In 1995, The American Legion presented its proposed vision for the Department of Veterans Affairs’ (VA’s) Veterans Health Administration (VHA) in the 21st Century. The American Legion’s goal is to increase timely access to quality health care for the entire veterans’ community, including their eligible family members. The two-tier strategy involves expanding the patient population and generating third-party reimbursement.

The GI Bill of Health’s (GIBOH) underlining principal is to provide the full-spectrum of health care for all service-connected veterans in the treatment of their service-connected medical conditions. Other veterans and eligible dependents would also have access to the full-spectrum of health care provided that they were willing to pay for their coverage on a premium basis or through third-party reimbursements. Ironically, shortly after the GI Bill of Health was created, the Department of Defense (DoD) created a similar “for-profit” version called TRICARE.

Yet, as we revisit the GIBOH six years later, many of the essential elements advocated in that “bold and visionary proposal,” have been passed in Congress under other names and titles. The GI Bill of Health is becoming a reality through a “piecemeal” process.

**Increase Access to VHA Health Care**

Six years ago, approximately 2 million veterans had access to the VHA medical system. Due to complicated rules and regulations, the vast majority of veterans (27 million) were basically locked out of the system. The American Legion advocated opened enrollment to all veterans.

Public Law 104-262 authorized eligibility reform, allowing all veterans access to VHA health care -- within existing appropriations. This was welcomed legislation; however, it did not identify new revenue streams to supplement annual discretionary appropriations. Furthermore, it established seven priority groups for access to care.

**Enrollment**

The GIBOH recommended that veterans and their dependents be allowed to enroll in the VHA healthcare system. By enrolling veterans into VHA, The American Legion believed VHA would have a better idea of the health care demands being placed on the system, identify new revenue streams to help supplement annual discretionary appropriations, and put more patients into an integrated healthcare plan. The American
Legion thought an enrollment plan would better solidify the patient population and help identify how their health care would be paid for prior to treatment.

The current enrollment plan identifies the priority level of care each veteran is authorized and potential third-party insurers. However, it does not recognize Medicare as a potential third-party insurer, but does identify Medicare supplement insurers as possible third-party payers.

**Bill, Collect, and Retain All Third-Party Reimbursements**

The GI Bill of Health realized that opening access to VHA would require additional funding; therefore, a core recommendation was to allow VHA to bill, collect, and retain all premiums, co-payments, deductibles and other third-party reimbursements received from veterans and their eligible family members.

Congress now allows VHA to bill, collect, and retain all third-party reimbursements. Unfortunately, the Centers for Medicare and Medicaid Services’ (CMS, formerly the Health Care Financial Agency or HCFA) rules prohibits VHA for billing CMS for the treatment on any medical treatment or services provided to Medicare-eligible veterans or their Medicare-eligible dependents. (See Medicare subvention section below.)

**Expanding Access Points**

Another major GIBOH component supported expanding the number of access points by entering sharing agreements with local healthcare providers. This recommendation would allow greater access to VA’s network of health care facilities and move health care closer to where veterans and their families lived.

Since 1995, the number of access points has increased dramatically because of the creation of Community Based Outpatient Clinics (CBOCs). Throughout VHA, a focused shift from inpatient to outpatient has reduced the number of hospital beds and has increase the number of outpatient visits. During this period VHA has doubled the number (4 million) of patients seen in a fiscal year. The objective of integrated health care is to provide quality health care in the most appropriate medical setting.

**Allowing Dependents Access to VHA Health Care**

In the GIBOH, The American Legion advocated opening access to the VHA health care system to include a veteran’s eligible family members. It makes sense for a family to be treated by the same health care provider. When the blueprint for the GIBOH was created in 1995, allowing dependents access to VA health care was met strong resistance from Congress, as well as most of the major VSOs. However, many VA officials in Central Office and the networks recognize the boon that it would give to their fiscal solvency and to their ability to attract new employees and residencies.
To date, some dependents are receiving VA treatment due to subcontracts with TRICARE – DoD for-profit health care providers.

**Defined Health Benefits Packages**

The American Legion wanted veterans and their families to be able to select the specific health benefits package that would be best suited for their particular health care needs. Therefore, it was decided that each veteran would have his choice of basic or comprehensive coverage, as well as an opportunity to select a supplemental health benefits package under the GIBOH. The supplemental health benefits package would include the specialized services provided by VHA to include long-term care, blind rehabilitation, spinal cord rehabilitation, and other such programs. The Secretary of VA would be given the authority to establish an individual and family schedule of premiums for each benefits package. Service-connected veterans would continue to receive treatment at no cost.

Currently, VHA has two defined health care benefits packages: veterans requiring critical care and veterans in need of regular care. Although legislation was enacted addressing billing for long-term care, the rules establishing the procedures have yet to be produced by VHA.

**Medicare Subvention**

Although Medicare is a Federal, third-party health care insurer, a Medicare-eligible veteran, enrolled and treated by VHA, cannot use Medicare healthcare dollars to pay for the treatment of nonservice-connected medical conditions -- even those normally covered by Medicare. The GIBOH would allow Medicare-eligible veterans to choose VHA as their primary health care provider for Medicare+Choice or fee-for-service options.

Early in the Bush Administration, HCFA was renamed CMS. Although VA Secretary Principi and HHS Secretary Thompson seem to be receptive to some form of Medicare subvention, VHA and CMS have not yet reached agreement. CMS Director Tom Scully continues to vocally oppose this concept claiming VA is already funded to care for Medicare-eligible veterans through annual discretionary appropriations. However, The American Legion argues that Medicare-eligibility is not a criterion for access to VHA health care, DoD health care or Indian Health Services (IHS). Yet DoD and IHS both enjoy Medicare Subvention. Under current law, Medicare-eligible veterans (treated for nonservice-connected medical conditions -- even those covered by Medicare) cannot use their Medicare coverage to pay their VHA medical bills. Ironically, VHA can bill some veterans or their private health care insurers, to include Medicare supplemental insurers.