discuss Veterans' eligibility to enroll in VA's health care system and present our views on H.R. 7469, the Modernizing Veterans' Healthcare Eligibility Act. Joining me today are Garth Miller, Executive Director, VHA Member Services, and Valerie Mattison Brown, VHA's Chief Strategy Officer. Eligibility for VA health care has been - and continues to be - a complex subject. Therefore, it is useful to present in broad strokes some history on how Congress has changed VA health care eligibility over the years, both before and after the landmark 1996 legislation that established the current VHA eligibility system. We will then turn to some general comments on VA health care eligibility and VA's views on H.R. 7469.

Veterans' Health Care Eligibility Reform Act of 1996

VA health care eligibility and the current system of patient enrollment are primarily based on the Veterans' Health Care Eligibility Reform Act of 1996 (Eligibility Reform Act), P. L. 104, which became law on October 9, 1996. The Eligibility Reform Act made major changes in the laws governing eligibility for VA health care benefits. Specifically, the law more comprehensively authorized VA to furnish hospital care, medical services (i.e., outpatient care) and nursing home care to Veterans. The Eligibility Reform Act also directed VA to establish a patient enrollment system that manages the care and services provided. It established seven priority groups and directed VA to enroll Veterans based on these priority groups, in the order listed in the law. Congress added an additional priority group in 2002.

In order to understand the purpose of eligibility reform, it is essential to understand the system it replaced. The Joint Explanatory Statement that accompanied the Eligibility Reform Act provides a concise description of the problems inherent in the old system. In discussing what was then the current law, the Joint Explanatory Statement states:

> Provisions of law governing eligibility for VA care, set forth in 38 U.S.C., chapter 17, are complex and not uniform across levels of care. All Veterans are "eligible" for hospital care and nursing home care, but "eligibility" does not in itself assure access. Existing law draws a broad distinction, for purposes of all levels of care, between two categories. The first is a "multi-tiered" cohort ("category A") of

> Veterans who have been recognized through a series of acts of Congress as having a priority to VA care, including service-connected Veterans, those considered unable to defray the expenses of necessary care and several special-eligibility subgroupings. The second category, which has a lower priority for VA care, encompasses all other Veterans who have no special eligibility and whose income exceeds means-test thresholds set in law.
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> With respect to hospital care, the law states that VA "shall" provide needed care to all category A Veterans, while VA "may" provide those same Veterans nursing home care. Eligibility for outpatient care is more fragmented. Only limited groups of Veterans are eligible for comprehensive outpatient care. VA "shall" furnish such care to those who are 50% or more service-connected, and "may" furnish it to former prisoners of war, World War I Veterans and certain profoundly disabled Veterans. Current law imposes specific limitations on certain other Veterans. Those not eligible for comprehensive services are limited generally to treatment "to obviate a need of hospital admission" or to complete treatment initiated on an inpatient basis. Veterans undergoing treatment based on a need to obviate hospitalization are specifically not eligible to receive prosthetic supplies.

See Joint Explanatory Statement, 104th Cong., 2d Sess., 142 Cong. Rec. S11646, (September 28, 1996), *reprinted in* 1996 U.S.C.C.A.N. 3616, 3617. A House Report from that time reflects similar concerns regarding the system in place prior to eligibility reform. See H.R. Rep. No. 104-690, 104th Cong., 2d Session, Veterans Health Care Eligibility Reform Act of 1996, at 3 where it states "The longstanding call for 'eligibility reform' reflects frustration with provisions of current law which are widely regarded as complex, confusing, and in some respects, inconsistent with sound medical practice."

Prior to the Eligibility Reform Act's passage, VA's statutory authority to provide care to Veterans was stratified according to the type of Veteran seeking care. While all Veterans were theoretically eligible to receive VA care, their access to different types of care was dictated according to their status. As discussed above in the legislative history, the old system was difficult to administer. The Eligibility Reform Act significantly changed the old system by establishing universal eligibility and an enrollment system to manage access to care.

The purpose behind eligibility reform was to replace the old system where the rules for access to different types of care could be very fragmented with a system where an enrolled Veteran may receive whatever medical care and services are deemed medically necessary. See H.R. Rep. No. 104-690, at 4 which states "While the new standard is a simple one, more importantly, it would employ a clinically appropriate 'need for care' test, thereby ensuring that medical judgment rather than legal criteria will determine when care will be provided and the level at which that care will be furnished"; and H.R. Rep. No. 104-690, at 13 which states that "H.R. 3118

would substitute a single, streamlined eligibility provision - based on clinical need for care - for the complex array of disparate rules currently governing veterans' eligibility for hospital and outpatient care."

Critically, the Eligibility Reform Act also gave the Secretary significant authority to limit access to needed medical care and services for lower priority Veterans when appropriated funds are insufficient to provide necessary care for all Veterans seeking such care. If sufficient funds or resources are unavailable to provide necessary medical care and services to enrolled Veterans or those seeking enrollment, the Secretary must manage the system by cutting off the enrollment of lower priority Veterans, and/or by disenrolling lower priority Veterans. In doing so, Congress chose not to establish VA medical care as an entitlement such as Medicare or VA compensation benefits. Instead it gave the Department a very prescribed mechanism to ensure the Secretary could revise the categories or subcategories of Veterans eligible to be enrolled based on the prescribed priority groups. In 2003, VA suspended the enrollment of Veterans in priority group 8. In 2009, VA established additional sub-priorities within priority group 8, and began enrolling priority group 8 Veterans whose income exceeds the applicable income thresholds by 10 percent or less.

Additional Changes to Eligibility

Since 1996, Congress amended VA health care eligibility on numerous occasions. For example, P.L. 105-368, the Veterans Programs Enhancement Act of 1998, established eligibility for health care for “a veteran who served on active duty in a theater of combat operations (as determined by the Secretary in consultation with the Secretary of Defense) during a period of war after the Persian Gulf War, or in combat against a hostile force during a period of hostilities…after [November 11, 1998].” P.L. 105-386 § 102 (*codified* at 38 U.S.C. § 1710(e)(1)(D) (as amended in 2002 by P.L. 107-330)). These Veterans were eligible to enroll during the 2-year period beginning on the date of their discharge or release.

In 2003, through P.L. 108-170, the Veterans Health Care, Capital Asset and Business Improvement Act of 2003, Congress granted VA health care eligibility for Veterans who participated in a test conducted by the Department of Defense Deseret Test Center as part of a program for chemical and biological warfare testing from 1962 through 1973 (including the program designated as Project Shipboard Hazard and Defense and related land-based tests).

In 2008, through P.L. 110-181, the National Defense Authorization Act of 2008, Congress extended the 2-year eligibility period for combat-theater Veterans to five years after discharge or release in most cases.

In 2012, with P.L. 112-154 Congress again expanded eligibility through the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 which granted VA health care eligibility for certain specified illnesses and conditions to Veterans who served on active duty at Camp Lejeune during a specified time period. That eligibility was premised on potential exposure to toxic agents at Camp Lejeune.

The Blue Water Navy Vietnam Veterans Act of 2019 (P.L. 116-23) extended the presumption of herbicide exposure, such as Agent Orange, to Veterans who served in the offshore waters of the Republic of Vietnam between January 9, 1962, and May 7, 1975; and extended health care eligibility to those Veterans.

Congress in other enactments legislated special rules associated with various other diseases and illnesses associated with toxic exposures. These are among the most complex eligibility rules to understand.

Eligibility for More Limited Health Care Benefits

One recent action by Congress established eligibility for VA mental and behavior health care for individuals who may not meet the definition of "Veteran." P.L. 115-141 § 258, the Consolidated Appropriations Act of 2018, established 38 U.S.C. § 1720I which, as amended, requires VA to provide certain former Service members with an initial mental health assessment; and to furnish the mental and behavioral health care services needed to treat their mental and behavioral health care conditions. To be eligible under this provision, a former Service member must satisfy all the following criteria:

- Is a former member of the Armed Forces, including Reserve components;
- Was discharged or released from Active Duty military, naval or air service under a condition that is not honorable but also not a dishonorable discharge or discharge by court-martial (see below);
- Is not enrolled in VA health care; and
- Served in the Armed Forces for a period of more than 100 cumulative days; and was either deployed in a theater of combat operations or while serving in the Armed Forces, was the victim of a physical assault of a sexual nature, a battery of a sexual nature or sexual harassment.

The criteria above exclude former Service members with dismissals, dishonorable discharges and bad conduct discharges, and several other exceptions also apply.

Other examples of limited VHA health care eligibility include provisions requiring VA to provide counseling, care and services to Veterans who experienced psychological trauma which resulted from a physical assault of a sexual nature, battery of a sexual nature or sexual harassment which occurred while the Veteran was serving on Active Duty, Active Duty for training or Inactive Duty training. Military Sexual Trauma (MST) related care is not subject to the usual minimum active duty service requirements. Therefore, Veterans may be able to receive MST-related care even if they are not eligible for VA health care under other treatment authorities.

Additionally, a Veteran is eligible for a screening examination, hospital care, medical services and nursing home care necessary for treating any cancer of the head or neck which VA finds may be associated with receiving nasopharyngeal radium irradiation treatments in active military, naval or air service.**Commission on Care**

The Commission on Care issued its Final Report (Report) on June 30, 2016. In this Report, the Commission found that substantial changes occurred since Congress last comprehensively examined eligibility for VHA care.[1] The Commission on Care recognized that this issue was outside the scope of its charge, yet recommended establishing an expert body to develop recommendations for VA care eligibility and benefit design. Report, at page 168. Then-VA Secretary Robert McDonald advised President Obama in a letter dated August 2, 2016, that this recommendation (#18) was both feasible and advisable. It was further noted that VA would work with various stakeholders to determine a path forward in tasking an expert body to examine and, as appropriate, develop recommendation for changes to VA health care eligibility. While the Commission on Care did not specifically recommend the forming of a commission as the "expert body" it contemplated, we understand that H.R. 7469, the Modernizing Veterans' Healthcare Eligibility Act, was, at least in part, based on this recommendation.

H.R. 7469, Modernizing Veterans' Healthcare Eligibility Act

H.R. 7469 would establish a Commission on Eligibility (the Commission) to examine VA health care eligibility. The Commission would be composed of 15 members: 12 members appointed by Congress and 3 members appointed by the President. In undertaking a comprehensive evaluation and assessment of VA health care eligibility, the Commission would be required to evaluate and assess, among other things, eligibility for long-term care and mental health care; required copayments and other cost sharing mechanisms; and eligibility of Veterans with service-connected conditions, with non-service-connected conditions, who have other insurance or health care coverage, who were exposed to combat and toxic substances or radiation and who have discharges under conditions other than honorable.

No later than 90 days and again no later than 1 year after the Commission's initial meeting, the Commission would report to the President, through the Secretary of Veterans Affairs, its findings and any recommendations for legislative or administrative action to revise and simplify VA health care eligibility. The President would require the Secretary of Veterans Affairs and other Federal departments and agencies to implement each recommendation the President considers feasible and advisable and that can be implemented without legislation. The President would also be required to

[1] Report, at page. 165 ("Two decades have passed since Congress last reexamined VHA eligibility and benefits, and many far-reaching changes that affect veterans' health care have occurred in that time. In more than a decade of war, 2.75 million troops have deployed to Iraq and Afghanistan where many have faced long and repeated deployments; constant risk of injury and death; and high levels of psychological disorders, substance abuse issues, and physical health problems. Post-9/11-era veterans are enrolling for VA care at historically high levels.").

report to Congress regarding the feasibility and advisability of the Committee's recommendations, including whether they require legislative or administrative actions.

The VA eligibility system legislated by Congress can in some instances be confusing for Veterans and difficult to understand, despite the success of the Eligibility Reform Act making what had been a very fragmented system much less fragmented and more comprehensive. Part of this confusion has been the result of the laudable special efforts Congress has made to reach those certain cohorts of individuals who otherwise would not have been eligible for VA health care, as described above.

VA is open to discussing with the Committee how the eligibility rules set by Congress can be improved, clarified and streamlined. VA also is open to discussing ideas for more fundamental eligibility reform. However, we do not support H.R. 7469 as a mechanism to have that discussion. We believe more exchanges among Congress, VA and Veterans Service Organizations should occur first before "outsourcing" the policy-making process to a Commission, as esteemed as the members of the Commission may be. VA believes there must be some fleshing out of the magnitude and direction of potential changes to eligibility before establishing a separate specialized body to recommend significant new policies. Because VA health care eligibility is subject to Congress' annual budget process, we also believe the Appropriations committees would be a vital part of any discussions regarding comprehensive eligibility reform.

We look forward to answering any questions you may have and to listening to the discussion that follows our panel.