

**STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
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Mr. Chairman and Members of the Committee:

Thank you for the opportunity to present the views of the Disabled American Veterans (DAV) on H.R. 4939, the Veterans Medicare Payment Act of 2002. As an organization of more than one million service-connected disabled veterans, DAV is especially concerned about maintaining a viable Department of Veterans Affairs (VA) health care system that can meet the unique health care needs of our nation's service-connected veterans. The health and well being of many severely disabled veterans is dependent upon sufficient resources for VA's specialized programs and services to allow for their timely, efficient delivery.

The Veterans Medicare Payment Act of 2002, H.R. 4939, would authorize a transfer of payment from Centers for Medicare & Medicaid Services (CMS) to the VA for Medicare-eligible veterans who receive outpatient care from VA. This measure would allow VA to collect a total amount equal to 12 times the monthly premium rate paid by an individual enrolled in the Medicare program under Part B of title XVIII of the Social Security Act (42 United States Code 1395j). H.R. 4939 would not prohibit Medicare-eligible veterans from receiving health care from other providers outside the VA system.

The Disabled American Veterans (DAV) supports Medicare reimbursement for Medicare-eligible veterans receiving care from VA for non service-connected disabilities. We firmly believe that veterans should be able to see the health care provider of their choice, and when they choose VA, Medicare should reimburse the Department for the cost of the care for their non service-connected disabilities. Unfortunately, VA is currently required to absorb the cost of care for treatment of Medicare-eligible veterans seeking care at its facilities for non-service-connected conditions. The Committee is aware of the extreme financial stress on VA at this time due to rising costs for health care and increased numbers of veterans seeking VA health care. As a result, VA is currently unable to provide timely health care to many of our nation's most severely disabled veterans. This bill seeks to ease that burden through collection of veterans Medicare premiums to help cover the cost of their care at VA. We appreciate the introduction of H.R. 4939 by the Chairman and other Members of the Committee. Introduction of this legislation is an initial step in the right direction, however; we do have some concerns about the bill.

Initially, this legislation does not distinguish between Medicare reimbursements for the treatment of service-connected versus non service-connected conditions. Likely, this would trigger an offset in appropriations since government funding is provided to VA for the treatment of service related disabilities. Secondly, this measure would not cover the cost for care as related

to services rendered but simply authorize the transfer of veteran's Medicare premiums as payment. We believe VA participation in a Medicare reimbursement initiative will benefit veterans, taxpayers, and ultimately VA as long as Medicare reimbursement dollars are a supplement to an adequate VA appropriation. However, we believe the reimbursement should cover the cost of their care and be limited to paying for conditions that are not service-connected. VA is currently receiving appropriations from the government to cover the cost of health care for veterans' service-related conditions. To offset federal appropriations for VA health care by revenue from Medicare makes no sense and benefits no one, not veterans, not the VA, not the Medicare Trust Fund, and not American taxpayers.

Although we support Medicare reimbursement, DAV believes a better solution to fully address VA's funding problems would be to shift VA health care from a discretionary funding program to a mandatory program. We are extremely pleased that the Chairman has taken initial steps to explore this solution. The VA health care system is in real distress. The needs of our nation's service-connected disabled veterans are not being met. We are hopeful that a meaningful legislative remedy will be forthcoming.

To receive VA health care, most veterans must enroll, with the exception of veterans with a service-connected disability of 50 percent or more, veterans who were discharged from the military within one year but have not yet been rated for a VA disability benefit, and veterans seeking care for only a service-connected disability. Although access to health care is an earned benefit, based on honorable military service, it is not considered an entitlement; therefore, it is subject to annual discretionary appropriations. Priority level funding may change from year to year, depending on congressional appropriations. Seven priority groups were established to help ensure that VA resources are allocated to veterans with the highest priority for care. Priority Group 1, made up of veterans with service-connected disabilities rated 50 percent or greater have the highest priority to care; although, once in the VA health care system, there is no priority to receive care. Priority Group 7 veterans are nonservice-connected veterans and noncompensable service-connected veterans with incomes and net worth above the established thresholds, who agree to pay specified copayments for medical care and prescription medication. Currently, VHA is authorized to retain all copayments collected from veterans and third-party reimbursements collected from their private insurance companies. However, VHA is prohibited from billing Medicare for services rendered to Medicare-eligible veterans.

Medicare-eligible veterans have earned the right to use VA health care services. We strongly believe that Congress should pass legislation that permits Medicare-eligible veterans the option of choosing VA health care and using their Medicare coverage. Citizens purchase Medicare coverage through payroll deductions and should have the right to use those benefits to receive care from the provider of their choice. The VA health care system is well known for its specialized programs in areas such as blind rehabilitation, spinal cord injury, amputations, post-traumatic stress disorder, traumatic brain injury and mental health. Medicare reimbursement would give veterans, who are seeking treatment for a non service-connected disability and, who currently cannot use their Medicare coverage at VA facilities, but who need specialized care, the option of choosing the VA system and using their Medicare coverage, i.e., allowing VA to collect from Medicare for the cost of care provided. Additionally, VA believes it can deliver care to Medicare beneficiaries at a discounted rate, which would save money for the Medicare

Trust Fund and stretch taxpayer dollars. Allowing Medicare-eligible veterans to apply their Medicare benefits in VA facilities would reduce the government's total health care expenditures for the treatment of non service-connected disabilities. VA health care costs less, at least 25 percent less, than private-sector providers billing at Medicare rates. The savings could be realized by reduced cost to patients, through low or no copayments, or passed on to taxpayers by setting reimbursement rates discounted from standard CMS rates, or by a combination.

In previous testimony before the President's Task Force To Improve Health Care Delivery For Our Nation's Veterans, DAV discussed the growing number of Priority Group 7 Medicare-eligible veterans seeking care at VA and support for Medicare reimbursement for their care. One way to more easily deal with the Medicare reimbursement issue for Medicare eligible veterans is to only include Priority Group 7 veterans for reimbursement. This way there would less likely be an offset in appropriations.

The VA Secretary determines Priority Group 7 veterans' access to VA health care on an annual basis. VA's ability to provide their care largely depends on if it receives an adequate appropriation for health care. From one year to the next, this group of veterans is not sure if they will be able to continue to use VA health care services. VA Secretary Principi was prepared to announce his decision to limit enrollment of new Priority Group 7 veterans for this year. At the last minute he reversed his decision based on a promise from the Administration to provide supplemental funding to VA to continue open enrollment for all priority groups in 2002. The potential closure of enrollment for new Priority Group 7 veterans demonstrates that appropriations cover only Priority Groups 1-6. Medicare reimbursement would obviate the need to deny access to Priority Group 7 users.

The cost of care for this growing population of enrolled Priority Group 7 veterans exceeds medical care cost recovery (MCCR) from these patients and their secondary insurers. The DAV along with the *Independent Budget (IB)* group has consistently opposed the offset of MCCR collections. We believe that it is the responsibility of the Federal government to fund the cost of veterans care; therefore, we do not include any cost projections for MCCR in the *IB* budget development. VA's historical inability to meet its collection goals has eroded our confidence in VA estimates. We have urged the Administration and Congress to drop this budget gimmick and address the veterans' medical care appropriations in a straightforward manner by providing a realistic budget fully funded by appropriations. We strongly believe monies collected through MCCR should be a supplement to, not a substitute for, discretionary appropriations. Collections from Medicare-eligible Priority Group 7 veterans do not cover the cost of their care, and since appropriations are not sufficient, these funds are redirected away from service-connected and poor veterans to subsidize the Medicare trust fund. Additionally, because of the shortfall in appropriated funds, services provided for the care of service-connected and poor veterans are delayed, and those veterans particularly must wait much too long to receive necessary care.

While we support Medicare reimbursement, we would want Congress to ensure that service-connected disabled veterans would not be displaced or forced to wait even longer for necessary care and that revenue generated from Medicare reimbursement will not be used to offset federal appropriations. It doesn't make any sense to replace appropriated funds with

Medicare funds. There is no benefit to VA, Medicare, or taxpayers if VA appropriations were offset by Medicare revenues.

The assumption that Medicare reimbursement dollars should necessarily be offset by VA appropriation reductions is invalid because it is based on the incorrect belief that current appropriations are sufficient to provide services to service-connected, poor, and Priority Group 7 Medicare-eligible veterans. While VA sets standards for quality and efficiency, veterans' access to health care is constrained. Consistently inadequate appropriations have forced VA to ration care by lengthening waiting times. Last year appropriations were barely sufficient to cover the cost of care for Priority Groups 1-6. Appropriations over the last several years have been insufficient to provide services to service-connected, poor, and Priority Group 7 Medicare eligible-veterans. By VA estimates, there are over 1 million Priority Group 7 users, with 50-65 percent of them being Medicare eligible. Only 15 percent of Priority Group 7 Medicare-eligible users have billable Medigap insurance, leaving 85 percent where VA receives no insurance reimbursement. The average collections from Medigap insurance for Priority Group 7 Medicare-eligible veterans is estimated at only 12-13 percent of the possible total billable portion. Obviously, VA spends a significant amount of resources on providing health care services for Priority Group 7 Medicare-eligible veterans with little reimbursement. We strongly believe their health care costs should be covered by Medicare funds.

The director of CMS has stated that veterans' care should be covered by VA appropriations and that Medicare reimbursement would represent a double payment by the government. This is a spurious argument; actually, the current situation represents "reverse subvention" with VA appropriations used to pay for care that has already been funded by contributions to the Medicare Trust Fund.

No veteran should be denied access to the veterans health care system. Veterans, even veterans like those in Priority Group 7, who are not poor, have the right to take advantage of VA health care. However, service-connected and poor veterans should not have to subsidize care for veterans who have public or private insurance coverage. Medicare reimbursement would allow Medicare-eligible Priority Group 7 veterans to become a source of funding rather than a drain on an already over-extended system.

In closing, if the Committee chooses to pursue this initiative we recommend amending H.R. 4939 to include Medicare reimbursement for services rendered versus collection of Medicare premiums, and only for veterans in Priority Group 7 or only for the treatment of non service-connected conditions; to avoid a potential offset in appropriations. However, we believe the best strategy to fully address the issue of inadequate appropriations for VA health care, is a shift in the funding source from discretionary to mandatory. We thank the Committee for holding this hearing and for its consideration of this important issue.