

Health Care for Veterans: Answers to Frequently Asked Questions

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Summary

The Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), operates the nation's largest integrated health care delivery system, provides care to approximately 6.7 million unique veteran patients, and employs more than 311,000 full-time equivalent employees.

Eligibility and Enrollment. Contrary to claims concerning promises of “free health care for life,” not every veteran is automatically entitled to medical care from the VA. Eligibility for VA health care is based primarily on veteran status resulting from military service. Generally, veterans must also meet minimum service requirements; however, exceptions are made for veterans discharged due to service-connected disabilities, members of the Reserve and National Guard (under certain circumstances), and returning combat veterans. The VA categorizes veterans into eight Priority Groups, based on factors such as service-connected disabilities and income (among others). Dependents, caregivers, and survivors of certain veterans are eligible for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), which reimburses non-VA providers or facilities for their medical care.

Medical Benefits. All enrolled veterans are offered a standard medical benefits package, which includes (but is not limited to) inpatient and outpatient medical services, pharmaceuticals, durable medical equipment, and prosthetic devices.

For female veterans, the VA provides gender-specific care, such as gynecological care, breast and reproductive oncology, infertility treatment, maternity care, and care for conditions related to military sexual trauma. Under current regulations, the VA is not authorized to provide, or cover the costs of, in vitro fertilization, abortion counseling, abortions, or medication to induce abortions.

Generally the VA provides audiology and eye care services (including preventive services and routine vision testing) for all enrolled veterans, but eyeglasses and hearing aids are provided only to veterans meeting certain criteria. Eligibility for VA dental care is limited and differs significantly from eligibility for medical care. For veterans with service-connected disabilities who meet certain criteria, the VA provides short- and long-term nursing care, respite, and end-of-life care.

Under certain circumstances, the VA may reimburse non-VA providers for health care services rendered to VA-enrolled veterans. Once such program is the Veterans Choice Program (VCP). Such community care may include outpatient care, inpatient care, emergency care, medical transportation, and dental services.

Costs to Veterans and Insurance Collections. While enrolled veterans do not pay premiums for VA care, some veterans are required to pay copayments for medical services and outpatient medications related to the treatment of nonservice-connected conditions. Copayment amounts vary by Priority Group and type of service (e.g., inpatient versus outpatient). The VA has the authority to bill most health care insurers for nonservice-connected care; any insurer's payment received by the VA is used to offset “dollar for dollar” a veteran's VA copayment responsibility. The VA is statutorily prohibited from receiving Medicare payments (with a narrow exception).

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Introduction

The Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), operates the nation's largest integrated direct health care delivery system, provides care to approximately 6.7 million unique veteran patients,¹ and employs more than 311,000 full-time equivalent employees.² While Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are also publicly funded programs, most health care services under these programs are delivered by private providers in private facilities. In contrast, the VA health care system could be categorized as a veteran-specific national health care system, in the sense that the federal government owns a majority of its health care delivery sites, employs the health care providers, and directly provides the majority of health care services to veterans.³

It should be noted that VA health care is *not* a health insurance plan similar to what many individuals or employers purchase in the private health insurance market and does not have the same health insurance plan characteristics, such as coinsurances,⁴ deductibles,⁵ and premiums.⁶

This report provides responses to frequently asked questions about health care provided to veterans through the VHA. It is intended to serve as a quick reference to provide easy access to information. Where applicable, it provides the legislative background pertaining to the question.

Eligibility

Are All Veterans Eligible for VA Health Care?

In general, not all veterans are eligible and entitled for free VA health care services.

Generally, a veteran has to meet certain criteria to be eligible for VA health care:⁷ (1) meet the statutory definition of a "veteran";⁸ (2) meet the statutory definition of "active duty";⁹ and (3) serve a minimum period of active duty.¹⁰

Although numerous claims have been made concerning "promises" to military personnel and veterans with regard to "free health care for life,"¹¹ presently, free medical benefits for life are

¹ CRS Report R44301, *Veterans' Medical Care: FY2016 Appropriations*, by (name redacted).

² U.S. Department of Veterans Affairs, *FY 2017 Budget Submission, Budget in Brief*, Washington, DC, February 2016, p. BiB-2.

³ Adam Oliver, "The Veterans Health Administration: An American Success Story?" *The Milbank Quarterly*, vol. 85, no. 1 (March 2007), pp. 5-35.

⁴ A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.

⁵ A fixed dollar amount during the benefit period—usually a year—that an insured person pays before the insurer starts to make payments for covered medical services.

⁶ A person enrolled in a private health insurance plan must pay a fee (premium), typically on a monthly basis, to maintain coverage under the plan. For more information on health insurance, see CRS Report RL32237, *Health Insurance: A Primer*, by (name redacted) and (name redacted).

⁷ Department of Veterans Affairs, Veterans Health Administration, *Eligibility Determination*, VHA HANDBOOK 1601A.02, April 3, 2015.

⁸ 38 U.S.C. §101(2).

⁹ 38 U.S.C. §101(21).

¹⁰ 38 U.S.C. §5303A or exceptions at 38 U.S.C. §5303A(b)(3).

not offered by VA to *all* veterans. Early history does point to a “promise” for *service-connected* veterans; “but no provision was made for implementing the promise.”¹² For instance, “Article III of the War Risk Insurance Act, in addition to making provision for compensation, provides that the United States shall furnish to the injured person such reasonable governmental medical, surgical, and hospital services, and such supplies, including artificial limbs, trusses, and similar appliances.”¹³

Eligibility for enrollment in VA health care has evolved over time. Prior to eligibility reform in 1996, all veterans were technically eligible for some care. However, the actual provision of care was based on available resources.¹⁴

The Veterans’ Health Care Eligibility Reform Act of 1996 (P.L. 104-262) established two eligibility categories and required VHA to manage the provision of hospital care and medical services through an enrollment system based on prioritization.¹⁵ (See **Appendix A** for the criteria for the Priority Groups.) P.L. 104-262 authorized the VA to provide all needed hospital care and medical services to veterans with service-connected disabilities;¹⁶ former prisoners of war; veterans exposed to toxic substances and environmental hazards such as Agent Orange; veterans whose attributable income and net worth are not greater than an established “means test”; and veterans of World War I. These veterans are generally known as “category A” or “core” veterans.¹⁷ The other category of veterans includes those with no service-connected disabilities and/or with attributable incomes above an established “means test.”

P.L. 104-262 also authorized the VA to establish a patient enrollment system to manage access to VA health care. As stated in the report language accompanying P.L. 104-262,

[t]he Act would direct the Secretary, in providing for the care of ‘core’ veterans, to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment system would operate.¹⁸

Furthermore, P.L. 104-262 was clear in its intent that the provision of health care to veterans was dependent upon available resources.

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¹¹ For a detailed discussion of “promised benefits,” see CRS Report 98-1006, *Military Health Care: The Issue of “Promised” Benefits*, by (name redacted) .

¹² William P. Dillingham, *Federal Aid to Veterans: 1917-1941* (Gainesville: University of Florida Press, 1952), p. 59.

¹³ The War Risk Insurance Act, which was established in 1914, provided insurance coverage for sailors/marines and their family members during World War I. Department of the Treasury, *Annual Report of the Director of the Bureau of War Risk Insurance*, Document No. 2886, Washington, DC, June 30, 1920, p. 7, <http://www.va.gov/vetdata/docs/FY1920.pdf>. Accessed on March 15, 2016.

¹⁴ Barbara Sydel, “Restructuring the VA Health Care System: Safety Net, Training and Other Considerations,” National Health Policy Forum, Issue Brief no. 716, March 1998.

¹⁵ U.S. Congress, House Committee on Veterans Affairs, *Veterans’ Health Care Eligibility Reform Act of 1996*, report to accompany H.R. 3118, 104th Cong. 2nd sess., H.Rept. 104-690, p. 2.

¹⁶ A service-connected disability is a disability that was incurred or aggravated in the line of duty in the U.S. Armed Forces (38 U.S.C. §101 (16)). The VA determines whether veterans have service-connected disabilities, and for those with such disabilities, assigns ratings from 0% to 100% based on the severity of the disability. Percentages are assigned in increments of 10% (38 C.F.R. §§4.1-4.31).

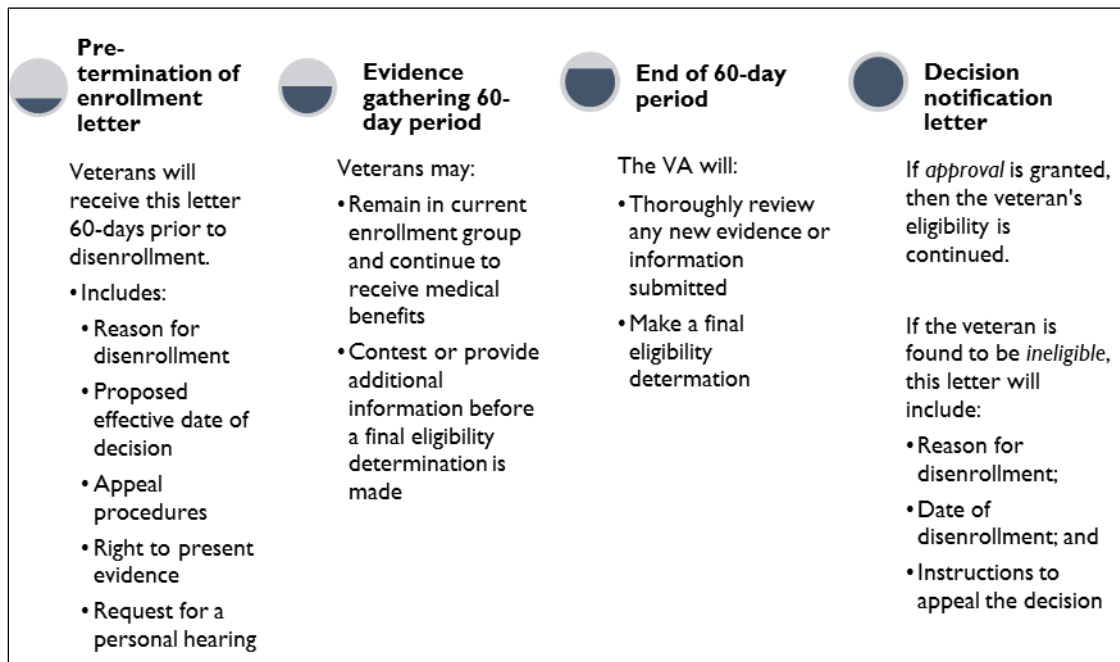
¹⁷ H.Rept. 104-690, p. 5.

¹⁸ Ibid., p. 6.

The committee report accompanying P.L. 104-262 states that the provision of hospital care and medical services would be provided to “the extent and in the amount provided in advance in appropriations Acts for these purposes. Such language is intended to clarify that these services would continue to depend upon discretionary appropriations.”¹⁹

Eligibility statuses of some veterans may become invalid at any time. “Enrolled veterans who are receiving health care benefits, and are later determined to not be eligible for enrollment will be notified via letter 60 days prior to disenrollment.”²⁰ **Figure 1** illustrates the process of VA’s determination of ineligibility procedures for currently enrolled veterans.

Figure 1. Ineligibility Determination Procedures for Enrolled Veterans



Source: Figure prepared by CRS based on Department of Veterans Affairs, Health Benefits, *The Application Process - Enrolled, but later Determined Ineligible*, http://www.va.gov/healthbenefits/apply/application_process.asp. Accessed on March 15, 2016.

Are Veterans’ Family Members Eligible for VA Health Care?

Veterans’ family members are not eligible for enrollment in VA health care services. However, certain dependents and survivors may receive reimbursement from the VA for some medical expenses.

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) pays for health care services to dependents and survivors of certain veterans. It is primarily a fee-for-service program that provides reimbursement for most medical care that is provided by non-VA providers or facilities. On May 5, 2010, President Barack Obama signed into law the

¹⁹ Ibid., p. 5.

²⁰ U.S. Department of Veterans Affairs, *Health Benefits: The Application Process - Enrolled, but later Determined Ineligible*, http://www.va.gov/healthbenefits/apply/application_process.asp. Accessed on March 15, 2016.

Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163), which expanded the CHAMPVA program to include the primary family caregiver of an eligible veteran who has no other form of health insurance, including Medicare and Medicaid.²¹ Health care services provided include counseling, training, and mental health services for the primary family caregiver. For more information, see CRS Report RS22483, *Health Care for Dependents and Survivors of Veterans*, by (name redacted)

Enrollment in the VA Health Care

Which Veterans Can Enroll in VA Health Care?

Enrollment in VA health care is based primarily on veteran status (i.e., previous military service), service-connected disability,²² and income.²³

At a minimum, the veteran must have served (1) in the military, naval, or air service; (2) for the required minimum period of duty;²⁴ and (3) received a discharge or release that is under other than honorable (e.g., general, honorable, under honorable conditions).²⁵

The Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262) required the VA to establish an enrollment system. The VA must establish which categories of veterans are eligible to be enrolled for VA health care. Once a veteran is enrolled, a veteran will remain enrolled in the VA health care system; unless the veteran formally wishes to disenroll. "Enrolled veterans may seek care at any VA facility without being required or requested to reestablish eligibility for VA health care enrollment purposes."²⁶ Exact requirements for enrollment eligibility depend on various criteria, such as when and in which component (i.e., active, Reserves, or National Guard) the veteran served. See below for questions and answers about returning combat veterans and members of the Reserves and National Guard.

²¹ For more information on the Comprehensive Assistance of Family Caregivers and a program of General Caregiver Support Services, see 38 C.F.R. Part 71.

²² A service-connected disability is a disability that was incurred or aggravated in the line of duty in the U.S. Armed Forces (38 U.S.C. §101 (16)). The VA determines whether veterans have service-connected disabilities, and for those with such disabilities, assigns ratings from 0% to 100% based on the severity of the disability. Percentages are assigned in increments of 10% (38 C.F.R. §§4.1-4.31).

²³ Veterans meeting certain income criteria may be eligible to enroll in the VA without a service-connected condition.

²⁴ Generally, persons enlisting in one of the Armed Forces after September 7, 1980, and officers commissioned after October 16, 1981, must have completed two years of active duty or the full period of their initial service obligation to be eligible for VA health care benefits. Servicemembers discharged at any time because of service-connected disabilities are not held to this requirement. For more information about how duty periods are defined, see U.S. Department of Veterans Affairs, "Duty Periods for Establishing Eligibility for Health Care," 78 *Federal Register* 78260, December 26, 2013.

²⁵ A veteran with an "other than honorable" discharge or "bad conduct" discharge may still retain eligibility for VA health care benefits for disabilities incurred or aggravated during service in the military. For more information on the nature of discharge requirements, see CRS Report R42324, *Who Is a "Veteran"?—Basic Eligibility for Veterans' Benefits*, by (name redacted); and CRS Report R43928, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*.

²⁶ Department of Veterans Affairs, Veterans Health Administration, *Enrollment Determinations*, VHA HANDBOOK 1601A.03, September 25, 2015, p. 2.

Is Enrollment Different for Returning Combat Veterans?

Veterans returning from a combat theater of operations are eligible to enroll in VA health care for five years from the date of their most recent discharge or release without having to demonstrate a service-connected disability or satisfy an income requirement. Veterans who enroll under this extended enrollment authority continue receiving health services after the five-year eligibility period ends.

This special period of enrollment eligibility for VA health care was established in 1998 and expanded in 2007. In 1998, Congress—responding to the growing concerns of Persian Gulf War Veterans’ undiagnosed illnesses—passed the Veterans Programs Enhancement Act of 1998 (P.L. 105-368); entitling a veteran who served on active duty in a theater of combat operations during a period of war after the Persian Gulf War to be eligible to enroll in VA health care during a two-year period following the date of discharge. In 2007, the National Defense Authorization Act (NDAA), FY2008 (P.L. 110-181) extended the period of enrollment eligibility for VA health care from two to five years for veterans who served in a theater of combat operations after November 11, 1998.²⁷ If returning veterans do not enroll during this five-year enrollment window (from the most recent date of discharge), future applications for enrollment will be evaluated according to the Priority Group classifications described in **Appendix A**.

For this reason, the VA encourages veterans to take advantage of the enhanced enrollment period. The Clay Hunt Suicide Prevention for American Veterans Act (P.L. 114-2) authorized an additional one-year period of eligibility to enroll for those veterans who were discharged from active duty after January 1, 2009, and before January 1, 2011, but did not enroll during the five-year period of post discharge eligibility. This one-year period began on February 12, 2015, the enactment date of the Clay Hunt Suicide Prevention for American Veterans Act. It ended on February 12, 2016.

Special Enrollment Provisions for Combat Veterans

- Do not have to demonstrate a service-connected disability.
- Eligible to enroll for five years after most recent date of discharge or release.
- Had been able to enroll under the Clay Hunt Suicide Prevention for American Veterans Act if the veteran missed the five year enrollment eligibility period (now expired).

Is Enrollment Different for Members of the Reserves?

When not activated to full-time federal service, members of the Reserve components have limited eligibility for VA health care services.

Similar to regular active duty servicemembers, members of the Reserve components may be eligible for enrollment into the VA health care system based on veteran status (i.e., previous military service), service-connected disability,²⁸ and income. Reservists achieve veteran status

²⁷ For those servicemembers who are called to duty multiple times, this will be the most recent discharge date. Generally, returning combat veterans are assigned to Priority Group 6, unless eligible for a higher Priority Group, and are not charged copays for medication and/or treatment of conditions that are potentially related to their combat service. At the end of the five-year period, veterans enrolled in Priority Group 6 may be re-enrolled in Priority Group 7 or 8, depending on their service-connected disability status and income level, and may be required to make copayments for nonservice-connected conditions. The above criteria apply to National Guard and Reserve personnel who were called to active duty by federal executive order and served in a theater of combat operations after November 11, 1998.

²⁸ A service-connected disability is a disability that was incurred or aggravated in the line of duty in the U.S. Armed Forces (38 U.S.C. §101 (16)). The VA determines whether veterans have service-connected disabilities, and for those with such disabilities, assigns ratings from 0% to 100% based on the severity of the disability. Percentages are assigned (continued...)

and are exempt from the 24-month minimum duty requirement (as described above) if they (1) were called to active duty, (2) completed the term for which they were called, and (3) were granted a discharge that is under other than honorable conditions.

Members of the Reserve components may be granted service connection for any injury they incurred or aggravated in the line of duty while participating in

- inactive duty training sessions,
- annual required training sessions, or
- active duty for training.

Injuries incurred during transfer from or to any of the above training sessions may also be granted as service-connected disabilities. Additionally, Reserve component members who experience a heart attack or stroke may have those medical events established as service-connected conditions. The granting of service-connection assures Reserve component members' eligibility to receive care from the VA for those conditions.

Is Enrollment Different for Members of the National Guard?

When not activated to full-time federal service, members of the National Guard have limited eligibility for VA health care services.

Similar to regular active duty servicemembers, members of the National Guard may be eligible for enrollment in VA health care based on veteran status (i.e., previous military service), service-connected disability,²⁹ and income.

National Guard members achieve veteran status and are exempt from the 24-month minimum duty requirement (as described above) if they (1) were called to active duty by federal executive order, (2) completed the term for which they were called, and (3) were granted an other than dishonorable discharge.

National Guard members are not granted service-connection for any injury, heart attack, or stroke that occurs while performing duty ordered by a governor for state emergencies or activities.³⁰

How Do Veterans Enroll in VA Health Care?

A veteran may apply for enrollment at any time of year by submitting the application for enrollment (online, in person, by mail, or by telephone) to a VA health care facility.³¹

To receive VA health care, veterans must enroll by completing and submitting the VA's application for Health Benefits (VA Form 10-10EZ).³² The application form includes information

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in increments of 10% (38 C.F.R. §§4.1-4.31).

²⁹ Ibid.

³⁰ 38 U.S.C. §101(24); 38 C.F.R. §3.6(c).

³¹ Veterans who meet the basic eligibility requirements may apply for enrollment into VA health care. For additional information, see <http://www.va.gov/HEALTHBENEFITS/apply/index.asp>. Accessed on March 15, 2016.

³² Veterans do not need to apply for enrollment in the VA's health care system if they fall into one of the following categories: veterans with a service-connected disability rated at 50% or more (percentages of disability are based upon the severity of the disability, and those with a rating of 50% or more are placed in Priority Group 1); veterans for whom less than one year has passed since the veteran was discharged from military service for a disability that the military (continued...)

about the veteran's military service, demographics, and (as applicable) financial status. There are many avenues for veterans to apply for enrollment:

Applying Online. Veterans may fill out and submit their benefit application electronically through the VA website.³³ After completing the application, a confirmation message will appear immediately on the veteran's screen. If recently discharged, the VA will gather veterans' service information for them.

Applying in Person. Veterans may go to their local VA health facility to apply for health care services. Within five to seven days, veterans will receive their enrollment notification letters in the mail.

Applying by Mail.³⁴ Veterans who choose to mail their VA Forms 10-10EZ to the VA may either download the form from the VA's website or pick up a form from their local VA health facility.

Applying by Telephone. Provisions for applications taken over the telephone changed. Previously, all veterans who applied for VA health care over the telephone had to wait five to seven days to receive, sign, and return their applications to the VA. At present, veterans can complete and submit their VA Forms 10-10EX over the telephone. Beginning March 15, 2016, all veterans who served in a theater of combat operations after November 11, 1998, and were discharged or released from active service on or after January 28, 2003, could apply for enrollment over the telephone.³⁵ Applications for other veterans to submit their enrollment application over the telephone are scheduled to begin on July 15, 2016.³⁶

How Does the VA Process Applications?

The VA processes applications through either a VA medical facility or Health Eligibility Center (HEC).

Veterans designate where they would like their application to be processed, with the exception of four medical facilities.³⁷ If veterans choose to have their applications processed through their local VA health facility, the staff will process their applications by using the Veterans Health Information Systems and Technology Architecture (VistA). VistA is an integrated electronic health record system that the VA uses to deliver care, which also includes administrative tools.

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determined was incurred or aggravated in the line of duty, but the VA has not yet rated; or the veteran is seeking care from the VA only for a service-connected disability (even if the rating is only 10%). VA Form 10-10EZ is available at <https://www.1010ez.med.va.gov/sec/vha/1010ez/https://www.1010ez.med.va.gov/sec/vha/1010ez/>. Accessed on March 15, 2016.

³³ To apply online, see <https://www.1010ez.med.va.gov/.https://www.1010ez.med.va.gov/>. Accessed on March 15, 2016.

³⁴ Applications are to be mailed to: Health Eligibility Center, 2957 Clairmont Road, Suite 200, Atlanta, GA 30329-1647.

³⁵ Department of Veterans Affairs, "Telephone Enrollment in the VA Healthcare System," 81 *Federal Register* 13994 - 13997, March 16, 2016.

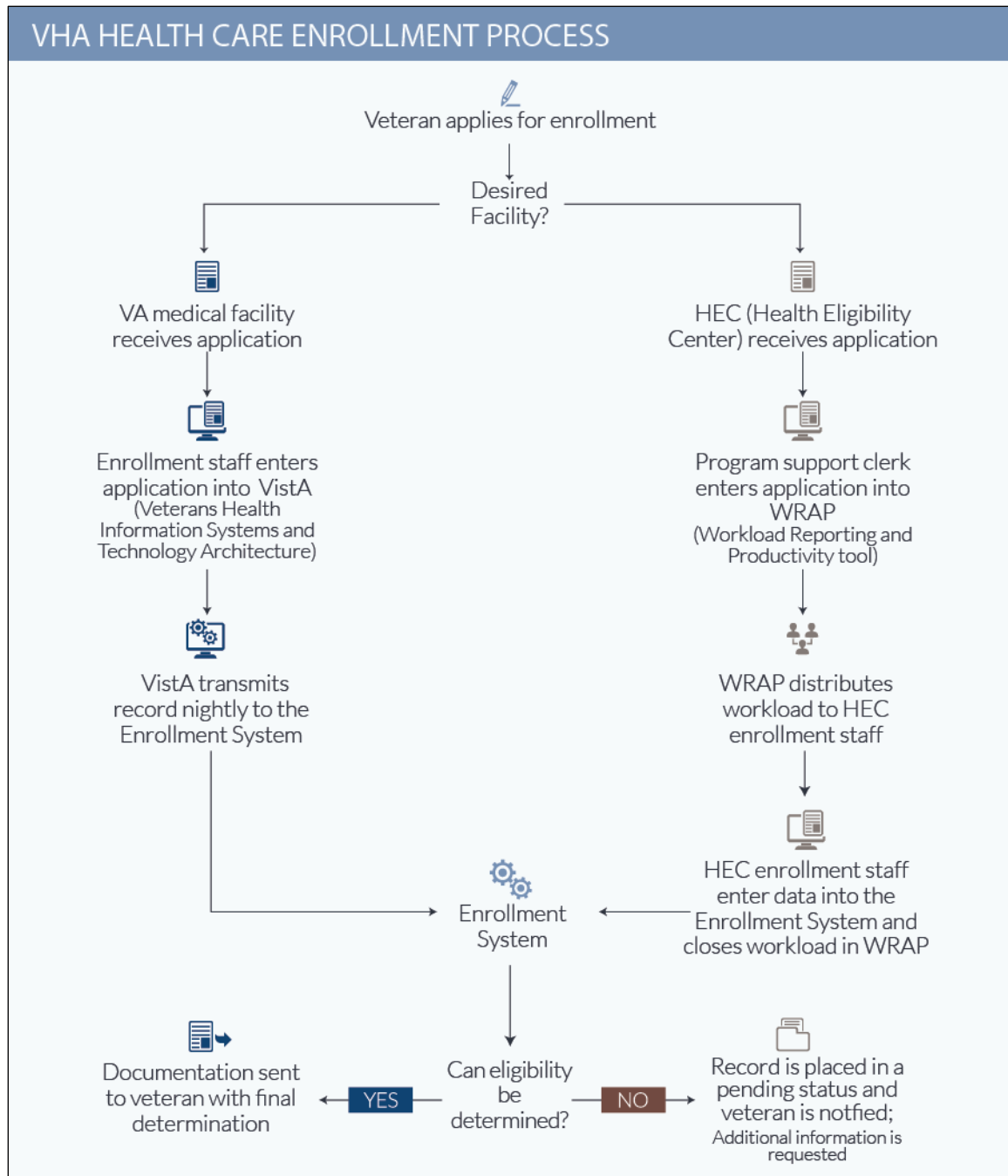
³⁶ Department of Veterans Affairs, "Combat Veterans Get Telephonic Health Care Application Option," press release, March 3, 2016, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2766>.

³⁷ Veterans at the following four VA health facilities will have their enrollment applications processed through HEC: the Atlanta VA Health Care System, Sioux Falls VA Health Care System, Fargo VA Health Care System, and VA Black Hills Health Care System. For additional information see <http://www.va.gov/oig/pubs/VAOIG-14-01792-510.pdf>. Accessed on March 15, 2016.

If the veterans choose to have a Health Eligibility Center (HEC) process their applications, the staff within the center will use the Workload Reporting and Productivity (WRAP) tool. HEC staff uses the WRAP tool to maintain and distribute health applications to reviewers, along with supporting documentations.³⁸ Illustrated in **Figure 2** is a flowchart of how the VA processes health care applications.

³⁸ VA Office of Inspector General, Veterans Health Administration, *Review of Alleged Mismanagement at the Health Eligibility Center*, 14-01792-510, September 2, 2015, p. 13, <http://www.va.gov/oig/pubs/VAOIG-14-01792-510.pdf>. Accessed on March 15, 2016.

Figure 2. VA Health Care Enrollment Process



Source: Figure prepared by CRS based on VA Office of Inspector General, Veterans Health Administration, *Review of Alleged Mismanagement at the Health Eligibility Center*, I4-01792-510, September 2, 2015, p. 25, <http://www.va.gov/oig/pubs/VAOIG-I4-01792-510.pdf>. Accessed on March 15, 2016.

What Happens After Veterans Receive Their Enrollment Notification Letters?

*Veterans who are accepted into the VA health care system and placed into a priority group are considered enrollees.*³⁹

Veterans who are approved to receive medical benefits may schedule their first VA health care appointment after receiving their approved enrollment notification letter. Veterans will also receive their personalized Veterans Health Handbook through the mail. This handbook will inform each veteran of his or her medical benefits, copay status, and Enrollment Priority Group assignment. Veterans who are found ineligible by the VA to receive medical benefits may appeal the decision. The VA will mail letters to unenrolled veterans explaining why they are unable to receive medical benefits. Within the letters are instructions that veterans must follow in order to appeal the VA's decision.

Enrollment Cancellation—Veterans may cancel their health care enrollment with the VA at any time. Applications for reenrollment are accepted at any time by the VA. “Acceptance for future VA health care enrollment will be based on eligibility factors at the time of application, which may result in a denial of enrollment.”⁴⁰

Medical Benefits

What Are the Standard Medical Benefits?

The VA offers all enrolled veterans a standard medical benefits package that includes (among other things) inpatient care, outpatient care, and prescription drugs.

The VA's standard medical benefits package promotes preventive and primary care and offers a broad spectrum of inpatient, outpatient, surgical and preventive health services as illustrated in Figure 3.

Does the VA Provide Gender-Specific Services for Women?

The VA's standard medical benefits package addresses the health care needs of enrolled female veterans by providing (directly or through access to non-VA providers) gynecological care, maternity care, infertility, breast and reproductive oncology, and care for conditions related to military sexual trauma (MST), among other services.

In addition, the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) authorized the VA to provide certain health care services to a newborn child of a female veteran receiving maternity care furnished by the VA. Health care for the newborn will be authorized for a maximum of seven days after the birth of the child if the veteran delivered the child in a VA facility or in another facility pursuant to a VA contract for maternity services.

³⁹ Department of Veterans Affairs, Veterans Health Administration, *Benefits Overview*, VHA Handbook 1601A.04, Washington, DC, February 16, 2016, p. 1.

⁴⁰ Department of Veterans Affairs, Veterans Health Administration, *VHA Handbook: Enrollment Determinations*, 1601A.03, Washington, DC, September 25, 2015, pp. 2-3.

Under current regulations, the VA is not authorized to provide or cover the cost of in vitro fertilization (IVF), abortions, abortion counseling, or medication to induce an abortion (e.g., mifepristone, also known as RU-486).⁴¹

Figure 3. Standard Medical Benefits Covered and Not Covered

Overall Covered Services	Covered Preventive Care Services	Non-Covered Services
<ul style="list-style-type: none"> • Medical, surgical, and mental health care, including care for substance abuse • Prescription drugs, including over-the-counter drugs, and medical and surgical supplies available under the VA national formulary system • Durable medical equipment and prosthetic and orthotic devices, including hearing aids and eyeglasses (subject to limitations) • Home health services, hospice care, palliative care, and institutional respite care • Noninstitutional adult day health care and noninstitutional respite care • Complementary and alternative medicine (CAM) therapies 	<ul style="list-style-type: none"> • Periodic medical exams • Health and nutrition education • Maintenance of drug-use profiles, monitoring, and education • Preventive services for mental health and substance abuse • Vaccinations against infectious diseases • Prevention of musculoskeletal deformity or other gradually-developing disabilities of a metabolic or degenerative nature • Genetic counseling for disease inheritance • Routine vision testing and care services • Periodic re-examination of members of high-risk groups for selected diseases, sensory organs decline 	<ul style="list-style-type: none"> • Abortions and abortion counseling • In-vitro fertilization • Drugs, biologicals, and medical devices not approved by the Food and Drug Administration (FDA) [with exceptions] unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption • Gender alterations • Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give such care or services • Membership in spas and health clubs; cosmetic surgery (plastic surgery) that is not medically necessary

Source: Table prepared by CRS based on 38 C.F.R. §17.38.

Does the VA Provide Infertility Services to Veterans?

The VA does provide infertility services to veterans.

Infertility services are provided to both service and nonservice-connected veterans. Illustrated in **Figure 4** is a listing of men and women infertility services offered by the VA.

⁴¹ 38 C.F.R. §17.38; and Department of Veterans Affairs, Veterans Health Administration, *Health Care Services for Women Veterans*, VHA Handbook 1330.01, May 21, 2010.

Figure 4. Infertility Services Offered by the VA

Men	Women
<ul style="list-style-type: none"> • Diagnostic Tests <ul style="list-style-type: none"> • Laboratory blood testing: serum testosterone • Genetic counseling and testing • Semen analysis • Evaluation of erectile dysfunction • Post-ejaculatory urinalysis • Transrectal and/or scrotal ultrasonography • Surgeries <ul style="list-style-type: none"> • Vasectomy reversal • Correction of structural pathology • Interventions <ul style="list-style-type: none"> • Sperm retrieval techniques • Treatment of erectile dysfunction • Hormonal therapies • Sperm cryopreservation 	<ul style="list-style-type: none"> • Diagnostic Tests <ul style="list-style-type: none"> • Laboratory blood testing: follicle stimulating hormone (FSH); luteinizing hormone (LH) • Genetic counseling and testing • Post-coital test • Endometrial biopsy • Pelvic and/or transvaginal ultrasound • Hysterosalpingogram (HSG) • Saline infused sonohysterogram • Surgeries <ul style="list-style-type: none"> • Reversal of tubal ligation • diagnostic laparoscopy or hysteroscopy • surgical correction of structural pathology • Interventions <ul style="list-style-type: none"> • Medication for ovulation induction (e.g., Clomiphene) • Certain hormonal therapies (for controlled ovarian hyper-stimulation) • Intrauterine insemination (IUI)

Source: Figure prepared by CRS based on U.S. Department of Veterans Affairs, Veterans Health Administration, and S.Rept. 113-106.

Does the VA Provide Dental Care?

Eligibility for dental care is extremely limited, and differs significantly from eligibility requirements for medical care.

For VA dental care eligibility, enrolled veterans are categorized into classes, which form the basis for the scope of dental treatment provided. **Table 1** describes the eligibility criteria and scope of treatment for VA-provided dental care.

Table 1. Eligibility Criteria and Scope of Treatment for VA Dental Care

Classification	Eligibility Criteria	Scope of Treatment Provided
Class I	Veteran has a service-connected compensable (disability compensation is paid) dental condition.	Any dental care and service needed.
Class II	<p>Veteran has a service-connected noncompensable dental condition (not subject to disability compensation) shown to have been in existence at the time of discharge or release from active duty service, which took place after September 30, 1981, if^a</p> <ul style="list-style-type: none"> the veteran served at least 180 days (or 90 days if a Veteran of the Gulf War era); and the veteran's DD214^b does not bear certification that the veteran was provided, within 90 days immediately prior to discharge or release, a complete dental examination (including dental x-rays) and all appropriate dental treatment indicated by the examination to be needed; and application for treatment is received within 180 days of discharge. 	A one-time course of dental treatment of the service-connected noncompensable dental condition.
Class II(a)	Veteran has a service-connected noncompensable dental condition or disability determined as resulting from combat wounds or service trauma.	"Any dental care necessary to provide and maintain a functioning dentition. A Dental Trauma Rating (VA Form 10-564-D) or VA Regional Office Rating Decision letter (VA Form 10-7131) identifies the tooth/teeth/condition(s) that are trauma rated."
Class II(b)	Veteran is enrolled and may be homeless and receiving care for a period of 60 consecutive days in specified settings stipulated at 38 U.S.C. §2062.	A one-time course of dental care that is determined clinically necessary to relieve pain, assist the veteran in gaining employment, or to "treat moderate, severe, or severe and complicated gingival and periodontal pathology."
Class II(c)	Veteran is a former prisoner of war (POW).	Any dental care and service needed.
Class III	Veteran has a dental condition clinically determined by VA to be aggravating a disability or condition from an associated service-connected condition or disability.	Dental care and services to treat such dental condition.
Class IV	Veteran whose service-connected disabilities have been rated at 100% or who is receiving the 100% rating by reason of individual unemployability.	Any dental care and service needed. ^c
Class V	Veteran is actively engaged in a vocational rehabilitation program (38 U.S.C. Chapter 31)	Dental treatment clinically determined to achieve specific objectives. ^d
Class VI	Veteran is receiving VA care or is scheduled for inpatient care and requires dental services for "a dental condition complicating a medical condition currently under treatment."	Outpatient dental care which is clinically necessary to treat "a dental condition complicating a medical condition currently under treatment."

Source: Table prepared by CRS based on 38 C.F.R. §§17.160 – 17.166; and Department of Veterans Affairs, Veterans Health Administration, *Eligibility for Outpatient Dental Care*, VHA Handbook 1601A.02, April 3, 2015.

- a. P.L. 84-83, enacted on June 16, 1955, amends veterans' eligibility for outpatient dental services. This amendment makes veterans who have noncompensable dental conditions-determined by the VBA before 1955 ineligible for Class II outpatient dental treatment.
- b. When servicemembers separate from active military service, they each receive a certificate of release or discharge from active duty, known as a DD-214. The DD-214 provides the member and the service with a concise record of a period of service with the Armed Forces at the time of the member's separation, discharge, or change in military status (reserve/active duty). In addition, the form serves as an authoritative source of information for both governmental agencies and the Armed Forces for purposes of employment, benefit, and reenlistment eligibility, respectively.
- c. Veterans who receive disability compensation based on a 100% temporary rating, such as extended hospitalization for a service-connected disability, convalescence or pre-stabilization are not eligible for comprehensive outpatient dental services based on this temporary rating.
- d. The objectives consist of: "(1) making possible [veteran's] entrance into a rehabilitation program; (2) achieving the goals of [the veteran's] vocational rehabilitation program; (3) preventing interruption of [the veteran's] rehabilitation program; (4) hastening the return to a rehabilitation program if [the veteran is] in interrupted or leave status; (5) hastening the return to a rehabilitation program of a veteran placed in discontinued status because of illness, injury or a dental condition; (6) securing and adjust to employment during the period of employment assistance; or (7) enabling [the veteran] to achieve maximum independence in daily living." (Source: Appendix B VHA Handbook 1601A.02, April 03, 2015).

What Is the VA Dental Insurance Program for Veterans and Survivors and Dependents of Veterans (VADIP)?

*The VA Dental Insurance Program (VADIP) is a pilot program that provides premium-based dental insurance coverage through which eligible individuals may choose to obtain dental insurance from a participating insurer.*⁴²

The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) authorized the VHA to conduct a three-year pilot program to assess the feasibility and advisability of providing private, premium-based dental insurance coverage to eligible veterans and certain survivors and dependents.⁴³ Generally, survivors and dependents that would qualify for the program will be Civilian Health and Medical Program of the VA (CHAMPVA) beneficiaries. Under the three-year pilot program (set to expire in August 2016), the VHA contracted with qualified dental insurance carriers that provide dental insurance and administer all aspects of the dental insurance plan. The VHA administers the contract with the private insurer and verifies eligibility of veterans, survivors, and dependents.⁴⁴

Does the VA Provide Hearing Aids and Eyeglasses?

Generally, the VA provides audiology and eye care services (including preventive care services and routine vision testing) for all enrolled veterans. The VA does not provide hearing aids or eye glasses for normally occurring hearing or vision loss.

⁴² The Department of Veterans Affairs is not the insurer—the entity that underwrites an insurance risk.

⁴³ Unlike VA health care coverage, veterans and eligible dependents are required to pay monthly premiums for the VADIP.

⁴⁴ C.F.R. §17.169. For more information on the VA Dental Insurance Program (VADIP), see <http://www.va.gov/healthbenefits/vadip/>, and http://www.va.gov/healthbenefits/vadip/VADIP_faq_02-18-15.pdf. Accessed on March 15, 2016.

Hearing aids and eyeglasses are provided to the following veterans:⁴⁵

- Veterans with any compensable service-connected disability.
- Veterans who are former prisoners of war (POWs).
- Veterans who were awarded a Purple Heart.
- Veterans receiving compensation for an injury, or an aggravation of an injury, that occurred as the result of VA treatment.
- Veterans in receipt of an increased pension based on being permanently housebound and in need of regular aid and attendance.
- Veterans with hearing or vision impairment resulting from diseases or the existence of another medical condition for which the veteran is receiving care or services from VA, or which resulted from treatment of that medical condition (e.g., stroke, polytrauma, traumatic brain injury, diabetes, multiple sclerosis, vascular disease, geriatric chronic illnesses, toxicity from drugs, ocular photosensitivity from drugs, cataract surgery, and/or other surgeries performed on the eye, ear, or brain resulting in a vision or hearing impairment).
- Veterans with significant functional or cognitive impairment evidenced by deficiencies in the ability to perform activities of daily living.⁴⁶
- Veterans who have hearing and/or vision impairment severe enough that it interferes with their ability to participate actively in their own medical treatment and to reduce the impact of dual sensory impairment (combined hearing and vision loss).

Does the VA Provide Long-Term Care?

The VA provides long-term care services (including residential, home-based, and community-based care) for veterans meeting specified criteria, which may include service-connected conditions and the need for such care.

The Veterans Millennium Healthcare and Benefits Act (P.L. 106-117) requires the VA to provide nursing home services to all enrolled veterans who are 70% or more service-connected disabled, or 60% or more service-connected disabled and unemployable and in need of such care, or who are service-connected for a condition that makes such care necessary.⁴⁷ The VA meets the requirements of P.L. 106-117 by providing short- and long-term nursing care, respite, and end-of-life care through three different settings: Community Living Centers (CLCs) located on VA medical campuses; contracted care in Community Nursing Homes (CNHs); and through the State Veterans Nursing Home (SVNH) program.

⁴⁵ 38 C.F.R. §17.149, and Department of Veterans Affairs, Prescribing And Providing Eyeglasses, Contact Lenses, and Hearing Aids, VHA Directive 1034(1), April 22, 2014.

⁴⁶ Activities of Daily Living (ADLs) generally refer to activities such as bathing, getting in and out of a bed or chair, eating, dressing, walking across the room, and using the toilet.

⁴⁷ 38 U.S.C. §1710A. This section is based on Carol J. Sheets and Heather Mahoney-Gleason, “Caregiver Support in the Veterans Health Administration: Caring For Those Who Care,” *GENERATIONS – Journal of the American Society on Aging*, vol. 34, no. 2 (Summer 2010), pp. 92-98.; U.S. Department of Veterans Affairs, Office of Care Coordination, Supporting Veterans’ Caregivers: A Frequently Asked Questions Guide, November 29, 2006, pp. 15-18.; and U.S. Congress, House Committee on Veterans’ Affairs, Subcommittee on Health, Legislative Hearing on H.R. 1293, H.R. 1197, H.R. 1302, H.R. 1335, H.R. 1546, H.R. 2734, H.R. 2738, H.R. 2770, H.R. 2898 and Draft Discussion Legislation, 111th Cong., 1st sess., June 18, 2009 (Washington: GPO, 2009), pp. 57-58.

Under the SVNH program, the VA subsidizes state-operated, long-term care facilities for veterans through a grant and per diem program in states that have petitioned the VA to build and operate a SVNH. The SVNH program primarily provides long-stay, maintenance-level care. Each SVNH is owned and operated by its host state; however, approximately two-thirds of new construction costs and about one-third of per diem costs are provided by the VA. For those veterans who are 70% or more service-connected disabled and reside in a SVNH, the VA provides the full cost of care.

The VA provides a range of non-institutional home and community based services for veterans, which include the following:

- **Skilled Home Care**—The Purchased Skilled Home Care Program (formerly known as fee basis home care) is a professional home care service that is purchased from private-sector providers by every VA medical center. A VA primary care provider must recommend Skilled Home Care in order for a veteran to receive it. The professional home care services program covers mostly nursing services, including medical care, social services, occupational therapy, physical therapy, skilled nursing care, and speech and language pathology.
- **Home Based Primary Care**—This program (formerly known as Hospital Based Home Care) began in 1970 and provides medical care to chronically ill or disabled veterans in their own homes through an interdisciplinary treatment team. These services are paid for by the VA and provided by VA personnel.
- **Veteran-Directed Home & Community Based Care**—The VA partners with federal Area Agencies on Aging to purchase needed services. This program allows the veteran to decide on a case mix of services to best meet care needs and those of the caregiver.
- **Spinal Cord Injury/Disorders Bowel & Bladder Care**—These programs provide specialized home care services for veterans with spinal cord injuries and related disorders. Services include respite care, long-term care, bowel and bladder care, and caregiver education to veterans.
- **Homemaker/Home Health Aide**—This program began in 1993 and provides assistance with personal care and related support services for veterans in their own homes through the homemaker/home health aide (H/HHA) benefit. H/HHA services may include assistance with activities of daily living (ADLs), as well as instrumental activities of daily living (IADLs).⁴⁸ Eligibility for the H/HHA program is based on a clinical judgment by the H/HHA Coordinator and interdisciplinary team that determine if the veteran would, in the absence of H/HHA services, require nursing home equivalent care. The VA pays for these services. H/HHA services are provided by contracted providers. H/HHAs are personnel who are trained and have completed a competency evaluation, and are under the general supervision of a nurse.

⁴⁸ Activities of Daily Living (ADLs) generally refer to activities such as bathing, getting in and out of a bed or chair, eating, dressing, walking across the room, and using the toilet. Instrumental Activities of Daily Living (IADLs) may include activities such as shopping for groceries, light housework, preparing hot meals, using the telephone, taking medications, and managing money.

- Community Residential Care (CRC)⁴⁹—CRC is a form of enriched housing that provides health care supervision to eligible veterans not in need of hospital or nursing home care, but who, because of medical and psychiatric and/or psychosocial limitations, as determined through a statement of needed care, are not able to live independently and have no suitable family or significant others to provide the needed supervision and supportive care. CRCs currently encompass
 - assisted living facilities;
 - personal care homes;
 - family care homes;
 - psychiatric community residential care homes; and
 - medical foster homes.

In general, each of the settings listed above must provide room, board, assistance with activities of daily living, and supervision as determined on an individual basis. The individual veteran makes the final choice of facility, and the cost of residential care is financed by the veteran's own resources. However, placement in residential settings is subject to inspection and approval by the appropriate VA medical center.

Does the VA Pay for Medical Care at Non-VA Facilities?

Under certain circumstances, the VA may reimburse non-VA providers for health care services rendered to VA-enrolled veterans on a fee-for-service basis.

Current law authorizes the VA to provide care outside of the VA health care system under the following circumstances: (1) when a clinical service cannot be provided at a VA medical center (VAMC); (2) when a veteran is unable to access a VA facility due to geographic inaccessibility; or (3) in emergencies when delays could lead to life-threatening situations.⁵⁰

Table 2 lists multiple services that are offered in the community. Non-VA care may include outpatient care, inpatient care, emergency care, medical transportation, and dental services.⁵¹

⁴⁹ The CRC program is authorized under 38 U.S.C. §1730.

⁵⁰ VA obtains the services of non-VA providers in non-VA facilities under the following statutory authorities: 38 U.S.C. §§1703, 1725, 1728, 8111, and 8153. Also see 38 C.F.R. §17.52 for various categories covered and eligibility for care under 38 U.S.C. §1703. The VA also has authority at 38 U.S.C. §7405(a)(2) to employ providers on a fee basis to provide care in VA-operated facilities.

⁵¹ Department of Veterans Affairs, Veterans Health Administration, *Audit of Non-VA Inpatient Fee Care Program*, Report No: 09-03408-227, Washington, DC, August 18, 2010, p. 1.

Table 2. VA Care in the Community

Title	Veterans' Choice Act (Veterans Choice Program) [38 U.S.C. §1701 note]	Traditional VA Care in the Community (formerly Non-VA Medical Care) [38 U.S.C. §1703]	Patient-Centered Community Care (PC3)	Project Access Received Closer to Home (ARCH) [38 U.S.C. §1703 note]	Indian Health Service (IHS)/Tribal Health Program (THP)^a [38 U.S.C. §8153]	Sharing of VA and Department of Defense (DOD) Health Care Resources [38 U.S.C. §8111]	Emergency Care for Certain Veterans with Service-Connected Conditions^b [38 U.S.C. §1728]	Emergency Care for Nonservice-connected Conditions^b [38 U.S.C. §1725]
Description	Temporary program to furnish Hospital Care and Medical Services to eligible Veterans through eligible non-VA providers.	Broad authority to make arrangement by contract or other forms of agreement, for the mutual use, or exchange of use, of health care resources between VA facilities and any health care provider, or other entity or individual. Sharing agreements with affiliates are executed under this authority.	Authority to contract for Hospital Care and Medical Services when VA facilities are not capable of furnishing economical care due to geographic inaccessibility or are not capable of furnishing care; can also furnish counseling and related Mental Health services under 38 U.S.C. Section 1712A(e)(1).	Pilot program in five VISNs to provide by contract covered health care services to covered Veterans. Pilot set to expire in August 2016.	Authorizes the Secretary of HHS to enter into or expand sharing arrangements between IHS, tribes, and Tribal Organizations, and VA and DOD. This authority is cited in VA's Direct Care Services reimbursement agreements with IHS and THP.	Authority to enter into sharing agreements and contracts with DOD for the mutual use or exchange of use of hospital and domiciliary facilities, and such supplies, equipment, material, and other resources as may be needed.	Authority to reimburse the usual and customary charges of emergency treatment furnished in a non-VA facility where such treatment was needed for/related to a service-connected condition or in certain instances vocational rehab or provided to a veteran permanently and totally disabled.	Authority to reimburse the reasonable value of emergency treatment furnished in a non-VA facility.

Title	Veterans' Choice Act (Veterans Choice Program) [38 U.S.C. §1701 note]	Traditional VA Care in the Community (formerly Non-VA Medical Care) [38 U.S.C. §1703]	Patient-Centered Community Care (PC3)	Project Access Received Closer to Home (ARCH) [38 U.S.C. §1703 note]	Indian Health Service (IHS)/Tribal Health Program (THP)^a [38 U.S.C. §8153]	Sharing of VA and Department of Defense (DOD) Health Care Resources [38 U.S.C. §8111]	Emergency Care for Certain Veterans with Service-Connected Conditions^b [38 U.S.C. §1728]	Emergency Care for Nonservice-connected Conditions^b [38 U.S.C. §1725]
Eligibility Criteria	Certain Veterans, generally based on residence or wait-time criteria. Criteria are specified in statute and regulations.	VA can use the authority to provide care to any individual VA is authorized to treat (or reimburse for treating).	Criteria specified in statute and regulations. Authority to contract for care based on type of care needed and whether or not the Veteran is service-connected.	Specific criteria set forth in statute, including enrollment, for a VA facility providing primary and tertiary care.	In general, agreements apply to American Indians and Alaska Native (AI/AN) Veterans, eligible for services from VA and IHS or the THP. Non AI/AN Veterans may also be eligible under agreements with Alaska THP.	N/A	Veteran must be eligible for VA health care and treatment must be rendered for conditions specified in statute.	Veteran must be an active health care participant and personally liable for the emergency treatment (terms are defined in the law).
Beneficiary	Certain Veterans	Veterans or individuals authorized to receive care under Title 38 U.S.C.	Certain Veterans as specified in statute	Certain Veterans based on driving times to certain services	Certain Veterans	Veterans Servicemembers	Service-connected Veterans	Certain Veterans
Payment	Contracting and Provider Agreement	Sharing authority; Contracting	Contracting	Pilot implemented via contract	Reimbursement	Sharing authority	Reimbursement	Reimbursement

Source: Table prepared by CRS based on U.S. Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, October 30, 2015, pp. 104-107, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf. 104-107, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf. Accessed March 15, 2016

Notes: This table does not show community care programs authorized under 38 U.S.C. §§1720 and 1720C, which includes community nursing home care; community adult health day care; home health care services; respite care; and hospice care.

- The VA and Indian Health Service/Tribal Health Programs signed a Memorandum of Understanding (MOU) to coordinate and share resources for services provided to eligible American Indian/Alaska Native Veterans.
- Treatment may either be for a service-connected condition or a nonservice-connected condition that is aggravating a service-connected connection.

What Is the Veterans Choice Program (VCP) or Choice Card Program?

The Veterans Choice Program (VCP), or Choice Card Program, is a new, temporary program that provides veterans the ability to receive medical care in the community from non-VA providers under certain circumstances.

On August 7, 2014, President Obama signed the Veterans Access, Choice, and Accountability Act of 2014 (H.R. 3230; H.Rept. 113-564; P.L. 113-146). The Department of Veterans Affairs Expiring Authorities Act of 2014 (H.R. 5404; P.L. 113-175), the Consolidated and Further Continuing Appropriations Act, 2015 (H.R. 83; P.L. 113-235), the Construction Authorization and Choice Improvement Act (H.R. 2496; P.L. 114-19), and the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (H.R. 3236; P.L. 114-41) made amendments to some provisions in P.L. 113-146. The act, as amended, makes a number of changes to programs and policies of the Veterans Health Administration (VHA) within the Department of Veterans Affairs (VA) that aim to increase access to care outside the VA health care system.⁵² Among other things, the act established a new program (the Veterans Choice Program) that would allow the VA to authorize care for veterans outside the VA health care system if they meet any of the following requirements:⁵³

- **30 Day Wait List:** Veteran is informed by the local VA medical facility that an appointment may not be scheduled either:
 - Within 30 days of when the veteran's clinician determines he/she need to be seen (clinically determined date), *or*
 - Within 30 days of when the veteran wishes to see a provider.
- **40 Miles or More Distance:** Veteran lives 40 miles from a VA medical facility that has a full-time primary care physician.
- **40 Miles or Less Distance:** Veteran does not reside in Guam, American Samoa, or the Republic of the Philippines *and*:
 - **Travel by Air, Boat, or Ferry:** Veteran travels by air, boat, or ferry in order to seek care from their local VA facility; *or*
 - **Unusual or Excessive Burden:**⁵⁴ Veteran incurs traveling burden based on environmental factors, geographic challenges, or a medical condition.⁵⁵
- **State or Territory without a VA facility that provides inpatient, emergency and complex surgical care (Full-Service VA Medical Facility):** Veteran residence is more than 20 miles from a VA medical facility *and* is in either:

⁵² For a section-by-section description of the provisions in the law see, CRS Report R43704, *Veterans Access, Choice, and Accountability Act of 2014 (H.R. 3230; P.L. 113-146)*, by (name redacted) et al.

⁵³ Regulations pertaining to the VCP are codified at 38 C.F.R. §§17.1500-17.1540.

⁵⁴ Local VA staff will decide whether or not the burden is unusual or excessive and likely to exist "at least 30 days or more from the date of the determination." Staff will document its decision on VA Form 119, Report of Contact, which includes the date of determination, expected duration of travel burden, and reason(s) behind the decision. Notification is sent in a letter by mail to the veteran. For more information see Department of Veterans Affairs, "Expanded Access to Non-VA Care Through the Veterans Choice Program," 80 *Federal Register* 66419 -66429, October 29, 2015.

⁵⁵ A local VA provider or the facility's Primary Care Patient Aligned Care Team (PACT) will determine whether or not a veteran is facing an unusual or excessive travel burden due to a medical condition. The duration of the burden is also assessed.

- Alaska, or
- Hawaii, or
- New Hampshire (excluding veterans who live 20 miles of the White River Junction VAMC), or
- U.S. Territory (excluding Puerto Rico).

Generally, to participate in the Veterans Choice Program (VCP) a veteran must be enrolled in the VA health care system. VA staff must determine a veteran's eligibility within 10 business days from the date of request. VA staff would review clinical and administrative records of veterans to determine appropriate medical benefits packages and clinical criteria. The VA informs the veteran if he/she is eligible to participate in the VCP. Veterans and network providers should verify eligibility status by calling the Choice Program Call Center at 866-606-8198 before scheduling any medical appointments. **Table 3** lists Community Programs that are not covered by the Veterans Choice Program.

Table 3. Community Care Programs Not Authorized under the Veterans Choice Program

Camp Lejeune Veteran & Family Member Program	Foreign Compensation & Pension exams	Pediatric services
Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)	Foreign Medical Program	Project ARCH- Access Received Closer to Home
Children of Women Vietnam Veterans	Homemaker and home health aide services	Spina Bifida
Chronic dialysis treatments	Hospice	State Veterans Homes
Compensation and Pension examinations	Long Term Care Programs	Tribal Health Programs
Dental care	Nursing home care	Unauthorized emergency care

Source: Table prepared by CRS based on data from the U.S. Department of Veterans Affairs.

How Is the Veterans Choice Program, or Choice Card Program, Administered?

A private Third Party Administrator (TPA) administers the program on behalf of the VA.

The VA signed contracts with two health care companies—Health Net Federal Services, LLC, and TriWest Healthcare Alliance Corporation—to help VA administer the Veterans Choice Program (VCP). Responsibilities of the contractors consist of managing: appointments, counseling services, providers, billing, Veterans Choice Program card distributions, and the call center.⁵⁶

Veterans found eligible under the VCP will receive a call from their respective contractor. Health Net or TriWest will provide veterans with information about the organization and schedule their appointments. All appointments for veterans must be within 30 calendar days. Once the appointments are scheduled, the contractor will inform the VA. After receiving the notification, the veteran's local VA facility staff will cancel his/her appointment at the VA if an appointment has been made.

⁵⁶ Department of Veterans Affairs, Veterans Health Administration, *Choice Champion Call*, November 10, 2015, p. 31.

All authorizations of care are issued by either Health Net or TriWest. Non-VA health care services must be pre-authorized prior to being delivered to veterans.⁵⁷ Medical services rendered to veterans without prior authorization may not be covered by the VA. Furthermore, veterans who do not live more than 40 miles from their nearest VA medical facility must first be unable to schedule an appointment with that VA facility; prior to requesting services under the VCP.

Veterans' out-of-pocket costs under the Choice Program are the same as those currently under the VA health care system. However, if a veteran has other health insurance (OHI), the veteran may have to pay out-of-pocket costs associated with the other insurance plan.⁵⁸ As explained in VA's final rulemaking:

For some veterans, particularly those with their own health insurance, there may be some differences under the Program [VCP], because while VA will attempt to cover the veteran's financial obligations under his or her insurance plan, VA cannot pay more than the Medicare rate (with limited exceptions) for the services provided, meaning the veteran may owe some copayment, cost share, or deductible amount from their other health insurance to the provider. VA is unable to completely eliminate any potential copayment liability because under the Program [VCP], VA is a secondary payer while under other non-VA care, we [VA] are the primary payer, and our payment to the non-VA health care provider is payment in full.⁵⁹

What Is Project ARCH (Access Received Closer to Home)?

Project ARCH is a five-year pilot program to evaluate how to improve access to health care for rural and highly rural veterans by providing these services closer to where they live through contractual agreements with non-VA medical providers.

The Veterans' Mental Health and Other Care Improvements Act of 2008 (P.L. 110-387/P.L. 110-387) was signed into law on October 10, 2008. Section 403 of this law required VA to conduct pilot programs during a three-year period to provide non-VA health care services through contractual arrangements to eligible veterans. The Caregiver and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163/P.L. 111-163), signed into law in May 2010, made technical corrections to Section 403 of P.L. 110-387/P.L. 110-387. In February 2011, the VA issued a Request for Proposals (RFP) for interested parties to submit proposals to provide services, and the Project ARCH sites became operational on August 29, 2011.

The three-year pilot program was set to expire on August 29, 2014. Section 104 of the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146)⁶⁰ extended this pilot program by another two years from the date of enactment of P.L. 113-146, and it is now set to expire on August 7, 2016. Furthermore, P.L. 113-146 also stipulated that the Secretary must ensure that medical appointments for those veterans eligible to participate in Project ARCH are scheduled not later than 5 days after the date on which the appointment is requested and occur no later than 30 days after such date.

⁵⁷ Non-VA health care providers should call the Operation Center for VCP at [redacted] to request authorization from either Health Net or TriWest prior to delivering medical services to veterans. Failure to obtain pre-authorization prior to rendering health services may result in uncompensated services.

⁵⁸ U.S. Department of Veteran Affairs, Veterans Health Administration, *Veterans Choice Program Other Health Insurance and Copayment Responsibility*, August 12, 2015, p. 1.

⁵⁹ Department of Veterans Affairs, "Expanded Access to Non-VA Care Through the Veterans Choice Program," 80 *Federal Register*, 66426, October 29, 2015.

⁶⁰ For a section-by-section description of the provisions in the law, see CRS Report R43704, *Veterans Access, Choice, and Accountability Act of 2014 (H.R. 3230; P.L. 113-146)*, by (name redacted) et al.

The Project ARCH pilot provides a range of specified health care services to eligible veterans in Veterans Integrated Service Networks (VISN) 1, 6, 15, 18, and 19. Eligibility for Project ARCH is based on statutory language. Specifically, eligible individuals include veterans who are enrolled in VA for health care services as of the date of the commencement of the pilot program and meet the statutory definition of “covered veterans.” Veterans may also participate in the pilot program if they are eligible to enroll under Section 1710(e)(3)(C) of Title 38 of the U.S.C. This includes Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) veterans and veterans who served on active duty in a theater of combat operations or in combat against a hostile force during a period of hostilities after November 11, 1998.

Covered veterans are defined as those veterans residing in a pilot VISN:

- More than 60 minutes away from the nearest VA health care facility providing primary care services,
- More than 120 minutes away from the nearest VA health care facility providing acute hospital care, or
- More than 240 minutes away from the nearest VA health care facility providing tertiary care.

What Are the Project ARCH Pilot Sites and Services?

Five pilot sites have been established across the country: Caribou, ME; Farmville, VA; Pratt, KS; Flagstaff, AZ; and Billings, MT. Health care services provided include primary care, outpatient specialty care, inpatient acute care, and outpatient diagnostic radiology services, among others. It should be noted that not all services are provided at all pilot sites (see **Table 4**).

Table 4. Description of Project ARCH Pilot Sites and Services

VISN	Parent VAMC	Pilot Site	Services Offered
VISN 1: VA New England Healthcare System	VA Maine Healthcare System (Togus)	Caribou, ME	Acute inpatient medical and surgical care, including related consultations and ancillaries. Outpatient specialty consultation, including related diagnostic imaging and laboratory services.
VISN 6: VA Mid-Atlantic Health Care Network	Hunter Holmes McGuire VAMC (Richmond)	Farmville, VA	Primary care, including routine preventive care, diagnostic imaging, and laboratory services.
VISN 15: VA Heartland Network	Robert J. Dole Medical Center (Wichita)	Pratt, KS	Primary care, including routine preventive care, diagnostic imaging, and laboratory services. Behavioral health screening and assessment.
VISN 18: VA Southwest Health Care Network	Northern Arizona VA Health Care System (Prescott)	Flagstaff, AZ	Acute inpatient medical and surgical care, including related consultations and ancillaries. Outpatient specialty consultation, including related diagnostic imaging and laboratory services.
VISN 19: Rocky Mountain Network	VA Montana Health Care System (Fort Harrison)	Billings, MT	Acute inpatient medical and surgical care, including related consultations and ancillaries. Outpatient specialty consultation, including related diagnostic imaging and laboratory services.

Source: Table prepared by CRS based on 38 U.S.C.

Does the VA Pay for Emergency Care at Non-VA Facilities?

The VA may pay for emergency⁶¹ care provided to enrolled veterans by non-VA providers based on several factors, such as whether the care is for a service-connected condition or not.

Prior to the passage of the Veterans' Emergency Care Fairness Act (P.L. 111-137), a veteran who was enrolled in the VA's health care system was reimbursed for emergency treatment received at a non-VA hospital. However, the statute only permitted such VA reimbursement if the veteran had no other outside health insurance, no matter how limited that other coverage was. P.L. 111-137 required the VA to pay for emergency treatment for a nonservice-connected condition if a third party is not responsible for paying for the full cost of care. The law also set two limitations on reimbursement as follows: (1) the VA is the secondary payer where a third-party insurer covers a part of the veteran's medical liability (e.g., his or her automobile insurance coverage, private health insurance, or Medicare Part A and Medicare Part B); and (2) the VA is only responsible for the difference between the amount paid by the third-party insurer and the VA allowable amount.

Veterans would continue to be responsible for copayments owed to the third-party insurer; if the veteran was responsible for copayments under a private health insurance or Medicare plan, then the veteran would still be liable to pay this (copayment rates and or coinsurance rates are set by the individual insurance policy or Medicare and not the VA). P.L. 111-137 clarifies that veterans are not liable for any remaining balance due to the provider after the third-party insurer and the VA have made their payments. **Table 5** lists certain criteria that veterans must meet in order to get reimbursement for emergency services received from non-VA health facilities.

⁶¹ According to the Department of Veteran Affairs, "a medical emergency is an injury or illness so severe that without immediate treatment, it threatens your life or health. Your situation is an emergency if you believe your life or health is in danger. If you believe your life or health is in danger, call 911 or go to the nearest ER right away. You do not need to call the VA before calling for an ambulance or going to an emergency room." Department of Veteran Affairs, *Non-Emergency Care*, Fact Sheet 20-02, May 2015, http://www.va.gov/PURCHASEDCARE/docs/pubfiles/factsheets/FactSheet_20-02.pdf. Accessed on March 15, 2016.

Table 5.VA Reimbursement for Emergency Care

The VA is required to pay or reimburse veterans for medical expenses incurred at non-VA facilities when the following conditions apply:^a	
Service-Connected	Nonservice-Connected
<p>To be reimbursed under 38 U.S.C. §1728, the veteran must meet the following criteria:</p> <p>(1) Emergency care or services were rendered in a medical emergency of such nature that delay would have been hazardous to life or health; <i>and</i></p> <p>(2) Emergency care or services were rendered to a veteran for an adjudicated service-connected disability, or for a nonservice-connected disability associated with and held to be aggravating a service-connected disability, or for any disability of a veteran who has a total disability permanent in nature from a service-connected disability; or for any illness, injury or dental condition in the case of a veteran who is participating in a vocational rehabilitation program and who is medically determined to be in need of hospital care or medical services; <i>and</i></p> <p>(3) VA or other federal facilities were not feasibly available, and an attempt to use them beforehand would not have been reasonable, sound, wise, or practical.</p> <p>All three of these statutory requirements must be met before VHA may authorize payment.</p>	<p>To be reimbursed under 38 U.S.C. §1725, the veteran must meet all of the following criteria:</p> <p>(1) The emergency care or services were provided in a hospital emergency department or a similar facility held out as providing emergency care to the public;</p> <p>(2) The claim for payment or reimbursement for the initial evaluation and treatment is for a condition of such a nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health;</p> <p>(3) A VA or other federal facility/provider was not feasibly available and an attempt to use them beforehand would not have been considered reasonable by a prudent layperson;</p> <p>(4) At the time the emergency care or services was furnished, the veteran was enrolled in the VA health care system and had received medical services from the VHA within the 24-month period preceding the furnishing of such emergency treatment;</p> <p>(5) The veteran is financially liable to the provider of emergency treatment for that treatment;</p> <p>(6) The veteran has no coverage under a health-plan contract for payment or reimbursement, in whole or in part, for the emergency treatment;</p> <p>(7) If the condition for which the emergency treatment was furnished was caused by an accident or work-related injury, the claimant has exhausted without success all claims and remedies reasonably available to the veteran or provider against a third party for payment of such treatment; and the veteran has no contractual or legal recourse against a third party that could reasonably be pursued for the purpose of extinguishing, in whole or in part, the veteran's liability to the provider; <i>and</i></p> <p>(8) The veteran is not eligible for emergency treatment reimbursement under 38 U.S.C. §1728.</p>

Source: Table prepared by CRS based on 38 U.S.C. §1728; 38 U.S.C. §1725; 38 C.F.R. §17.120; and 38 C.F.R. §17.1002.

- a. Prior to the enactment of the Veterans' Mental Health and Other Care Improvements Act of 2008 (P.L. 110-387), the VA was not required to reimburse the non-VA facility for the cost of care after the point of stabilization. P.L. 110-387 mandated that the VA reimburse or pay for the reasonable value of treatment for any veteran who meets above eligibility criteria and defined "emergency treatment" as continuing until the veteran can be transferred safely to a VA or other federal facility, and the VA or other federal facility agrees to accept such a transfer.

Costs to Veterans and Insurance Collections

Do Veterans Have to Pay for Their Care?

*Whether a veteran is required to pay for VA health care services depends primarily on (1) whether the condition being treated is service-connected, and/or (2) the veteran's enrollment Priority Group.*⁶²

Veterans who are enrolled in the VA health care system do not pay any premiums; however, some veterans are required to pay copayments for medical services and outpatient medications related to the treatment of a nonservice-connected condition. **Table 6** summarizes which Priority Groups are charged copayments for inpatient care, outpatient care, outpatient medication, and long-term care services. Only veterans in Priority Group 1 (those who have been rated 50% or more service-connected) and veterans who are deemed catastrophically disabled by a VA provider are never charged a copayment, even for treatment of a nonservice-connected condition.⁶³

For veterans in other priority groups, VHA currently has four types of nonservice-connected copayments for which veterans may be charged: outpatient, inpatient, extended care services, and medication.⁶⁴ Veterans in all priority groups are not charged copayments for a number of outpatient services, including the following: publicly announced VA health fairs; screenings and immunizations; smoking and weight loss counseling; telephone care; laboratory services; flat film radiology; and electrocardiograms.

For primary care outpatient visits, there is a \$15 copayment charge and for specialty care outpatient visits, a \$50 copayment. Veterans do not receive more than one outpatient copayment charge per day. That is, if the veteran has a primary care visit and a specialty care visit on the same day, the veteran pays only for the specialty care visit. For veterans required to pay an inpatient copayment charge, rates vary based upon whether the veteran is enrolled in Priority Group 7 or not. Veterans enrolled in Priority Group 8 and certain other veterans are responsible for the VA's full inpatient copayment. Veterans enrolled in Priority Group 7 and certain other veterans are responsible for paying 20% of the VA's inpatient copayment. Veterans in Priority Groups 1 through 5 do not have to pay inpatient or outpatient copayments. Veterans in Priority Group 6 may be exempt due to special eligibility for treatment of certain conditions.

For veterans required to pay long-term care copayments, these charges are based on three levels of nonservice-connected care, including inpatient, noninstitutional and adult day health care. Actual copayments vary depending on the veteran's financial situation.

⁶² The VA classifies veterans into eight enrollment Priority Groups based on an array of factors including (but not limited to) service-connected disabilities or exposures, prisoner of war (POW) status, receipt of a Purple Heart or Medal of Honor, and income. The criteria for each Priority Group are summarized in **Appendix A**.

⁶³ The manner in which the VA determines that a veteran is catastrophically disabled is established in regulation. The determinations are based on clinical criteria, rather than (as was formerly the case) medical codes, which change over time. For more information, see U.S. Department of Veterans Affairs, "Criteria for a Catastrophically Disabled Determination for Purposes of Enrollment," 78 *Federal Register* 72576-72579, December 3, 2013 and Department of Veterans Affairs, Veterans Health Administration, *Catastrophically Disabled Veteran Evaluation, Enrollment, and Certain Copayment Exemptions*, VHA Directive 1630(1) Transmittal Sheet, Washington, DC, May 7, 2015, pp. T1-1.

⁶⁴ For additional information see U.S. Department of Veterans Affairs, Veterans Health Administration, *2016 Copayment Rates*, IB 10-430, January 2016, http://www.va.gov/healthbenefits/resources/publications/IB10-430_copay_rates.pdf and Veterans Health Administration, *2016 Copayment Requirements at a Glance*, IB 10-431, January 2016, http://www.va.gov/healthbenefits/resources/publications/IB10-431_copay_requirements_at_a_glance.pdf. Accessed on March 15, 2016.

The VHA bills private health insurers for medical care, supplies, and prescriptions provided to veterans for their nonservice-connected conditions. While the VA cannot bill Medicare, it can bill Medicare supplemental health insurance carriers for covered services.⁶⁵ Veterans are not responsible for paying any remaining balance of the VA's insurance claim that is not paid or covered by their health insurance carrier. Any payment received by the VA is used to offset "dollar for dollar" a veteran's VA copayment responsibility.⁶⁶

⁶⁵ 38 U.S.C. §1729.

⁶⁶ U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Identifying the Causes of Inappropriate Billing Practices by the U.S. Department of Veterans Affairs*, 111th Cong., 1st sess., October 15, 2009 (Washington: GPO, 2010), p. 43.

Table 6. Copayments for Health Care Services (CY2016)

	Outpatient Services (per visit)				Medications ^a				Inpatient Services						Long-Term Care Services (Daily Max)							
Priority Group	Basic Care		Specialty Care		30-day or less supply		Annual cap limit		First 90 days of care during a 365-day period		Each additional 90 days during a 365-day period		Daily Per Diem Charge		Nursing Home Care/ Inpatient Respite Care/ Geriatric Evaluation		Adult Day Health Care/ Outpatient Geriatric Evaluation/ Outpatient Respite Care		Domiciliary Care		Spousal Resource Protection Amount	
	SC	NSC	SC	NSC	SC	NSC	SC	NSC	SC	NSC	SC	NSC	SC	NSC	SC	NSC	SC	NSC	SC	NSC	SC	NSC
1	\$0	\$0	\$0	\$0	\$0	\$0	\$0	NA	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
2 ^a	\$0	\$0	\$0	\$0	\$0	\$8	\$0	\$960	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
3 ^b	\$0	\$0	\$0	\$0	\$0	\$8	\$0	\$960	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
4 ^c	\$0	\$0	\$0	\$0	\$0	\$0	\$0	NA	\$0	\$0	\$0	\$0	\$0	\$0	\$0	Up to \$97	\$0	\$0	\$0	Up to \$5	\$0	\$119,220
5 ^d	\$0	\$0	\$0	\$0	\$0	\$8	\$0	\$960	\$0	\$0	\$0	\$0	\$0	\$0	\$0	up to \$97	\$0	up to \$15	\$0	up to \$5	\$0	\$119,220
6 ^e	\$0	\$15	\$0	\$50	\$0	\$8	\$0	\$960	\$0	\$0	\$0	\$0	\$0	\$0	\$0	up to \$97	\$0	up to \$15	\$0	up to \$5	\$0	\$119,220
7 ^f	\$0	\$15	\$0	\$50	\$0	\$9	\$0	No Cap	\$0	\$258	\$0	\$129	\$0	\$2	\$0	up to \$97	\$0	up to \$15	\$0	up to \$5	\$0	\$119,220
8 ^g	\$0	\$15	\$0	\$50	\$0	\$9	\$0	No Cap	\$0	\$1,288	\$0	\$644	\$0	\$10	\$0	up to \$97	\$0	up to \$15	\$0	up to \$5	\$0	\$119,220

Source: CRS summary based on U.S. Department of Veterans Affairs, “2016 Copayment Rates” (IB 10-430), http://www.va.gov/HEALTHBENEFITS/resources/publications/IB10-430_copay_rates.pdf (dated January 2016). Accessed on March 15, 2016.

Notes: SC=Service-connected NSC=Non-service-connected.

- For the period from July 1, 2010, through December 31, 2016, the copayment amount for veterans in Priority Groups 2 through 6 is \$8. There is an annual cap of \$960 per calendar year. When veterans reach the annual cap, they continue to receive medications without making a copayment. For veterans in Priority Groups 7 and 8 the copayment amount from July 1, 2010, through December 31, 2016, is \$9. There is no annual cap for these priority groups.
- No medication copayments if medication is for a service-connected disability. Former POWs are exempt from all medication copayments.

- c. The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163P.L. 111-163) exempted Veterans determined by VA to be catastrophically disabled from inpatient, outpatient, medication, and non-institutional extended care services copayments.
- d. No medication copayments if veteran is in receipt of VA pension or whose annual income does not exceed the applicable pension threshold.
- e. Priority Group 6 are veterans claiming exposure to Agent Orange; veterans claiming exposure to environmental contaminants; veterans exposed to ionizing radiation; combat veterans within five years of discharge from the military; veterans who participated in Project 112/SHAD (Shipboard Hazard and Defense); veterans claiming military sexual trauma; Camp Lejeune Veterans receiving VA-provided health care for one of the 15 identified illnesses or conditions; and veterans with head and neck cancer who received nasopharyngeal radium treatment while in the military are subject to copayments when their treatment or medication is not related to their exposure or experience. The initial registry examination and follow-up visits to receive results of the examination are not billed to the health insurance carrier and are not subject to copayments. However, care provided that is not related to exposure, if it is nonservice-connected, will be billed to the insurance carrier and copayments can apply.
- f. Priority Group 7a and 7c veterans have incomes above the VA Means Test threshold but below the Geographic Means Test threshold and are responsible for 20% of the inpatient copayment and 20% of the inpatient per diem copayment. The Geographic Means Test copayment reduction does not apply to outpatient and medication copayments, and veterans will be assessed the full applicable copayment charges.
- g. Priority Group 8a and 8c veterans have incomes above the VA Means Test threshold and above the Geographic Means Test threshold. Veterans enrolled in these priority groups are responsible for the full inpatient copayment and the inpatient per diem copayment for care of their nonservice-connected conditions. Veterans in these priority groups are also responsible for outpatient and medication copayments for care of their nonservice-connected conditions.

Do Veterans Have to Pay for Their Medications?

For medication copayments, veterans are not billed if they have a service-connected disability rating of 50% or greater, are former prisoners of war (POWs), catastrophically disabled, or if the medication is for a service-connected disability.

Veterans enrolled in Priority Groups 2 through 6 have a \$960 calendar-year cap on the amount that they can be charged for these copayments.⁶⁷ Veterans who are unable to pay VA's copayment charges may submit requests for assistance, including waivers, hardships, compromises, and repayment plans.⁶⁸

Beginning January 1, 2017, VA is proposing to change the copayment rate of nonservice-connected conditions that are treated in an outpatient setting. Currently, medication copayments are either \$8 or \$9 per 30-day or less supply. The new proposed rule, if adopted in 2017, would place medications into three tiers. For a 30-day or less supply of medication, Tier 1 medications would cost \$5; Tier 2 would cost \$8; and Tier 3 would cost \$11.⁶⁹

Can Veterans who Receive Health Care from the VA for Service-Connected Conditions Contribute Toward Health Savings Accounts (HSAs)?⁷⁰

Provided the veterans meet certain eligibility criteria, they could contribute towards health savings accounts (HSAs).

The Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (P.L. 114-41) expands the ability of veterans who receive care from the VA for service-connected conditions to contribute towards health savings accounts.

HSAs are one way individuals can pay for unreimbursed medical expenses (deductibles, copayments, and services not covered by health insurance) on a tax-advantaged basis.⁷¹ Only eligible individuals can establish and fund HSAs. To be an eligible individual, one must be covered under a qualifying high-deductible health plan (HDHP),⁷² cannot have any other insurance or coverage except what is permitted,⁷³ and cannot be claimed as a dependent on a different taxpayer's return. In general, an individual's eligibility to contribute to an HSA is determined on a monthly basis.

⁶⁷ CRS summary based on U.S. Department of Veterans Affairs, "Copayments for Medications in 2014," 78 *Federal Register* 79315, December 30, 2013. 2016 Copayment Rates" (IB 10-430), http://www.va.gov/HEALTHBENEFITS/resources/publications/IB10-430_copay_rates.pdf (dated January 2016). Accessed on March 15, 2016

⁶⁸ U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Identifying the Causes of Inappropriate Billing Practices by the U.S. Department of Veterans Affairs*, 111th Cong., 1st sess., October 15, 2009 (Washington: GPO, 2010), p. 43.

⁶⁹ Department of Veteran Affairs, "Copayments for Medications Beginning January 1, 2017," 81, 5 *Federal Register* 196, January 5, 2016.

⁷⁰ This section was written by (name redacted), Analyst in Health Care Financing, Congressional Research Service.

⁷¹ The rules governing health savings accounts are codified in Section 223 of the Internal Revenue Code (IRC).

⁷² A qualified high deductible health plan is one that has a minimum deductible and an annual out-of-pocket limit. For 2015, the minimum deductible is \$1,300 for single coverage and \$2,600 for family coverage. The 2015 annual out-of-pocket limit is \$6,450 for single coverage and \$12,900 for family coverage.

⁷³ Permitted insurance and coverage includes, but is not limited to, property insurance, hospital indemnity insurance, insurance for a specified disease or illness, and coverage for dental care, vision care, or long-term care.

Previously, receiving care from VA limited veterans' ability to contribute to HSAs. Veterans who were otherwise eligible to contribute to an HSA (i.e., veterans who were eligible individuals) could contribute in a month only if they had not received care from the VA in the preceding three months.

Veterans who were otherwise eligible but had received care from the VA in the preceding three months were not allowed to contribute to the HSA for the month.⁷⁴

Under P.L. 114-41, individuals are not prohibited from contributing to an HSA merely because they receive medical care from the VA for a service-connected disability. In other words, individuals who are otherwise eligible to contribute to an HSA will not be prevented from doing so merely because they receive care from the VA. This change went into effect January 1, 2016.

Can the VA Bill Private Health Insurance?

The VA has the authority to bill most health care insurers for nonservice-connected care provided to veterans enrolled in the VA health care system.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), enacted into law in 1986, gave the VHA the authority to bill some veterans and most health care insurers for nonservice-connected care provided to veterans enrolled in the VA health care system to help defray the cost of delivering medical services to veterans.⁷⁵ This law also established means testing for veterans seeking care for nonservice-connected conditions. Congress authorized the VHA to collect reasonable charges for medical care or services (including the provision of prescription drugs) from a third party to the extent that the veteran or the provider of the care or services would be eligible to receive payment from the third party for (1) a nonservice-connected disability for which the veteran is entitled to care (or the payment of expenses of care) under a health plan contract;⁷⁶ (2) a nonservice-connected disability incurred as a result of the veteran's employment and covered under a worker's compensation law or plan that provides reimbursement or indemnification for such care and services;⁷⁷ or (3) a nonservice-connected disability incurred as a result of a motor vehicle accident in a state that requires automobile accident reparations (no fault) insurance.⁷⁸ Similarly, the VHA can receive payments from Medicare supplemental coverage plans for nonservice-connected conditions for which the veteran receives care at VHA facilities.

Veterans are not responsible for paying any remaining balance of the VA's insurance claim not paid or covered by their health insurance. Any payment received by the VA is used to offset "dollar for dollar" a veteran's VA copayment responsibility.⁷⁹

⁷⁴ Internal Revenue Service, *Health Savings Accounts – Additional Qs&As*, Notice 2004-50, August 16, 2004.

⁷⁵ Veterans' Health-Care and Compensation Rate Amendments of 1985 ([http://www.congress.gov/cgi-lis/bdquery/R?d099:FLD002:@1\(99+272\)](http://www.congress.gov/cgi-lis/bdquery/R?d099:FLD002:@1(99+272))), P.L. 99-272.

⁷⁶ 38 U.S.C. §1729(a)(2)(D), and 38 C.F.R. §17.101(a)(1)(i).

⁷⁷ 38 U.S.C. §1729(a)(2)(A), and 38 C.F.R. §17.101(a)(1)(ii).

⁷⁸ 38 U.S.C. §1729(a)(2)(B), and 38 C.F.R. §17.101(a)(1)(III).

⁷⁹ U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Identifying the Causes of Inappropriate Billing Practices by the U.S. Department of Veterans Affairs*, 111th Cong., 1st sess., October 15, 2009 (Washington: GPO, 2010), p. 43.

Can the VA Bill Medicare?

The VA is statutorily prohibited from billing Medicare⁸⁰ in most situations. Additionally, veterans are responsible for paying all Medicare premiums, deductibles, and co-insurance. The VA has no authority to reimburse Medicare beneficiaries for expenses they incur to obtain medical care under Medicare.⁸¹

In general, Medicare is prohibited from reimbursing for any services provided by a federal health care provider unless

- the provider is determined by the Secretary of Health and Human Services (HHS) to be providing services to the public as a community institution or agency;
- the provider is providing services through facilities operated by the Indian Health Service (IHS),⁸² or
- the services were provided in an emergency (in a hospital setting).

Medicare is also prohibited from making payments to any federal health care provider who is obligated by law or contract to render services at public expense.⁸³ Therefore, the VHA is statutorily prohibited from receiving Medicare payments for services provided to Medicare-covered veterans.⁸⁴ Although the legislative history does not indicate congressional intent for this decision, “a safe assumption to be drawn from the exclusion of Medicare [from paying for health care services provided through other federal entities] is that Congress wanted to avoid the unnecessary transfer of federal funds from Medicare to the VA when the money is all coming out of the same coffer.”⁸⁵

It should be noted that there is a narrow exception to this statutory prohibition of Medicare reimbursing the VHA. Under current law the VHA can be reimbursed by Medicare (notwithstanding any condition, limitation, or other provision in title XVIII of the Social Security Act) when the VA provides services to Medicare-covered individuals who are not eligible for care under Chapter 17 of Title 38 United States Code (U.S.C.)⁸⁶ and who are afforded VA care or services under a “sharing” agreement.⁸⁷ Medicare can reimburse veterans for VA copayment amounts charged for VA authorized services provided by non-VA sources (or provide credit toward Medicare may also pay for (Medicare covered) services for which the VA does not make any payment. “For example, if a veteran is authorized ‘fee basis’ care at VA expense for a service-

⁸⁰ “Medicare is a federal insurance program that pays for covered health care services of qualified beneficiaries.” CRS Report R40425, *Medicare Primer*, coordinated by (name redacted) and (name redacted).

⁸¹ 42 U.S.C. §1395y(a)(3)).

⁸² In 1976, Congress authorized Medicare and Medicaid payments for services delivered in Indian health facilities (whether operated by the IHS or Tribes) through amendments to the Social Security Act made in the Indian Health Care Improvement Act of 1976 (P.L. 94-437) (IHCIA). This was permanently authorized by the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148).

⁸³ 42 U.S.C. §§1395f(c), 1395n(d), 1395f(a).

⁸⁴ 42 U.S.C. §1395f(c), and 38 U.S.C. §1729(i)(1)(B)(i).

⁸⁵ *United States v. Blue Cross & Blue Shield of Maryland, Inc.*, 989 F.2d 718, 727 n. 5 (4th Cir.).

⁸⁶ Chapter 17 of Title 38 U.S.C. details the eligibility criteria as well as programs relating to the provision of medical care, and nursing home care, among other things, for veterans and their eligible dependents.

⁸⁷ 38 U.S.C. §8153(d). A sharing agreement is a written contract that allows VHA to buy, sell, or exchange health care resources and services with non-VA facilities. VHA could enter into noncompetitive sharing agreements with affiliated institutions (such as affiliated medical schools—affiliated with VHA under 38 U.S.C. §7302) and other entities associated with these affiliated institutions (such as university hospitals).

connected back injury, and treatment for a different condition for which the VA does not pay, Medicare can pay for the (covered) services that are not reimbursable by the VA.”⁸⁸

⁸⁸ Ibid. Fee basis care is care purchased by the VA from non-VA/community providers, as compared to VA care that is delivered by VA providers in VA-owned and VA-operated sites of care.

Appendix A. VA Priority Groups and Their Eligibility Criteria

The VA classifies veterans into eight enrollment Priority Groups based on an array of factors including (but not limited to) service-connected disabilities or exposures,⁸⁹ prisoner of war (POW) status, receipt of a Purple Heart or Medal of Honor, and income. The criteria for each Priority Group are summarized in **Figure A-1**.

The eight Priority Groups fall into two broad categories. The first group is composed of veterans with service-connected disabilities or with incomes below an established means test. These veterans are regarded by the VA as “high priority” veterans, and they are enrolled in Priority Groups 1-6. Veterans enrolled in Priority Groups 1-6 include the following:

- veterans in need of care for a service-connected disability;
- veterans who have a compensable service-connected condition;
- veterans whose discharge or release from active military, naval, or air service was for a compensable disability that was incurred or aggravated in the line of duty;
- veterans who are former prisoners of war (POWs);
- veterans awarded the Purple Heart;
- veterans who have been determined by the VA to be catastrophically disabled;
- veterans of World War I;
- veterans who were exposed to hazardous agents (such as Agent Orange in Vietnam) while on active duty; and
- veterans who have an annual income and net worth below a VA-established means test threshold.

The VA looks at applicants’ gross household income (earned and unearned) and deductible medical expenses for the previous year to determine their specific priority categories and whether they have to pay copayments for nonservice-connected care.⁹⁰ In addition, veterans are asked to provide the VA with information on any health insurance coverage they have, including coverage through employment or through a spouse. The VA may bill these payers for treatment of conditions that are *not* a result of injuries or illnesses incurred or aggravated during military service.

The second group of veterans is composed of those who do not fall into one of the first six priority groups—primarily veterans with nonservice-connected medical conditions and with incomes above the VA-established means test threshold (see **Table A-1**). These veterans are enrolled in Priority Groups 7 or 8.⁹¹

⁸⁹ For example, veterans who may have been exposed to Agent Orange during the Vietnam War or veterans who may have diseases potentially related to service in the Gulf War may be eligible to receive care.

⁹⁰ To align the VA’s health care program with other federal health care programs’ financial assessment requirements, effective January 1, 2015, the VA stopped collecting veterans’ net worth information for purposes of financial assessment for health benefits.

⁹¹ The VA considers a veteran’s gross household income (both earned and unearned income, as well as his/her spouse’s and dependent children’s income) for the previous year. Earned income is usually wages received from working. Unearned income includes interest earned, dividends received, money from retirement funds, Social Security payments, annuities, and earnings from other assets. The number of persons in the veterans’ family will be factored into the (continued...)

Figure A-1.VA Priority Groups and Their Eligibility Criteria

Priority Group 1
<ul style="list-style-type: none"> • Veterans with service-connected disabilities rated 50% or more disabling • Veterans determined by VA to be unemployable due to service-connected conditions
Priority Group 2
<ul style="list-style-type: none"> • Veterans with service-connected disabilities rated 30% or 40% disabling
Priority Group 3
<ul style="list-style-type: none"> • Veterans who are former POWs^a • Veterans awarded the Purple Heart^b • Veterans in receipt of the Medal of Honor^c • 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
<ul style="list-style-type: none"> • Veterans who are receiving aid and attendance or housebound benefits • Veterans who have been determined by VA to be catastrophically disabled
Priority Group 5
<ul style="list-style-type: none"> • Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose previous year's gross household income (earned and unearned income) is below the established VA means test thresholds^d • Veterans receiving VA pension benefits • Veterans eligible for Medicaid benefits
Priority Group 6
<ul style="list-style-type: none"> • Compensable 0% service-connected veterans • Mexican Border War veterans • Veterans solely seeking care for disorders associated with the following events: <ul style="list-style-type: none"> • Exposure to herbicides while serving in Vietnam between January 9, 1962, and May 7, 1975; or • Ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or • Project 112/SHAD participants; or • For disorders associated with service in the Gulf War and who served between August 2, 1990, and November 11, 1998; 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, as follows: <ul style="list-style-type: none"> • Veterans discharged from active duty before January 27, 2003 and did not enroll on or before such date, for a three-year period beginning on January 27, 2008; • Veterans discharged from the active duty after January 27, 2003, for a five-year period beginning on the date of such discharge or release; or • Veterans discharged from active duty after January 1, 2009, and before January 1, 2011, but did not enroll during the five-year period of post discharge eligibility there is a one-year period beginning on the date of the enactment of the Clay Hunt Suicide Prevention for American Veterans Act (P.L. 114-2). • Veterans who served on active duty at Camp Lejeune in North Carolina for not less than 30 days during the period beginning on August 1, 1953, and ending on December 31, 1987, for any of the 15 medical conditions specified in 38 U.S.C. 1710(e)(1)(F).
Priority Group 7
<ul style="list-style-type: none"> • Veterans who agree to pay specified copayments with income above the VA means test threshold and income below the VA national geographic income thresholds
Priority Group 8
<ul style="list-style-type: none"> • Veterans who agree to pay specified copayments with income above the VA means test threshold and the VA national geographic threshold. Priority Group 8 is further broken down into Subpriority Groups: <ul style="list-style-type: none"> • Subpriority a: Noncompensable 0% service-connected and enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status • Subpriority b: Noncompensable 0% service-connected and enrolled on or after June 15, 2009, whose income exceeds the current VA means test threshold or VA national geographic income thresholds by 10% or less • Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status • Subpriority d: Nonservice-connected veterans enrolled on or after June 15, 2009, whose income exceeds the current VA means test threshold or VA national geographic income thresholds by 10% or less • Subpriority e: Noncompensable 0% service-connected veterans not meeting the above criteria (currently not eligible for enrollment) • Subpriority g: Nonservice-connected veterans not meeting the above criteria (currently not eligible for enrollment)

Source: Prepared by CRS based on information from the Department of Veterans Affairs.

(...continued)

calculation to determine the applicable income threshold. 38 C.F.R. §17.36(b)(7).

Notes: Service-connected disability means, with respect to disability, that such disability was incurred or aggravated in the line of duty in the active military, naval or air service.

- h. Veterans who are former prisoners of war (POWs) are placed in Priority Group 3. This change occurred with the enactment of the Former Prisoner of War Benefits Act of 1981 (P.L. 97-37) on August 14, 1981.
- i. Veterans in receipt of a Purple Heart are in Priority Group 3. This change occurred with the enactment of the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) on November 30, 1999.
- j. Veterans in receipt of the Medal of Honor are in Priority Group 3. This change occurred with the enactment of the Caregiver and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) on May 5, 2010.
- k. To align VA's health care program with other federal health care programs' financial assessment requirements, effective January 1, 2015, VA stopped collecting veterans' net worth information for purposes of financial assessment for health benefits.

Table A-1. National Income Thresholds for CY2016

Veterans with—	Free VA prescriptions and travel benefits for veterans with incomes of—	Free VA prescriptions and travel benefits for veterans with Aid and Attendance incomes of—	Free VA prescriptions and travel benefits for veterans with Housebound Benefit incomes of—	Free VA Health Care for veterans with incomes of—	Enrollment in Priority Group 8 for veterans with incomes of—
No dependents	\$12,868 or less	\$21,466 or less	\$15,725 or less	\$31,978 or less	\$35,176 or less
1 dependent	\$16,851 or less	\$25,488 or less	\$19,710 or less	\$38,374 or less	\$42,211 or less
2 dependents	\$19,049 or less	\$27,646 or less	\$21,908 or less	\$40,572 or less	\$44,629 or less
3 dependents	\$21,247 or less	\$29,844 or less	\$24,106 or less	\$42,770 or less	\$47,047 or less
4 dependents	\$23,445 or less	\$32,042 or less	\$26,304 or less	\$44,968 or less	\$49,465 or less
For each additional dependent above two dependents, add:	\$2,198	\$2,198	\$2,198	\$2,198	\$2,198

Source: Table prepared by CRS based on information from the Department of Veterans Affairs.

Notes: For geographic variations, see <http://nationalincomelimits.vaftl.us/>. Accessed on March 15, 2016.

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