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STATEMENT OF
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UNITED STATES HOUSE OF REPRESENTATIVES
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Chairman Takano, Ranking Member Roe and Members of the Committee

Thank you for inviting DAV (Disabled American Veterans) to testify before the Committee today regarding potential changes and reforms to veterans' eligibility to enroll in and receive medical care from the Department of Veterans Affairs (VA) health care system.

As you know, DAV has more than a million members, all of whom were injured or made ill during wartime service in the armed forces. DAV members rely heavily on VA for their health care, so ensuring that VA provides a safe, high-quality and accessible system of care is of paramount importance to us, as well as millions of other veterans who choose and rely on VA.

Mr. Chairman, in my testimony today I will discuss the history and effect of the Veterans Health Care Eligibility Reform Act of 1996 (Public Law 104-262), political attempts to restrict eligibility since enactment of that law, recent eligibility issues that Congress has considered, and the proposal (H.R. 7469) to create an independent commission on eligibility reform.

Background and History of VA Health Care Eligibility

Prior to enactment of eligibility reform in 1996, VA had administratively complicated and clinically limiting eligibility criteria that unnecessarily hindered its ability to provide comprehensive, high-quality, accessible and cost-effective care. Essentially, prior to 1996, VA primarily provided hospital inpatient care to veterans with service-connected disabilities, veterans with low incomes and additional categories of what were labeled "exempt" veterans, which included former prisoners of war and veterans who had been exposed to Agent Orange. VA was also authorized, but not required, to provide outpatient care to these veterans, but generally only when such outpatient care would "obviate the need" for inpatient care.

VA was bound by a complicated matrix of inpatient versus outpatient eligibility criteria that often resulted in veterans requiring hospitalization in order for them to receive outpatient services or medical equipment. VA was strictly limited to providing

care for service-connected conditions even when a veteran's nonservice-connected condition was their greatest health care issue. Without the freedom to treat the whole veteran and all their interconnected medical conditions, VA clinicians were hamstrung in providing the highest quality of care for their patients. Former VA Under Secretary for Health Dr. Ken Kizer, who led the 1996 VA eligibility reforms, wrote in the 2009 *Annual Review of Public Health*, that the VA health care system in the mid-1990s had become "highly dysfunctional." Kizer wrote that:

> The quality of [VA] care was irregular; service was fragmented, disjointed, and insensitive to individual needs; inpatient care was over-utilized; customer service was poor; and care was often difficult to access (patients sometimes traveled hundreds of miles or waited months for routine appointments).

To remake and modernize VA health care, Kizer and other VA officials laid out an ambitious plan ("Vision for Change") to transform VA from a hospital-based health care system that treated service-connected conditions to a modern outpatient-based system that provided primary and preventative care. One of the most critical steps in this transformation was reforming eligibility rules so that veterans could receive primary care from VA in the most appropriate setting, whether inpatient or outpatient. In order for VA to offer broad-based primary care, it was necessary for VA clinicians to have sufficient workload to ensure the delivery of safe and high-quality medicine.

Essentially, the 1996 law made all veterans eligible for VA medical care, as outlined in 38 U.S.C. 1710, subject to enrollment decisions to be made by VA. The law required that VA "shall" provide hospital care and medical services to veterans with service-connected disabilities and low incomes, those who are "catastrophically disabled" as well as those who qualify under specific criteria, such as former prisoners of war, Medal of Honor awardees, Purple Heart recipients and veterans exposed to radiation and toxic substances. These veterans, who comprise VA priority groups 1-6, have "mandatory" health care eligibility. The remaining veterans, placed in priority groups 7 and 8, have a "discretionary" eligibility under which VA "may" provide hospital care and medical services "to the extent resources and facilities are available. Since 2003, VA has used its authority under the 1996 Eligibility Reform Act to limit enrollment of veterans with "discretionary" eligibility based on a determination that funding would not be sufficient.

Currently, in order to receive health care from VA, veterans must first be determined eligible and then be enrolled into the system and placed into one of VA's health care priority groups. For veterans rated 50% service connected or greater, there is no copayment or cost-sharing for care provided for any condition. For veterans rated 0-40% service-connected by VA, copayments may be applicable depending upon their assigned priority group and the specific medical services provided. However, all enrolled veterans are eligible for VA's standard medical benefits package, which encompasses both inpatient and outpatient services, including primary care, specialty care, mental health care, readjustment programs and an array of other services and supports. In general, long-term care and caregiver supportive services are available to

veterans that are rated 70% service-connected or greater or for a veteran whose service-connected condition requires such care.

Over the past two decades, Congress and VA have modified and expanded both the medical benefits package as well as eligibility for certain groups and subgroups of veterans. For example, veterans who served in a theater of combat operations are now provided “mandatory” eligibility for five years from discharge. Congress also expanded eligibility for non-VA provided community care with both the Veterans Access, Choice and Accountability Act of 2014 (“Choice Act”) and the VA MISSION Act of 2018. Most recently, Congress expanded access to emergency mental health care to help veterans in suicidal crisis with the passage of the Veterans’ Comprehensive Prevention, Access to Care, and Treatment Act of 2020 (“Veterans COMPACT Act”). However, while Congress has and must continue to make adjustments to both VA eligibility and its medical benefits package, the core of the 1996 eligibility law remains intact: all veterans are eligible for VA health care subject to the availability of resources.

Success and Challenges of the 1996 Eligibility Reform Act

Together with other management and clinical changes, the 1996 eligibility reforms dramatically improved the VA health care system. With enactment, VA implemented universal primary care for almost all of its enrolled patients, leading to significant and measurable quality improvements and better health outcomes for veterans. Congress approved funding for hundreds of new community-based outpatient clinics (CBOCs) as care shifted from inpatient to outpatient settings, greatly expanding access to millions more veterans around the country. The greatly increased number of VA health care access points and VA’s generous prescription drug benefit further encouraged many newly eligible veterans to enroll in the system.

Unfortunately, funding did not keep pace with VA’s steady growth, leading to a dramatic mismatch between demand and capacity, which resulted in extremely long wait times in the early 2000s. Yet despite the access problems, independent experts and studies, including the 2003 *President's Task Force to Improve Health Care Delivery for Our Nation's Veterans*, found that the quality of VA health care had significantly improved since the 1996 eligibility reform act, and agreed that VA was providing care as good as or better than the private sector.

Some members of the House and Senate sought to address the mismatch between funding and demand for VA care by attacking the increasing costs for veterans’ health care. There were proposals to limit eligibility only to combat veterans or to provide medical care only for service-connected conditions. Discussions of eligibility reform in the mid-2000s centered around ways to redefine who were “core veterans” that VA should have responsibility to provide health care, leaving the remaining veterans on their own to secure health care from other sources, such as their employer, Medicare or Medicaid. Some politicians whose political ideology favored smaller government solutions preferred limiting veterans’ access to VA health care rather than expanding funding to meet the growing demand. Over the past two decades there have

been calls for privatization and even elimination of the VA health care system altogether.

However, Congress has remained supportive of VA health care and more than 9 million veterans have made their preference known by choosing to enroll in the VA health care system. Veterans frequently cite the high quality of care, the comprehensive medical benefits package (including prescription drug coverage), specialized services and the expanded network of convenient CBOCs that were built around the country as the reason they choose VA. Despite attempts by some elected officials to limit eligibility to reduce spending on veterans health care, successive Congresses and Administrations over the past two decades have publicly committed to providing sufficient funding to permit enrolled and eligible veterans to access the VA health care system, notwithstanding the reality that final appropriations levels have not always been adequate to meet the actual demand each year. As the number of veterans choosing VA for their health care soared, and funding needs grew, Congress approved the Veterans Health Care Budget Reform and Transparency Act of 2009 (Public Law 111-81), which authorized advance appropriations for VA health care to better assure that funding levels met the projected demand for care. The VA MISSION Act was another broadly supported, bipartisan law that further enshrined Congress' commitment to modernizing and maintaining a robust VA health care system for all veterans who need, choose and rely on it for their care.

Modifications to VA Health Care Eligibility

While the foundation of the 1996 eligibility reform law has remained intact, Congress and VA have made some notable changes to expand eligibility for certain veterans and to expand certain medical services, including the Choice Act, the VA MISSION Act and the Veterans COMPACT Act discussed above. There are also other eligibility changes under consideration currently, specifically enhanced eligibility for veterans exposed to toxic substances and for veterans who received other than honorable (OTH) discharges.

- **Eligibility for Veterans Exposed to Toxic Substances and Burn Pits**

  A new eligibility issue under discussion is how to provide VA health care access to veterans who were exposed to toxic substances, particularly those who served near burn pits, but who have not been granted service connection as a result of that exposure. VA already provides health care eligibility (Priority Group 6) to certain groups of veterans who were exposed to specific toxic substances (Agent Orange), radiation, Camp Lejeune water or who served during the first Persian Gulf war under 38 U.S.C. 1710(a)(2)(F), notwithstanding a lack of service connection.

  The recent wars in Afghanistan and Iraq have exposed hundreds of thousands, if not millions, of veterans to toxic substances emitted from burn pits and through other means; however, establishing a direct service connection from such exposure to specific illnesses or diseases has been difficult for most to prove. Establishing

presumptive service connection for these exposures can take decades, as was the case with Agent Orange and radiation. To bridge the gap, DAV supports efforts to provide eligibility to health care for veterans who served in areas that were near burn pits in Afghanistan, Iraq and other countries in those regions.

H.R. 4137, the Jennifer Kepner HOPE Act, would add a new subsection to Section 1710 that would extend health care eligibility to veterans exposed to burn pits since the onset of the first Persian Gulf War. S. 4393, the TEAM Act of 2020, which was approved by the Senate Veterans' Affairs Committee, would take a similar approach by expanding eligibility under Priority Group 6 for veterans who are eligible for inclusion in the Airborne Hazards and Open Burn Pit Registry; or who have been identified by the Secretary of Defense to have been possibly exposed to a burn pit or other toxic substance. The Senate bill would also provide eligibility for veterans who received one of six specific campaign medals confirming their service in areas where burn pits and/or toxic substances were prevalent. DAV strongly supports both of these bills that would modify VA health care eligibility to address the emerging science on the dangers from burn pits and toxic exposures.

- **Other Than Honorable (OTH) Discharges**

  Another current eligibility issue is whether former service members who receive non-punitive administrative discharges characterized as other than honorable (OTH), sometimes referred to as "bad paper" discharges, should have eligibility for medical care or other VA benefits. In recent years, there have been significant numbers of Afghanistan and Iraq service members who received "bad paper" discharges who may have had undiagnosed traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), military sexual trauma (MST) or other trauma. Without access to VA medical care and benefits, these former service members could become at higher risk of suicide and homelessness, as well as greater risk of involvement in the criminal justice system. To address this issue, DAV supports a more liberal review of other than honorable discharges for purposes of receiving VA benefits and health care services specifically in cases of former service members whose undiagnosed PTSD, TBI and MST or other trauma may have contributed to their administrative discharges characterized as other than honorable.

Proposal to Establish an Independent Eligibility Reform Commission

In 2016, as mandated by the Choice Act, the Commission on Care delivered its final report and recommendations in response to the access crisis and waiting list scandal of 2014. While most of the recommendations concerned changes to VA management and clinical operations, the Commission on Care also included a couple of recommendations related to eligibility. One was to provide veterans with OTH discharges health care eligibility, as discussed above. The other recommendation was that Congress should, "establish an expert body to develop recommendations for VA care eligibility and benefit design." H.R. 7469, the Modernizing Veterans' Healthcare Eligibility Act, proposes to fulfill that recommendation by establishing a "Commission on

Eligibility" to examine veterans' health care eligibility rules and regulations and to make recommendations to change them. In September 2020, DAV testified before this Committee and noted that we could find no compelling reasons for the creation of such a commission.

As noted above, most of the impetus over the past two decades for discussions about eligibility reform has been based on the premise that the only way to address the mismatch between funding and demand for care was to limit the number of veterans receiving VA health care to reduce federal spending requirements. We strongly disagree with that premise.

The Commission's recommendation for a new commission to review VA health care eligibility was based on the same flawed premise. In its report, the Commission clearly stated its rationale: "Although VHA continues to offer the promise of health care to all veterans, its capacity to meet that promise is constrained by appropriated funding. Congress and VA leadership must work to identify who VHA will serve, and what services it will provide…"

In other words, the Commission on Care began with an assumption that future Congresses and Administrations would not provide adequate funding to the VA health care system, and that therefore it was necessary to consider how best to reduce future VA health care usage. Furthermore, understanding that Congress would have difficulty directly voting to limit the number of veterans eligible for VA health care, the Commission recommended creating an "independent" commission in order to insulate elected officials from being held accountable by veterans and other voters who would likely oppose such reductions. The Commission did not argue that current eligibility rules are preventing VA from administering modern medicine in the most cost-effective manner, as was the case prior to 1996. Instead, their focus was primarily on the challenge of providing sufficient funding to the VA health care system.

A couple of members of the Commission also indicated an interest in developing a pilot program that would allow some family members of veterans to receive care at VA facilities with significant excess capacity by paying for it with other health insurance. While DAV would not be opposed to consideration of such ideas, there is nothing preventing members of Congress from proposing such ideas and allowing the authorizing committees to thoroughly examine them through regular order, without the need for an independent commission. However, regardless of the Commission on Care's rationale for establishing a commission on eligibility, DAV opposes this proposal on its own merits for a number of reasons.

No Need for an Independent, Unaccountable Commission on Eligibility

First, Congress already has the authority to modify eligibility and has done so on numerous occasions as discussed above. Veterans' health care eligibility and VA's medical benefits package for enrolled veterans are both clearly defined in title 38, United States Code, and accompanying federal regulations. Because Congress has full

authority to modify eligibility requirements or VA's medical care benefits package through the regular legislative process, it is unclear why a special outside commission is necessary. The legislation does not provide any indication of the types of serious problems the commission should address, proposals it should consider or a compelling rationale for why Congress and VA are unable to properly exercise control under current authorities. There are no systemic impediments to providing and receiving care comparable to what existed in the 1990s, when VA was unable to provide primary care or rationally provide care in outpatient settings. We agree that modifications will continue to be necessary, such as for veterans with OTH discharges or veterans who have been exposed to toxins and toxicants from burn pits; however, such changes do not require a separate, independent commission charged with reexamining the entire basis of VA health care eligibility. We do note, however, that one area that Congress and this Committee would have difficulty addressing would be proposals to significantly limit or reduce the number of veterans eligible for VA health care.

Historically, independent commissions have been created by Congress for three main purposes: to respond to a disaster or crisis, to bring special expertise that Congress lacks, or to help make unpopular decisions that Congress has been unable to make on its own. Examples of independent commissions that were created to find the root causes of crises and make recommendations to help prevent or mitigate any recurrence include those created to examine the September 11th terrorist attacks, the financial crisis of 2008, and the VA access crisis and waiting list scandals of 2014. A second type of independent commission is formed when there are subject matters that are so complex that they reach beyond the expertise the Congress possesses, such as the Commission to Assess Threat to the United States from Electromagnetic Pulse Attacks and the National Security Commission on Artificial Intelligence. A third type of independent commissions are those created to help make hard decisions that Congress is either unwilling or unable to make, such as the Base Realignment and Closure (BRAC) Commission, National Commission on Fiscal Responsibility and Reform (often called "Simpson-Bowles") and the recent Military Compensation and Retirement Modernization Commission.

The proposed commission on eligibility was not created in response to any disaster or crisis related to eligibility. It does not require any technical expertise that Congress lacks: the judgement of how many and which veterans have earned the right to receive health care from the federal government in exchange for their military service is a value judgement, not a technical matter. Instead, it appears to be most similar to commissions like the BRAC commission, which was established to help Congress make politically sensitive decisions (closing military bases) that had proven too difficult for elected representative who are accountable to their constituents.

Mr. Chairman, eligibility at its heart is about the obligation of our nation to the men and women who served and will serve in the future. It is about fulfilling the promises made to all those who wear the uniform. It is about how we prioritize the obligations of the federal government to America's veterans. We believe strongly Congress and this Committee have the responsibility and sufficient expertise to conduct

oversight of VA health care eligibility and determine whether legislative or regulatory changes are necessary. Only if Congress finds itself unable to properly exercise these functions should an outside commission even be considered. Such is not the case today and for these reasons, DAV opposes H.R. 7469.

Mr. Chairman, this concludes my testimony, and I would be happy to respond to any questions the Committee may have.