

Statement of the
MILITARY OFFICERS ASSOCIATION OF AMERICA

on
the Final Report of
The President's Task Force to Improve Health Care Delivery for
Our Nation's Veterans

before the

House Committee on Veterans' Affairs

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Presented by
Colonel Robert F. Norton, USA (Ret.)
Deputy Director, Government Relations
Military Officers Association of America



Biography of Robert F. Norton, COL, USA (Ret.)
Deputy Director, Government Relations, MOAA
Co-Chair, Veterans' Committee, The Military Coalition

A native New Yorker, Bob Norton was born in Brooklyn and raised on Long Island. Following graduation from college in 1966, he enlisted in the U.S. Army as a private, completed officer candidate school, and was commissioned a second lieutenant of infantry in August 1967. He served a tour in South Vietnam (1968-1969) as a civil affairs platoon leader supporting the 196th Infantry Brigade. He transferred to the U.S. Army Reserve in 1969 and pursued a teaching career at the secondary school level. He joined the 356th Civil Affairs Brigade (USAR), Bronx, NY and served in various staff positions from 1972-1978.

Colonel Norton volunteered for active duty in 1978 and was among the first group of USAR officers to affiliate with the "active Guard and Reserve" (AGR) program on full-time active duty. Assignments included a tour on the Army Staff in the Office of the Deputy Chief of Staff for Personnel; advisor to the Assistant Secretary of the Army (Manpower & Reserve Affairs); and personnel policy and plans officer for the Chief, Army Reserve.

Colonel Norton served two tours in the Office of the Secretary of Defense (OSD) from 1982-1985 and from 1989-1995. As a staff officer in the Office of the Assistant Secretary of Defense for Reserve Affairs, he was responsible for implementing the new Reserve Montgomery GI Bill. In the later tour, he was the senior military assistant in Reserve Affairs, where he was responsible for advising the Assistant Secretary and coordinating a staff of over 90 military and civilian personnel. During this tour, Reserve Affairs oversaw the call-up of more than 250,000 National Guard and Reserve component troops for the first Gulf War. Colonel Norton completed his career as special assistant to the Principal Deputy Asst. Secretary of Defense, Special Operations / Low Intensity Conflict and retired in 1995.

In 1995, Colonel Norton joined Analytic Services, Inc. (ANSER), Arlington, VA as a senior operational planner supporting various clients including United Nations humanitarian organizations and the U.S. Air Force's counter proliferation office. He joined MOAA's national headquarters as Deputy Director of Government Relations in March 1997.

Colonel Norton holds a B.A. in philosophy from Niagara University (1966) and a Master of Science (Education) from Canisius College, Buffalo (1971). He is a graduate of the U.S. Army Command and General Staff College, the U.S. Army War College, and Harvard University's Senior Officials in National Security course at the Kennedy School of Government.

Colonel Norton's military awards include the Legion of Merit, Defense Superior Service Medal, Bronze Star, Vietnam Service Medal, Armed Forces Reserve Medal, Army Staff Identification Badge and Office of the Secretary of Defense Identification Badge.

Chairman and Distinguished Members of the Committee, I am pleased to present the views of the Military Officers Association of America (MOAA) on the Final Report of the President's Task Force (PTF) to Improve Health Care Delivery for Our Nation's Veterans. MOAA does not receive any grants or contracts from the federal government.

Introduction

MOAA is very pleased to see that a number of our recommendations for improving collaboration between the VA and DoD health care systems have been incorporated into the Final Report. MOAA testified before the PTF on 15 January 2002, early in its deliberations, and we contributed to the statement presented by The Military Coalition on 7 March 2002 before a joint hearing of the Military Personnel Subcommittee of the House Armed Services Committee and the Subcommittee on Health of the House Veterans Committee. MOAA also was a signatory of a letter from The Military Coalition to the PTF Co-Chairs on 20 September 2002 outlining key issues that we collectively recommended for inclusion in the final report.

From the outset, we have emphasized that the work of the PTF ultimately would be judged by stakeholders on the principle of preserving or improving access to quality health care for all beneficiary groups. To its credit, the PTF did not take up an administration budget proposal that would have singled out dually eligible military retired veterans to relinquish earned health care benefits available from either the DoD or VA systems.

Task Force Recommendations

Provide Clearer Leadership

Collaboration between the Department of Defense and the Department of Veterans Affairs begins with leader commitment and strategic planning. The administration's commitment to this enterprise has instilled a new sense of purpose between DoD and VA senior leaders. Congress recognized the importance of leader engagement by establishing the Joint Executive Council. Now, legislation recently passed by the House would advance PTF Recommendation 2.1 by creating a broader charter for the interagency leadership committee beyond health care. MOAA endorses this recommendation.

MOAA supports PTF Recommendation 1.1 that the Secretaries of Defense and Veterans Affairs report annually to Congress on their joint plans and programs for collaborative activities. We believe the departments should issue from time-to-time a "national strategy for DoD – VA collaboration." MOAA also recommends that the Armed Services and Veterans Affairs Committees hold periodic joint hearings on the progress of the departments in strategic cooperation. These interactions should be informed by a vision that focuses on the needs of servicemembers from the first day they enter military service and throughout their lives as the primary reason for DoD – VA collaborative activities.

Create a Seamless Transition from Military to Veteran Status

MOAA applauds Task Force Commissioners and staff for the strong recommendations in the Final Report on seamless transition. Despite tremendous strides in management efficiency and service delivery, the VA is still not able to provide timely delivery of benefits for our nation's veterans. Late last year, approximately 463,000 claims including 97,000 on appeal were backlogged in the VA system. The problem has its roots in absent or incomplete medical records, the lack of a common separation physical, non-existent documentation on occupational exposures, and an inability of DoD and VA to seamlessly share medical data.

MOAA strongly recommends that Congress incorporate PTF Report recommendations in Chapter Three on seamless transition into public law and authorize the necessary funding to implement the recommendations as soon as possible. We believe that implementation of these recommendations can have a sustained, positive impact on the lives of millions of veterans and enable more efficient and effective use of government resources.

Remove Barriers to Collaboration

MOAA appreciates Report Recommendation 4.4, which would permit prescriptions written by either the VA or DoD to be filled for dually eligible military retired veterans by the other Department's pharmacies.

The PTF Report recommends a strategic approach to medical facilities planning between DoD and the VA and we support this approach. (Recommendations 4.7 and 4.8)

We have some reservations about Report Recommendation 4.3 that proposes the creation of a national (DoD – VA) core formulary. The VA conducts pharmacy operations within its direct care (or, closed) system, whereas the DoD TRICARE pharmacy benefit is delivered through direct (military treatment facilities) care, retail (purchased care) and mail order. As the Report notes, DoD and the VA can realize increased efficiencies and savings through joint purchasing from the federal schedule. It also notes that a joint national formulary "could reduce the number of therapeutic alternatives within a drug class. . ." and reduce adverse events as beneficiaries move between facilities and Departments. It is our view that reducing therapeutic alternatives would lead to lower quality care for all beneficiary groups; and, the interaction of eligible patients with either system is best served by upgrading the information management capabilities of the two Departments as indicated in Recommendation 4.6 of the Report. Therefore, MOAA questions whether a national core formulary would maintain or enhance the quality of care and increase savings.

Address the Mismatch Between VA Demand and Resources

Dr. Gail Wilensky, PTF Co-Chair, emphasized in her testimony before the Committee on 3 June 2003 that improved coordination between VA and DOD could not be fully realized until the gap between demand for care and resources is resolved. We agree.

On March 20, before a joint hearing of the House and Senate Veterans Affairs Committees, MOAA testified that "demand for VA health care continues to exceed the VA's capacity to provide timely, quality services to enrolled veterans. Under the VA's open enrollment program (which was suspended in January this year) 6.5 million veterans were enrolled in VA care (as of September 2002) and nearly five million veterans sought care in the system last year."

The MOAA statement continues: "Last summer [2002], 315,000 veterans were on unacceptably long waiting lists ranging from six-months to one-year for initial or specialty appointments. That number has dropped to about 200,000 veterans on these waiting lists, a considerable improvement. But this issue is not about making the numbers look good. It's about real people, our nation's veterans, who are in many parts of the country still forced to wait long periods for their health care appointments. The demand – resources gap is having an adverse impact on veterans' health because many simply can't get care when they need it. MOAA believes that the VA should be fully funded to meet its own access standards. That means that a veteran should be able to obtain routine care within 30 days. Once the VA has agreed to accept a veteran for care there is an absolute obligation of the government to provide high quality care in a timely manner."

The means to achieve full funding in accordance with VA access standards was a matter of intense discussion and debate in the PTF and among external stakeholders. MOAA believes that the PTF's concept (p. 77) of forming an impartial board of outside experts to identify the funding required to meet the full funding objective is sound and should be adopted.

MOAA supports mandatory funding or modification of the current system to fully fund the care of core mission veterans, those in Priority Groups 1-7. (Recommendation 5.1) More importantly, we urge the Committee and Congress to make an absolute commitment to ensure full funding as soon as possible. Pending the outcome of debate on this issue, MOAA recommends Congress approve a supplemental appropriation to ensure full funding of PG 1-7 veterans for FY 2004.

The Report (pg. 70) points out the current demand-resources mismatch is a product of unrestrained demand from open enrollment and a policy that "omits explicit funding for Priority Groups 7 and 8, in part because VA anticipated that first-and third-party collections would cover a significant part of the cost of care provided to these veterans." But revenues for these groups cover only about 24% of the cost according to the PTF. In building annual budget requests, the projected revenues from third-party collections are incorporated into the budget and that amount is offset, thereby nullifying any net gain from collections. In other words, the VA does not consider lowest priority enrollees for budget purposes until they actually are seen

in a VA facility; and, then, when they are counted, the cost of their care is understated by subtracting third party medical insurance collections.

MOAA strongly recommends that if Congress elects to continue the current annual appropriations process, it should require the administration to submit a true estimate of the cost to fully fund the care of core mission veterans in accordance with VA access standards.

Should the Committee and Congress endorse mandatory funding, the panel of outside experts should be used to develop a costing model that will cover future projected costs. The enabling legislation should include authority for a medical board of actuaries to recommend adjustments to the capitation formula to assure it keeps pace with the actual cost of full funding over time. As Chairman Smith suggested at the 3 June hearing, mandatory funding might fall short of the full funding mark if a flawed capitation model were used to calculate the needed resources.

Veterans currently enrolled in the new PG-8 category are grandfathered in the system and the cost of their care should be included in mandatory funding or modification of the existing appropriations process.

The PG-8 category was created just a few short months ago in response to overwhelming demand on the system. In our view, The PTF was not established to parse specific "rules of engagement" on enrollment, but to take the longer view on DoD – VA health care collaboration. We do agree that the situation presented by the uncertain status and funding of PG-8s is unacceptable and we support Recommendation 5.3 that the administration and Congress must resolve this problem.

MOAA was disappointed that the PTF Report did not address the use of Medicare funds in VA facilities for the care of Medicare-eligible veterans with no service connection. We believe that a properly structured Medicare Subvention program would benefit PG 7 and 8 enrollees, the VA health care system and, the government -- potentially, a "win-win-win" situation.

Veterans who have paid into Medicare throughout their working lives should have the option of choosing to receive their Medicare benefits in VA facilities. VA research has shown that the government often pays twice for similar diagnostic tests and procedures performed in Medicare-sponsored facilities and repeated in VA facilities. The theory behind Medicare subvention is that the government could potentially reduce costs if the VA can demonstrate greater efficiency than Medicare providers. The VA plans to implement a Medicare + Choice Plan for PG-8 veterans later this year. Such a program may help relieve funding and access challenges for this cohort.

Conclusion

The Military Officers Association of America appreciates the hard work of the Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans. The continued support of the Veterans Affairs Committee in partnership with the

Armed Services Committee will be pivotal to realizing the far-reaching recommendations in the PTF Report. Thank you for the opportunity to submit testimony on behalf of the members of MOAA.