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HOUSE OF REPRESENTATIVES
REPORT
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VETERANS' HEALTH CARE ELIGIBILITY REFORM ACT OF 1996

JULY 18, 1996.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STUMP, from the Committee on Veterans' Affairs, submitted the following

R E P O R T

[To accompany H.R. 3118]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 3118) to amend title 38, United States Code, to reform eligibility for health care provided by the Department of Veterans Affairs, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

INTRODUCTION

On July 19, 1995, the Committee received testimony about the need to reform health care eligibility of the Department of Veterans Affairs, Veterans Health Administration. Those testifying included the Under Secretary for Health, Kenneth W. Kizer, M.D., who was accompanied by Ms. Mary Lou Keener, the General Counsel of the Department. Also testifying were Mr. David P. Baine, Director, Federal Health Care Delivery, Health, Education and Human Services Division, the General Accounting Office (GAO), who was accompanied by Messrs. James Linz and Paul Reynolds, assistant directors of GAO. Subsequent panels of individuals offering testimony were Gregory A. Bresser, National Service Director, of the Military Order of the Purple Heart; Frank C. Buxton, Deputy Director for Veterans Affairs and Rehabilitation of The American Legion; David W. Gorman, Deputy Legislative Director of the Disabled American Veterans; Robert I. Keimowitz, M.D., Dean for Academic Affairs of the George Washington University School of Medicine and Health Sciences representing the Association of American

★ 29–006

Medical Colleges; James N. Magill, National Legislative Service Director of the Veterans of Foreign Wars; Gordon H. Mansfield, Executive Director of the Paralyzed Veterans of America; Larry D. Rhea, Deputy Director of Legislative Affairs of the Non-Commissioned Officers Association; Lynna C. Smith, MN, RN, CS, ARNP, President of the Nurses Organization of Veterans Affairs; and Kelli R. Willard West, Deputy Director, Government Relations of the Vietnam Veterans of America.

The Subcommittee on Hospitals and Health Care met on May 8, 1996, and ordered H.R. 3118 reported favorably to the full Committee by unanimous voice vote.

The full Committee also met on May 8, 1996, and ordered H.R. 3118 reported favorably to the House by unanimous voice vote.

SUMMARY OF THE REPORTED BILL

H.R. 3118 would:

1. Within appropriations, authorize the VA to provide all needed hospital care and medical services (including preventive and home health care) to veterans with compensable service-connected disabilities, former prisoners of war, veterans exposed to toxic substances and environmental hazards (for care of conditions specified in existing law), veterans meeting the "means test" as provided under existing law, and veterans of World War I.
2. Eliminate restrictions on VA providing prosthetic devices, subject to a requirement that VA furnish hearing aids and eyeglasses to veterans only in accordance with guidelines to be prescribed.
3. Require VA to manage the provision of hospital care and medical services through an enrollment or registration system based on a system of priorities. Priority is assigned in the following order: (a) veterans 30 percent or more service-connected disabled, (b) former POWs and veterans with service-connected disabilities rated 10 or 20 percent, (c) veterans receiving aid and attendance or housebound benefits and otherwise eligible veterans who suffer from a catastrophic disability, (d) veterans who are unable to defray the cost of their care, and (e) all others. The VA is authorized to establish additional priorities within the above groups.
4. Clarify that service-connected veterans continue to be eligible for any benefit for which they are eligible under existing law.
5. Permit VA to contract, pursuant to VA-prescribed acquisition procedures and policies, for hospital care and medical services for any enrolled veteran when VA facilities are not capable of furnishing the care or services economically.
6. Extend indefinitely VA's authority to provide services to dependents of active-duty members and retired servicemembers under contract arrangements with the Department of Defense (DOD) or a DOD contractor; clarify VA's authority to collect from insurance plans of DOD beneficiaries cared for by VA to the same extent as DOD recovers for care rendered to those

beneficiaries in its facilities; and authorize VA to retain such funds.

7. Expand VA's authority to execute "sharing" agreements by permitting any medical resource to be provided under such an agreement; authorize the VA to develop such arrangements with any entity; authorize flexibility in establishment of payment levels; and exempt personnel involved in providing services under such arrangements from the otherwise applicable Department personnel floor.
8. Direct VA to maintain its capacity to provide for the specialized treatment and rehabilitation of disabled veterans within distinct programs or facilities dedicated to the specialized needs of those veterans.

BACKGROUND AND DISCUSSION

HISTORICAL PERSPECTIVE

The veterans medical system was first developed to provide needed care to veterans injured or ill as a result of service during wartime. At the end of World War II, the federal government undertook the task of increasing the number of Veterans Administration (VA) medical facilities to meet the expected demand for health care for veterans returning with injuries or illnesses sustained during hostilities. The primary focus of the expansion was to immediately tend to the medical needs of returning combatants for acute care and then to address the longer term rehabilitation needs of more seriously injured veterans. Within a few years after the cessation of hostilities, the initial demand for acute care services for service-connected conditions diminished and the VA initiated what was later to become its specialized services mission. Services such as spinal cord injury care, blind rehabilitation, and prosthetics were very limited and almost non-existent in the private medical market of the late 1940s.

The VA system has evolved and expanded since World War II. Congress has enlarged the scope of the Department's health care mission and has enacted legislation requiring the establishment of new programs and services. Through numerous laws, some narrowly focused, others more comprehensive, Congress has also extended to additional categories of veterans eligibility for the many levels of care the VA now provides. 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. Legislative proposals aimed at ensuring access to comprehensive care and service through the VA for any veteran, or even just service-connected and indigent veterans, have been unsuccessful. Budget considerations have been a frequent brake on such legislative initiatives. The resulting body of VA health care eligibility law is one which many view as more of a patchwork than a rational, comprehensive system.

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.

With the Administration's submission in 1993 of its proposed national health care reform bill, the Congress was presented for the first time with a proposal for comprehensive reform of VA eligibility laws. Those proposed VA reforms were tied, however, to the broader goals of the legislation and did not survive the Health Security Act's demise. It was not until 1995 that the VA submitted for the first time an "eligibility reform" proposal directed exclusively at veterans' law. In transmitting the draft legislation to the Speaker of the House, the Secretary of Veterans Affairs identified the following objectives that should be achieved by a revised eligibility system:

> First, the eligibility system should be one that both the persons seeking care and those providing the care are able to understand.
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> Second, the eligibility system should ensure that the VA is able to furnish patients the most appropriate care and treatment that is medically needed, cost effective and in the most appropriate setting.
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> Third, veterans should retain eligibility for those benefits that they are now eligible to receive.
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> Fourth, VA management should gain the flexibility needed to manage the system effectively.
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> Fifth, the proposal should be budget neutral.
>
> Sixth, the proposal should not create any new and unnecessary bureaucracy.

VETERANS' HEALTH CARE ELIGIBLITY REFORM ACT OF 1996

The reported bill would revise provisions of chapter 17 of title 38, United States Code, governing eligibility for VA hospital and outpatient care, and would achieve the objectives set forth by the Secretary. It would substitute a single uniform eligibility standard for the complex array of standards governing access to VA hospital and outpatient care. 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.

Section 2. Hospital and medical services

Section 2 of the reported bill would strike the complex provisions of law governing eligibility for outpatient care. Those provisions, set forth in section 1712(a) of title 38, require the VA to apply at least four different legal tests to distinct veteran classifications. Specifically, under section 1712(a), the VA "shall furnish" comprehensive treatment to certain service-connected veterans, "may furnish" such broad treatment to certain other classes of veterans, and either "shall" or "may" furnish treatment of more limited scope (to "obviate" the need of hospital admission or to complete treatment begun during hospitalization) to still other groups of veterans. In contrast, in the case of each of these groups (the service-connected, former prisoners of war, etc.), the VA is required under section 1710 of title 38 to provide needed hospital care for any health problem.

Section 2 would authorize the VA to provide any needed hospital care and medical services (including preventive services and home care) to the service-connected disabled, low-income veterans, former prisoners of war, and World War I veterans who enroll with VA for needed care. These changes would expand the array of services that VA could provide to many of these beneficiaries, while eliminating statutory barriers to providing care in the most economical manner.

As amended, section 1710(a)(1) would qualify the Secretary's obligation to provide care as follows: "to the extent and in the amount provided in advance in appropriations Acts for these purposes". Such language is intended to clarify that these services would continue to depend upon discretionary appropriations; the Act would not require a certain level of appropriations. The qualifying phrase, quoted above, is identical to the language the Secretary of Veterans Affairs has employed in the legislation submitted to the Speaker of the House.

While expanding the scope of services which VA would be authorized to provide to many of its core "category A" veterans (those described in section 1710(a)(1) of title 38), section 2 would not reduce any veterans' eligibility for health care benefits. The measure would explicitly address the status of a veteran with a service-connected disability which is not compensable in degree. In the case where such a veteran is not otherwise afforded eligibility for hospital and medical services under section 1710(a)(1), as amended in section 2 of the Act, new section 1706(d) would provide that such a veteran would continue to be eligible for health care benefits for which that veteran had been eligible prior to the enactment of the Veterans' Health Care Eligibility Reform Act of 1996. Other veterans—both higher-income individuals and veterans with special eligibility based on exposure to toxic substances—would continue to be eligible for services under existing law.

Section 3. Prosthetics

Section 3 would remedy a frequently cited anomaly in VA health care eligibility law which poses a statutory barrier to providing many veterans who rely on VA health care with needed prosthetics. The measure would eliminate a restriction in current law which effectively prohibits the VA from furnishing such needed devices to most nonservice-connected veterans unless the VA has hospitalized the individual. Under the amendment, however, VA prosthetics may be furnished only as part of ongoing VA care (regardless of the level at which that care is furnished). This would clarify that the Committee does not intend that the VA provide costly prosthetics to nonservice-connected veterans who do not otherwise rely on VA care and simply view the VA as a means to obtain services not covered by their health care insurer.

Section 4. Management of health care

Section 4 of the Act would meet the Secretary's objective of gaining needed flexibility to manage VA health care effectively. Its provisions would both improve the VA's ability to plan and budget for meeting its medical care mission, and foster flexibility in delivering needed services.

The provisions of this section would not only enable the VA to plan for treating patients in a comprehensive manner rather than episodically responding to acute problems, but would also authorize the VA to establish a system or systems of patient enrollment and thereby improve substantially the management of care delivery. Moreover, the Act would alleviate the restrictions currently imposed on administrators in contracting for veterans' treatment. In place of a body of law limiting who could be provided treatment from a private physician and for what conditions, the Act would vest the VA with authority to contract for hospital care and medical services on behalf of any enrollee described in new section 1710(a)(1) when it is less costly to provide needed care and services by contract. Further, the Act would lift restrictions which bar VA facilities from entering into arrangements with other institutions for shared use of VA resources, subject to reimbursement. Finally, the Act would explicitly recognize that the extent of the Secretary's obligations under law are limited by the funds made available in advance by appropriations acts.

Enrollment.—Section 4 of the Act would in new section 1705 of title 38 provide the VA with an important tool, the authority to design and manage access to care through a system of patient enrollment. The authority to enroll patients is a logical extension of the longstanding statutory requirement that outpatient care be provided in accordance with specified priorities.

While an enrollment mechanism has not previously been specifically authorized by law, the VA has clearly embraced that concept in its recent planning and has begun to employ it. A directive issued by the Office of the Under Secretary for Health in October 1994, *Guidance for the Implementation of Primary Care in the Veterans Health Administration (VHA)*, for example, includes among facilities' responsibilities in instituting a primary care program the responsibility to "define the patient population . . . to be treated" and to ensure that "every patient enrolled in primary care must have a primary care provider." As currently instituted at many VA facilities, an enrollment system does not involve a contractual relationship between the VA and the enrollee or otherwise guarantee the enrollee that the VA will necessarily deliver all needed care. Enrollment, however, would help the VA plan more effectively, so that facilities can better calculate and dedicate the resources needed to provide the care its enrollees require.

The Act would direct the Secretary, in providing for the care of "core" veterans (described in new section 1710(a)(1) of title 38), to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment (or registration) system would operate. For example, the VA would be able to establish a system which simply registers patients throughout all or part of a fiscal year, or could employ a time-limited registration period. Significantly, the Act would permit the Secretary to set priorities within the specified priority classifications established in the Act. The Secretary could, for example, establish a policy which, within any priority classification, gives veterans who have previously been

"enrolled" as VA patients priority over new applicants. However, the Committee expects any enrollment system to be designed and administered to assure that any veteran with a service-connected condition would receive priority treatment for that condition whether or not that veteran had enrolled for VA care.

The relative priority classifications in new section 1705, which assigns highest priority to veterans with service-connected disabilities rated 30 percent or greater, are derived substantially from the prioritization requirement in current law at section 1712(i) of title 38. In refining that prioritization requirement, the measure would make noteworthy changes. First, the measure would elevate to a second tier the priority of former prisoners of war, who under current law occupy a third priority tier. And second, it would create a category of priority for those otherwise eligible veterans under a new section 1710(a) who are catastrophically disabled, such as veterans with spinal cord injuries. Such veterans would be included in a third tier priority with other profoundly disabled nonservice-connected veterans who receive increased pension based on a need of regular aid and attendance or permanent housebound status.

Contracting for services.—In providing a new statutory framework to assist the VA in meeting the nation's commitment to provide health care services to its most deserving veterans, the Act for the first time would lift rigid limits on which patients can receive VA-sponsored care through contract arrangements with community providers. In the context of the broad policies of the Act, such limits on contracting are unnecessary constraints. They serve, at best, as a crude means of limiting expenditures; in their place, the Act would authorize, but not require, the VA to contract for hospital care and medical services when VA facilities cannot furnish such care and services economically. Such a provision is also intended to encourage VA facilities to assess the relative costs of in-house and contractor-provided services, with an eye to contracting where significant savings can be achieved at comparable quality of service.

The Act in new section 1706 of title 38 would also vest the Secretary with broad discretion to make such rules and regulations regarding acquisition procedures and policies as deemed necessary to provide needed care and services. This provision is intended to enable the Secretary to tailor contracting policies and process to the unique needs of cost-effective care delivery and to free contracting officials from cumbersome procedures which would impede that objective.

While it would generally ease restrictions in current law, the Act would limit the Secretary in some respects. For one, it would provide that in designing an enrollment system and providing care, the VA may not enroll or otherwise attempt to treat so many patients as to result either in diminishing the quality of care to an unacceptable level or unreasonably delaying the timeliness of VA's care delivery.

Specialized services.—The Act would further limit the VA's discretion as it relates to the Department's important mission of providing for the specialized treatment and rehabilitative needs of disabled veterans. While provisions of the Act would otherwise vest considerable discretion in the Secretary, considerations unique to

the VA's specialized treatment programs would require a far more prescriptive response, in the Committee's view.

The provision of specialized services, identified generally in the Act as the VA's service capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness), constitutes a vital core of the VA's health care mission. The development and refinement over decades of specialized treatment and rehabilitation programs to serve these disabled populations has greatly enhanced veterans' lives. The scope and quality of those programs is not matched in the private sector, where, because of the great expense associated with such care, there has generally been little incentive to tailor programs for these chronic conditions.

Budgetary pressures and an ongoing reorganization within the Veterans Health Administration (VHA) raise concern on the Committee's part that the VA's costly specialized programs may be particularly vulnerable and disproportionately subject to budget-cutting. On April 6, 1995, a hearing before the Subcommittee on Hospitals and Health Care on the proposed VHA reorganization produced testimony on this issue. In the Committee's view, neither the Department's testimony nor subsequent actions have altogether alleviated the widespread concern that a newly decentralized organization, under budget pressures and focused heavily on instituting new primary care programs, will not respond to these pressures at the expense of the very programs on which some of the Department's most vulnerable beneficiaries depend.

To avoid erosion of its specialized capacities, the Act would require the Secretary to ensure that the Department's systemwide capacity to provide for the needs of this disabled population would be maintained. In setting this requirement, the Committee does not seek or discourage the development of new or refined treatment modes that may change the mix of VA services, or in any way discourage an appropriate shift of care from inpatient to outpatient settings, but only to ensure that the resource levels devoted to these services remain at least stable.

Given the importance of permitting programs and treatment methods to evolve, the Committee has not sought to identify or catalogue specific "programs" in either the Act or in this discussion. Its intent is to ensure that specialized treatment and rehabilitation continue to be available to serve unique populations who suffer from the kind of profound, costly-to-treat disabilities cited in the Act. The Committee notes that the Department has from time to time employed terms like "special programs" which are more inclusive than the Act's provision and may employ the term "special" for reasons unrelated to the profound nature of a disability. Such "special" programs are not necessarily within the ambit of this provision.

Impact of the Act.—Although the Act would revise substantially the body of law governing VA health-care eligibility, its impact would be less far-reaching in practice than it appears on its face. While the Committee believes the revision of law proposed in the Act is necessary and overdue, it appears that many VA medical fa-

cilities have, on their own, instituted changes in delivery practice that largely mirror changes proposed in the Act.

To test this thesis, the Committee's ranking member requested that the Veterans Health Administration conduct a survey of VA medical centers. The survey, conducted in September 1995, was intended to explore the possible impact of eligibility reform legislation. The survey sought to document the extent to which the VA facilities were already providing primary care to patients and to obtain some current measure of demand for care which might be sparked by enactment of reform legislation.

In that regard, the Committee took note of a 1995 analysis prepared by the Congressional Budget Office (CBO). For example, in trying to estimate the costs associated with a legislative initiative which would have expanded the scope of outpatient care for service-connected veterans rated 30 percent and 40 percent disabled, CBO analysts, in attempting to derive an estimate of minimum costs, "assumed that the number of veterans refused outpatient care equals the number turned down for inpatient care." The analysts cited data derived from the 1992 Survey of Veterans to the effect that "about 61,000 veterans were denied inpatient care who should have received care" and concluded that number would rise to almost 70,000 in 1996. CBO continues to cite the 1992 survey data in estimating additional costs deemed to arise from an extension of outpatient care.

The VHA survey posed the following questions:

a. Has your facility instituted a primary care program (i.e., a clinic which includes at least intake and initial assessment, treatment/management of acute conditions, patient education/health promotion, continuity of care, and access to other components of VA-provided or sponsored health care)?
b. If so, please estimate the percentage of total facility unique patients enrolled in primary care.
c. Please identify any classes of "category A" veterans who are not currently enrolled or being enrolled in a primary care program.
d. During the period of FY 1994, did your facility find it necessary because of limited resources to turn away (or provide only one-time, limited treatment to) any category A veterans who needed hospital or outpatient care?
e. If so, please estimate by needed level of care the numbers turned away.

The VA survey indicated that with respect to needed hospital care, only six of 162 facilities either turned away category A veterans or provided one-time, limited treatment to such individuals. With respect to outpatient treatment, only 22 facilities denied treatment or provided only one-time treatment, according to the survey.

As GAO noted in testimony, only veterans with service-connected disabilities rated at 50 percent or more—about 450,000 veterans—are entitled to comprehensive outpatient treatment. (Another GAO report, profiling veterans who used VA medical centers in 1991, stated that of veterans receiving VA care in 1991, only 300,000 were 50 percent service-connected disabled.) GAO noted that "eligi-

bility rules impede the provision of efficient health care to other veterans in that they may not be eligible for preventive services or treatment of medical conditions until such conditions, if left untreated, warrant hospital care or specialized outpatient treatment."

The survey showed, however, that despite the limited numbers entitled to routine outpatient treatment, VA facilities are providing routine care to substantial percentages of their patients. For example, of the 162 facilities responding to the survey, 62 reported that 60 percent or more of their patients had been enrolled in primary care programs; 25 facilities reported that 80 percent or more of their patients were enrolled. In most instances these programs are relatively new and were established pursuant to the above-cited October 1994 VA directive, *Guidance for the Implementation of Primary Care in the Veterans Health Administration*. In expressing a "need to implement primary care throughout VHA," the directive cited a 1993 survey which "revealed that VA does not currently provide primary care to a large number of veterans." The new policy pronouncement expressly directed that "[t]he VHA will implement the Primary Care Program to provide primary care to all eligible veterans requiring coordinated care." The policy did not define the term "eligible veterans", but in identifying the need to implement primary care, cited "the development of eligibility reform proposals, the managed care task force report, and . . . the VA National health care reform report *Meeting the Challenge of Health Care Reform*."

In essence, a health care system often criticized in prior years for its failure to provide routine outpatient care is undergoing a much-needed reform and is increasingly delivering care at the least costly level. The change in practice has resulted in widespread anticipation of a change in law.

Section 5. Improved efficiency in health care resource management

Title II of Public Law 102–585 authorized an expansion of the cooperative arrangements between VA and DOD facilities instituted under Public Law 97–174. P.L. 102–585 authorized the Departments to enter into agreements under which VA facilities could provide medical services to beneficiaries of DOD's CHAMPUS program. Under this new authority, the VA has begun to provide care to dependents of active-duty members and retirees. Section 5 would repeal section 204 of P.L. 102–585, under which expanded VA/DOD sharing authority would have expired.

Section 5 of the reported bill would in new section 207 of Public Law 102–585 also clarify VA's authority to recover or collect from the insurance plans (including so-called "CHAMPUS supplemental" plans) of CHAMPUS beneficiaries cared for by the VA to the same extent as DOD recovers for care rendered to these beneficiaries in its facilities. This section would also direct that all funds received by the VA from insurance plans of CHAMPUS beneficiaries be credited to the VA facility that furnished the care.

Section 6. Sharing agreements for health care resources

While revising VA law governing health care eligibility, the Act would help the VA achieve greater efficiencies inherent in shifting

more care from costly hospital beds to outpatient clinics and also would help the VA achieve greater economies through improved resource utilization.

Under existing law, the VA may, subject to reimbursement, enter into agreements with specified health care entities for the mutual use or exchange of use of "specialized medical resources," a narrowly defined term. Among the changes proposed by the reported bill, section 6 would authorize VA facilities to enter into such "sharing agreements" not only with health care facilities but with health insurers or any other entity or individual and would expand to include, for example, support services, the scope of resources which might be sold or purchased under such a contract to any health care entity. The Committee contemplates that the Department would broadly construe this new authority.

Section 6, developed with an eye to both the difficult budget environment and the dynamic marketplace within which the VA health care facilities are operating, reflects a belief that these facilities need far greater flexibility than existing law affords them to work out contractual arrangements with other providers, institutions, and entities to "share" health care resources. Both veterans organizations and the Department have cited the importance such expanded VA sharing authority holds to achieve efficiencies and new revenues.

Section 7. Personnel furnishing shared resources

The provisions of section 7 are companion provisions to sections 5 and 6, and are intended to overcome disincentives in existing law to initiate or maintain arrangements to "share" resources, and thus, to achieve needed efficiencies. Under current law, VA facilities have operated under employment ceilings conforming to section 712 of title 38. Such ceilings have created a dilemma for many medical center directors because they have often forced a choice between dedicating staff solely to internal service delivery, regardless of the level of efficiency of such service, or to providing as well some level of service delivery to other entities under the auspices of efficiency-driven "sharing" agreements. Faced with such a choice, many directors have opted not to embark on any new sharing agreements or have questioned the merits of maintaining those in place. This tension can easily lead facilities to operate inefficiently simply to avoid the perverse impact of an employment ceiling. Section 7 would remedy this problem by exempting from the applicable personnel ceiling those staff involved in providing services under sharing agreements.

SECTION-BY-SECTION

Section 1 would provide that this title may be cited as the "Veterans' Health Care Eligibility Reform Act of 1996."

Section 2 would: (1) amend sections 1710 and 1712 of title 38, United States Code, to establish medical need as the sole criterion of eligibility for VA hospital care and medical services for any veteran who (a) has a compensable service-connected disability, (b) is a former prisoner of war, (c) is unable to defray the cost of care, or (d) is a veteran of World War I; (2) provide that such care shall

be furnished subject to the availability of appropriations; and (3) recodify other veterans' eligibility for care in accordance with existing criteria.

Section 3 would: (1) amend the definition of medical services in chapter 17 of title 38, to strike language conditioning certain veterans' eligibility for prosthetics on the individual's being hospitalized; (2) provide that a veteran may be furnished such devices in the course of his or her VA care or treatment; and (3) require that eyeglasses and hearing aids may only be furnished in accordance with guidelines to be prescribed by VA.

Section 4 would first add a new section 1705 applicable to managing delivery of care under new section 1710(a)(1) to: (1) require the VA to administer care-delivery through an annual patient enrollment, with a veterans' ability to enroll to be governed by the availability of appropriations and by reference to a system of listed priorities; (2) require that the size of the enrollment pool be governed by the requirement that provision of care to enrollees be timely and acceptable in quality; (3) require that the VA promote cost-effective delivery of care in the most clinically appropriate setting; and (4) require the VA to maintain its capacity to provide for the specialized treatment needs of disabled veterans; and second add a new section 1706 which would (1) permit VA to contract for care when its facilities cannot furnish care and services economically; (2) strike other limitations in current law on contracting for care of a veteran; and (3) require that any service-connected veteran is provided all benefits to which that individual had been eligible before the Act's enactment.

Section 5 would repeal section 204 of Public Law 102–585 under which VA's authority to provide care and services through contract arrangements to Department of Defense beneficiaries under chapter 55 of title 10, United States Code, would have expired, and would clarify VA's authority to recover or collect from insurance plans of CHAMPUS beneficiaries cared for by the VA.

Section 6 would amend provisions of subchapter IV of chapter 81, title 38, to: (1) expand both the range of health care resources which can be the subject of mutual use or exchange of use contracts, and the kind of entities with which VA may so contract; (2) provide that VA may execute such contracts involving any health care resource, and may contract with any individual or entity, including a health plan; (3) provide greater flexibility as to when a VA facility may enter into such a contract, and what payment requirements it may negotiate in selling services, while conditioning the circumstances under which VA furnishes services to non-veterans to those (a) that would not delay or deny veterans' care and (b) that would result in improving the care of veterans, or is necessary to maintain an acceptable level or quality of service at that facility; and (4) clarify that the VA is to be reimbursed when it provides services under a "sharing agreement" to a Medicare-covered patient.

Section 7 would amend section 712 of title 38, to provide that for purposes of determining the minimum number of positions to be maintained in the Department of Veterans Affairs during a fiscal year, the number of positions in the Department in any fiscal year

(to be reduced under existing law by reference to specified categories of positions) is to be further reduced by the number of positions in that fiscal year held by persons involved in providing health care resources under "sharing agreements" executed under section 8111 (as expanded by section 201 of Public Law 102–585) or section 8152 of title 38.

OVERSIGHT FINDINGS

With respect to clause 2(*l*)(3)(A) of rule XI of the Rules of the House of Representatives, this legislation results from hearings and other oversight activities conducted by the Committee pursuant to clause 2(b)(1) of rule X. The Committee's oversight findings are generally contained in the *Background and Discussion* portion of the bill report. The relevant oversight activities of the Committee have included the following:

On February 24, 1995, the Committee held a hearing on the Administration's fiscal year 1996 budget request and its deficit reduction proposals;

On April 6, 1995, the Subcommittee on Hospitals and Health Care of the Committee held a hearing on the reorganization of the Veterans Health Administration;

On July 19, 1995, the Committee held a hearing on health care eligibility reform;

On March 21, 1996, the Subcommittee on Hospitals and Health Care held a hearing on VA medical care and construction priorities;

On March 29, 1996, the Committee held a hearing on the Administration's fiscal year 1997 budget request.

With respect to clause 2(*l*)(3)(B) of rule XI of the Rules of the House of Representatives and section 308(a)(1) of the Congressional Budget Act of 1974, this legislation does not include any new spending or credit authority, nor does it provide for any increase or decrease in tax revenues or expenditures. The bill does, however, authorize appropriations.

OVERSIGHT FINDINGS OF THE COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

No oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

COMMITTEE COST ESTIMATE

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. In so doing, it would lift restrictions on VA's providing ambulatory treatment. Those restrictions currently tie many veterans' eligibility for outpatient treatment to determinations that the care would either "obviate the need for hospital admission" or provide services needed to complete treatment initiated during hospitalization. The application of these medically indefinable standards has contributed substantially, in the Committee's view, to relative disparities veterans experience in different areas of the country in gaining access to VA care.

An analysis of the budgetary impact of H.R. 3118 should take account of two components: potential costs stemming from anticipated new demand for outpatient care, and potential savings from an anticipated shift in delivery patterns from inappropriately furnished inpatient care to ambulatory treatment. In reviewing this bill, the Congressional Budget Office expressed the view that the costs associated with "new demand" for care "would far outweigh" the savings. (CBO's cost estimate follows the Committee's cost estimate.)

CBO's estimate of July 15, 1996, states that the costs associated with the reported bill's proposed changes to VA eligibility law "are very uncertain". Yet CBO offers estimates of cost. There is little in the way of a methodology for those estimates and seemingly little more than speculation supporting its projections. In the Committee's view, CBO's estimate reflects a fundamental misunderstanding of the scope of services VA is already providing, the savings it has achieved through changes in medical practice, and the demand for VA services from those not now served.

In CBO's estimation, "demand-for-VA-outpatient-care" has two elements. First, by lifting the major restriction on VA's providing veterans outpatient treatment (that is, eliminating the eligibility requirement applicable to many veterans that treatment must be necessary to "obviate the need of hospital admission"), VA might experience an increase in the number of outpatient visits by current users for treatment previously barred under the "obviate" requirement. Second, with a revision of eligibility law, veterans not now receiving VA care might turn to VA in greater numbers.

The Committee finds that neither component of demand is likely to increase dramatically. First, the hypothesis that lifting statutory restrictions on outpatient care would cause VA to expand substantially the services it provides to current patients has little evidentiary support. That hypothesis, however, is central to CBO's analysis, which begins as follows:

> Currently, nearly 10 million veterans are eligible for outpatient care only if it involves pre- or post-hospitalization visits or if it obviates the need for inpatient care. Section 2 of H.R. 3118 would remove current restrictions and would enable VA to provide these veterans with a full range of outpatient treatments. As a result, a substantial number of veterans who have been denied access to outpatient care, or have been discouraged from seeking treatment at VA outpatient clinics, could demand care.

That hypothesis assumes that existing statutory requirements have in fact been a major barrier to clinicians and administrators, and have resulted in VA's not providing veterans needed services. Though not well documented by VA, all indications are that VA facilities have for some time been meeting patients' medical needs—sometimes hospitalizing patients, but most frequently providing care on an ambulatory basis. The growth annually in the volume of VA-provided outpatient care (as reflected in the steady increase in outpatient visits from some 22 million in fiscal year 1991 to an estimated 28 million in fiscal year 1996) calls into question the

view that existing law is a major barrier to VA provision of outpatient treatment.

There appear to be differing views as to the precise breadth of VA's outpatient authority, but little to suggest that eligibility law has been a complete obstacle to category A veterans receiving needed outpatient services. Recent General Accounting Office (GAO) testimony at an April 24, 1996 hearing before the Subcommittee on Hospitals and Health Care on "Efforts to Improve Veterans' Access to Primary Care Services" reflects a narrow reading of the law, but, more importantly, effectively rebuts CBO's central premise that because the law restricts many veterans' eligibility to "pre-, post-, and obviate" care, VA must be denying these veterans outpatient care which is outside the "pre-,post-, obviate" limits. GAO, in fact, explicitly recognizes that VA is providing outpatient care without regard to the very restrictions CBO assumes are in place:

> VA is not adhering to statutory limitations that govern what services VA may provide and who may be served. As a result veterans are receiving more services than current statutes allow.

In contrast, as the Congressional Budget Office noted in analyzing H.R. 901 (101st Congress), a bill which would have required the VA to provide needed outpatient care to all "Category A" veterans, "[t]here is very little medically necessary outpatient care that cannot be viewed as obviating the need for inpatient care." (House Report 101–107.) CBO's estimate on H.R. 3118 stands in striking contrast to its 1989 cost estimate of H.R. 901, for which it projected annual costs ranging from $40 million in the first year to $60 million in the fifth. Of this bill, CBO states that it "estimates that the new benefit for outpatient care would entail net costs of about $3 billion each year."

CBO now projects that increased outpatient costs would arise both from expanded benefits provided to existing users as well as demand from new users. With respect to the question of "new demand", the CBO's 1989 estimate on H.R. 901—a more expansive bill than H.R. 3118—is illustrative. Of H.R. 901, CBO reasoned that "[t]he fact that these [category A] veterans would now be entitled to care and the publicity surrounding the change could draw veterans to VA facilities who might otherwise have sought non-VA care." However, CBO projected only a relatively slight increase in workload associated with new demand, pointing to the fact that "[w]hen Category A veterans were granted entitlement to inpatient care in P.L. 99–272, the Consolidated Omnibus Budget Reconciliation Act of 1985, an increase of about 1.5 percent in the number of inpatient episodes of these veterans appears to have resulted from the change in law."

In contrast to H.R. 901, which CBO characterized as an entitlement to outpatient care, H.R. 3118 specifically and substantially limits VA's obligations to provide care. The scope of VA's mandate reaches only "to the extent and in the amount provided in advance in appropriations Acts for these purposes." Moreover, unlike H.R. 901, under which category A veterans could seek and expect to receive services, whether comprehensively or simply on an episodic basis, H.R. 3118 creates no such expectation. The "new demand"

which CBO projects does not assure every veteran access to care. In fact, the bill specifically requires the VA, in managing care delivery, to establish and operate a system of annual patient enrollment, with enrollment to be managed in accordance with specified statutory priorities and within any additional priority classifications in the specified priorities which VA may promulgate. With respect to "new demand", therefore, the reported bill gives VA new tools both to limit demand consistent with available funding and to discourage veterans from seeking VA care simply to fill an occasional need not met by a private health plan.

The view of VA being besieged by a large wave of new enrollees for VA care is unrealistic. Studies and focus groups indicate that health care consumers tend to seek out and select health care plans which cover themselves and family members, and do not tend to switch plans simply because another alternative exists or becomes available. In that regard, GAO's estimate that nine out of ten veterans have some form of health care coverage is noteworthy. In the absence of data suggesting that large numbers of veterans are being denied VA outpatient services, the view that many new category A veterans would seek to enroll for VA care is at odds with studies on health consumers' behaviors, formal surveys of veterans, and focus group studies.

Focus groups conducted by GAO, for example, led GAO to the conclusion that "veterans, other than those without health insurance, seem to use VA only for certain services such as the treatment of service-connected disabilities, rather than relying on VA for all their care. (Hearing before the Subcommittee on Oversight and Investigations of the Committee on Veterans Affairs on "Veterans Perceptions of VA Health Care", April 20, 1994). Even if H.R. 3118 enticed some veterans who had not previously sought VA care to enroll, GAO and other focus group studies would lead one to conclude that VA would attract relatively few "new users". At the Committee's April 1994 hearing on veterans' perceptions on VA care, the Paralyzed Veterans of America (PVA) testified on the findings of the 14 focus groups they conducted in six locations. The PVA study attempted to look at several cross-sections of the veterans' community, including veterans who had never used the VA system and others who had used the system but had ceased to do so. PVA found that:

> Like VA, we found that VA's best potential market is those who have the most familiarity with the system—that is, those currently using the system and, perhaps also, their dependents. Some veterans who have fallen away from the system because of access issues are also eager to regain access to the system—in our groups this was particularly true of rural veterans (we happened to choose a community that was distraught over the recent closure of its VA satellite clinic.) Regardless of past utilization, veterans without other insurance options were receptive to the idea of enrolling in VA health plans. Other veterans from our studies were not anxious to enroll. By and large, our discussions with lapsed users indicated that they were the least favorably disposed to enrolling in VA. Non-users did

> not have much familiarity with VA one way or the other, but negative portrayals of VA in the press seem to have hurt its image with these individuals . . . Most often, resistance to the idea of using VA services came from the fact that it was not likely they would be able to choose their own physician. Choice of physician was of the utmost importance to veterans and this importance increased with veterans' ages . . . Many veterans had established bonds with their community physicians that would be difficult to break. Many veterans claimed that even with significant financial incentives . . . they would not be parted from their physicians.

VA's National Survey of Veterans, published in 1995, provides further support for the view that there does not exist a large unmet demand for VA care. Most veterans have other alternatives to VA care. The survey data "indicate that a large proportion of veterans would rather go to a non-VA facility for their medical care if given a choice." Thus, when the survey asked veterans who had been hospitalized in a non-VA facility in 1992 the reason for not choosing a VA hospital for needed care, 78.4 percent responded that they had adequate health insurance.

In its ongoing efforts to effect a shift in VA practices from bed-based care to still greater reliance on ambulatory care, VA has apparently induced some additional demand for services in creating "new access points". In testifying before the Subcommittee on Hospitals and Health Care on April 24, 1996, on efforts to improve access to primary care, GAO stated that VA, in establishing its first fifteen community-based "access-points", had enrolled nearly 5,000 veterans (representing unspecified numbers of both current and new users). As discussed in that hearing, however, VA's policy on the establishment of new community-based clinics is evolving. But VA's testimony made it clear that one key aspect of that policy is firm—that the development and activation of new community clinics (whether a VA-established clinic or contractual arrangement with a community provider) must be "within available resources" (VHA Directive 10–95–017, February 8, 1995). Whatever theoretical level of demand could be induced by the presence of a VA facility or "access point", availability of funding will necessarily limit the number of "access points" VA can open, and thus the level of demand VA would experience.

CBO further suggests that there might be substantial new demand from potential new users who might seek to avail themselves of services not covered under their health benefit plans. It is hypothesized, for example, that veterans might turn to the VA to get prosthetic devices. The suggestion that "eligibility reform" would provoke heightened demand from those seeking prosthetic devices is unfounded. It is critical to note that H.R. 3118, like existing law, would not permit the VA simply to serve as a veterans' "drug store", providing medications, prosthetic devices, or other medical supplies prescribed by a private physician who has no affiliation or contractual relationship with the VA.

CBO's projections regarding "new demand" also fail to take account of veterans who cease to use VA services. For example, there

is evidence that as veterans reach age 65 a significant percentage cease to rely on VA health care benefits. A 1993 VA Statistical Brief shows that approximately 10 percent of VA system users elect to receive their care through Medicare providers upon reaching the age of 65. That VA analysis projected a decline in VA usage continuing for those over 65 at an estimated rate of 4 to 6 percent. It is conceivable that such factors as improved customer service might diminish the attrition rate of such veterans from the VA to Medicare providers, but one cannot with any degree of confidence project that H.R. 3118 would produce any significant increase in demand for VA services on the part of Medicare-eligible veterans.

H.R. 3118 does not assume that the VA system would remain static. To the contrary, it assumes that system reforms the VA has adopted in recent years, documented in hearings conducted by the Subcommittee on Hospitals and Health Care as well as the full Committee, would continue and accelerate with the enactment of the reported bill. The VA has made significant progress in developing a primary care capacity within existing budget levels, even in the face of statutory ambiguities. The expansion of the VA's ambulatory care capacity and resultant increased volume of VA-provided outpatient care has been funded by redirecting resources. The funds which the VA has deployed to outpatient care have stemmed from such management initiatives as hospital "mergers", ward closures, and establishment of managed-care practices, such as telephone triage systems, increased use of physician extenders, and diminished reliance on physician specialists. The enactment of H.R. 3118 would enable VA to expand such practices and achieve additional efficiencies to offset further expansion of its ambulatory care capacity.

The VA has advised the Committee of its projection that the enactment of H.R. 3118 would result in a 5 percent reduction in the number of episodes of inpatient care in the first year after enactment. The VA further projects that the bill would yield its full impact in terms of a shift in care, with a 15 percent reduction in inpatient care in the second year after enactment. This 20 percent shift over two years is projected to represent a reduction of approximately 1.2 million days of bed-care and, thus, a reduction of more than $700 million. The savings associated with these reductions would be partially offset by the shift in such care to the far less costly outpatient arena with a resultant increase in total outpatient care costs. The VA's analysis assumes that each inpatient episode which is "shifted" to outpatient care would result in an increase in VA outpatient costs representing 70 percent of the inpatient episode, for a total of some $500 million.

The Committee concludes that the approximately $200 million in annual savings associated with these anticipated shifts in workload under the reported bill would be largely absorbed by the additional demand for VA care, primarily from "new users". Most of this new demand would arise from VA establishment of new community-based clinics which would provide convenient access for category A veterans in currently underserved areas. The Committee expects that the numbers and capacities of such clinics would be managed to maintain expenditures, including expenditures for inpatient

services, within available resources, as provided under the bill. As a result, the Committee estimates, pursuant to clause 7 of rule XIII of the Rules of the House of Representatives, that H.R. 3118 would be budget neutral for annual outlays in fiscal year 1996 and in each of the five following fiscal years.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

The following letter was received from the Congressional Budget Office concerning the cost of the reported bill:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 15, 1996.

Hon. BOB STUMP,
Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 3118, the Veterans' Health Care Eligibility Reform Act of 1996, as ordered reported by the House Committee on Veterans' Affairs on May 8, 1996. The bill would affect direct spending and is subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

The bill contains no intergovernmental or private-sector mandates as defined in Public Law 104–4 and would impose no direct costs on State, local, or tribal governments.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

JUNE E. O'NEILL,
Director.

Attachment

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 3118

2. Bill title: Veterans' Health Care Eligibility Reform Act of 1996

3. Bill status: As ordered reported by the House Committee on Veterans' Affairs on May 8, 1996.

4. Bill purpose: The bill would expand eligibility for veterans outpatient care and prosthetics and authorize certain management practices.

5. Estimated cost to the Federal Government:
Expanding eligibility for outpatient services would ultimately increase the cost of veterans medical care by about $3 billion a year, assuming appropriation of the necessary amounts. The bill's provisions affecting direct spending would have no net budgetary impact.

6. Basis of estimate:
The estimate assumes enactment of the bill and appropriation of the authorized amounts for each fiscal year.

Spending subject to appropriations action

The bill contains several sections that would be subject to annual appropriations action.

Hospital care and medical services

Currently, nearly 10 million veterans are eligible for outpatient care only if it involves pre- or post-hospitalization visits or if it obviates the need for inpatient care. Section 2 of H.R. 3118 would remove current restrictions and would enable VA to provide these veterans with a full range of outpatient treatments. As a result, a substantial number of veterans who have been denied access to outpatient care, or have been discouraged from seeking treatment at VA outpatient clinics, could demand care

The budgetary impact of this provision has two parts—savings from shifting the current workload from unauthorized inpatient care to outpatient care, and costs from the increased demand for outpatient care. Anecdotal evidence suggests that some VA hospitals admit some veterans as inpatients to circumvent the restrictions on outpatient care. VA estimates suggest that shifting the currently unauthorized inpatient workload to the less costly outpatient setting would save about $214 million annually. CBO estimates that new demand for outpatient care, accompanying new demand for inpatient care, and additional costs from long-term care would far outweigh these savings. CBO estimates that expanding eligibility for outpatient care would raise VA's costs by about $3 billion for 1997 if the bill took full effect in that year.

The costs of this section, however, are very uncertain. Many factors influence a veteran's decision on where to seek medical care, including income, insurance, special health needs, personal tastes, and, in this case, eligibility for care and distance from a VA facility. Although the population of veterans is getting smaller, older veterans have greater health care needs, and may seek services from VA that are not provided under Medicare or other insurance programs. These factors are major sources of uncertainty for estimates of veterans medical programs.

WHICH VETERANS WOULD BE AFFECTED? H.R. 3118 would provide a new benefit for outpatient care to certain veterans, mostly those with service-connected disabilities rated less than 50 percent and those with annual incomes below thresholds set in law. (The threshold for 1996 is $21,001 for a single veteran.) Thus, the bill would allow nearly 10 million veterans who now have very limited access to VA outpatient facilities to receive unrestricted outpatient care. Many would turn to VA for care, although some would continue to use their current sources of medical care based on economic considerations and personal tastes.

HOW MANY VETERANS WOULD USE THE NEW BENEFITS? CBO estimates that about 1.2 million additional veterans would be drawn to VA for medical care each year by the new benefit. This estimate reflects the pattern of usage among more severely disabled veterans who now have unlimited outpatient benefits. According to the 1992 Survey of Veterans (SOV), 43 percent of these veterans who used health care services and were eligible for VA outpatient benefits received at least some of their care from VA.

Based on the 1992 survey, CBO estimates that the bill would make approximately 10 million veterans eligible for outpatient benefits based on their income or disability. Of this number, approximately 5.2 million used health care services in 1992, including 1.1 million who received at least some care from VA. Under H.R. 3118, the number of these veterans seeking health care from VA would double to about 2.3 million, if newly eligible veterans sought care from VA and non-VA sources in the same proportions as the more severely disabled veterans currently eligible for outpatient care. An additional 0.9 million veterans would seek only outpatient services, 0.2 million would seek both outpatient and inpatient care, and fewer than 0.1 million more would seek care only in VA hospitals.

COSTS OF THE NEW BENEFIT. CBO estimates that the new benefit for outpatient care would entail net costs of about $3 billion each year. The new benefit would allow VA to treat some veterans as outpatients that it now sees as inpatients, saving about $0.2 billion a year. But the new benefit would also lead these and other veterans to come to VA for outpatient care they receive from other sources under current law. The related increase in costs has three parts—the cost of extra outpatient visits, the cost of additional hospital admissions that would stem from those visits, and the cost of additional long-term care.

Savings from shifting workload.—VA expects that expanding eligibility for outpatient care would allow it to shift some of its inpatient workload to less costly care on an outpatient basis. Under current law, some VA facilities admit veterans to hospitals even though outpatient care would be more efficient because eligibility rules prohibit the less costly means of care. CBO cannot independently measure the extent that this takes place, and thus uses VA's estimate of the savings—about $0.2 billion a year—for purposes of this estimate.

Added costs for outpatient care.—H.R. 3118 would cost about $1.5 billion each year for outpatient visits alone. CBO estimates that about 1.1 million veterans would expect outpatient care from VA each year under the bill. Based on budgetary information obtained from VA, the estimate assumes that 435,000 veterans would visit an outpatient facility 10 to 12 times a year at a cost of about $189 a visit. Another 630,000 veterans who now come to VA for some of their outpatient care would increase their use of VA, but they would also continue to receive care from non-VA sources. In both cases, the additional outpatient visits would also lead to a greater number of hospital admissions, which would cost additional sums.

Added costs for induced inpatient care.—Additional hospital admissions would also cost about $1.5 billion each year. Veterans who would be drawn to VA for outpatient care by the bill could also be expected to add to the workload in VA hospitals. Under current law, many such veterans would be admitted to a non-VA hospital, but by going to VA for their outpatient care they would be more likely to enter a VA hospital. CBO estimates that an additional 115,000 veterans would be admitted to a VA hospital during a year for an average of about 13 days. Another 95,000 veterans would add to the workload of VA hospitals by a smaller amount because VA already meets some of their need for hospital care.

Long-term care.—This estimate does not include any added costs for long-term care because most new users of VA under the bill would have low incomes, and Medicaid would tend to cover those costs under current law. CBO assumes VA would continue its current policy of helping Medicaid- and Medicare-eligible veterans apply for these benefits and also find appropriate long-term care. However, it seems plausible that there would be some new users whom VA would have to place in nursing homes or non-institutional care programs at its expense.

Prosthetics

VA currently furnishes prosthetic devices-including artificial limbs, braces, orthotics, eye glasses, hearing aids, and wheel chairs—to veterans only as part of their inpatient care. Section 3 would make prosthetics available on an outpatient or ambulatory care basis and would direct VA to issue new regulations to reflect this expanded access within 30 days.

Because insurance coverage for assistive technology in the private and public sectors is not generous, and because the costs to consumers are high, this change would increase the demand on VA to provide prosthetics and other aids. CBO used the 1987 National Medical Expenditure Survey to determine the need for eyeglasses, orthotic devices, hearing aids, and other assistive technology by veterans in various age groups. CBO estimates that this provision would cost about $50 million in 1997 and $62 million in 2002 if eligibility for outpatient care is expanded at the same time. Costs of this provision would grow faster than prices for prosthetic devices because the veteran population is aging and the incidence and severity of disabilities increase with age.

Management of health care

Section 4 would require that VA establish a patient enrollment system for hospital care and medical services, and it would define priorities for which veterans should receive care when resources are scarce. It would not, however, authorize any copayments or cost sharing that would affect veterans' demand for health care or the costs of providing that care.

Sharing agreements with the Department of Defense

Section 5 would extend indefinitely an expansion of sharing agreements between VA and the Department of Defense (DOD) that enable the two agencies to treat patients eligible for each other's programs. Because current agreements cover a relatively small number of beneficiaries, this provision by itself would probably involve relatively low costs. But sharing agreements could ultimately make it easier to treat veterans who do not use their benefits under current law and those who would become eligible under section 2 of the bill.

Sharing agreements for health care resources

Section 6 would allow VA to agree to share equipment and other resources with a broad range of individuals and entities. These agreements would allow the resources to be used more efficiently and lead to budgetary savings or costs depending on the extent

that VA would otherwise purchase or forgo the resource. CBO cannot estimate the budgetary impact of this provision.

Personnel furnishing shared resources

Under section 7, personnel furnishing services under sharing agreements would no longer be counted under employment ceilings. This section would allow VA to employ more people under sharing agreements and to employ more regular VA workers to the extent that VA currently employs and counts these personnel against its ceilings. The necessary data, however, for a specific estimate are not available.

Direct spending

Section 5 of the bill would allow VA medical facilities to continue to treat certain beneficiaries of the Department of Defense's health care program; these costs would be subject to appropriations action. This section would also allow VA to bill third party insurers of these beneficiaries and to spend the proceeds. The receipts and the outlays would constitute direct spending but would offset each other over time and would have no net budgetary impact.

Section 6 would grant VA broad authority to share resources with other entities and individuals. These sharing agreements would allow VA to collect and spend receipts derived from allowing nonveterans to use its equipment, facilities, or services. This spending would not be subject to appropriations action. Like the previous section, this section would have no net budgetary impact in the long run.

7. Pay-as-you-go considerations:

The Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1998. The bill would have the following pay-as-you-go impact:

[By fiscal years, in millions of dollars]

	1996	1997	1998
Change in outlays	0	0	0
Change in receipts	Not applicable		

8. Estimated cost to State, local, and tribal governments:

CBO estimates that this bill would impose no intergovernmental mandates as defined by Public Law 104–4 and would have no direct budgetary impact on State, local, or tribal governments.

9. Estimated impact on the private sector:

CBO estimates that H.R. 3118 would impose no private-sector mandates as defined in Public Law 104–4.

10. Previous CBO estimate: None.

11. Estimate prepared by:

Federal cost estimate: Michael Groarke and Mary Helen Petrus. Ellen Breslin Davidson and Nathan Stacy.

Impact on State, local, and tribal governments: Marc Nicole.

Impact on private sector: Ellen Breslin Davidson.

12. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(*l*)(4) of rule XI of the Rules of the House of Representatives, the Committee concludes that the bill would have no inflationary impact.

APPLICABILITY TO LEGISLATIVE BRANCH

The reported bill would not be applicable to the legislative branch under the Congressional Accountability Act, Public Law 104–1, because it would apply only to certain Department of Veterans Affairs programs and benefits recipients.

STATEMENT OF FEDERAL MANDATES

Pursuant to section 423 of Public Law 104–4, this legislation contains no federal mandates with respect to state, local, and tribal governments, nor with respect to the private sector. Similarly, the bill provides no federal intergovernmental mandates.

VIEWS OF THE ADMINISTRATION

The following letter was received from the Department of Veterans Affairs concerning the reported bill:

DEPARTMENT OF VETERANS AFFAIRS,
UNDER SECRETARY FOR HEALTH,
Washington, DC, May 7, 1996.

Hon. BOB STUMP,
Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: We have reviewed the Committee's VA health care eligibility reform legislation, H.R. 3118. A principal objective of the legislation is to make the delivery of health care to eligible veterans more rational by eliminating the current "pre-, post-, and obviate" restrictions on outpatient care. In that respect, H.R. 3118 is consistent with VA's Reinventing Government II initiative and with the following objectives which we consider essential to beneficial reform:

- First, the eligibility system should be understandable to the ordinary person. Both the persons seeking care and those providing the care should be able to understand what is covered and what is not.
- Second, the eligibility system should provide incentives to ensure that practitioners and health care managers provide patients the most medically appropriate care in the most economical setting.
- Third, veterans should retain eligibility for those benefits they are now eligible to receive.
- Fourth, VA management should be given the flexibility needed to manage the system effectively.
- Fifth, the new system should not cost taxpayers more; that is, the reform proposal should be budget neutral.

• Sixth, the new system should not create any new or unnecessary bureaucracy.

According to the costing methodology we applied to the Administration's eligibility reform proposal and to the Committee's proposed bill, VA believes that H.R. 3118 is indeed budget neutral. A copy of that methodology is enclosed.

I hope this information is helpful to the Committee. If we can provide additional information or assistance, please let us know.

Sincerely,

KENNETH W. KIZER, M.D., M.P.H.,
Under Secretary for Health.

Attachments:

REFORMING VA HEALTH CARE ELIGIBILITY AND TREATMENT

As yet VA has no experience with eligibility reform on which to base reasonable cost estimates. Therefore, a formula has been developed which includes significant assumptions and results in rough estimates based on these assumptions. The operating premise for the formula and the VA proposal is that eligibility reform will be budget neutral.

Overall, eligibility reform will assist VA in achieving greater efficiencies through effective management of the care of the veteran patients. The proposed action does not alter the definition of the mandatory category ("Core" or Category A) of veterans. As a result of the application of a variety of managed care practices, in combination with the removal of the statutory barriers to effecting managed care, VA expects that there will be a shift in workload from inpatient to outpatient. The attached analysis depicts the application of the formula and the related assumptions. Since full efficiency should not be expected in the first year, it is roughly estimated that approximately 5 percent of VA inpatient workload will be shifted to outpatient care in year one, and an additional 15 percent will be shifted in year two. This 20 percent shift over two years could equate to a reduction of roughly 1.2 million inpatient days of care and an inpatient cost avoidance of $761 million which would be applied to the increased costs of outpatient care. For purposes of estimating, VA has assumed that for every "shifted" inpatient episode, outpatient care will increase by 70 percent of the average cost of the shifted inpatient admissions. This "guesstimate" results in a total increase over the two years of roughly $533 million in outpatient costs. In addition to the deferred inpatient dollars, VA estimates that 10 percent of current contract fee care and 10 percent of beneficiary travel will also be avoided as a result of improved access to VA outpatient services. These additional "saving" are roughly estimated at $39 million. Applying the total of the "savings" from the shifted inpatient care, reduced contract fee care, and reduced beneficiary travel to the new outpatient cost estimate, $268 million over two years may possibly be available for new outpatient workload (and concomitant inpatient workload), new non-institutional care, and greater access to primary care. Therefore, VA expects this proposal to be budget neutral and it does not affect adjustments for pay and inflation through the year 2000.

ESTIMATING ELIGIBILITY REFORM

FORMULA: $P' = (No \times Lo \times Cip) - (No \times Ciop) + (F + B)^*$

	# Admissions	$/Admis.	ALOS	# Days	# Visits*	5% Inpat. Admis. Shift	15% Inpt. Admis. Shift	Days Shifted
Year 1 1996	891,400	9,623	15.20	13,549,280	25,300,000	44,570		311,990
Year 2 1996	846,830	9,667	15.26	12,922,626	27,528,708	0	127,025	889,172
2-Year Total	719,805	10,591	16.72	12,033,454	28,310,711		171,595	1,201,162

	Cip		Cop	Cadm	iop=.7 Cad	Ciop=.7 Cadm		P@Ciop=.7 Cadm
	$/ Day*	Inpt. $ Saved	$/Visit*	$/Shifted Admission	Avg. New Outpt. Cost	New Outpatient Increases		Net Inpt./Outpt. Shift Savings
						Increase ($)	Visit Increase	
Year 1 1996	633.50	197,645,665	176.92	4,434.50	3,104.15	138,351,966	782,003	59,293,700
Year 2 1996	633.50	563,290,145	176.92	4,434.50	3,104.15	394,303,102	2,228,708	168,987,044
2-Year Total		760,935,810				532,655,067	3,010,711	228,280,743

* $P = (No \times Lo \times Cip) - (No \times Ciop) + (F + B)$, where

P = amount available for reinvestment into VA, e.g., for construction costs, new VA workload, and new noninstitutional long-term car
No = number of patients shifted from inpatient to outpatient care as a result of reforming the eligibility rules.
Lo = average of hospital stay in days for No patients.
Cip = average per diem cost per inpatient day (FY 96).
Cop = average cost of care per outpatient visit.
Cadm = average cost of care for the shifted admission = inpatient days shifted x the inpatient per diem / # shifted admissions.
Ciop = average cost of care provided on an outpatient basis for shifted patients = .7 Cadm.
F = 10% of outpatient fee-basis cost ($283,320,000).
B = 10% of beneficiary travel cost ($108,900,000).

$P = (171,595 \times 7 \times \$633.50) - (171,595 \times \$3,104.15) = \$228,280,743 + \$39,222,000 = \$267,502,743$
The $39,222,000 represents 10% savings in outpatient fee-basis plus 10% savings in beneficiary travel ($28,332,000 + $10,890,000).

Assumptions:
1. Eligibility reform will cause a 5% reduction the 1st year and a 15% reduction the 2nd year in admissions with shifts to outpatient care.
2. The 1996 budget projections are used for all utilization measures.
3. The ALOS for the admissions shifted to outpatient care is 7. (Lo)
4. The ALOS for remaining inpatients is constrained to a 2-yr. 10% increase for acuity since inpatient practice efficiencies are also assumed.
5. The cost of outpatient shifts, Ciop, is 0.7 of the shifted admission cost, Cadm.

Notes:
The Total line indicates either the second year sum for some variables, or the ending result after two years for other measures.
Inpatient utilization does not include contract hospital; outpatient visits do not include fee-basis; beneficiary travel is not included.
The outpatient visit increase equals the Cadm increase ($) divided by the Cop ($).
Calculated variables illustrated in table cells and formulas below are rounded, but actual calculations carry many digits accuracy.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

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PART I—GENERAL PROVISIONS

* * * * * * *

CHAPTER 7—EMPLOYEES

* * * * * * *

§ 712. Full-time equivalent positions: limitation on reduction

(a) * * *

(b) In determining the number of full-time equivalent positions in the Department of Veterans Affairs during a fiscal year for purposes of ensuring under section 5(b) of the Federal Workforce Restructuring Act of 1994 (Public Law 103–226; 108 Stat. 115; 5 U.S.C. 3101 note) that the total number of full-time equivalent positions in all agencies of the Federal Government during a fiscal year covered by that section does not exceed the limit prescribed for that fiscal year under that section, the total number of full-time equivalent positions in the Department of Veterans Affairs during that fiscal year shall be the number equal to—

(1) the number of such positions in the Department during that fiscal year, reduced by

(2) [the sum of—] *the sum of the following:*

(A) [the] *The* number of such positions in the Department during that fiscal year that are filled by employees whose salaries and benefits are paid primarily from funds other than appropriated funds[; and].

(B) [the] *The* number of such positions held during that fiscal year by persons involved in medical care cost recovery activities under section 1729 of this title.

(C) The number of such positions in the Department during that fiscal year held by persons involved in providing health-care resources under section 8111 or 8152 of this title.

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PART II—GENERAL BENEFITS

* * * * * * *

CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

SUBCHAPTER I—GENERAL

SUBCHAPTER I—GENERAL

§ 1701. Definitions

For the purposes of this chapter—
(1) * * *

* * * * * * *

(6) The term "medical services" includes, in addition to medical examination, treatment, and rehabilitative services—

(A)(i) surgical services, dental services and appliances as described in sections 1710 and 1712 of this title, optometric and podiatric services [(in the case of a person otherwise receiving care or services under this chapter)], preventive health services, and [(except under the conditions described in section 1712(a)(5)(A) of this title),] *(in the case of a person otherwise receiving care or services under this chapter)* wheelchairs, artificial limbs, trusses, and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as the Secretary determines to be reasonable and necessary, *except that the Secretary may not furnish sensori-neural aids other than in accordance with guidelines which the Secretary shall prescribe,* and (ii) travel and incidental expenses pursuant to the provisions of section 111 of this title; and

* * * * * * *

[§ 1703. Contracts for hospital care and medical services in non-Department facilities]

§ 1703. Annual report on furnishing of care and services by contract

[(a) When Department facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or are not capable of furnishing the care or services required, the Secretary, as authorized in section 1710 or 1712 of this title, may contract with non-Department facilities in order to furnish any of the following:

[(1) Hospital care or medical services to a veteran for the treatment of—

[(A) a service-connected disability;

[(B) a disability for which a veteran was discharged or released from the active military, naval, or air service; or

[(C) a disability of a veteran who has a total disability permanent in nature from a service-connected disability.

[(2) Medical services for the treatment of any disability of—

[(A) a veteran described in section 1712(a)(1)(B) of this title;

[(B) a veteran described in paragraph (2), (3), or (4) of section 1712(a) of this title, for a purpose described in section 1712(a)(5)(B) of this title; or

[(C) a veteran described in section 1712(a)(3) (other than a veteran who is a former prisoner of war) of this title if the Secretary has determined, based on an examination by a physician employed by the Department (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in Department facilities.

[(3) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving medical services in a Department facility or nursing home care under section 1720 of this title until such time following the furnishing of care in the non-Department facility as the veteran can be safely transferred to a Department facility.

[(4) Hospital care for women veterans.

[(5) Hospital care, or medical services that will obviate the need for hospital admission, for veterans in a State (other than the Commonwealth of Puerto Rico) not contiguous to the contiguous States, except that the annually determined hospital patient load and incidence of the furnishing of medical services to veterans hospitalized or treated at the expense of the Department in Government and non-Department facilities in each such noncontiguous State shall be consistent with the patient load or incidence of the furnishing of medical services for veterans hospitalized or treated by the Department within the 48 contiguous States and the Commonwealth of Puerto Rico.

[(6) Diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, furnishing medical services at independent Department out-patient clinics to obviate the need for hospital admission.

[(7) Outpatient dental services and treatment, and related dental appliances, for a veteran described in section 1712(b)(1)(F) of this title.

[(8) Diagnostic services (on an inpatient or outpatient basis) for observation or examination of a person to determine eligibility for a benefit or service under laws administered by the Secretary.

[(b) In the case of any veteran for whom the Secretary contracts to furnish care or services in a non-Department facility pursuant to a provision of subsection (a) of this section, the Secretary shall periodically review the necessity for continuing such contractual arrangement pursuant to such provision.]

[(c)] The Secretary shall include in the budget documents which the Secretary submits to Congress for any fiscal year a detailed report on the furnishing of contract care and services during the most recently completed fiscal year under [this section, sections] *sections 1710,* 1712A, 1720, 1720A, 1724, and 1732 of this title, and section 115 of the Veterans' Benefits and Services Act of 1988 (Public Law 100–322; 102 Stat. 501).

* * * * * * *

§ 1705. Management of health care: patient enrollment system

(a) In managing the provision of hospital care and medical services under section 1710(a)(1) of this title, the Secretary, in accordance with regulations the Secretary shall prescribe, shall establish and operate a system of annual patient enrollment. The Secretary shall manage the enrollment of veterans in accordance with the following priorities, in the order listed:

(1) Veterans with service-connected disabilities rated 30 percent or greater.

(2) Veterans who are former prisoners of war and veterans with service connected disabilities rated 10 percent or 20 percent.

(3) Veterans who are in receipt of increased pension based on a need of regular aid and attendance or by reason of being permanently housebound and other veterans who are catastrophically disabled.

(4) Veterans not covered by paragraphs (1) through (3) who are unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

(5) All other veterans eligible for hospital care, medical services, and nursing home care under section 1710(a)(1) of this title.

(b) In the design of an enrollment system under subsection (a), the Secretary—

(1) shall ensure that the system will be managed in a manner to ensure that the provision of care to enrollees is timely and acceptable in quality;

(2) may establish additional priorities within each priority group specified in subsection (a), as the Secretary determines necessary; and

(3) may provide for exceptions to the specified priorities where dictated by compelling medical reasons.

§ 1706. Management of health care: other requirements

(a) In managing the provision of hospital care and medical services under section 1710(a) of this title, the Secretary shall, to the extent feasible, design, establish and manage health care programs in such a manner as to promote cost-effective delivery of health care services in the most clinically appropriate setting.

(b) In managing the provision of hospital care and medical services under section 1710(a) of this title, the Secretary—

(1) may contract for hospital care and medical services when Department facilities are not capable of furnishing such care and services economically, and

(2) shall make such rules and regulations regarding acquisition procedures or policies as the Secretary considers appropriate to provide such needed care and services.

(c) In managing the provision of hospital care and medical services under section 1710(a) of this title, the Secretary shall ensure that the Department maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans described in section 1710(a) of this title (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 those veterans in a manner that (1) affords those veterans reasonable access to care and services for those specialized needs, and (2) ensures that overall capacity of the Department to provide such services is not reduced below the capacity of the Department, nationwide, to provide those services, as of the date of the enactment of this section.

(d) In managing the provision of hospital care and medical services under section 1710(a) of this title, the Secretary shall ensure that any veteran with a service-connected disability is provided all benefits under this chapter for which that veteran was eligible before the date of the enactment of this section.

SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

§ 1710. Eligibility for hospital, nursing home, and domiciliary care

[(a)(1) The Secretary shall furnish hospital care, and may furnish nursing home care, which the Secretary determines is needed—

[(A) to any veteran for a service-connected disability;

[(B) to a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty, for any disability;

[(C) to a veteran who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement described in such section, for any disability;

[(D) to a veteran who has a service-connected disability rated at 50 percent or more, for any disability;

[(E) to any other veteran who has a service-connected disability, for any disability;

[(F) to a veteran who is a former prisoner of war, for any disability;

[(G) to a veteran exposed to a toxic substance, radiation, or environmental hazard, as provided in subsection (e) of this section;

[(H) to a veteran of the Mexican border period or World War I, for any disability; and

[(I) to a veteran for a non-service-connected disability, if the veteran is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

[(2) In the case of a veteran who is not described in paragraph (1) of this subsection, the Secretary may, to the extent resources and facilities are available, furnish hospital care and nursing home care to a veteran which the Secretary determines is needed for a nonservice-connected disability, subject to the provisions of subsection (f) of this section.]

(a)(1) The Secretary shall, to the extent and in the amount provided in advance in appropriations Acts for these purposes, provide hospital care and medical services, and may provide nursing home care, which the Secretary determines is needed to any veteran—

(A) with a compensable service-connected disability;

(B) whose discharge or release from active military, naval, or air service was for a compensable disability that was incurred or aggravated in the line of duty;

(C) who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section;

(D) who is a former prisoner of war;

(E) of the Mexican border period or of World War I;

(F) who was exposed to a toxic substance, radiation, or environmental hazard, as provided in subsection (e); and

(G) who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

(2) In the case of a veteran who is not described in paragraph (1), the Secretary may, to the extent resources and facilities are available and subject to the provisions of subsection (f), furnish hospital care, medical services, and nursing home care which the Secretary determines is needed.

* * * * * * *

(e)(1)(A) Subject to paragraphs (2) and (3) of this subsection, a veteran—

(i) who served on active duty in the Republic of Vietnam during the Vietnam era, and

(ii) who the Secretary finds may have been exposed during such service to dioxin or was exposed during such service to a toxic substance found in a herbicide or defoliant used in connection with military purposes during such era,

is eligible for [hospital care and nursing home care] *hospital care, medical services, and nursing home care* under [subsection (a)(1)(G) of this section] *subsection (a)(1)(F)* for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

(B) Subject to paragraphs (2) and (3) of this subsection, a veteran who the Secretary finds was exposed while serving on active duty to ionizing radiation from the detonation of a nuclear device in connection with such veteran's participation in the test of such a device or with the American occupation of Hiroshima and Nagasaki, Japan, during the period beginning on September 11, 1945, and

ending on July 1, 1946, is eligible for [hospital care and nursing home care] *hospital care, medical services, and nursing home care* under [subsection (a)(1)(G) of this section] *subsection (a)(1)(F)* for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

(C) Subject to paragraphs (2) and (3) of this subsection, a veteran who the Secretary finds may have been exposed while serving on active duty in the Southwest Asia theater of operations during the Persian Gulf War to a toxic substance or environmental hazard is eligible for [hospital care and nursing home care] *hospital care, medical services, and nursing home care* under [subsection (a)(1)(G) of this section] *subsection (a)(1)(F)* for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

(2) Hospital and nursing home care *and medical services* may not be provided under [subsection (a)(1)(G) of this section] *subsection (a)(1)(F)* with respect to a disability that is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than an exposure described in subparagraph (A), (B), or (C) of paragraph (1) of this subsection.

* * * * * * *

[(f)]*(g)*(1) The Secretary may not furnish medical services under subsection (a) of this section (including home health services under section 1717 of this title) to a veteran who is eligible for hospital care under this chapter by reason of [section 1710(a)(2) of this title] *subsection (a)(2) of this section* unless the veteran agrees to pay to the United States the amount determined under paragraph (2) of this subsection.

(2) A veteran who is furnished medical services under subsection (a) of this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such services shall be liable to the United States, in the case of each visit in which such services are furnished to the veteran, for an amount equal to 20 percent of the estimated average cost (during the calendar year in which the services are furnished) of an outpatient visit in a Department facility. Such estimated average cost shall be determined by the Secretary.

(3) This subsection does not apply with respect to home health services under section 1717 of this title to the extent that such services are for improvements and structural alterations.

(4) Amounts collected or received by the Department under this subsection shall be deposited in the Treasury as miscellaneous receipts.

[(g)] *(h)* Nothing in this section requires the Secretary to furnish care to a veteran to whom another agency of Federal, State, or local government has a duty under law to provide care in an institution of such government.

* * * * * * *

§ 1712. Eligibility for outpatient services

[(a)(1) Except as provided in subsection (b) of this section, the Secretary shall furnish on an ambulatory or outpatient basis such medical services as the Secretary determines are needed—

[(A) to any veteran for a service-connected disability (including a disability that was incurred or aggravated in line of duty and for which the veteran was discharged or released from the active military, naval, or air service);

[(B) for any disability of a veteran who has a service-connected disability rated at 50 percent or more;

[(C) to any veteran for a disability for which the veteran is in receipt of compensation under section 1151 of this title or for which the veteran would be entitled to compensation under that section but for a suspension pursuant to that section (but in the case of such a suspension, such medical services may be furnished only to the extent that such person's continuing eligibility for medical services is provided for in the judgment or settlement described in that section); and

[(D) during the period before December 31, 1996, for any disability in the case of a veteran who served on active duty in the Southwest Asia theater of operations during the Persian Gulf War and who the Secretary finds may have been exposed to a toxic substance or environmental hazard during such service, notwithstanding that there is insufficient medical evidence to conclude that the disability may be associated with such exposure.

[(2) The Secretary shall furnish on an ambulatory or outpatient basis medical services for a purpose described in paragraph (5) of this subsection—

[(A) to any veteran who has a service-connected disability rated at 30 percent or 40 percent; and

[(B) to any veteran who is eligible for hospital care under section 1710(a) of this title and whose annual income (as determined under section 1503 of this title) does not exceed the maximum annual rate of pension that would be applicable to the veteran if the veteran were eligible for pension under section 1521(d) of this title.

[(3) The Administrator may furnish on an ambulatory or outpatient basis medical services which the Secretary determines are needed—

[(A) to any veteran who is a former prisoner of war;

[(B) to any veteran of the Mexican border period or of World War I; and

[(C) to any veteran who is in receipt of increased pension or additional compensation or allowances based on the need of regular aid and attendance or by reason of being permanently housebound (or who, but for the receipt of retired pay, would be in receipt of such pension, compensation, or allowance).

[(4) Subject to subsection (f) of this section, the Secretary may furnish on an ambulatory or outpatient basis medical services for a purpose described in paragraph (5) of this subsection to any veteran who is eligible for hospital care under section 1710 of this title and who is not otherwise eligible for such services under this subsection.

[(5)(A) Medical services for a purpose described in this paragraph are medical services reasonably necessary in preparation for hospital admission or to obviate the need of hospital admission. In the case of a veteran described in paragraph (4) of this subsection, services to obviate the need of hospital admission may be furnished only to the extent that facilities are available.

[(B) In the case of a veteran who has been furnished hospital care, nursing home care, or domiciliary care, medical services for a purpose described in this paragraph include medical services reasonably necessary to complete treatment incident to such care. Such medical services may not be provided for a period in excess of 12 months after discharge from such care. However, the Secretary may authorize a longer period in any case if the Secretary finds that a longer period is required by reason of the disability being treated.

[(6) In addition to furnishing medical services under this subsection through Department facilities, the Secretary may furnish such services in accordance with section 1503 of this title.

[(7) Medical services may not be furnished under paragraph (1)(D) with respect to a disability that is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than an exposure described in that paragraph.]

[(b)] *(a)*(1) Outpatient dental services and treatment, and related dental appliances, shall be furnished under this section only for a dental condition or disability—

(A) * * *

* * * * * * *

[(c)] *(b)* Dental services and related appliances for a dental condition or disability described in paragraph (1)(B) of subsection (b) of this section shall be furnished on a one-time completion basis, unless the services rendered on a one-time completion basis are found unacceptable within the limitations of good professional standards, in which event such additional services may be afforded as are required to complete professionally acceptable treatment.

[(d)] *(c)* Dental appliances, wheelchairs, artificial limbs, trusses, special clothing, and similar appliances to be furnished by the Secretary under this section may be procured by the Secretary either by purchase or by manufacture, whichever the Secretary determines may be advantageous and reasonably necessary.

[(f)(1) The Secretary may not furnish medical services under subsection (a) of this section (including home health services under section 1717 of this title) to a veteran who is eligible for hospital care under this chapter by reason of section 1710(a)(2) of this title unless the veteran agrees to pay to the United States the amount determined under paragraph (2) of this subsection.

[(2) A veteran who is furnished medical services under subsection (a) of this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such services shall be liable to the United States, in the case of each visit in which such services are furnished to the veteran, for an amount equal to 20 percent of the estimated average cost (during the calendar year in which the serv-

ices are furnished) of an outpatient visit in a Department facility. Such estimated average cost shall be determined by the Secretary.

[(3) This subsection does not apply with respect to home health services under section 1717 of this title to the extent that such services are for improvements and structural alterations.

[(4) Amounts collected or received by the Department under this subsection shall be deposited in the Treasury as miscellaneous receipts.]

[(h)] *(d)* The Secretary shall furnish to each veteran who is receiving additional compensation or allowance under chapter 11 of this title, or increased pension as a veteran of a period of war, by reason of being permanently housebound or in need of regular aid and attendance, such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of any illness or injury suffered by such veteran. The Secretary shall continue to furnish such drugs and medicines so ordered to any such veteran in need of regular aid and attendance whose pension payments have been discontinued solely because such veteran's annual income is greater than the applicable maximum annual income limitation, but only so long as such veteran's annual income does not exceed such maximum annual income limitation by more than $1,000.

[(i) The Secretary shall prescribe regulations to ensure that special priority in furnishing medical services under this section and any other outpatient care with funds appropriated for the medical care of veterans shall be accorded in the following order, unless compelling medical reasons require that such care be provided more expeditiously:

[(1) To a veteran (A) who is entitled to such services under paragraph (1) or (2) of subsection (a) of this section, or (B) who is eligible for counseling and care and services under section 1720D of this title, for the purposes of such counseling and care and services.

[(2) To a veteran (A) who has a service-connected disability rated at less than 30-percent disabling or (B) who is being examined to determine the existence or severity of a service-connected disability.

[(3) To a veteran (A) who is a former prisoner of war, or (B) who is eligible for hospital care under section 1710(e) of this title.

[(4) To a veteran eligible for medical services under subsection (a)(3)(B) or (a)(3)(C) of this section.

[(5) To a veteran not covered by paragraphs (1) through (4) of this subsection who is unable to defray the expenses of necessary care as determined under section 1722(a)(3) of this title.]

[(j)] *(e)* In order to assist the Secretary of Health and Human Services in carrying out national immunization programs under other provisions of law, the Secretary may authorize the administration of immunizations to eligible veterans who voluntarily request such immunizations in connection with the provision of care for a disability under this chapter in any Department health care facility. Any such immunization shall be made using vaccine furnished by the Secretary of Health and Human Services at no cost

to the Department. For such purpose, notwithstanding any other provision of law, the Secretary of Health and Human Services may provide such vaccine to the Department at no cost. Section 7316 of this title shall apply to claims alleging negligence or malpractice on the part of Department personnel granted immunity under such section.

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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY; ENHANCED-USE LEASES OF REAL PROPERTY

SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

§ 8110. Operation of medical facilities

(a) * * *

* * * * * * *

(c)(1) * * *

* * * * * * *

(3) The provisions of paragraph (1) of this subsection do not apply—

(A) to a contract or agreement under chapter 17 or section 8111, 8111A, or [8153] *8152* of this title or under section 1535 of title 31; or

* * * * * * *

SUBCHAPTER IV—SHARING OF MEDICAL FACILITIES, EQUIPMENT, AND INFORMATION

* * * * * * *

[§ 8151. Statement of congressional purpose

[It is the purpose of this subchapter to improve the quality of hospital care and other medical service provided veterans under this title, by authorizing the Secretary to enter into agreements with medical schools, health-care facilities, and research centers throughout the country in order to receive from and share with such medical schools, health-care facilities, and research centers the most advanced medical techniques and information, as well as certain specialized medical resources which otherwise might not be feasibly available or to effectively utilize other medical resources with the surrounding medical community, without diminution of services to veterans. Among other things, it is intended, by these means, to strengthen the medical programs at those Department hospitals which are located in small cities or rural areas and thus are remote from major medical centers. It is further the purpose of this subchapter to improve the provision of care to veterans under this title by authorizing the Secretary to enter into agreements with State veterans facilities for the sharing of health-care resources.]

§ [8152.] *8151.* Definitions

For the purposes of this subchapter—

(1) The term "research center" means an institution (or part of an institution), the primary function of which is research, training of specialists, and demonstrations and which, in connection therewith, provides specialized, high quality diagnostic and treatment services for inpatients and outpatients.

(2) The term "specialized medical resources" means medical resources (whether equipment, space, or personnel) which, because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to maximum utilization only through mutual use.

(3) The term "health-care resource" includes hospital care, medical services, and rehabilitative services, as those terms are defined in paragraphs (5), (6), and (8), respectively, of section 1701 of this title, any other health-care service, and any health-care support or administrative resource.

(4) The term "hospital", unless otherwise specified, includes any Federal, State, local, or other public or private hospital.

§ [8153.] *8152.* Specialized medical resources

(a)(1) To secure certain specialized medical resources which otherwise might not be feasibly available, or to effectively utilize certain other medical resources, the Secretary may, when the Secretary determines it to be in the best interest of the prevailing standards of the Department medical care program, make arrangements, by contract or other form of agreement for the mutual use, or exchange of use, of—

(A) [specialized medical resources] *health-care resources* between Department health-care facilities and [other health-care facilities (including organ banks, blood banks, or similar institutions), research centers, or medical schools] *any medical school, health-care provider, health-care plan, insurer, or other entity or individual*; and

(B) health-care resources between Department health-care facilities and State home facilities recognized under section 1742(a) of this title.

(2) The Secretary may enter into a contract or other agreement under paragraph (1) [only if (A) such an agreement will obviate the need for a similar resource to be provided in a Department health care facility, or (B) the Department resources which are the subject of the agreement and which have been justified on the basis of veterans' care are not] *if such resources are not, or would not be,* used to their maximum effective capacity.

(b) Arrangements entered into under this section shall provide for [reciprocal reimbursement based on a methodology that provides appropriate flexibility to the heads of the facilities concerned to establish an appropriate reimbursement rate after taking into account local conditions and needs and the actual costs to the providing facility of the resource involved.] *payment to the Department in accordance with procedures that provide appropriate flexibility to negotiate payment which is in the best interest of the Government.* Any proceeds to the Government received therefrom shall be credited to the applicable Department medical appropriation and to funds that have been allotted to the facility that furnished the resource involved.

(c) Eligibility for hospital care and medical services furnished any veteran pursuant to this section shall be subject to the same terms as though provided in a Department health care facility, and provisions of this title applicable to persons receiving hospital care or medical services in a Department health care facility shall apply to veterans treated under this subsection.

(d) When a Department health care facility provides hospital care or medical services, pursuant to a contract or agreement authorized by this section, to an individual who is not eligible for such care or services under chapter 17 of this title and who is entitled to hospital or medical insurance benefits under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), such benefits shall be paid, notwithstanding any condition, limitation, or other provision in that title which would otherwise [preclude such payment, in accordance with—

[(1) rates prescribed by the Secretary of Health and Human Services, after consultation with the Secretary, and

[(2) procedures jointly prescribed by the two Secretaries to assure reasonable quality of care and services and efficient and economical utilization of resources,

to such facility therefor] *preclude such payment to such facility for such care or services* or, if the contract or agreement so provides, to the community health care facility which is a party to the contract or agreement.

(e) The Secretary may make an arrangement that authorizes the furnishing of services by the Secretary under this section to individuals who are not veterans only if the Secretary determines—

(1) that such an arrangement will not result in the denial of, or a delay in providing access to, care to any veteran at that facility; and

(2) that such an arrangement—

(A) is necessary to maintain an acceptable level and quality of service to veterans at that facility; or

(B) will result in the improvement of services to eligible veterans at that facility.

[(e)**]** *(f)* The Secretary shall submit to the Congress not more than 60 days after the end of each fiscal year a report on the activities carried out under this section. Each report shall include—

(1) an appraisal of the effectiveness of the activities authorized in this section and the degree of cooperation from other sources, financial and otherwise; and

(2) recommendations for the improvement or more effective administration of such activities.

§ **[8154.]** *8153.* Exchange of medical information

(a) The Secretary is authorized to enter into agreements with medical schools, hospitals, research centers, and individual members of the medical profession under which medical information and techniques will be freely exchanged and the medical information services of all parties to the agreement will be available for use by any party to the agreement under conditions specified in the agreement. In carrying out the purposes of this section, the Secretary shall utilize recent developments in electronic equipment to provide a close educational, scientific, and professional link between Department hospitals and major medical centers. Such agreements shall be utilized by the Secretary to the maximum extent practicable to create, at each Department hospital which is a part of any such agreement, an environment of academic medicine which will help such hospital attract and retain highly trained and qualified members of the medical profession.

(b) In order to bring about utilization of all medical information in the surrounding medical community, particularly in remote areas, and to foster and encourage the widest possible cooperation and consultation among all members of the medical profession in such community, the educational facilities and programs established at Department hospitals and the electronic link to medical centers shall be made available for use by the surrounding medical community (including State home facilities furnishing domiciliary, nursing home, or hospital care to veterans). The Secretary may charge a fee for such services (on annual or like basis) at rates which the Secretary determines, after appropriate study, to be fair and equitable. The financial status of any user of such services shall be taken into consideration by the Secretary in establishing the amount of the fee to be paid. Any proceeds to the Government received therefrom shall be credited to the applicable Department medical appropriation.

(c) The Secretary is authorized to enter into agreements with public and nonprofit private institutions, organizations, corporations, and other entities in order to participate in cooperative health-care personnel education programs within the geographical area of any Department health-care facility located in an area remote from major academic health centers.

§ [8155.] *8154.* Pilot programs; grants to medical schools

(a) The Secretary may establish an Advisory Subcommittee on Programs for Exchange of Medical Information, of the Special Medical Advisory Group, established under section 7312 of this title, to advise the Secretary on matters regarding the administration of this section and to coordinate these functions with other research and education programs in the Department of Medicine and Surgery. The Assistant Under Secretary for Health charged with administration of the Department of Medicine and Surgery medical research program shall be an ex officio member of this Subcommittee.

(b) The Secretary, upon the recommendation of the Subcommittee, is authorized to make grants to medical schools, hospitals, and research centers to assist such medical schools, hospitals, and research centers in planning and carrying out agreements authorized by section [8154] *8153* of this title. Such grants may be used for the employment of personnel, the construction of facilities, the purchasing of equipment when necessary to implement such programs, and for such other purposes as will facilitate the administration of this section.

(c)(1) There is hereby authorized to be appropriated an amount not to exceed $3,500,000 for fiscal year 1976; $1,700,000 for the period beginning July 1, 1976, and ending September 30, 1976; $4,000,000 for fiscal year 1977; $4,000,000 for fiscal year 1978; and $4,000,000 for fiscal year 1979 and for each of the three succeeding fiscal years, for the purpose of developing and carrying out medical information programs under this section on a pilot program basis and for the grants authority in subsection (b) of this section. Pilot programs authorized by this subsection shall be carried out at Department hospitals in geographically dispersed areas of the United States.

(2) Funds authorized under this section shall not be available to pay the cost of hospital, medical, or other care of patients except to the extent that such cost is determined by the Secretary to be incident to research, training, or demonstration activities carried out under this section.

(d) The Secretary, after consultation with the Subcommittee shall prescribe regulations covering the terms and conditions for making grants under this section.

(e) Each recipient of a grant under this section shall keep such records as the Secretary may prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grant, the total cost of the project or undertaking in connection with which such grant is made or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such records as will facilitate an effective audit.

(f) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access, for the purpose of audit and examination, to any books, documents, papers, and records of the recipient of any grant under this section which are pertinent to any such grant.

§ [8156.] *8155.* Coordination with health services development activities carried out under the National Health Planning and Resources Development Act of 1974

The Secretary and the Secretary of Health and Human Services shall, to the maximum extent practicable, coordinate programs carried out under this subchapter and programs carried out under part F of title XVI of the Public Health Service Act (42 U.S.C. 300 et seq.).

§ [8157.] *8156.* Joint title to medical equipment

(a) Subject to subsection (b), the Secretary may enter into agreements with institutions described in section [8153(a)] *8152(a)* of this title for the joint acquisition of medical equipment.

(b)(1) The Secretary may not pay more than one-half of the purchase price of equipment acquired through an agreement under subsection (a).

(2) Any equipment to be procured under such an agreement shall be procured by the Secretary. Title to such equipment shall be held jointly by the United States and the institution.

(3) Before equipment acquired under such an agreement may be used, the parties to the agreement shall arrange by contract under section [8153] *8152* of this title for the exchange or use of the equipment.

(4) The Secretary may not contract for the acquisition of medical equipment to be purchased jointly under an agreement under subsection (a) until the institution which enters into the agreement provides to the Secretary its share of the purchase price of the medical equipment.

(c)(1) Notwithstanding any other provision of law, the Secretary may transfer the interest of the Department in equipment acquired through an agreement under subsection (a) to the institution which holds joint title to the equipment if the Secretary determines that the transfer would be justified by compelling clinical considerations or the economic interest of the Department. Any such transfer may only be made upon agreement by the institution to pay to the Department the amount equal to one-half of the depreciated purchase price of the equipment. Any such payment when received shall be credited to the applicable Department medical appropriation.

(2) Notwithstanding any other provision of law, the Secretary may acquire the interest of an institution in equipment acquired under subsection (a) if the Secretary determines that the acquisition would be justified by compelling clinical considerations or the economic interests of the Department. The Secretary may not pay more than one-half the depreciated purchase price of that equipment.

§ [8158.] *8157.* Deposit in escrow

(a) To facilitate the procurement of medical equipment pursuant to section [8157] *8156* of this title, the Secretary may enter into escrow agreements with institutions described in section [8153(a)] *8152(a)* of this title. Any such agreement shall provide that—

(1) the institutions shall pay to the Secretary the funds necessary to make a payment under section [8157(b)(4)] *8156(b)(4)* of this title;

(2) the Secretary, as escrow agent, shall administer those funds in an escrow account; and

(3) the Secretary shall disburse the escrowed funds to pay for such equipment upon its delivery or in accordance with the contract to procure the equipment and shall disburse all accrued interest or other earnings on the escrowed funds to the institution.

(b) As escrow agent for funds placed in escrow pursuant to an agreement under subsection (a), the Secretary may—

(1) invest the escrowed funds in obligations of the Federal Government or obligations which are insured or guaranteed by the Federal Government;

(2) retain in the escrow account interest or other earnings on such investments;

(3) disburse the funds pursuant to the escrow agreement; and

(4) return undisbursed funds to the institution.

(c)(1) If the Secretary enters into an escrow agreement under this section, the Secretary may enter into an agreement to procure medical equipment if one-half the purchase price of the equipment is available in an appropriation or fund for the expenditure or obligation.

(2) Funds held in an escrow account under this section shall not be considered to be public funds.

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VETERANS HEALTH CARE ACT OF 1992

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TITLE II—HEALTH-CARE SHARING AGREEMENTS BETWEEN DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE

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[SEC. 204. EXPIRATION OF AUTHORITY.

[The authority to provide services pursuant to agreements entered into under section 201 expires on October 1, 1996.]

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SEC. 207. AUTHORITY TO BILL HEALTH-PLAN CONTRACTS.

(a) RIGHT TO RECOVER.—In the case of a primary beneficiary (as described in section 201(2)(B)) who has coverage under a health-plan contract, as defined in section 1729(i)(1)(A) of title 38, United States Code, and who is furnished care or services by a Department medical facility pursuant to this title, the United States shall have

the right to recover or collect charges for such care or services from such health-plan contract to the extent that the beneficiary (or the provider of the care or services) would be eligible to receive payment for such care or services from such health-plan contract if the care or services had not been furnished by a department or agency of the United States. Any funds received from such health-plan contract shall be credited to funds that have been allotted to the facility that furnished the care or services.

(b) ENFORCEMENT.—The right of the United States to recover under such a beneficiary's health-plan contract shall be enforceable in the same manner as that provided by subsections (a)(3), (b), (c)(1), (d), (f), (h), and (i) of section 1729 of title 38, United States Code.

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