# HJR

# 33

Amendment #1 - passed 3/23/06

Amendment to HJR33 by Senator

Page 2 line 9
delete "and" after hospitals
insert "with"

Page 2 line 17
delete [redacted] "possibly"
insert "United States Department of Veteran Affairs doctors and hospitals are not easily accessible"

# ALASKA STATE LEGISLATURE


***Chair:***
Legislative Council

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## REPRESENTATIVE PETE KOTT
**DISTRICT 17 – EAGLE RIVER**


Sponsor Statement
For
House Joint Resolution 33

**Urging the Alaska Department of Health and Social Services to seek authority and funding from the United States Department of Veterans Affairs to establish a system of allowing Alaska veterans treatment in both public and private Alaska Facilities.**

With approximately 72,000 veterans that call our great state home, I believe that Alaska's veterans deserve top quality health care in their own communities. Currently forced to seek medical treatment with U.S. Veteran's facilities, many of these heroes have to leave their communities and even go outside of Alaska. Many millions of dollars have been spent in airfare alone in order to get Alaskan's treatment when the treatment and facilities are available in state. This policy is costly and inefficient, and it disrupts Alaskans' lives.

House Joint Resolution 33 urges the United States Department of Veterans' Affairs to authorize funding and management to establish a system whereby Veterans can seek treatment from medical facilities other than that of the U.S. Military and Veteran's Affairs doctors and hospitals, many of which are available in the State of Alaska. This would give veterans a greater choice and flexibility for healthcare and increase the interaction between the Department and Military and Veterans Affairs doctors and the public and private medical facilities in the state thus, significantly reducing medical costs and increasing efficiency for veterans' medical care. This system would support the use of a veteran's medical identification card as an insurance card for medical billing to the U.S. Department of Military and Veteran's Affairs.

The passage of HJR 33 will give veterans a choice, and will allow them local access to quality healthcare.

# FISCAL NOTE

**STATE OF ALASKA**
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: 1 ****CORRECTED****
Bill Version: HJR 33
(H) Publish Date: 3/3/2006

Revision Date/Time (Note if correction):
Dept. Affected:
Title: Supporting In-State Med.Care for Vets
RDU
Component
Sponsor: Representative Kott
Requester: House Mil & Vet Affairs Committee
Component No.

**Expenditures/Revenues** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

| OPERATING EXPENDITURES | FY 2007 | FY 2008 | FY 2009 | FY 2010 | FY 2011 | FY 2012 |
|---|---|---|---|---|---|---|
| Personal Services | | | | | | |
| Travel | | | | | | |
| Contractual | | | | | | |
| Supplies | | | | | | |
| Equipment | | | | | | |
| Land & Structures | | | | | | |
| Grants & Claims | | | | | | |
| Miscellaneous | | | | | | |
| **TOTAL OPERATING** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** |
| **CAPITAL EXPENDITURES** | | | | | | |
| **CHANGE IN REVENUES ( )** | | | | | | |

**FUND SOURCE** (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| 1002 Federal Receipts | | | | | | |
| 1003 GF Match | | | | | | |
| 1004 GF | | | | | | |
| 1005 GF/Program Receipts | | | | | | |
| 1037 GF/Mental Health | | | | | | |
| Other (Specify Type--Do not abbreviate) | | | | | | |
| **TOTAL** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** |

**Estimate of any current year (FY2006) cost:** 0.0
**Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:**

**POSITIONS**

| | | | | | | |
|---|---|---|---|---|---|---|
| Full-time | | | | | | |
| Part-time | | | | | | |
| Temporary | | | | | | |

**ANALYSIS:** *(Attach a separate page if necessary)*

Prepared by: Nancy Manly, Committee Aide
Phone 907-465-2794
Division: House Special Committee on Military and Veterans' Affairs
Date/Time 3/23/06 11:36 AM
Approved by: Representative Lynn
Date 3/23/2006
Agency: Chairman

(Revised 9/23/2004 OMB)

**COMMITTEE COPY**

# FISCAL NOTE

**STATE OF ALASKA**
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: 1
Bill Version: HJR 33
(H) Publish Date: 3/3/2006

Revision Date/Time (Note if correction):
Dept. Affected:
Title: Supporting In-State Med.Care for Vets
RDU
Component
Sponsor: Representative Kott
Requester: House Mil & Vet Affairs Committee
Component No.

**Expenditures/Revenues** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

| OPERATING EXPENDITURES | FY 2006 | FY 2007 | FY 2008 | FY 2009 | FY 2010 | FY 2011 |
|---|---|---|---|---|---|---|
| Personal Services | | | | | | |
| Travel | | | | | | |
| Contractual | | | | | | |
| Supplies | | | | | | |
| Equipment | | | | | | |
| Land & Structures | | | | | | |
| Grants & Claims | | | | | | |
| Miscellaneous | | | | | | |
| TOTAL OPERATING | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| CAPITAL EXPENDITURES | | | | | | |
| CHANGE IN REVENUES ( ) | | | | | | |

**FUND SOURCE** (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| 1002 Federal Receipts | | | | | | |
| 1003 GF Match | | | | | | |
| 1004 GF | | | | | | |
| 1005 GF/Program Receipts | | | | | | |
| 1037 GF/Mental Health | | | | | | |
| Other (Specify Type--Do not abbreviate) | | | | | | |
| TOTAL | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**Estimate of any current year (FY2005) cost:** 0.0
**Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:**

**POSITIONS**

| | | | | | | |
|---|---|---|---|---|---|---|
| Full-time | | | | | | |
| Part-time | | | | | | |
| Temporary | | | | | | |

**ANALYSIS:** *(Attach a separate page if necessary)*

Prepared by: Nancy Manly, Committee Aide
Phone 907-465-2794
Division: House Special Committee on Military and Veterans' Affairs
Date/Time 3/3/06 10:22 AM
Approved by: Representative Lynn
Date 3/3/2006
Agency: Chairman

(Revised 9/23/2004 OMB)

ALASKA VETERANS FOUNDATION

# VA/AK VETERANS HEALTH CARE CONCEPTS/working DRAFT (RD) 2 5 06

This is a working draft of ideas/concepts crafted by Ric Davidge and a small working group toward defining solutions to the ongoing structural (service and funding) issues within our federal veterans' health care system in Alaska. The ultimate re-crafted solution(s) may have application in other states with Alaska functioning as a demonstration project. NOTHING in this working paper is final nor does it represent the position of the Foundation or the other participants in this discussion. This paper is only necessary due to the complexity of these issues. We find it easier to outline things on paper so that there is clearer understanding by all parties as to

## Structural Problems:

1. Veterans Heath Care funding is not annually assured based on either our nations moral obligation to the men/women who have been injured in service or retired after 20 plus years of honorable service. Funding levels are politically negotiated within the context of annual budgets and political agendas without regard to veteran health care need/demand or the quality of service. Recent General Accounting Office reports requested by the leadership of both the House and Senate veterans program oversight committee have highlighted the structural nature of these problems.
2. The old system of federal hospitals, for veterans or even when combined with active duty military medical facilities is no longer efficient or capable of meeting the location, medical, or mental health needs of our veterans and their families. This is especially true with regional federal medical service centers that require significant patient and employee travel and other support costs that could be far more efficiently turned directly into medical service through existing privately provided hospital and clinical services.

## Moral Imperatives:

1. In the face of continued efforts by our federal government to reduce or otherwise restrict the levels and categories of medical care for our veterans at a time of growing demand by old and new veterans for services, why should not a state, especially the richest state per capita in America with the highest per capita number of veterans, step up to ensure that its veterans receive adequate and appropriate care in their community?
2. The quality and certainty of veteran care must not be a partisan issue. It is an American obligation to those few citizens willing to step forward and answer the call to stand guard for America. If our federal government is politically unwilling or financially unable to provide adequate care for its veterans, then we/Alaskan's must step up to this obligation for Alaska's veterans.

## Veterans Care at existing private Alaskan hospitals and clinics

1. In years past veterans in Alaska were treated at private health care facilities with VA employees working within these facilities. Even today close to $40 million is spent annually by the VA through local hospitals and clinics.
2. This allows veterans, connected under the VA Health Care Program, to receive services for either service related injuries or other health needs at any hospital or clinic in Alaska.
3. The VA ID card should work just like an insurance card. The veteran shows the card when paying the bill (co-pay levels established). The medical service provider then bills the state program. The state pays the provider within 30 days of receiving the bill consistent with a negotiated reimbursement schedule for the procedure/service. The state then bills the VA for

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reimbursement consistent with a negotiated reimbursement schedule with the VA which is adjusted annually based on cost and service demand.

4. Alternatively, some argue that our veterans should be "covered" by an established healthcare insurance company at the level of care selected by the veteran and/or their family. Appropriate co-pay agreements could be structured based on the veteran's income level, however for any veteran with a service connected disability any related medical services for that disability must be fully covered. Veterans who have retired after 20 or more years of honorable service would receive full coverage possibly minus an appropriate co-pay based on income.
5. Reimbursement schedules must be negotiated between the hospitals and clinics, the state, and the VA. Any medical provider that wants to participate must be "certified" by the state and/or VA to participate in the program. This is really no different then existing VA programs for some services and third party insurance procedures.
6. Alaska VA receipts from third party billings ("other insurance" - insurance companies used by veterans now treated at VA clinics/hospitals) should be transferred to a state program for veterans' health care as a federal grant similar to what is done at the Indian Health Service. This sets up a potential federal matching strategy for state veterans' health care. (may require federal law or regulatory changes. Look at IHS or Public Health Service third party receipts programs for comparables. Also look at VA authorization to run "demonstration projects" in states.)
7. This program will require state legislation to set up (authorize) the program, allow receipt of federal funds, receipt of billings from medial providers, reimbursement payments to medical service providers, and approval of some range of reimbursement schedules as can be negotiated and annually adjusted and provided in regulations.
8. The state's reimbursement schedule should be the same or greater then the VA schedule.
9. The state is in a far more powerful position to negotiate with the federal VA for an appropriate reimbursement schedule for Alaskan communities then are individual medical service providers.
10. Based on increased efficiencies within the overall Alaskan based medical services industry, new economies of scale should push reductions in the cost of services. (the more beds filled the lower cost per bed, the more clients seen the lower cost per client)

**Why should the State of Alaska put itself in the middle?**

1. Alaskans (National Guard and Reserve) are becoming more and more involved in fighting our wars. Even if these troops are federalized, the state has a moral and ethical obligation to ensure that its veterans receive appropriate medical services after leaving active duty.
2. When an Alaskan who likely is fully employed in his/her civilian life and has a personal or family health insurance program linked to that job, is federalized/deployed - he/she will likely loose his/her income from this nonmilitary employment for years, suffer a sig. ificant loss of annual income, unable to pay the premiums for this private health insurance and his/her employer will likely not continue employer co-payments as the employee is gone - resulting in a loss of personal health insurance for the soldier and/or family. Then when the Alaskan returns to private life they will likely have to start their health insurance all over again but NOT be able to apply any new private insurance to any military related injury or illness (known or unknown at the time) as it would be considered a "preexisting condition" under any new private insurance. If the veteran is n connected" to the VA Health Care program to cover these "service related" costs – he/she is SOL. This is not in Alaska's best interest.
3. This program should ensure that Alaska's veterans receive adequate health care OUTSIDE of the current federal appropriations processes. A process that, regardless of need, continues to reduce the per-veteran level of federal services and the per-veteran level of programmatic federal funds compared to the growing level of need from the veterans in Alaska.
4. Alaska should explore new medical service concepts for veterans that are far more cost effective then the building of new VA hospitals/clinics especially in areas of Alaska with small populations that do not enable the levels of medical service efficiencies essential to compete in this market.
5. Alaska could be a pilot project in the evolution of new national approaches to more efficient medial insurance/services for veterans In fact, we may not be reinventing the wheel here, we may just be returning to an approach that some years past provided services in this manner.

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**Questions for the VA/AK:**

1. How many Alaskan veterans are sent out of state for medical/mental health services? What is the average number of Alaskans per year over the past ten years?
2. How much does the VA spend annually (in air fare, taxi, hotel, meals) to send veterans outside for medical/mental health services? ***ANSWER: $2,057,222 for airfare alone in 2004.***
3. What medical/mental health services/treatments are veterans receiving outside of Alaska?
4. What is the total cost/value of these "outside" medical services to the VA annually?
5. If these services are available in Alaska, why does the VA send the veteran out of state?
6. Does the VA provide any family assistance to spouses/families to be close to a veteran when sent out of state for medical services? Is there some gradation based on seriousness of condition?
7. How many veterans in Alaska are classified as having a service related PTSD claim? How many of them receive regular treatment in Alaska? How many receive treatment outside of Alaska?
8. How many veterans are served annually instate at VA clinics and hospitals?
9. What is the total cost of medical services (do not include VA Administration) provided by VA in Alaska? ***ANSWER: $38,681,991 in part.***
10. How many veterans receive medical services at private or other than VA facilities in Alaska annually?
11. What is the total cost of medical services received by veterans in Alaska at other than VA facilities?
12. What is the nature of these medical services?
13. What is the cost per patient ratio for VA medical services in Alaska?
14. How many facilities in Alaska currently have reimbursement schedules with the VA?

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**Problems Solved**

1. Maximizes use of existing underutilized Alaskan hospital services/beds increasing the operational efficiency of existing facilities allowing lower service fees especially in rural areas.
2. The emotional cost to veterans and their families when the veteran is separated by thousands of miles (now sent outside of Alaska) for treatment. Veterans can be treated in Alaska allowing families to be by their side during these difficult times. This is often a critical component of a patient's recovery during medical or mental health care.
3. The cost [significantly reduced travel (air fare, hotel, taxi, meals) expenses] of providing services to veterans should be reduced overall with the retention of veterans in Alaska for medical care.
4. New expensive Veterans Hospitals and clinics will not have to be built and operated by the federal government.
5. The existing Military/VA Hospital at Elmendorf can revert to active duty service only. Elmendorf will not have to adjust their fence/perimeter to put this hospital outside of the existing security zone. Saving money, time, manpower, and enhancing on base security while at the same time providing services to veterans in a far more friendly way. This action is also responsive to the general desire of veterans to receive their medical services within their community.
6. Veterans will be allowed/enabled to use existing private facilities based on cost and quality of service.
7. No additional land will need to be developed for new hospitals in areas with little land available.
8. Existing VA Clinic employees could shift to other medical service providers, but should remain under VA employment status as their principle area of service is veterans within those facilities.
9. The VA Clinic could be relocated to an existing medical campus such as Providence or Alaska Regional rather than moved to Elmendorf providing better professional services integration within the medical communities that exist. Additional efficiencies may be realized with the consolidation of all VA services at one medical campus (now five (5) commercial spaces are under "fair market value" lease by the VA in Anchorage alone).
10. Existing medical service providers who offer services in demand by veterans can enhance their practices and increase their cost efficiencies.
11. Veterans are allowed to "shop" for their service related medical care/services based on quality of service and, with existing co-payment requirements, cost. They are empowered in their choice of medical services whereas currently they are given no service or service that may not be at the same level or in their community or state.
12. Services can be responsive to demand within established health service markets.

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# News Flash


## Congressman Lane Evans wants full accounting from VA on FY07 budget

House Committee on Veterans Affairs – Democratic Office
Lane Evans Ranking Democratic Member
333 Cannon House Office Building
Washington, DC 20515

http://veterans.house.gov/democratic/welcome.htm

FOR IMMEDIATE RELEASE: February 15, 2005
CONTACT: Geoffrey Collver 202/225-9756

Early Indicators Warn of Possible Shortfalls at VA ... Again

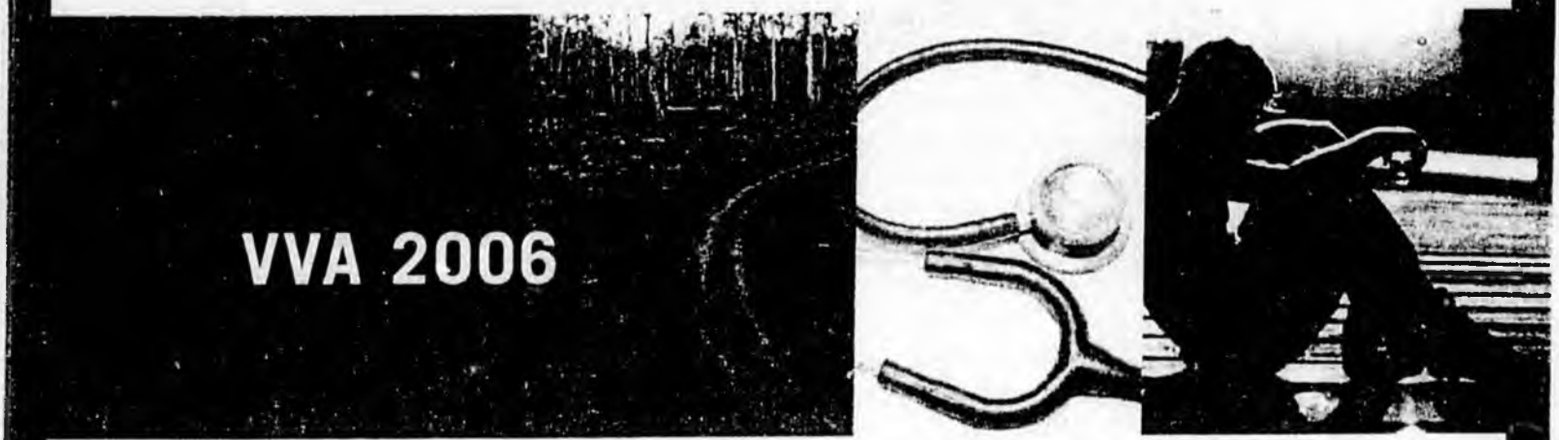
Washington, DC - Rep. Lane Evans (D-IL), ranking Democrat on the House Veterans Affairs Committee, warned that the problem of chronic underfunding of veterans' health care is again causing budget shortfalls at Department of Veterans Affairs (VA) hospitals and clinics across the nation. Evans and Rep. Michael Michaud (D-ME), ranking Democrat on the Health Subcommittee, have called upon the Secretary of the Department of Veterans Affairs, in a joint-letter sent today, to provide a full and accurate accounting of current shortfalls.

"I am distressed by reports of $500,000 to $18 million shortfalls we are hearing from VA medical facilities across the nation from Seattle, Washington to West Palm Beach, Florida, from White River Junction, Vermont to San Diego, California," said Evans.

In response to Rep. Michaud's questions at the February 14, 2006, Committee hearing on the VA health care budget, VA officials conceded to shortfalls at some facilities. While denying a system-wide problem, VA officials revealed that VA was planning to notify Congress that it needed to shift money around in its medical care program accounts to cover gaps in funding. VA officials also acknowledged regional health care networks might be transferring funds between networks to cover funding gaps. In their letter to the Secretary, Representatives Evans and Michaud warned, "These actions are early warning indicators that something is amiss with VA's funding for FY 2006."

Rep. Filner (D-CA), a Senior Member on the House Veterans' Affairs Committee, representing San Diego, urged early action. "Veterans' health care needs real funding. In the short-run, transferring funds may camouflage the shortfall but it does not rectify the underlying problem," said Filner.

# VVA 2006



## LEGISLATIVE AGENDA & POLICY INITIATIVES

VIETNAM VETERANS OF AMERICA®

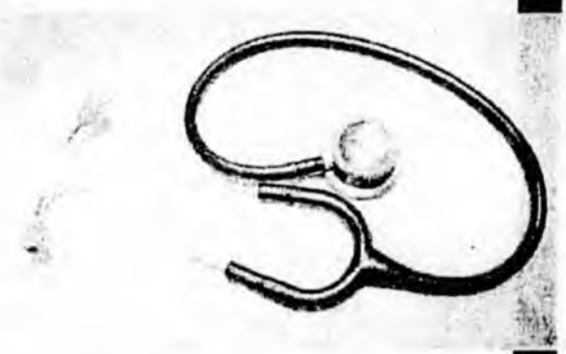
In Service to America

*There are other issues of concern that warrant the attention of Congress and the American people. What follows are VVA's legislative priorities in these areas.*

## Veterans' Health Care

- When the VA cannot provide the highest quality care within a reasonable distance or travel time from a veteran's home and in a timely manner, the VA has a duty to provide care via a fee-basis provider of choice for service-disabled veterans.

- VVA is committed to protecting and advancing the rights to access VA health care programs and services for all veterans who meet the definition set forth in Title 38, U.S. Code, and shall continue our efforts to ensure that clinicians at VA medical facilities take a military history as a matter of course for all veterans currently in or entering the VA health care system.



- To better provide health care for women veterans, VVA will seek legislation or regulation to re authorize the biennial Report of the Advisory Committee on Women Veterans, with submission to the Secretary of Veterans Affairs for response, and to members of Congress; and VVA shall seek legislation to provide contract care, for up to 14 days post-delivery, for infants born to women veterans who receive delivery benefits through the VA.

# *WHITE PAPER*

# The Position of Vietnam Veterans of America On Health Care Funding For *All* Veterans

July 2003

VIETNAM VETERANS OF AMERICA®

# *Vietnam Veterans of America*

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*A Not-For-Profit Veterans Service Organization Chartered by the United States Congress*


July 2003

Dear Friends and Colleagues,

This White Paper makes the argument for what Vietnam Veterans of America (VVA) and other Veterans Service Organizations (VSOs) have been advocating for too long: the need to shift the funding of the VA's medical operations from a discretionary to an obligatory model at an appropriate level of funding. We believe the time for Congress and the President to address and rectify this situation is now, while another generation of American troops is fighting a new, global war that doesn't promise a swift conclusion.

It is our hope that all the VSOs and all Americans will unite and push for enactment of legislation to restore the base funding for VA medical operations; and to bring a measure of sanity to how veterans health-care is funded so that we can turn our attention to how to improve that care and introduce greater accountability and efficiencies into the system.

We look forward to working with our fellow veterans and with members of Congress who believe that this is the right thing to do and the right time to do it.

We welcome your comments and your support.

Sincerely,

Thomas H. Corey
National President

*Vietnam Veterans of America*

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# EXECUTIVE SUMMARY

The highest legislative priority of Vietnam Veterans of America is the institution of obligatory, or assured, funding for medical operations at the VA based on the per capita use of the veterans health-care system (including long-term care) at the 1996 level of funding, indexed for medical inflation.

The debate of the past several years has been whether to fund the veterans health-care system at a very inadequate level or a grossly inadequate level. This debate needs to end. We must give more than lip service to the health-care mandates set forth in law, and by the will of the American people, to care for those who have borne the battle.

In the mid-1990s, the VA health-care system welcomed higher income, non-disabled veterans, with the caveat that these enrollees pay a nominal co-payment. The rationale behind this initiative was to ensure a patient base that would support the infrastructure needed to develop a modern, integrated health-care system. Congress endorsed this initiative and enacted Public Law 104-262, the Veterans Health Care Eligibility Reform Act of 1996.

Because the law did not mandate a level of funding, it established an annual enrollment process and categorized veterans into "priority groups" to manage enrollment. Last year, the system hemorrhaged, and Secretary Principi had to make a difficult call. Overburdened by an influx of enrollees, the VA did not have the financial resources to provide care for all who chose to enroll. The Secretary then temporarily suspended new enrollments of Priority 8 veterans. This suspension, which went into effect January 17, 2003, will continue through Fiscal Year 2004. Although this decision is to be reviewed annually, many fear that Priority 8 veterans have been effectively banished from the health-care system as the VA, with no promise of an infusion of supplemental appropriations, refocuses on its "core mission" of serving veterans "with service-connected disabilities, the indigent, and those with special health care needs."

The VA is not assured adequate funding that complies with Public Law 104-262. This law, undermined by years of flat-line budgeting by Congress and by medical inflation, effectively strained the VA system beyond capacity and rendered the VA unable to respond adequately to the needs of veterans who have chosen to use its health-care system. Access to this care is their right as veterans, and that right is being abrogated.

To adequately serve all of those who seek its services, the VA needs $28.5 billion in hard, appropriated dollars in FY 04. Using a very conservative methodology and government figures, some $36 billion should have been appropriated for VA medical operations in FY 04. To restore the eroded funding base would take a four-year "off-budget" restoration plan of $8-10 billion. To avoid future funding crises, Congress must go beyond the rhetoric of considering whether the current discretionary-funding model needs to be replaced by an obligatory system of funding indexed both to per capita costs of treatment and medical inflation. Congress and the President must not pass the buck any longer. They must grapple with the issues keeping the compact between our government and our veterans at the forefront of debate, and they must enact legislation that will ensure a consistent, predictable, and appropriate level of funding for VA medical services.

*The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the Veterans of earlier wars were treated and appreciated by their nation.*

*– George Washington*

## INTRODUCTION

Americans have long held that health care for veterans is a national obligation, part of the covenant between the American people, through our democratically elected representatives and agencies of government, and the men and women who have pledged to defend the Constitution and the cherished principles of our nation. Because those who render military service pledge not only their loyalty but their life, knowing that they may be called to combat, understanding that they may give up their life, this covenant is more profound than a legal contract. Now, at a time when a new generation of our sons and daughters is on the front lines defending America's interests, it is our obligation as citizens of a generous and compassionate society to ensure that the funding to care for the injuries, illnesses, and disabilities they may suffer is assured and not relegated to a "discretionary" appropriation of inadequate proportions.

Those who serve during times of war or conflict, particularly those who are deployed to a war zone, return home changed. Many are seared psychologically. Some are wounded or maimed by the weapons of modern warfare. Yet just as they have fulfilled their obligation to their country – to all of us – it is our collective obligation to do all that we can, through the appropriate agencies of government, to restore as much as possible each veteran who has been lessened physically, psychologically, or economically; and all that we can individually and through our communal and religious institutions to heal each veteran who has been lessened spiritually.

All Americans committed to justice for veterans understand that the annual budget battles in Congress do little to inspire confidence that we will do right by our veterans. Budgets and appropriations are, of course, a reflection of the values and priorities of the administrators who design them and the legislators who approve them. What does "discretionary" funding for the care of men and women who defend our country say about America? Which is more important: the pet highway construction projects of a powerful member of Congress or adequate funding for veterans health care? What does the "temporary"

triage of veterans classified as "Priority 8" say about the state of the VA health-care system? Beyond political platitudes, what legislation will the administration and the congressional leadership debate and enact to eliminate the uncertainty in funding veterans' health care?

The debate over the past several years has been whether to fund VA medical operations at a very inadequate level or a grossly inadequate level. The flat-lined budgets passed by Congress and signed by the President during the mid- and late-1990s so eroded the base funding for health care that the VA is hard-pressed to meet the mandate of its mission. This annual debate needs closure. It is time to act to ensure a consistent, predictable, and appropriate level of funding that will give more than lip service to the mandates for health care set forth in law, and by the will of the American people, for those who have borne the battle in the fertile fields of Europe, the islands of the South Pacific, the rice paddies and jungles of Southeast Asia, the sands of Kuwait and Afghanistan and Iraq, and the myriad peacetime confrontations of the Cold War.

## BACKGROUND

The Department of Veterans Affairs, the second largest of the 15 Cabinet departments, is the largest integrated health-care provider in the nation, with 163 medical centers, more than 900 outpatient clinics, 180 nursing homes and domiciliaries, and 206 Vet Centers divided into 21 Veterans Integrated Service Networks administered under the aegis of the Veterans Health Administration.

In the mid-1990s, the leadership of the VA, with the bi-partisan support of Congress, embarked on a significant shift in policy. They opened the VA health-care system to non-indigent, non-disabled veterans, with the caveat that these enrollees pay a nominal co-payment. The rationale behind this initiative was to ensure a patient base that would support the infrastructure needed to develop a modern, integrated health-care system. Congress and the President endorsed this initiative, enacting Public Law 104-262, the Veterans Health Care Eligibility Reform Act of 1996, which gave the VA the legal authority to do what it had proposed.

The new law reaffirmed the VA's mandate to provide care for its core constituency: service-connected disabled veterans, indigent veterans, and others such as ex-prisoners of war and veterans who had been exposed to environmental hazards, toxic substances, and radiation. It also required that the VA provide "for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness)."

However, even though the new law was predicated on the assumption that the VA would be reimbursed from Medicare as well as from third-party collections from private insurers for the services it provided, a provision of the law stipulated that "hospital care and medical services shall be effective in any fiscal year only to the extent and in the amount provided in advance in appropriations acts for such purposes." The law gave the Secretary of Veterans Affairs the authority and responsibility to determine eligibility for enrollment based on available resources in any given fiscal year. Although the law did not mandate a level of funding, or a standard of care, it did establish an annual enrollment process and categorized veterans into "priority groups" to manage enrollment (see Appendix, an explanation of these priority groups).

A confluence of events and conditions served to swell the roster of those who sought service at the VA. Outreach to veterans who had never considered care in VA facilities was stimulated by the fissures and faults of a national health-care system that does a terrible job of containing costs. Double-digit inflation priced health insurance beyond the reach of millions of Americans. The soaring costs of prescription drugs – and the unavailability of a drug program in Medicare – caused veterans to flock to the VA. The

Veterans' Millennium Health Care and Benefits Act of 1999 further increased demand by expanding benefits. Because funding of VA medical operations is not based on per capita usage, the VA's resources shrunk while enrollment was soaring. Caseloads ballooned. Waits for appointments to see physicians lengthened from several weeks to several months. Veterans using the system were frustrated by a system that had bogged down.

Last year, VA Secretary Principi had to make a difficult call. The system did not have the financial resources to provide care for all who chose to enroll. Confronted by dire fiscal realities, the Secretary created a new category, Priority 8, for prioritizing medical care in the VA system. ("Priority 8" is comprised of veterans who agree to pay specified co-payments and whose income and/or net worth is above the VA means-test threshold and the HUD geographic index.)

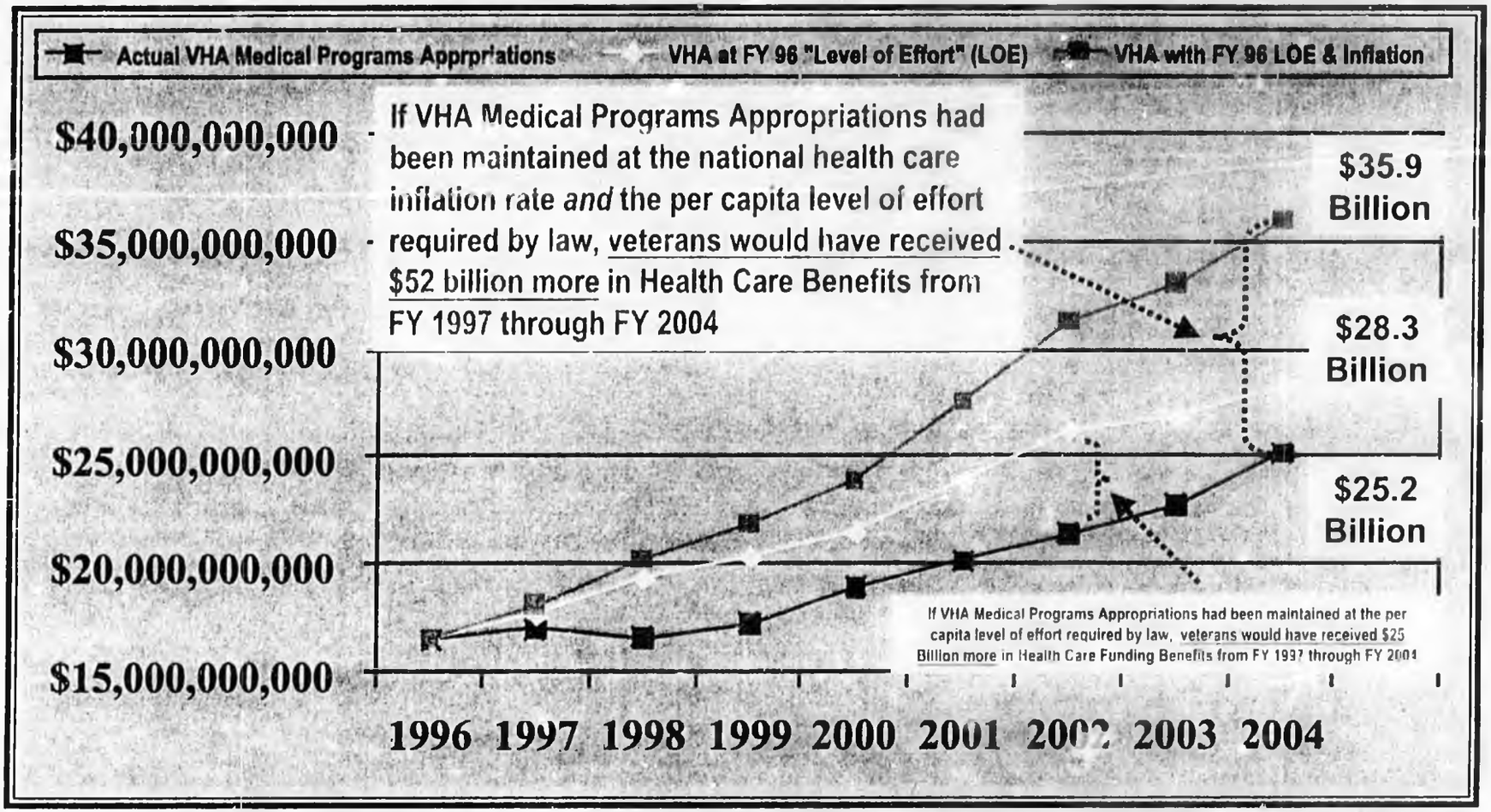
The Secretary then temporarily suspended new enrollments of veterans in that category. This suspension, which went into effect January 17, 2003, will continue through Fiscal Year 2004 (which runs from October 1, 2003, through September 30, 2004). While this decision is to be reviewed on an annual basis, many fear that Priority 8 veterans have been effectively banished from the health-care system as the VA, with no promise of an infusion in supplemental appropriations, refocuses on its "core mission" of serving veterans "with service-connected disabilities, the indigent, and those with special health care needs."

How did it come to pass that Secretary Principi felt compelled to take so drastic an action as suspending registration and access for Priority 8 veterans? Part of the answer lies in how the system is funded. The VA is not assured adequate funding that enables it to comply with the provisions of Public Law 104-262, which mandates that funding for health care meet the "level of care" provided by the VA in 1996. While recent increases to the VA health-care budget have been reasonable, the law has been effectively undermined by years of flat-line budgeting during the mid- to late-1990s. The situation has been compounded by the eroding effects of medical inflation, straining the VA system beyond capacity and rendering the VA unable to respond adequately to the needs of veterans who have chosen to avail themselves of its health-care system. This is their right as veterans, and that right is being abrogated.

The following graphs illustrate the problem. While enrollment in the VA system has increased by almost 120 percent since 1996 – from some 3.4 million to more than 7.0 million projected in FY 2004 – Veterans Health Administration (VHA) per capita expenditures have decreased over the same period by 30 percent (Graph 2, page 6). The ratio of patients to licensed practical nurses has shot up more than 100 percent, while the ratio of patients to registered nurses had grown by 67 percent (Graph 3, page 7). Likewise, the doctor-patient ratio has increased by almost 60 percent (Graph 4, page 8). While this situation is exacerbated by an increase in Priority 7 and 8 veterans, in fact more Priority 1–6 veterans entered the system over the same period (Graph 5, page 9).

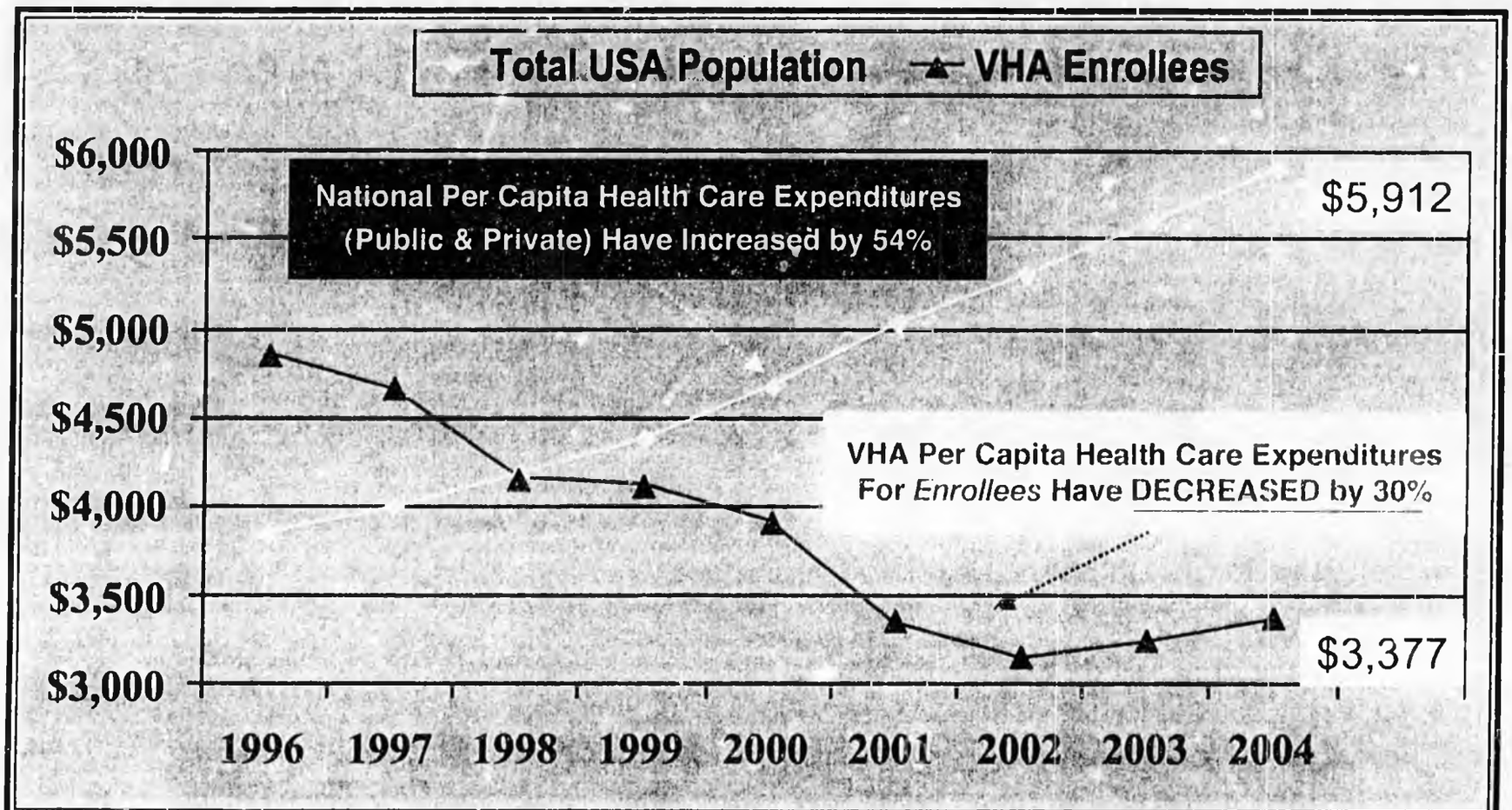
Perhaps most telling is Graph 1 (page 5): Had the level of funding mandated by law been met – and the law requires that funding for the VA's medical operations funding match the "level of effort" in Fiscal Year 1996 – this funding would be hovering at $36 billion for FY 04. The debate would reflect this higher figure. In order for the VA to serve all veterans who are eligible and who seek care at VA facilities, VA officials have acknowledged that, beyond the $1.7 billion they anticipate collecting in third-party billings in FY 2004, they will need at least $28.5 billion in hard, appropriated dollars to re-open the medical system to all eligible veterans in FY 04.

# VHA Medical Programs "Should Spend" Budget



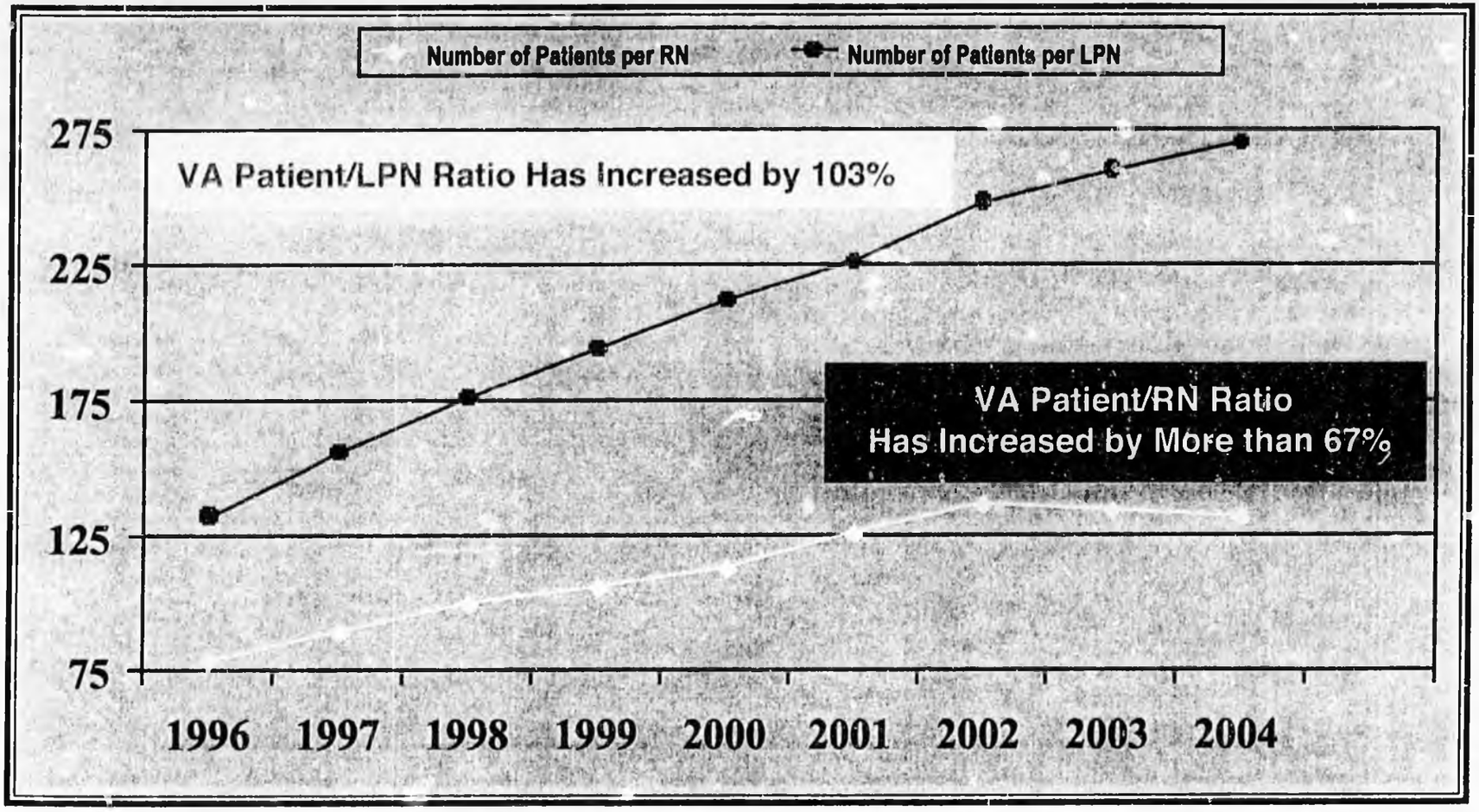

Sources: ***(VHA Medical Program Appropriations)*** - VHA Appropriations history/projections were e-mailed from the Veteran's Administrations Central Office (VACO) on 2-04-03. ***(VHA at FY 96 "Level of Effort" Budget Line)*** - Data derived by multiplying the FY 96 Per Capita "Level of Effort" ($5,633) by the number of VHA Users. FY 96-98 VHA Users are a VVA estimate. FY 99-04 VHA Users came from the VHA Policy and Forecasting Office and utilize the "full demand" figures for FY 03 and 04.
***(VHA at FY 96 LOE & Inflation Budget Line)*** – Health care inflation figures for each FY were faxed to VVA from the Centers for Medicare and Medicaid Services (CMS) Actuarial Offices, and can be viewed for 1998-2004 at www.cms.gov/statistics/nhe/projections-2002/t1.asp. The CMS data are conservative because they do not reflect price inelasticity accounted for in the slighily higher health care inflation figures of the Consumer Price Index (patients cannot as easily substitute lower cost drugs/treatments as in other sectors)

# Annual Per Capita Health Care Expenditures



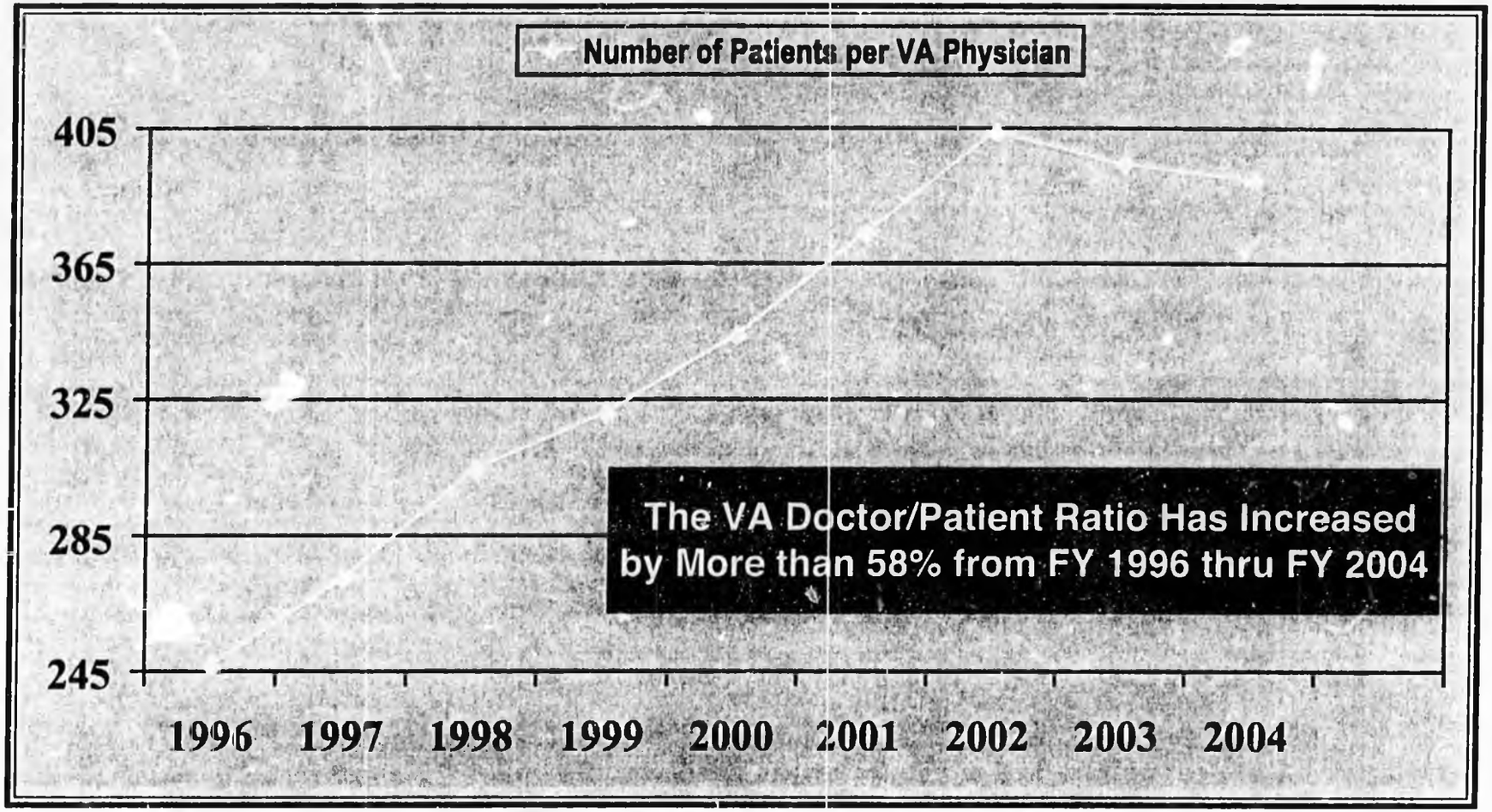

Sources: ***(National Health Care)*** - Per Capita Expenditures are derived from the Centers for Medicare and Medicaid Services data found at http://www.cms.gov/statistics/nhe/, the "nhegdp01.zip" file (2nd table at bottom of web page). Projections for FY 02-04 are based on the average 5.5% per capita growth rate from FY 96-01.
***(VHA)*** - Enrollee Per Capita Expenditures are derived by dividing FY 96-04 VHA Appropriations by the number of VHA enrollees. FY 96-98 are estimates based on the 16% enrollee/user difference in FY 99. FY 99-04 actual and projected enrollees are from the VHA Policy and Forecasting Office and utilize the "full demand" figures for FY 03 and 04 VHA Appropriations history and projections were e-mailed to VVA from the Veterans Administration Central Office (VACO) on 2-04-03.

# VA Nurse/Patient Ratio




Source: Department of Veteran Affairs Forecasting and Policy Office Fax on 3-13-03

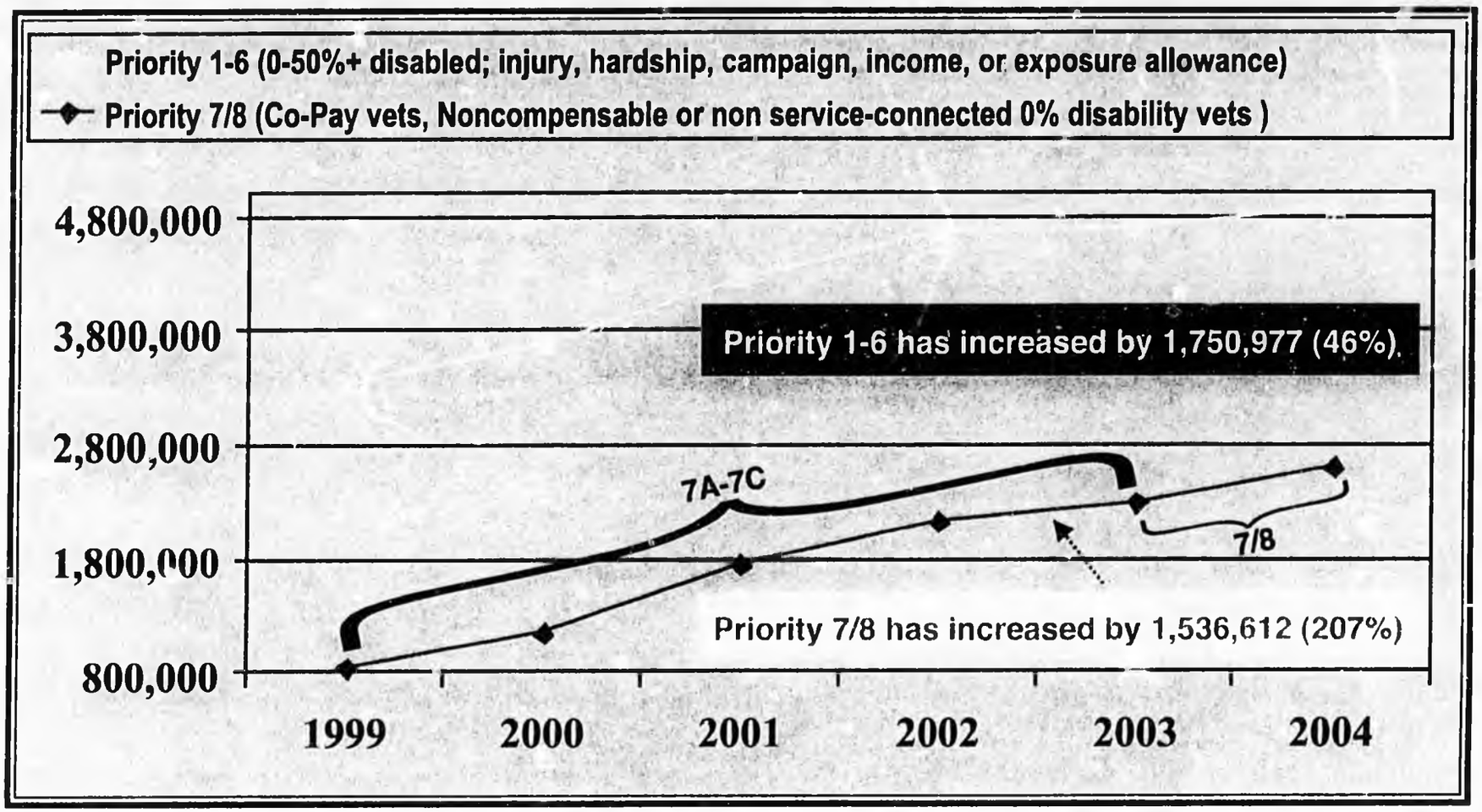
# VA Doctor/Patient Ratio




Source: Department of Veteran Affairs Forecasting and Policy Office Fax on 3-13-03

# Total VHA Enrollee Growth

## (by Priority and FY)




Sources: FY 99-02 data are from an Excel file e-mailed to VVA from the VHA Policy and Forecasting office titled "enrollees and pts fy99-04 by priority.xls." FY 03 & 04 estimates are from the same office and utilize the full demand figures. 7A-7C are previous designations for the current priority 7 and 8 categories.

## VVA's POSITION

The highest legislative priority of Vietnam Veterans of America is the institution of obligatory, or assured, funding for veterans' health care, funding that is based on the per capita use of the veterans' health-care system (including long-term care) at the 1996 level of funding, indexed for medical inflation. Why the "accepted" level of care at the rates expended in FY 96? Because that's when the law was passed, even though FY 96 was not at the time considered a banner year for medical appropriations by anyone familiar with the process.

VVA initially acknowledged that for the VA to adequately minister to the core groups eligible to receive care at its facilities, the course of action taken by Secretary Principi, while wrenching, was justified and even necessary – but only as a stopgap, temporary palliative. It was the only reasonable action he could take to stanch the hemorrhaging of the system and prevent its collapse. VVA strongly opposes making this exclusion of Priority 8 veterans permanent. VVA has asked that Congress direct that the VA use numbers for its future planning and projection purposes that include provision of services to Priority 8 veterans.

VVA is gratified that the hue and cry raised by veterans service organizations is finally being heard by Congress. Several measures are being considered that would, if a bill is finally enacted, restructure the way medical operations of the VA are funded and effectively remove the annual uncertainty over the VA's budget for health care. The time for serious consideration of these measures is now. A government that can afford to outlay billions for a war against terrorism can find the funding, and reconfigure the funding mechanism, to help heal the veterans of this war and the wars that preceded it.

With funding uncertainties removed, the VA leadership could focus on implementing measures to create a true veterans health-care system, a system in which every veteran who enrolls would be given a full physical examination that would include a comprehensive military health/medical history, a psychosocial workup, and the drawing of blood samples.

This history would provide an epidemiological baseline to help measure future health conditions not only for a particular veteran but potentially for others with whom (s)he served. When an extensive epidemiological database is finally compiled, it can serve as an invaluable tool for physicians. With more information about a patient's military background, a doctor would know to test for particular conditions, parasites, and toxic exposures that may already be adversely affecting the health of that veteran. Such a database could reveal whether others who served in the same outfit reported similar conditions. It would not only help a doctor render an accurate diagnosis and establish an effective treatment plan, it would enable the VA to more effectively identify occupational illnesses and diseases that may be connected to a veteran's military service. Such a database, if accessible to private physicians – and the vast majority of veterans are not enrolled in the VA health-care system – can inform these medical professionals about potential health issues in their patients.

## ADJUSTING the FUNDING BASE for VA MEDICAL OPERATIONS

VVA believes, however, that in addition to restructuring the way in which the medical operations of the VA are funded, an adjustment to the base funding must be made.

The percentage increases appropriated for VA medical operations from FY 2002 to FY 2003, and the proposed increase from FY 2003 to FY 2004, are reasonable, even generous. However, the base upon which these increases are predicated is inadequate. The "should-spend" budget illustrated by Graph 1 on page 5 illustrates why. VA officials acknowledge they require an infusion of $1.2 billion over and beyond

the amount appropriated by Congress for FY 04 to reopen the system to Priority 8 veterans. This translates to an appropriation of $28.5 billion in FY 04. And the VA needs $8-10 billion more to effectively comply with the law and meet the 1996 "level of effort" for veterans' health care. Using very conservative figures for medical inflation, funding of the VA's medical operations should be some $36 billion for FY 04.

Congress must revisit this issue and consider ways to right this wrong as part and parcel of any move to rework the way the VA health-care system is funded. Whether additional funding is on-budget or off-budget, or whether these additional funds are "discretionary," "mandatory," "assured," or "obligatory," the funding base for the veterans health care must be restored to the proper level, starting the next fiscal year.

## TOWARD REAL ACCOUNTABILITY

VVA has long maintained that managerial accountability goes hand-in-hand with obligatory funding. The entire VA system warrants continued management systems reforms, the prime goal of which must be to ensure the accountability of senior managers.

The VA's focus on accountability concentrates on providing incentives to senior managers, rewarding those who perform their jobs adequately with annual bonuses that average almost $11,000. There are few, if any, sanctions imposed on those managers who demonstrate incompetence or recalcitrance to do what they are paid to do. It is useful to note that a VISN director and a director of a VA Medical Center received bonuses greater than $10,000 for several years even after lice had been found in the bodies of veterans under their care.

While many very fine managers who are able leaders and dedicated public servants are employed by the VA, there are others who don't feel compelled to act in the manner of true public servants. Rarely if ever is a senior manager denied a bonus, even in instances in which that manager is known to have ignored directives or deliberately misled top officials at the VA.

While there is a legitimate need to make significant adjustments in the compensation for critical health-care workers, the current use of "merit bonuses" has been corrupted. Merit bonuses must be just that: bonuses for merit and achievement above and beyond that which is required. The current mode does a disservice to the many fine VA physicians and administrators who deserve more competitive pay and bonuses for truly outstanding performance. The system of rewards and punishment must be adjusted to sanction those who do a poor job or are not fully open and honest with appointed or elected officials.

To ensure accountability, the VA must develop a modern financial tracking system and standardize its financial systems so that the costs at one medical center can be easily tracked and compared to similar expenditures at other VA medical centers. Similarly, VA must develop a real-time Management Information System (MIS) to track how many clinicians or specialists are available at each medical center at any given time. VVA believes that the VA must subscribe to the old military adage that "a unit does well which the commander checks well."

## CONCLUSION

We as a nation can and must do better for our veterans. Funding for veterans' health care has been woefully inadequate for years. As Dr. Linda Spoonster Schwartz, then chair of VVA's National Veterans Healthcare Committee (and currently Commissioner of Veterans Affairs for the State of

Connecticut) testified before Congress: "The lack of a consistent, reliable budget has, in essence, obstructed VA's capacity to respond to the changing needs of the health-care system, to efficiently grow, to acquire competent personnel and maintain a viable service infrastructure." And as the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans has concluded: "Funding provided through the current budget and appropriations process for VA health care delivery has not kept pace with demand, despite efforts to increase efficiencies and focus health care delivery in the most cost-effective manner. . . . Full funding should occur through modification to the current budget and appropriation process by using a mandatory funding mechanism, or by some other change in the process that achieves the desired goal."

VVA believes it is imperative to enact legislation that would mandate obligatory funding for veterans' health care. Such legislation would make moot the issue of eligibility of Priority 8 veterans to receive medical services from the VA. Making veterans' health-care funding obligatory would eliminate the annual uncertainty about funding levels that has prevented planners at the VA from meeting the needs of the growing number of veterans seeking treatment. An assured, steady funding stream would enable the VA to concentrate on achieving accountability for performance from senior managers and building a system that is not only cost-effective and cost- efficient, but truly contributes to the mission of restoring veterans who have been lessened physically through injury or illness or the psychic wounds of war, or economically by virtue of military service.

To rectify past injustices, the system must be funded at a level that will enable Secretary Principi to re-open the VA health-care system to new enrollees who may be classified as Priority 8. It is imperative that at least $28.5 billion (in addition to projected third-party payments of $1.7 billion) be appropriated by Congress for VA medical operations for FY 04.

VVA and other VSOs believe it is disingenuous for our government to promise health care to veterans and then fail to provide adequate funding. Rationed health care must only be a temporary expedient as Congress moves toward an obligatory funding model. We endorse the proposition that "by including all veterans currently eligible and enrolled for care, we protect the system and the specialized programs VA has developed to improve the health and well-being of our nation's sick and disabled veterans." We expect our government to respect the covenant and honor its commitment and our obligation to those who have placed life and limb in harm's way.

APPENDIX

# EXPLANATION OF PRIORITY GROUPS 1-8

*The following is taken from the VA Web site, www.va.gov.*

In October 1996, Congress passed Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996. This legislation paved the way for the creation of a Medical Benefits Package - a standard enhanced health benefits plan available to all enrolled veterans. Like other standard health care plans, the Medical Benefits Package emphasizes preventive and primary care, offering a full range of outpatient and inpatient services.

VA places a priority on improved veteran satisfaction. Our goal is to ensure that the quality of care and service you receive is consistently excellent, in every location, in every program. Under the Medical Benefits Package, VA offers you, the veteran, a comprehensive health care plan that provides the care you need.

What are the Priority Groups?

Once you apply for enrollment, your eligibility will be verified. Based on your specific eligibility status, you will be assigned a priority group.

The priority groups are as follows, ranging from 1-8 with 1 being the highest priority for enrollment. Under the Medical Benefits Package, the same services are generally available to all enrolled veterans.

As of January 17, 2003, VA is not accepting new Priority Group 8 veterans for enrollment (veterans falling into Priority Groups 8e and 8g.)

**Priority Group 1**

- Veterans with service-connected disabilities rated 50 percent or more disabling

**Priority Group 2**

- Veterans with service-connected disabilities rated 30 percent or 40 percent disabling

**Priority Group 3**

- Veterans who are former POWs
- Veterans awarded the Purple Heart
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with service-connected disabilities rated 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

**Priority Group 4**

- Veterans who are receiving aid and attendance or housebound benefits
- Veterans who have been determined by VA to be catastrophically disabled

**Priority Group 5**

- Nonservice-connected veterans and noncompensable service-connected veterans rated 0 percent disabled whose annual income and net worth are below the established VA Means Test thresholds
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid benefits

**Priority Group 6**

- Compensable 0 percent service-connected veterans
- World War I veterans
- Mexican Border War veterans
- Veterans solely seeking care for disorders associated with:
  - exposure to herbicides while serving in Vietnam; or
  - exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
  - for disorders associated with service in the Gulf War; or
  - for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.

**Priority Group 7**

***Veterans who agree to pay specified co-payments with income and/or net worth above the VA Means Test threshold and income below the HUD geographic index***

- Subpriority a: Noncompensable 0 percent service-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- Subpriority e: Noncompensable 0 percent service-connected veterans not included in Subpriority a above
- Subpriority g: Nonservice-connected veterans not included in Subpriority c above

**Priority Group 8**

***Veterans who agree to pay specified co-payments with income and/or net worth above the VA Means Test threshold and the HUD geographic index***

- Subpriority a: Noncompensable 0 percent service-connected veterans enrolled as of January 16, 2003, who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003, who have remained enrolled since that date
- Subpriority e: Noncompensable 0 percent service-connected veterans applying for enrollment after January 16, 2003
- Subpriority g: Nonservice-connected veterans applying for enrollment after January 16, 2003

*This White Paper was prepared by Vietnam Veterans of America*



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*www.vva.org*

# Additional Support for HJR 33

March 23, 2006
Testimony before the State House
HJR 33

My name is Ric Davidge and I serve as President of the Vietnam Veterans of America, Chapter 904 – the Anchorage Chapter and the largest in Alaska. I also serve as President of the Alaska Veterans Foundation, Inc. a statewide veteran service organization that serves Alaskan War Veterans. And I serve as Vice Chairman of the Anchorage Military & Veterans Affairs Commission.

In 1965 I was a medic with the First Air Cavalry in Vietnam and served honorably for 6 years.

Why do we have this resolution before you and just what does it really do?

I assume you have, in your packet, a copy of the most recent "Talking Paper" that we update regularly about the problems Alaskan veterans face in securing appropriate healthcare. This paper is an open ended discussion of problems that continue to come to light as our working group, made up of a wide range of veterans, VA employees, politicos of both political parties, and medical service professionals, wrestles with the challenges of meeting the moral and legal obligations of our community in the provision of healthcare for our veterans. We would be delighted to add any of you to the email tree we have set up on this issue so that you and your staff are kept informed of any developments. There is much to learn.

As our talking paper points out, the health care of Alaska's veteran's faces serious and difficult structural problems in securing the funding authorized by federal law but not appropriated because veteran healthcare has become a partisan football. Veteran healthcare like so many other federal programs is politically "negotiated," regardless of need, every year unlike healthcare provided to our poor, our homeless, our elderly, and even our illegal aliens. Are not our war veterans at least as deserving as these groups when it comes to healthcare? Are not the men and women who voluntarily stand guard for America worth at least as much to our community?

The other day a member of our legislature said to me, "You know veterans are really just another welfare group." This Alaskan of prominence never served in the military, and clearly does not understand that healthcare for veterans is not "welfare" but the moral, ethical, and legal obligation of our people and our leaders for the service and sacrifices we faced to ensure your liberties. We are only asking for what was promised and appropriate.

As a community of veterans we are tired of all the talk. We are tired of all the political promises. We are tired of receiving healthcare based on "administrative convenience" rather than appropriate care at home. We are tired of being shipped outside of our communities and our state to receive healthcare available right here at home. We are tired and we are angry.

So, why are we here before the State Legislature asking you to direct the Commissioner of Health and Social Services to "talk" to the Veterans Administration about what the state might be able to do to help Alaskan veterans? Yes, that's all we are asking is that our legislature recognize this problem, one that will likely not be solved in Washington DC as it should, but that will continue to harm, even destroy the lives of Alaskan veterans and their families. **72,000 veterans** have chosen to be Alaskans. The highest per-capita in the nation. When extended to their immediate families, we estimate that at least **150,000**

Alaskans are directly affected by veteran policies. We should be proud that this many veterans choose to live in Alaska. And now our Alaskan guard and Reserves face the largest and longest active duty deployments in combat in our state's history. But as a state, what are we – what is Alaska doing to ensure they receive the healthcare they have earned when they come home?

We don't have all the answers, but we are gathering lots of the questions. We have asked the VA to provide the facts and figures identified in the last page of our talking paper. This is something our legislature and our state government can help us with, and this resolution will facilitate that and more.

We have talked about veteran healthcare, but let's now look at some of the other implications of current VA policies on our Alaskan based medical services industry. We are told for example that the VA spent over $2 million in air fare alone to send veterans out of state for healthcare. We know that at least most of these medical services are available not only in Alaska but often in the veteran's home community. We are told that over $17 million of healthcare services were proved veterans outside of Alaska. With all other costs considered, that's over $20 million in healthcare services that are taken out of our economy.

We know of prominent Alaskan doctors who have recently lost their significant veteran client base as their patients are now sent out of state. We know of Alaskan based hospitals, now loosing money because the services they built to serve a particular medical need in their community, including long-term veteran patients, are no longer economically viable due to the loss of these patients causing other Alaskan patients to assume these losses. So, there are serious economic implications to VA policies that now ship more and more Alaskan veterans outside for medical services. Certainly if these services are not available in Alaska one can understand this. But when they are here, and the veterans are currently being served here in their home communities, there are other "costs" associated with these policies. Taking a veteran away from his/her family at a critical and vulnerable time, is clearly not in the best interests of our veterans, their families, or of Alaskans as a community.

So, we are asking our State Legislature to direct the Commissioner of Health and Social Services to "talk" with the VA and see if there is something we in Alaska can do to better serve our veterans. That's all.

Now, what we would like the Commissioner to also do is gather information that should be reported back to you. We believe the Commissioner can prepare an assessment of these problems and their implications to veterans, our economy, and our community in a few months and provide it back to this and other committees of the legislature so that we can begin to get a real handle on what is happening, what it all means, and why. We believe the Commissioner has it within his department's budget to gather a taskforce of veterans, medical groups, and the VA and seriously, openly, look at the healthcare of our veterans in Alaska and what it will mean over time. We believe you can do this with committee language in the appropriations bill for the Office of the Commissioner of Health and Social Services.

**"Never will one generation of veterans abandon another."** That is the motto of the Vietnam Veterans of America and the Alaska Veterans Foundation. Please remember that when we came home, not only did our nation, and our communities dishonor our service, most national veteran service organizations refused us membership. That is why the Vietnam Veterans of America was chartered by Congress.

We have stood guard for America and human liberty in the jungles and deserts of our world when you, our elected officials, have asked us to do so. We now stand before you and ask for your help. Help to ensure we receive the healthcare we have earned, is morally and ethically appropriate, and consistent with what is in the best interests of our families, our state, and our nation.

Thank you very much for your time and consideration,

Ric Davidge, President


February 17, 2006

Alex Spector, Director
Alaska VA Healthcare System
2925 DeBarr Road
Anchorage, Alaska 99508

Director Spector:

As you may know by now a group of Anchorage legislators held an open forum on December 7th, 2005 to open discussions with local veteran organizations on issues of concern. A group of about 25 veterans and a dozen legislators showed up for the forum and the discussions were wide ranging, hot at times (both ways), and may have been productive in both informing state legislators about the various concerns of Alaskan veterans and veterans getting to understand legislative interests in their concerns.

From this forum an informal working group was set up by some of the participants that includes veterans, VA employees, politicos, hospital and medical clinic interests, etc. Although this working group does not have a leader per se, in an effort to give form to the chatter and get things down on paper, I've stepped forward to provide this service.

Attached is the product of the working group so far. Two state legislative bills have been introduced in response to the issues outlined in the talking paper. As is pointed out in the paper, the paper is not the position of the Veterans Foundation nor any particular veterans' organization, only the developing thoughts and concerns of the working group and a growing number of email contacts who have asked to be kept informed.

I'm certain you are aware of the continuing controversy of Congressional funding or rather the lack thereof for Veteran Health Care. The competing efforts of the Republicans and Democrats may, from time to time, align with the current administration. But, the bottom line, as expressed by our national office, Vietnam Veterans of America, on behalf of the nine national veterans organizations last year, is that Congressional appropriations have not kept up with the needs of veterans. If you do not have a copy of the White Paper produced by the VVA last year that has some excellent graphic analysis of funding trends, I can get you one or you can access it on their web site www.vva.org.

As part of the discussion of the working group, we have tried to identify critical FACTS or DATA or questions that may or may not provide a basis for understanding the "Alaskan" situation. Those questions are contained in the last page of the Talking Paper that I've enclosed for you.

We would appreciate your timely response to these sixteen questions. If they are presented by us in a manner that is not productive to the gathering of data or information, please let us know. If you have questions about these questions, we are also most open to your thoughts.

Thanks for your attention to this ongoing debate;

Ric Davidge, President

Vietnam Veterans of America Alaska Chapter 904
3705 Arctic Blvd. #548, Anchorage, Alaska 99503 Web Site: www.VVA904.org

ALASKA VETERANS FOUNDATION

# VA/AK VETERANS HEALTH CARE CONCEPTS/working DRAFT (RD) 2/5/06

This is a working draft of ideas/concepts crafted by Ric Davidge and a small working group toward defining solutions to the ongoing structural (service and funding) issues within our federal veterans' health care system in Alaska. The ultimate re-crafted solution(s) may have application in other states with Alaska functioning as a demonstration project. NOTHING in this working paper is final nor does it represent the position of the Foundation or the other participants in this discussion. This paper is only necessary due to the complexity of these issues. We find it easier to outline things on paper so that there is clearer understanding by all parties as to

## Structural Problems:

1. Veterans Heath Care funding is not annually assured based on either our nations moral obligation to the men/women who have been injured in service or who have retired after 20 plus years of honorable service. Funding levels are politically negotiated within the context of annual budgets and political agendas without regard to veteran health care need or the quality of service.

   2006 General Accounting Office reports requested by the leadership of both the Congressional House and Senate veteran's program oversight committees highlight the structural nature of these problems. Problems that can not be solved by opposing political parties, but by new ideas.

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## Moral Imperatives:

1. In the face of continued efforts by our federal government to reduce or otherwise restrict the levels and categories of medical care for our veterans at a time of growing demand by old and new veterans for services, why should not a state, especially the richest state per capita in America with the highest per capita number of veterans (72,000), step up to ensure that its veterans – Alaska's veterans receive adequate and appropriate care in their community?
2. The quality and certainty of veteran care must not be a partisan issue. It is an American obligation to those few citizens willing to voluntarily stand guard for America. If our federal government is politically unwilling or financially unable to provide adequate care for its veterans, then we - Alaskan's must step up to this obligation for Alaska's veterans.

## Veterans Care at existing private Alaskan hospitals and clinics

1. In years past veterans in Alaska were treated at private health care facilities with VA employees working within these facilities. Even today close to $40 million is spent annually by the VA through local Alaskan hospitals and clinics. Our program extends this proven method and captures even more efficiencies while keeping our veterans at home for medical service.
2. Our program allows veterans, connected under the VA Health Care program, to receive services for either a service related injury or other health needs at any hospital or clinic in Alaska.
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days of receiving the bill, again consistent with a negotiated reimbursement schedule for the specific procedure or service.

4. Alternatively, some argue that our veterans should be "covered" by an established national healthcare insurance company at the level of care selected by the veteran and/or their family. Appropriate co-pay agreements could be structured based on the veteran's income level, however for any veteran with a service connected disability any related medical services for that disability would be fully covered. The insurance company bills the VA for reimbursement for all service related medical treatments. Veterans who have retired after 20 or more years of honorable service would receive full coverage possibly minus appropriate co-pay based on income.
5. Reimbursement schedules would be negotiated between the hospitals and clinics and the state. The state would negotiate with the VA. Any medical provider that wants to participate must be "certified" by the state to participate in the program. This is really no different then existing VA programs for some services and third party insurance procedures except that the state is a player.
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11. We effectively eliminate the need for a separate, with its own heavy administrative costs, federal medical service program in Alaska and push all of the efficiencies directly into the private sector where they are far more efficient.

**Why should the State of Alaska put itself in the middle?**

1. Alaskans (National Guard and Reserve) are becoming more and more involved in fighting our wars. Even if Alaska's troops are federalized, the state has a moral and ethical obligation to ensure that Alaska's veterans receive adequate and appropriate medical services after leaving active duty.
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3. This program should ensure that Alaska's veterans receive adequate health care OUTSIDE of the current federal appropriations processes. A process that, regardless of need or the existence of federal laws, continues to reduce the per-veteran level of federal services and the per-veteran level of programmatic federal funds compared to the growing level of need from our veterans, old and new, in Alaska.
4. Alaska should explore new medical service concepts for veterans that are far more cost effective then the building of new VA hospitals/clinics especially in areas of Alaska with small populations that do not enable the levels of medical service efficiencies essential to compete in this market.
5. Alaska could be a pilot project in the evolution of new national approaches to more efficient medial insurance/services for veterans. In fact, we may not be reinventing the wheel here, we may just be returning to an approach that some years past provided services in this manner.

**Problems Solved**

1. Maximizes use of existing underutilized Alaskan hospital services/beds increasing the operational efficiency of existing private facilities allowing lower service fees especially in rural areas.
2. By bringing back into Alaska's economy the tens of millions of "lost dollars" for medical service now required by the VA outside of Alaska we can inject this significant cash flow through our existing private hospitals and clinics close to the homes of Alaskan veterans.
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4. The cost [significantly reduced travel (air fare, hotel, taxi, meals) expenses] of providing services to veterans should be reduced overall with the retention of veterans in Alaska, and closer to their homes, for medical care.
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6. The existing Military/VA Hospital at Elmendorf can revert to active duty service only. Elmendorf will not have to adjust their fence/perimeter to put this hospital outside of the existing security zone. Saving money, time, manpower, and enhancing on base security while at the same time providing services to veterans in a far more friendly and efficient way. This action is also responsive to the general desire of veterans to receive their medical services within their community.
7. Veterans will be allowed/enabled to use existing private facilities based on cost and quality of service in Alaska and in their own communities.
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10. The VA Clinic could be relocated to an existing medical campus such as Providence or Alaska Regional rather than moved to Elmendorf providing better professional services integration within the medical communities that exist. Additional efficiencies can be realized with the consolidation of all VA services at one medical campus (now five (5) commercial spaces are under "fair market value" lease by the VA in Anchorage alone).
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4. How often are Alaskans flown in for medical services only to find out that the service is not available because the VA doctor (often flown in from out of state) is not available?
5. What medical/mental health services/treatments are veterans receiving outside of Alaska?
6. What is the total cost/value of these "outside" medical services to the VA annually? ***ANSWER: $17,000,000 in outside healthcare. Number not yet verified in writing.***
7. If these services are available in Alaska, why does the VA send the veteran out of state?
8. Does the VA provide any family assistance to spouses/families to be close to a veteran when sent out of state for medical services? Is there some gradation based on seriousness of condition?
9. How many veterans in Alaska are classified as having a service related PTSD claim? How many of them receive regular treatment in Alaska? How many receive treatment outside of Alaska?
10. How many veterans are served annually instate at VA clinics and hospitals?
11. What is the total cost of medical services (do not include VA Administration) provided by VA in Alaska? ***ANSWER: $38,681,991 in part.***
12. How many veterans receive medical services at private or other than VA facilities in Alaska annually?
13. What is the total cost of medical services received by veterans in Alaska at other than VA facilities?
14. What is the nature of these medical services?
15. What is the cost per patient ratio for VA medical services in Alaska?
16. How many facilities in Alaska currently have reimbursement schedules with the VA?

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# Additional Support for HJR 33

March 23, 2006
Testimony before the State House
HJR 33

My name is Ric Davidge and I serve as President of the Vietnam Veterans of America, Chapter 904 – the Anchorage Chapter and the largest in Alaska. I also serve as President of the Alaska Veterans Foundation, Inc. a statewide veteran service organization that serves Alaskan War Veterans. And I serve as Vice Chairman of the Anchorage Military & Veterans Affairs Commission.

In 1965 I was as a medic with the First Air Cavalry in Vietnam and served honorably for 6 years.

Why do we have this resolution before you and just what does it really do?

I assume you have, in your packet, a copy of the most recent "Talking Paper" that we update regularly about the problems Alaskan veterans face in securing appropriate healthcare. This paper is an open ended discussion of problems that continue to come to light as our working group, made up of a wide range of veterans, VA employees, politicos of both political parties, and medical service professionals, wrestles with the challenges of meeting the moral and legal obligations of our community in the provision of healthcare for our veterans. We would be delighted to add any of you to the email tree we have set up on this issue so that you and your staff are kept informed of any developments. There is much to learn.

As our talking paper points out, the health care of Alaska's veteran's faces serious and difficult structural problems in securing the funding authorized by federal law but not appropriated because veteran healthcare has become a partisan football. Veteran healthcare like so many other federal programs is politically "negotiated," regardless of need, every year unlike healthcare provided to our poor, our homeless, our elderly, and even our illegal aliens. Are not our war veterans at least as deserving as these groups when it comes to healthcare? Are not the men and women who voluntarily stand guard for America worth at least as much to our community?

The other day a member of our legislature said to me, "You know veterans are really just another welfare group." This Alaskan of prominence never served in the military, and clearly does not understand that healthcare for veterans is not "welfare" but the moral, ethical, and legal obligation of our people and our leaders for the service and sacrifices we faced to ensure your liberties. We are only asking for what was promised and appropriate.

As a community of veterans we are tired of all the talk. We are tired of all the political promises. We are tired of receiving healthcare based on "administrative convenience" rather than appropriate care at home. We are tired of being shipped outside of our communities and our state to receive healthcare available right here at home. We are tired and we are angry.

So, why are we here before the State Legislature asking you to direct the Commissioner of Health and Social Services to "talk" to the Veterans Administration about what the state might be able to do to help Alaskan veterans? Yes, that's all we are asking is that our legislature recognize this problem, one that will likely not be solved in Washington DC as it should, but that will continue to harm, even destroy the lives of Alaskan veterans and their families. **72,000 veterans** have chosen to be Alaskans. The highest per-capita in the nation. When extended to their immediate families, we estimate that at least **150,000**

Alaskans are directly affected by veteran policies. We should be proud that this many veterans choose to live in Alaska. And now our Alaskan guard and Reserves face the largest and longest active duty deployments in combat in our state's history. But as a state, what are we – what is Alaska doing to ensure they receive the healthcare they have earned when they come home?

We don't have all the answers, but we are gathering lots of the questions. We have asked the VA to provide the facts and figures identified in the last page of our talking paper. This is something our legislature and our state government can help us with, and this resolution will facilitate that and more.

We have talked about veteran healthcare, but let's now look at some of the other implications of current VA policies on our Alaskan based medical services industry. We are told for example that the VA spent over $2 million in air fare alone to send veterans out of state for healthcare. We know that at least most of these medical services are available not only in Alaska but often in the veteran's home community. We are told that over $17 million of healthcare services were proved veterans outside of Alaska. With all other costs considered, that's over $20 million in healthcare services that are taken out of our economy.

We know of prominent Alaskan doctors who have recently lost their significant veteran client base as their patients are now sent out of state. We know of Alaskan based hospitals, now loosing money because the services they built to serve a particular medical need in their community, including long-term veteran patients, are no longer economically viable due to the loss of these patients causing other Alaskan patients to assume these losses. So, there are serious economic implications to VA policies that now ship more and more Alaskan veterans outside for medical services. Certainly if these services are not available in Alaska one can understand this. But when they are here, and the veterans are currently being served here in their home communities, there are other "costs" associated with these policies. Taking a veteran away from his/her family at a critical and vulnerable time, is clearly not in the best interests of our veterans, their families, or of Alaskans as a community.

So, we are asking our State Legislature to direct the Commissioner of Health and Social Services to "talk" with the VA and see if there is something we in Alaska can do to better serve our veterans. That's all.

Now, what we would like the Commissioner to also do is gather information that should be reported back to you. We believe the Commissioner can prepare an assessment of these problems and their implications to veterans, our economy, and our community in a few months and provide it back to this and other committees of the legislature so that we can begin to get a real handle on what is happening, what it all means, and why. We believe the Commissioner has it within his department's budget to gather a taskforce of veterans, medical groups, and the VA and seriously, openly, look at the healthcare of our veterans in Alaska and what it will mean over time. We believe you can do this with committee language in the appropriations bill for the Office of the Commissioner of Health and Social Services.

**"Never will one generation of veterans abandon another."** That is the motto of the Vietnam Veterans of America and the Alaska Veterans Foundation. Please remember that when we came home, not only did our nation, and our communities dishonor our service, most national veteran service organizations refused us membership. That is why the Vietnam Veterans of America was chartered by Congress.

We have stood guard for America and human liberty in the jungles and deserts of our world when you, our elected officials, have asked us to do so. We now stand before you and ask for your help. Help to ensure we receive the healthcare we have earned, is morally and ethically appropriate, and consistent with what is in the best interests of our families, our state, and our nation.

Thank you very much for your time and consideration.

Ric Davidge, President


February 17, 2006

Alex Spector, Director
Alaska VA Healthcare System
2925 DeBarr Road
Anchorage, Alaska 99508

Director Spector:

As you may know by now a group of Anchorage legislators held an open forum on December 7th, 2005 to open discussions with local veteran organizations on issues of concern. A group of about 25 veterans and a dozen legislators showed up for the forum and the discussions were wide ranging, hot at times (both ways), and may have been productive in both informing state legislators about the various concerns of Alaskan veterans and veterans getting to understand legislative interests in their concerns.

From this forum an informal working group was set up by some of the participants that includes veterans, VA employees, politicos, hospital and medical clinic interests, etc. Although this working group does not have a leader per se, in an effort to give form to the chatter and get things down on paper, I've stepped forward to provide this service.

Attached is the product of the working group so far. Two state legislative bills have been introduced in response to the issues outlined in the talking paper. As is pointed out in the paper, the paper is not the position of the Veterans Foundation nor any particular veterans' organization, only the developing thoughts and concerns of the working group and a growing number of email contacts who have asked to be kept informed.

I'm certain you are aware of the continuing controversy of Congressional funding or rather the lack thereof for Veteran Health Care. The competing efforts of the Republicans and Democrats may, from time to time, align with the current administration. But, the bottom line, as expressed by our national office, Vietnam Veterans of America, on behalf of the nine national veterans organizations last year, is that Congressional appropriations have not kept up with the needs of veterans. If you do not have a copy of the White Paper produced by the VVA last year that has some excellent graphic analysis of funding trends, I can get you one or you can access it on their web site www.vva.org.

As part of the discussion of the working group, we have tried to identify critical FACTS or DATA or questions that may or may not provide a basis for understanding the "Alaskan" situation. Those questions are contained in the last page of the Talking Paper that I've enclosed for you.

We would appreciate your timely response to these sixteen questions. If they are presented by us in a manner that is not productive to the gathering of data or information, please let us know. If you have questions about these questions, we are also most open to your thoughts.

Thanks for your attention to this ongoing debate:

Ric Davidge, President

Vietnam Veterans of America Alaska Chapter 904
3705 Arctic Blvd, #548, Anchorage, Alaska 99503 Web Site: www.VVA904.org

ALASKA VETERANS FOUNDATION

# VA/AK VETERANS HEALTH CARE CONCEPTS/working DRAFT (RD) 2/5/06

This is a working draft of ideas/concepts crafted by Ric Davidge and a small working group toward defining solutions to the ongoing structural (service and funding) issues within our federal veterans' health care system in Alaska. The ultimate re-crafted solution(s) may have application in other states with Alaska functioning as a demonstration project. NOTHING in this working paper is final nor does it represent the position of the Foundation or the other participants in this discussion. This paper is only necessary due to the complexity of these issues. We find it easier to outline things on paper so that there is clearer understanding by all parties as to

## Structural Problems:

1. Veterans Heath Care funding is not annually assured based on either our nations moral obligation to the men/women who have been injured in service or who have retired after 20 plus years of honorable service. Funding levels are politically negotiated within the context of annual budgets and political agendas without regard to veteran health care need or the quality of service.

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9. How many veterans in Alaska are classified as having a service related PTSD claim? How many of them receive regular treatment in Alaska? How many receive treatment outside of Alaska?
10. How many veterans are served annually instate at VA clinics and hospitals?
11. What is the total cost of medical services (do not include VA Administration) provided by VA in Alaska? ***ANSWER: $38,681,991 in part.***
12. How many veterans receive medical services at private or other than VA facilities in Alaska annually?
13. What is the total cost of medical services received by veterans in Alaska at other than VA facilities?
14. What is the nature of these medical services?
15. What is the cost per patient ratio for VA medical services in Alaska?
16. How many facilities in Alaska currently have reimbursement schedules with the VA?

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