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OFFICE OF MANAGEMENT AND BUDG
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March 1, 1995

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MEMORANDUM FOR ALICE RIVLIN
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FROM: Nancy-Ann Min and Dorothy Berry
Co-chairs, NPR Advisory Team

SUBJECT: Department of Veterans Affairs NPR-II Briefing

Attached is a copy of the Department of Veterans Affairs' (VA) presentation to the NPR-II Steering Committee which includes a summary of the proposals recommended and considered by VA and the NPR Advisory Team (Tab A). Additionally, I am including a brief item-by-item assessment of the options to assist you during the session with VA (Tab B). The presentation is currently scheduled for Thursday, March 2nd, at 3:00 in Room 248. VA attendees will include:

Deputy Secretary Hershel Gober
Deputy Chief of Staff Rich Pell
VA Reinvention Coordinator Ray Wilburn
Under Secretary for Health Ken Kizer
Under Secretary for Benefits John Vogel
Director, Loan Guaranty Service Keith Pedigo
General Counsel Mary Lou Keener
Assistant Secretary for Finance Information & Resource Management Mark Catlett
Assistant Secretary for Congressional Affairs Ed Scott
Director, National Cemetery System Jerry Bowen

VA's FY 1996 total discretionary budget authority is $19.2 billion. The Veterans Health Administration (VHA) portion totals $17.3 billion, and includes the operation of 174 hospitals, 370 out-patient clinics, 133 nursing homes, and 39 domiciliaries. The Veterans Benefit Administration (VBA) discretionary budget is $0.132 billion and it includes 58 regional claims processing offices and 204 VetsNet outreach offices. The construction budget is $0.787 billion, and other VA governmental operating expenses total $1.024 billion.

Section 1102 of the Veterans' Benefits Improvements Act of 1994 established an FTE floor for VA of 224,377, effective through the end of FY 1999. This floor does not include the approximately 5,400 FTE paid for out of unappropriated funds. This law precludes VA from reducing its FTE below the floor unless (1) VA has insufficient funds to support this number of FTE, or (2) another law overrides the floor. VA is currently at this floor. Thus, any proposal or set of proposals intended to streamline VA must address this provision. For example, in cases where we are suggesting privatization, it could actually cost money if we are paying a contractor and must hire elsewhere in the Department to maintain the floor.

The NPR Advisory Team agrees with the VA that much of what the Department does to serve veterans should be viewed as an inherently federal function. The VA has offered to move forward with privatizing in some areas (such as food service in hospitals) where it is not essential that the Federal government be providing the service. In other areas, such as the home loan program, we have encouraged them to go further: *why is it essential for the VA to be in the real estate business by holding foreclosed properties and then providing subsidized loans to the general public to purchase these properties?*

In the critical area of VA health care, we would observe that VA has had 172 hospitals for 4 years, while total available beds have dropped 24% and utilization of these beds is dropping still. Most of the health care recommendations submitted to NPR-II by VA try to solve the problem by ***expanding*** the system to fill these hospitals. Another approach might be to begin to tackle the difficult problems of downsizing and moving away from inpatient hospital care.

VA's FY 1996 budget incorporates $4.4 billion in budget authority reductions below the FY 1996 level for FY 1997 - FY 2000. The VA NPR-II proposals total $104 million. As requested, the Advisory Team identified some additional options to assist in meeting the FY 1997 - FY 2000 targets for budget authority reductions. These options are outlined in the Attachment 1 table to Tab B.

cc: Bill Halter

Clinton Presidential Records
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This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Divider Title: A

DEPARTMENT OF VETERANS AFFAIRS

REINVENTING GOVERNMENT

PHASE II

February 27, 1995

DEPARTMENT OF VETERANS AFFAIRS
OPTIONS PAPER

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February 28, 1995

Material on this page was developed in response to requirements of the Vice President's Reinventing Government initiative. As such, it is for discussion purposes only, and shall not be construed to represent the views or the policy of the Department of Veterans Affairs.

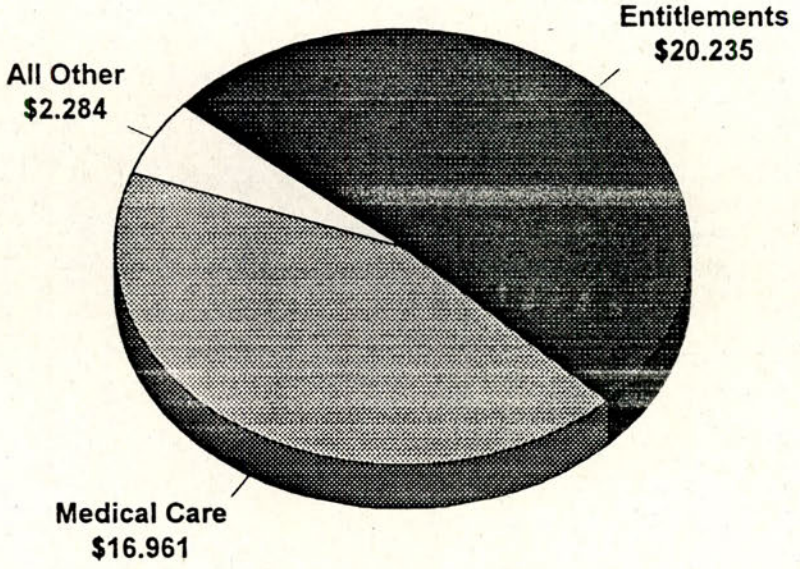
DEPARTMENT OF VETERANS AFFAIRS
OPTIONS PAPER

Overview

Programs and benefits for veterans in the United States date back to 1636 when Plymouth Colony was at war with the Pequot Indians. The Veterans Administration was created in 1930 with the merger of three separate agencies. The Department was established in 1989. Today, VA administers non-health benefits from 58 benefits offices; operates 114 national cemeteries; and manages the nation's largest public health care system with 173 medical centers, 133 nursing homes, 39 domiciliaries, 200 veterans counseling centers, and 376 clinics. VA's FY 1996 Budget Submission is $39.48 billion, with $16.96 billion for medical care, $20.24 billion for benefits transfers to disabled and low income veterans, and $2.28 billion for general operating and miscellaneous expenses. Average employment will be 224,377, with an additional 5,700 medical care cost recovery and canteen employees that are exempt. VA functions as a unified Department delivering an integrated and comprehensive program of benefits and services in a high quality, cost effective, and timely manner to serve veterans and their families.

Department of Veterans Affairs

Discretionary/Entitlements Budget Authority



1996 Request – $39.480 Billion

Mission and Goals

The Department's mission is to serve America's 26.5 million veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support, and recognition earned in service to this Nation. A wide variety of VA programs have been created, each intended to meet specific veteran needs. They include compensation for disabilities incurred in service, education, guaranteed home loans, burial benefits, and life insurance. In addition to providing direct health care, VA's medical missions include research, education and training, and emergency preparedness. National cemeteries provide burial services and are shrines to the heroes of the past.

VA examined its basic missions, reviewed all of its major programs and concluded that benefits and services for veterans are inherently the responsibility of the Federal government and cannot be terminated. Veterans wore the uniforms of the United States and the United States is responsible for providing the benefits and services that are due them. It would not be possible to devolve this responsibility on any large scale to states or local governments, although VA has for many years offered grant programs to states for veteran cemeteries and veteran homes. Although veterans programs, by and large, cannot be terminated or devolved, significant improvements can, and should, be made. Working with our Advisory Group, VA is proposing a number of specific initiatives for consideration. These include one program elimination and significant privatizations, consolidations, reengineerings, and franchising.

Options

1. Eliminating the Manufactured Home Loan Program

The number of veterans obtaining VA guaranteed manufactured home loans has declined significantly over the years, from a high of 13,502 in FY 1983 to only 24 in FY 1994. Manufactured home loan foreclosure rates are significantly higher than those for loans for site-built homes (a cumulative rate of 38.7 percent compared to 5.58 percent) with no sign of improvement. Due to the low volume, there is virtually no lender interest in using the VA manufactured home loan program; however, VA must maintain expertise in consumer installment finance, which differs in many respects from traditional real estate finance. If the VA manufactured home loan program were eliminated, veterans would still be able to purchase and finance such homes under the FHA Title 1 program or through conventional loans which have similar terms as VA manufactured home loans, including a 5 percent downpayment requirement. Veterans would still be able to purchase permanently sited units (and considered as real estate) with traditional no downpayment, 30 year VA guaranteed loans. Five-year savings of $575,000 would be realized by avoiding future foreclosures. Due to the very low volume, no FTE savings can be expected.

2. Eliminating Acquisition of Foreclosed Properties

Currently, VA acquires properties from mortgage lenders following foreclosure of defaulted guaranteed home loans when, following a statutorily-based formula, it determines that it is cost-beneficial to the Government to do so. These properties are then resold to the general public to recover the Government's investment. To facilitate the sales, VA offers direct financing to buyers at terms which are competitive with those available in the conventional mortgage market. A feasibility study will be conducted to determine (1) if it would be cost-beneficial to discontinue acquiring foreclosed properties, instead paying the VA guaranty and requiring lenders to retain and dispose of the properties themselves, and (2) if VA should no longer offer direct financing to buyers of its existing property inventory.

3. Contracting Out Portfolio Loan Servicing and Accounting

VA runs a complete mortgage servicing operation for a portfolio of approximately 29,000 loans with a value of $1.1 billion. Most of these loans were made to finance the sale of property which VA acquired through the operation of the Loan Guaranty Program. VA normally sells loans every four months, however the bulk of the loans in this portfolio are ones that cannot be sold because they are in default, have a bad payment history, or are otherwise unsalable. In the private sector, loan holders often hire subcontractors to service their mortgages because these companies have more current equipment, more experienced staff and, because of economies of scale, can do so at a lower cost. By following this example, and subcontracting servicing, we estimate VA will save $16.8 million ($34.3 million discretionary savings and $17.5 million in mandatory outlays) over 5 years and 171 FTE. It would also mean that a new information system, necessary in order to comply with new legal requirements regarding tax and escrow accounts, would not be required.

4. Privatizing Insurance Operations

Seven veterans life insurance programs are administered directly by VA. These programs cover 2.8 million veterans and coverage amounts to $25.7 billion. In many ways these programs operate as a mutual life insurance company. Administrative costs are paid from appropriated funds by legal contract, not from premiums or dividends. VA is proposing to conduct a feasibility study of contracting out the administrative functions of these programs.

5. Consolidating VA Insurance Activities

Savings can be achieved through consolidation of all VA Insurance activities at Philadelphia. Currently, 86 percent of VA insurance staffing is located at Philadelphia with the remainder at St. Paul, Minnesota. The costs and effect on St. Paul employees, will be minimized by phasing the consolidation over three years, FY 1997 to 1999. The estimated five-year savings will be $2.2 million and 16 FTE.

6. Using Electronic Benefits Transfer for VA's Education Program

We will reinvent the administration of the GI Bill Education Program by replacing the current paper-based claims processing with an expert system. Enrollment information from training facilities will be transmitted to VA, automatically compared to the veteran's' record, and education assistance funds will be transferred to the student's bank account. The expert system should be in place by FY 1999, reducing education processing staff by 40 percent (240 FTE). This will also improve customer service by improving accessibility, timeliness, and quality. Five-year savings will be $21.6 million.

7. Reforming VA Health Care

Currently the effort required for a veteran to receive care from VA can be confusing and frustrating. Some examples can be described as absurd. From the decision process to ensuring that veterans are treated in the most clinically appropriate setting, the need for change and streamlining is evident. Existing law makes it impossible for VA to effectively manage care and promotes the use of more expensive and often unnecessary inpatient care. VA is forced to provide care in a manner that provides few incentives for cost containment. VA proposes several options to correct this situation ranging from simple eligibility reform to allowing VA to offer a health plan in which veterans will enroll and pay premiums. The simplest option, (Option A - Fixing Prosthetics Eligibility) would enable VA to treat on an outpatient basis and provide of devices such as crutches; this would be budget neutral and legislation should be sought immediately. Other options, larger in scope, are offered.

Option B-1, Permit Care to be Provided in Appropriate Settings
Option B-2, Treat Category A patients without restrictions but use current restrictions for other veterans
Option C, Provide VA with Flexibilities to Compete and Cooperate
Option D, Form a VA Quasi-Government Corporation

The B Options can provide budget neutrality by apportioning resources. Option C, providing VA with flexibilities to compete and offer health plans, has uncertain budget implications that can only be determined prospectively. Option D, forming a quasi-governmental corporation, is the subject of a feasibility study by a non-Federal entity due to be completed in November 1995. It may be appropriate to conduct pilot tests at selected locations to identify the budget implications of Options C and D. Each option would enable VA to better meet the needs of the customers it serves - the veteran.

8. Enhancing Veterans' Health Care Choices

Currently, veterans who may wish to choose VA as their health care provider do not have that option because VA's medical care appropriation is insufficient to allow the VA health care delivery system to provide services to all veterans. Only those with service-connected disabilities and low-income veterans are generally covered by the appropriation. Other higher-income, non-service connected veterans should be able to choose VA and bring their insurance or personal resources to VA to cover the cost of their care. To ensure that these veterans have this choice available to them, VHA proposes to recover and retain revenues from Medicare and other third party payers for certain care and for designated categories of veterans. By permitting VHA access to these revenues, VA will be able to expand the choices of veterans and potentially offer some savings to these programs that are now paying for the health care needs of these veterans in what VHA believes are more expensive settings. VA believes that these proposals would be budget neutral and would not result in new expenditures from Medicare. Reimbursement from Medicare for current VA users would be offset by that amount in VA's discretionary account. VA proposes to work with OMB, NPR, and HCFA to develop a demonstration project. Implementation of the demonstration will require PAYGO offsets or adjustment to the caps.

9. Integrating, Consolidating And Privatizing

In support of restructuring efforts to improve the delivery of health care services to eligible veterans, VA has been proceeding with efforts involving facility integrations, service (program) consolidations and mergers, delegations of authority, consolidated contracting, and procurement streamlining. In addition to these ongoing efforts, VA is proposing several initiatives which the potential exists for greater efficiencies and savings by consolidating or contracting out for the services. These include laundry and housekeeping services, VA Police, food management, grounds' maintenance, transportation , painting and drafting services, and construction project management. Contracting processing of cemetery headstone/marker applications for the National Cemetery System is also proposed. A total five-year savings of $35.48 million and a reduction of 8,510 FTE could be realized.

10. Simplifying the Means Test

VA is required by current law to assess the "means" of a veteran to pay for health care in the context of determining eligibility. Currently, that process involves a substantive interview process once each year or each time the veteran seeks care at a different VA medical center. A verification matching program with income records of the Internal Revenue Service (IRS) and Social Security Administration is also performed after the fact. A substantial simplification of the means testing process is proposed which, executed in partnership with IRS, would substantially improve customer service and would reduce the human time and effort committed to the

effort. The veteran would be asked for permission to access his or her IRS information and would affirm that no significant changes in income or net worth had occurred. Five-year savings of $10.5 million and 280 FTE are expected.

11. Enhancing VA/DoD Health Care Sharing and Integration

VA and DoD both provide direct medical care to a variety of beneficiaries throughout the U.S. DoD operates three direct care systems (Army, Navy and Air Force) as well as the CHAMPUS system for retirees and dependents who receive care at locations other than military medical treatment facilities. VA proposes that the Vice President task the Secretaries of Defense and Veterans Affairs to investigate and report on the feasibility of greatly increasing sharing and integration of the VA and DoD health care systems. Potential savings and program improvements are expected from reductions in overhead, infrastructure (possible closure of redundant facilities), personnel needs, common administrative systems, and uniform health benefits packages. Savings cannot be estimated at this time, but considering that the combined VA and DoD health care budgets are approximately $30 billion, the possible savings could be very significant.

Summary Cost Information *

($000)	FY 1996 program levels in Budget	Estimated Savings in FY 1996	Estimated Savings in FY 1997	Estimated Savings in FY 2000	5-Year Cumulative Savings (FY 1996-2000)
Discretionary Budget Authority	19,245,000	12,438	23,510	27,878	104,128
Discretionary Budget Outlays	19,006,513	12,438	24,510	27,878	104,128597
Mandatory Outlays	18,944,776	-3,800	-3,512	-3,041	-16,905
Governmental Receipts	1,129,130				
FTE Changes	230,077	2,512	4,207	9,217	9,217

* Savings and Costs for Options 7 and 8 are not included since both have multiple suboptions

Option Papers

1. ELIMINATION OF THE MANUFACTURED HOME LOAN PROGRAM

DISCUSSION: Since 1970, VA has had the authority to guarantee manufactured home loans. The number of veterans making use of the manufactured home loan program has declined significantly over the years. There is virtually no lender interest in using the program.

Fiscal Year	Number of Manufactured Home Loans
1984	13,110
1985	8,916
1986	6,022
1987	5,100
1988	2,071
1989	834
1990	434
1991	313
1992	126
1993	67
1994	24

OPTION: Eliminate VA's authority to guarantee manufactured home loans under the provisions of 38 USC 3712.

ADVANTAGES:

1. The manufactured home loan program has experienced extremely high foreclosure rates for a long period of time with no signs of improvement. Cumulatively through FY 1994, VA has paid guaranty claims on 38.7 percent of all manufactured home loans guaranteed, compared to a 5.58 percent foreclosure rate on site-built VA guaranteed home loans.

2. While the number of manufactured home loans is small, VA's obligation to guarantee these loans requires expertise in consumer installment finance, which differs in many respects from traditional real estate finance. Elimination of the manufactured home loan program would free VA from having to develop and retain this expertise.

3. Veterans would still be able to obtain VA financing to purchase manufactured homes that are permanently affixed to a foundation and treated as real estate under State law. These homes are considered the same as traditional site-built homes, and can be financed with no downpayment, 30 year VA guaranteed loans.

DISADVANTAGES:

o The manufactured home loan program is a source of financing for affordable housing. However, equivalent financing is available under the FHA Title 1 program. These FHA loans are available with 5 percent down and loan terms of 20 years for single-wide manufactured homes and 25 years for double-wides, the same terms as are available from VA, and with no use of the veteran's home loan entitlement. Conventional loans are also available with 5 percent down.

AREAS OF CONSIDERATION: Legislation would be required.

COST BENEFIT ANALYSIS: In FY 1994 VA guaranteed 24 mobile home loans (for credit reform only 13 loans actually closed in FY 1994). For budget purposes we have estimated 30 loans a year for FY 1997-2001. GOE resources to support new loan activity is minimal and spread around the country. Therefore, eliminating new loan originations produces no GOE savings. The only savings from this proposal is the subsidy appropriated to fund future loan foreclosures. Subsidy savings for the five year period FY 1997-2001 is estimated to be $728,000.

FY	Subsidy
1997	$136,000
1998	143,000
1999	145,000
2000	151,000
2001	153,000
	$728,000

2. Eliminating Acquisition of Foreclosed Properties

DISCUSSION:

1. OMB Proposal. OMB holds that the law should be changed so that, for future GI loans which are terminated, VA will not acquire the property.

VA claim payments would remain at the same level (i.e., claims will be calculated as they are now, VA will determine the net value of the property--which is its market value minus estimated costs of managing and reselling it and minus any estimated losses on resale--and pay a claim for the difference between the net value and the total loan balance).

Lenders will accept this change as an opportunity to make additional profits through REO acquisition and resale.

2. VA Position. VA holds that such a change will impact the Loan Guaranty programs benefit to veterans because:

a. Lenders will stop making GI loans; and/or,

b. Charge significantly higher fees to cover their perceived risks--these costs will be passed through to veterans in the form of higher interest rates and loan discount points.

AREAS OF CONSIDERATION: Legislation would be required. Lenders will strongly object. Similar proposals put forth in the past have been defeated by lender organizations using political and legal weapons.

BUDGET IMPACT. The proposal has no visible budget impact. The average GI loan which is foreclosed is 7.5 years old by the time the veteran loses the home. OMB's proposal will not result in a noticeable reduction in property acquisitions or VA staffing within a 5-year budget period.

PRELIMINARY COST BENEFIT ESTIMATE:

1. VA Costs versus FHA Program. VA's home loan program is a Government success story. For no-down-payment GI loans made in FY 1996, veterans will pay a funding fee of 2% and the Government will pay a subsidy of 1.56% to cover future costs. On the other hand, the FHA program requires a down payment and still must charge an insurance premium with a present value of 6.2% of the loan to cover future costs. There are two differences between the programs which account for VA's lower cost: VA helps veterans avoid foreclosure with supplemental servicing; and, VA minimizes the costs of foreclosure with an effective seller-financed property resale effort.

2. Higher Private Sector Costs. The private sector has expressed its attitude toward the risk involved in buying property for net value and reselling it to recover the investment. They have done so by an overwhelming choice of the buydown to avoid having to retain and resell REO: in the first quarter of FY 1995, 84% of all no-bids were bought down. Lenders can expect average losses equal to 10% of the original loan amount on the resale of each property acquired for net value. With an average GI loan of $96,000 and a foreclosure rate of 16% projected for FY 1996, lenders would charge veterans $1,500 on the average loan to cover their increased risk. Many will simply quit offering no-down-payment GI loans and restrict themselves to more profitable product lines (e.g., FHA loans).

ADDITIONAL CONSIDERATIONS:

The discussion between VA and OMB on this issue has devolved to the point where it rests on the question of whether VA is more (or less) effective than the private sector at REO disposal. We hold that VA is much more effective and that VA's effectiveness explains how we can acquire property at net value (i.e., the appraised value minus our estimated costs, including losses, of management and resale) and resell it without losing money while the private sector cannot do so and will not undertake the risk. VA's effectiveness is based on advantages we have as an organization with a high business volume--which make us more efficient--and on our ability to offer seller-financing. Separate papers are provided on each of these topics.

•PROPOSAL B: Eliminate the Vendee Loan Program

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•DISCUSSION:

OMB believes that the Government should not be in the business of financing sales of Real Estate Owned (REO).

VA information shows that cash sales of REO result in sizable losses in comparison with term sales.

1. In FY 1994 VA sold 18,889 properties on terms with an average selling price of $70,063 and an average gain of $3,826 over their initial net value; 3,552 were sold for cash at an average price of $44,954 and an average loss of $5,562. Assuming that the total debt at foreclosure is 15% higher than the average original loan amount, the spread represents an average loss equal to 15% of the original loan and the net cash sale loss equals 11% of the original loan.

2. Even during the 1980s, when VA's authority to use term sales was limited, data show the same bias. In FY 1988 VA sold 18,634 properties on terms with an average selling price of $41,794 and an average loss of $4,777 over their initial net value; 16,246 were sold for cash at an average price of $44,239 and loss of $9,711. The

additional loss on cash sales equates to 10% of the average original loan amount and the gross loss to 18.4%.

3. VA recently audited a national mortgage company which services loans and sells REO for a number of our loan sale trusts. Based in Nashville, it uses a national real estate brokerage to sell its properties. Sales are for cash and oversight in the field is limited. We found their recovery rate to be well below VA's. In fact, review of loss recovery data from all of VA's mortgage trusts showed losses greater than 35% of the original average loan amounts.

OPTIONS FOR PROPOSALS A AND B: VA and OMB have agreed to further study the feasibility of proposals A and B.

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3. Contracting Out Portfolio Loan Servicing and Accounting

•Discussion: Current Portfolio

• VA services 29,000 loans at 46 VAROs. All financial accounting for the portfolio is done by the Finance Divisions at almost every regional office. All accounting transactions and servicing actions depend on a 25-year-old Austin DPC mainframe system known as the Portfolio Loan System or PLS. It is cost prohibitive or impossible to make it comply with today's legal and regulatory requirements.

• We are unable to administer tax and insurance escrow accounts as required by recent law (RESPA). A penalty of $100 per incident can be imposed.

• PLS is unable to process payments as required in Ch. 13 bankruptcies.

• PLS is unable to properly calculate the total due on seriously delinquent loans, often requiring labor-intensive manual calculations.

VA sells over 20,000 loans each year. The sale scheduled for September 1995, and all subsequent sales, will have to be postponed until VA can provide borrowers with information required by RESPA. This could take years with the PLS system.

Contracting for these services will enable VA to avoid violating laws in the servicing of our portfolio and reduce internal operating staff. The private sector has much newer equipment for accounting and servicing than VA and greater flexibility in operations; it can perform these functions at a far lower cost.

Option: Contract Out Portfolio Loan Servicing

Contractor processes payments, maintains accounting records on an ADP system, does all delinquent loan servicing, provides VA with required reports on the portfolio (including updates to the General Ledgers), handles escrow accounts in compliance with RESPA, pays taxes and insurance (using third party vendors at its discretion) timely, obtains necessary flood hazard certifications as required by FEMA, sets up new accounts at VA's direction, refers seriously delinquent accounts to VA for foreclosure, sends final accounting on terminated loans to VA and provides account information and performs reviews at VA's direction for loan sales.

Advantages:

- Immediate ability to comply with RESPA
- No need to devote staff time to correction of accounting errors
- No need to replace PLS (estimated cost is $1 million)
- Loan sales can resume in 6-12 months
- Reduced tax penalties (current cost is $350,000 per year)
- Compliance with flood hazard legislation
- VA won't need to review flood maps

- Reduced staffing requirement
- VA retains control of accounts which require special handling, such as refunded and native-american loans

Disadvantages:

- Loss of servicing control over portfolio loans
- Loss of hands-on training opportunity for new technicians

Areas of Consideration:

- VA will control foreclosures and monitor the servicer
- OMB approval will be needed to use loan income instead of GOE
- Also, VA will have to pay a price above market if servicing subcontracts must be periodically rebid; legislation is needed to overcome this FAR restriction

4. Privatize VA Insurance Operations

DISCUSSION: Currently, VA directly administers seven distinct programs of life insurance for veterans, including one program of mortgage life insurance. These programs were created under Federal laws dating back to 1919. Within these insurance programs, 2.8 million veterans are covered, with total insurance covered amounting to $25.7 billion. The largest group of insured veterans are the World War II era, national Service Life Insurance policyholders, consisting of 2.3 million. These policies were issued between 1940 and 1951. There are still almost 27,000 World War I veterans insured under the United States Government Life Insurance (USGLI) program, whose policies were issued between 1919 and 1940.

In many ways, the Government Life Insurance (GLI) programs operate in the same manner as a mutual life insurance company. Five of the seven programs are mandated to be self supporting, with claims paid from premium collections, previously established reserves, and interest received on investments.

The Insurance trust funds have assets in excess of $15 billion. By law, investments are made in Treasury securities. Trust fund moneys not required to pay claims or to be set aside as reserves or investments are redistributed to policyholders annually as dividends. Over $928 million in dividends will be paid in the programs during calendar year 1995.

Administrative costs for the GLI programs are paid by regular government appropriations, except in the Veterans Reopened Insurance (VRI) program. These costs primarily include employee salaries and benefits, equipment, ADP costs, postage and office materials. In FY 1994, these costs amounted to $33 million. It has been proposed several times that the administrative cost of the GLI programs be paid out of dividends, which would, in effect, make them entirely self-sufficient. This was originally proposed by the Hoover Commission in 1949, and most recently by VA in 1994, as a legislative initiative. If this proposal were adopted, $32 million of the $33 million mentioned above would be saved each year. It is estimated that if administrative costs were paid by the insured it would reduce dividends by only $12 per policy. A serious legal question arises with the proposal to shift this cost from the government to the insured. In a 1953 opinion by the Solicitor of the VA held that the Administrator of Veterans Affairs did not have the discretionary authority to transfer the administrative costs of the VA Life Insurance Program. This proposal was further considered in the late 1950's with the idea of seeking legislation to provide for the programs to be self-supporting. The Department of Justice concluded that there was substantial doubt that the Supreme Court would uphold such legislation. In 1994, VA's General Counsel expressed a similar opinion, but concluded that ultimately only the courts could decide that issue.

The operations of the Government Life Insurance programs are carried out in the two Regional Office and Insurance Centers, one in Philadelphia and one in St. Paul. The Insurance Service Staff is also located in Philadelphia. The total FTE directly involved

with operating and managing the programs is approximately 425. There are an additional 221 FTE accounted for by support elements including the Benefits Delivery Center, the Systems Development Center, Finance, Human Resources, Administration and VA Central Office Staff.

The Government Life Insurance Program is rapidly declining. The largest group of policyholders, constituting 82% of the policies in force, are those held by WW II veterans, whose average age now exceeds 72 years. Only two of the seven GLI programs are open to new issues of life insurance. Even these two programs, both intended for veterans who have incurred service-connected disabilities, lose more policyholders each year through death, lapses and cash surrenders than the number of policies issued.

GLI program projections indicate the likelihood of a 53% drop in policies in force over the next 10 years, from 2.9 million to 1.3 million.

In addition to the contractual nature of the policies issued, the GLI programs are also deemed a title 38 benefit. Major aspects of the program such as premium structure (i.e. mortality tables), investment policies, and eligibility requirements are set in Federal law. Title 38 also grants full authority to the Secretary of Veterans Affairs to promulgate and establish regulations and operating procedures for the programs.

Under this proposal, VA would turn over all administrative functions to a private sector entity. VA would retain an oversight role similar to the current OSGLI (Prudential) - VA relationship for the Servicemen's and Veterans Group Life Insurance programs. **Administrative costs of running the programs would continue to be paid by governmental appropriations.** Under the VA-OSGLI arrangement, the Prudential Insurance Company does not charge VA for running SGLI/VGLI nor make a profit from this operation in any other way. It is uncertain if such an arrangement could be obtained with another carrier.

ADVANTAGES:

FTE Reduction: Privatization of the GLI programs would support the President's goal of reducing federal employment. Specifically, there would be an immediate loss of the over 378 FTE involved directly in the daily operations of the programs, which include, collecting premiums, answering correspondence and telephone calls, processing applications and paying death claims. In addition, some of the 44 FTE on the Insurance Service management staffs could be eliminated. While a direct loss of all of the support FTE from other areas cannot be assumed, it is likely that there would be some reduction there.

Administrative Cost Savings: Potentially, there could be administrative cost savings achieved if a private company could perform administrative finctions more efficiently. This is, at the very least, highly debatable. As will be discussed later, available data indicate that VA's insurance operations compare favorably with

private industry. Arguably, however, there are may be some savings forthcoming due to more efficient procurement and similar procedures now governed by regulatory requirements that tend to drive up administrative costs.

DISADVANTAGES:

A major consideration is whether this would be seen as a positive step for our insured veterans and their beneficiaries. VA's mission is clearly to serve veterans. Could any private enterprise embrace such a mission as diligently as VA? GLI policyholders have had their policies for as many as 75 years; even Vietnam-era veterans have had their policies for 25 years. Do we want to risk diminished performance and service at this point in the programs?

VA Cost Efficiency: It is not a "given" that VA's administration of the GLI programs must necessarily be more costly than private industry. As evidence of this, there is data to indicate the OSGLI;s cost per policy for running the Veterans Group Life Insurance program, which is a "no frills" group life insurance operation, is approximately $20.71. VA's estimated cost per policy for managing the administered GLI programs is $12.26. Using OSGLI's cost as a benchmark, the administrative cost of a private carrier managing GLI would be as much as $60 million annually (based on FY 94 figures), compared to VA's actual FY 904 administrative costs of $33 million. There is a very favorable relationship between the benefits provided to veterans and the program cost structure for VA Insurance Programs. In an independent study conducted by the Office of Program Planning and Evaluation in 1984, they concluded that the GLI program was one of VA's least costly programs in relation to the benefits it provides. The ratio has improved since then, with a volume of $26 billion in insurance coverage currently in force, and annual operating expenses of only $33 million.

There are several precedents that further demonstrate a favorable comparison between VA operations and the private sector. The United States Department of Treasury is responsible for overseeing the cash management practices of other executive branch agencies. In the early 1980's the Treasury Department rolled out a nationwide system of commercial lock boxes in order to privatize all cash collections in the government. The then Department of Veterans Benefits (DVB), lock box systems in Philadelphia and St. Paul were identified as potential targets for this privatization effort. Prior to awarding the work to a private lock box, DVB was required to conduct a management study, using the "A-76" methodology, to determine if DVB, or a private vendor, could do the work at lower costs more efficiently. The results of the study found that DVB's operations was less costly and more efficient then any of the vendors in the Treasury Department's lock box network. Therefore, the Treasury Department elected to leave the cash management operations for Insurance with DVB.

The VA Insurance Activity's remittance processing activity compared so favorably to private industry lock box operations that VA not only retained insurance premium

and loan payment collections, but also absorbed additional work from the Loan Guaranty Service that was being performed by a commercial bank. Specifically, a study proved that it was not only more efficient, but also more cost effective to award the Portfolio Loans and Funding Fee payment processing to the Philadelphia Insurance Activity. This work is still being done in Philadelphia and if Insurance were privatized, provisions would have to be made

to contract the work to a third party private vendor. It should be noted that as recently as the summer of 1994, the Treasury Department reviewed its study of Funding Fees alone and found it to be far too costly to contract the work to a lock box in their network. It is also important to note that the St. Paul lock box currently processes Centralized Accounts Receivable payments and Education Loan payments for the Debt Management Service in addition to Insurance payments.

In a 1984 study, the VA Inspector General concluded the VA could save in excess of $89,000 annually by running the Veteran's Mortgage Life Insurance Program (VMLI) in its entirety, rather than sharing operational responsibilities with Banker's Life of Omaha. As a result, VMLI was "deprivatized" and the contract with Banker's Life terminated. An A-76 review of insurance ADP processing was conducted in 1988. Based on the findings of the study, the Philadelphia Benefit Delivery Center's "most efficient organization" plan was accepted and a full study was waived.

Other Quality Measures: According to data obtained from the Life Office Management Associates (LOMA), a prestigious national life insurance oversight organization, the VA insurance activity compares favorably to insurance companies in private industry in terms of timely processing of work. For example, VA can state that about 32% of claims for death benefits are processed within one day of their receipt. The VA Insurance Activity enjoys a justifiable reputation as one of the most efficient, customer oriented operations within VBA. Evidence of this can be found in the fact that insurance played a large role in the winning of the 1989 President's Council for Management Improvement Award, the 1992 Federal Quality Institute's Quality Improvement Prototype Award, as well as the Secretary's Robert W. Carey Quality Award in 1992. Formal customer surveys and other informal tracking of customer feedback such as complimentary calls and letters indicate that VA insurance customers are quite happy with the service they receive.

UNIQUENESS OF VA INSURANCE PROGRAM: There are few, if any, insurance companies in the private sector whose products are similar to GLI policies. The Insurance ADP system, which is undergoing a redesign, uses non-standard language and operating procedures. It is unclear whether a commercial company could readily absorb an insurance program with a database of over 2.5 million policies without substantial startup costs and an extensive learning curve. In addition to ADP considerations, no commercial insurance company could

possibly absorb the organizational memory of the GLI programs. These programs are not simply policies of insurance but also veterans benefits administered by employees whose mission is to serve veterans. This is an intangible but very real factor. Most government life insurance policy holders have been customers for a least forty-five years and in some cases up to seventy-five years. A special relationship between these policyholders, (as well as the Service Organizations who represent them) has been established.

COMPARISON OF VA AND OSGLI (PRUDENTIAL) ADMINISTERED PROGRAMS: The "administration" of SGLI is not analogous to the in-house programs. Although 2.8 million servicemembers are covered under SGLI, it is a group insurance program. Prudential's primary function is to pay death claims. No records are maintained by Prudential for the individual servicemembers. The military service branches collect premiums and maintain the only insurance records kept on the individual servicemembers.

The VA administered programs are not group insurance programs but rather individual contracts of insurance. These in-house policies require that records be maintained on each of the 2.8 million policyholders. A variety of services must be provided on these individual accounts that are not necessary under group coverage. For example, a VA administered policyholder may request a loan or cash surrender; remittances must be processed and accounting maintained on a variety of premiums rates depending on the plan of insurance; total disability income riders are offered and maintained; dividends are paid; there is a much greater need for communication with the individual policyholders which results in 850,000 telephone calls and 300,000 pieces of correspondence annually; paper and computer records must be maintained on each account; a variety of applications must be processed such as conversion from term insurance to permanent plan or reinstatement of lapsed policies.

Prudential maintains records and provides full policy maintenance only in the VGLI program, which covers only 347,000 individuals. The maintenance of VGLI coverage is far less complex than that of the VA administered policies. Like SGLI, VGLI is a "no frills" group term program that offers basic life insurance protection only. VGLI policies have no cash or loan value, earn no dividends, offer no choices for other plans of insurance, no disability coverage nor any other similar policy features.

Prudential has been contacted regarding possible administration of VA administered programs. Prudential related the following:

> Prudential is unable, at this time, to furnish the information requested by the Department of Veterans Affairs. Prudential understands OMB is interested in pursuing cost information associated with Prudential assuming all administrative functions for 2.8 million life insurance policies, and seven insurance programs administered by the Department of Veterans Affairs, but requires additional information and detail to properly respond.

In order to appropriately respond to this request for information, Prudential needs a thorough understanding of the expectation levels and service and other administrative requirements associated with these programs. Prudential cannot provide cost proejctions within the limited time frame provided by OMB, and without complete details relative to the requirements and performance expectations for administering these programs. Upon receipt of this information, Prudential has indicated it would be pleased to respond within 60 days.

CONCLUSIONS:

At this stage in the program life of the GLI programs, it is doubtful that a transition to having them administered by a private insurance company would stand either our customers or the Department of Veterans Affairs in good stead. As discussed above, it is uncertain whether a private carrier could provide the same level of service as the VA Insurance Service does currently. Further, there is no guarantee that there would be a company available to assume an operation as currently large and unique as the GLI operation who would not demand a management fee or who could keep transition costs at a reasonable figure.

AREA OF CONSIDERATION

APPROPRIATIONS: Currently, 38 USC 1982 provides that the United States shall bear the cost of administering the government life insurance programs. It would appear the Government is legally responsible to continue paying the administrative expenses, including any "profit" that a commercial company would require in order to operate the program.

RECOMMENDATION: If legislation were contemplated to privatize the VA Insurance Programs, it would be in the best interests of all parties that detailed A-76 study be conducted before the introduction of any such legislation. It should also be noted that the Office of the Inspector General is currently looking into similar issues regarding the relationship between VA and OSGLI. In fact, IG is assessing the feasibility of both privatization of VA Insurance and the absorption of the operational aspects of the SGLI/VGLI programs by VA. It is uncertain when their draft report will be forthcoming.

5. Consolidation Of Va Insurance Activities

Discussion: Substantial savings can be achieved through the consolidation of all VA Insurance activities at the Veterans Affairs Regional Office and Insurance Center (VAROIC) in Philadelphia, PA. Currently, approximately 86 percent of all Insurance staffing is located at the Philadelphia VAROIC with the remaining 14 percent at the St. Paul, MN. VAROIC. Moving those functions currently housed at the St. Paul office to Philadelphia will result in economies of scale (through the elimination of supervisory and clerical overhead positions) which will produce a more efficient and cost effective operational structure. The cost of the consolidation as well as the effect on St. Paul employees will be minimized through the use of a phased-in approach. In addition to savings from reduction in supervision and clerical overhead positions, there would be a significant savings associated with reduced overall GSA space (SLUC) costs.

Activities to be moved would include the Insurance Operations Division as well as related support. Support includes portions of the Administrative Division, Finance (primarily the Collections activity need for Insurance remittance processing), Sector Service Center and Human Resources Management functions.

In 1997, we estimate that St. Paul's total staffing for Insurance, including related support activities. will be 78 FTE. The St. Paul Insurance and support functions could be absorbed by the Philadelphia office with the transfer of 43 FTE to that office. We estimate that 16 supervisory and clerical overhead positions will no longer be needed based on projected savings that will result from initiatives currently in progress (listed below.).

ADVANTAGES: A consolidation that is conducted over a three year period from 1997 to 1999 would result in a recurring annual savings of approximately $1.1 million beginning in fiscal year 2000. The estimated five year savings from 1997 through 2001 would be $3.3 million.

The consolidation will centralized all VA Insurance activities into one location resulting in net savings of 16 FTE and a substantial savings of SLUC costs. Assuming a transfer of 43 FTE to Philadelphia, that office will be able to absorb all of St. Paul's Insurance workload. This will be made possible not only by the more efficient operational structure but also because of several initiatives in progress which will result in staffing reductions that would coincide with the implementation of the consolidation. These initiatives are the Single On-Line Insurance System with Enhanced Master Record, the Insurance Annual Statement, the Beneficiary and Option Settlement Change mailing and the Interactive Voice Response System. Each of these initiatives is aimed at improving service and reducing the staffing required to support the program. The consolidation of Insurance activities from St. Paul to Philadelphia will result in savings associated with reduced overall SLUC costs. No difficulty is anticipated in obtaining another tenant for the space currently occupied by Insurance personnel in St. Paul. We estimate that $425,000 will be saved in St. Paul SLUC costs each year at the end of the phase-in period. In addition, no minor construction will be necessary to accommodate insurance folder files that would be transferred from St. Paul. A new Philadelphia VAROIC building is scheduled to be completed by the fall of 1996. At this time space can be re-designed to accommodate the St. Paul files at little or no additional cost.

By conducting the consolidation over a three year period the effect on employees can be minimized. Hiring freezes would be implemented in all possible areas prior to the beginning of the consolidation. Most, if not all, current employees could be reassigned to other elements of the St. Paul VAROIC, the Debt Management Center, and the VAMC during that timeframe assuming that these employees would be given priority to fill positions as opening became available.

DISADVANTAGES: There will be certain one-time costs connected with the consolidation. These would include the cost of transferring the Insurance folders currently housed in St. Paul to Philadelphia and the cost of reassigning each ADP insurance master record as it is transferred to Philadelphia. To minimize the cost of folder transfers, folder retirements will be conducted prior to the transfers in order to eliminate the transfer inactive records. As the Insurance folder is transferred, each ADP master record will be reassigned to Philadelphia and all billing and other associated activities will be moved to Philadelphia.

In addition, the transferring of computer records and insurance files could cause some confusion and concern to our policyholders. Policyholders in each group will be notified that their records are being transferred to Philadelphia through a message printed on their annual statement.

COST/(SAVINGS) AND FTE ASSIGNED
(dollars in thousands)

	1997	1998	1999	2000	2001
Net Cost/Savings	$(247)	$(407)	$(408)	$(1,077)	$(1,091)
Cumul. Cost/Savings	$(247)	$(654)	$(1,134)	$(2,211)	$(3,302)
FTE	(6)	(10)	(13)	(16)	(16)

6..Using Electronic Benefits Transfer for VA's Education Program

Discussion: Under this proposal, VA would reinvent the administration of the GI Bill education program by replacing (a) the manual eligibility/entitlement processing with an expert system, and (b) the current system of delivering monthly benefit checks by mail to veterans with a voucher to be drawn upon by veterans through a nationwide program of electronic benefits transfer (EBT).

By statute, the purpose of the Montgomery GI Bill is to assist servicemembers in their readjustment to civilian life and strengthen the total force to aid in the recruitment and retention of qualified servicemembers. This function is critical to the VA mission based on customer input. The function cannot be done as well or better at the state or local level. It is a national program with statutory requirements and benefits and, accordingly, must be administered at the national level.

The expert system for eligibility/entitlement processing would require electronic submission of enrollment information from training facilities to VA where the data would be automatically compared to eligibility and entitlement files. Successful processing would result in the electronic transfer of funds to the financial institution(s) and notification to the veteran of the availability of the funds and terms of withdrawal. Electronic notification of changes in enrollment from the training facility or from the student through a monthly verification process would result in automatic modification of the funds available for withdrawal. The electronic transfer of enrollment information (VACert) to VBA, which became available in 3d Qtr, FY'93, is growing in acceptance and use throughout the education community. At the end of FY'94, 8% of colleges and technical schools were using this capability.

The electronic transfer of education benefits, which are used for the payment of tuition, fees and subsistence expenses, would use existing commercial EFT. For those eligible students who lack a bank account, federal EBT accounts would be established. This is consistent with the Administration's desire to deliver all federal payments through EFT.

Implementation would require the development of the expert system logic for each of the education benefit programs, the linkages to all the files used in the administration of education benefits, and the addition of bank numbers to all of the student records. Beginning in FY'97, implementation would require obtaining contractor services to design and program the expert system, notice to eligible persons of the impending change and collection of bank numbers. Installation of the expert system could begin in 4th Qtr, FY'98, and be completed in FY'99. Timeliness improvements and FTE savings resulting from the improved processing would begin in FY'99.

Reliance on an expert system would require enhanced monitoring of all facets of the education program to insure data and processing integrity, as well as compliance with applicable law and regulations. Consequently, some FTE would have to be redirected from claims processing to this enhanced audit activity.

Processing efficiencies on the following order could be anticipated as the expert system was phased in:

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	FY 97	FY 98	FY 99	FY 00
% schools using VACert	60%	75%	85%	90%
Total transactions (000)	2,617	2,634	2,600	2,600
Expert Sys transactions (000)	0	123	1,252	1,648

Reinvention in the form of development of an expert claim processing system in conjunction with EBT would result in an estimated cost-savings of $12.6 million by fiscal year 2000 and an estimated FTE reduction of 240.

Anticipated costs/savings for systems development:

Cost (000)	FY 97	FY 98	FY 99	FY 00
Budget Authority	$1,500	----	----	
Outlays		$ 500	$ 500	$ 500
FTE	----		90 120	240
BA/Outlays	----	$-4,374	$-6,065	$-12,615

Advantages:

- Proposal implements direct deposit in the education programs, which is in line with Treasury Department goals to deliver all federal benefits electronically.
- Proposal reduces time and manpower required to process education benefit claims by taking advantage of telecommunications and expert system technologies.
- FTE reduction of up to 240 depending upon numbers required for enhanced audit of the system.
- "Instant" cash disbursement to veterans resulting from time savings in claims processing and use of EFT. Should reduce pay inquiries.

Disadvantages:

Areas of Consideration:

- Funding to complete development of an expert system is required before FTE is reduced.
- Legislation to ease computer matching burden for public schools wishing to use VACert and to clarify signature requirements for electronically submitted applications would be useful.

Recommendation: Recommend implementation because it provides both cost savings and maintains appropriate levels of fiscal control. It is consistent with the Administration's desire to deliver all federal payments through EFT. Funding for implementation costs should come from the RB account.

7. Reforming VA Health Care

Decisions Run Amok: Currently, the effort required for a veteran to receive care from the VA is difficult. The number of decisions that must be made and the extent of the inquiry that the veteran must undergo suggest a costly, inefficient, and clinically inappropriate process that is sorely in need of streamlining.

Why Must I Be Admitted? Veterans are hospitalized rather than being treated as outpatients or provided other non-institutional services. This is usually more costly, more stressful to the patient, and frustrating to the clinician who sees "a better way." Viewed from the outside, VA appears to be out of step with current clinical practices and general medical trends.

Irrational Medicine: Prosthetic devices, like crutches, can only be provided to a patient if he/she is hospitalized, even though the need for them may be caused by something that can be treated in an outpatient clinic. Other examples of the absurdities that result from VA's current eligibility requirements include:

- veterans with diabetes or hypertension always at risk of being discharged from primary outpatient care if they are not sick enough to require hospitalization in the immediate future;
- elderly veterans followed on an outpatient basis having to be hospitalized so that they may be placed in an adult day health care program.
- veterans whose broken legs may be cast on an outpatient basis but who must be hospitalized in order to be given crutches;
- older veterans with progressive deterioration from rheumatoid arthritis who have not been hospitalized in the past year cannot be followed in a clinic or receive medications from VA because the condition does not require hospitalization.

Whole Person or a Condition? Current law relates a veteran's access to care to his/her particular medical condition. Comprehensive treatment of the entire body is discouraged by a focus on fragmented care of body parts and conditions.

Customer Unfriendly: Eligibility requirements are extremely confusing to veteran users and potential customers. Many veterans having been found "ineligible" for the care they have sought, may choose never to even try to use VA again. Older veterans are faced with a system of eligibility that makes Medicare's confusing requirements seem simple...they choose to go elsewhere for their care.

Not Permitted to Play: The Rules of the Health Care Game have changed considerably as has the basic playing field...but VA is generally not a player in this marketplace. Veterans do not have included among their health coverage options the choice of a VA health plan. Nor can they expect that the health plans that are available to them will include VA facilities among their preferred provider options.

Goals: Veterans assured access to a rational cost-effective health care delivery system - VA recognized as a "customer-friendly" system - All veterans having VA as a choice.

Discussion:

In the interest of cost containment and patient satisfaction, health care providers in the United States have substantially broadened the use of non-hospital care so that customers might have more convenient access to care in their communities, work locations, etc., in appropriate and cost-effective settings. Unfortunately, this cannot be the case for VA under current law which promotes the use of inpatient hospital care and forces VA to administer care in a manner that provides few incentives for cost containment.

The health care marketplace (in large part driven by employers) has seen the rise of integrated and virtual networks that provide ready access, service options, and reasonable costs to their customers. The marketplace is dominated by mergers, joint ventures, and corporate medicine--the way of the future. Employers and citizens are forcing these approaches through demands for cost controls and reductions while retaining and improving quality of care and patient outcomes. While VA could 'hold its own' in this arena, we do not have the authorities and flexibilities that will permit VA to readily form or participate in such networks, or offer a comprehensive or basic health plan to veterans, or to otherwise respond to market pressures and the apparent interests of veterans customers (actual or potential).

There are a number of approaches that might be taken to remedy this situation. Some more comprehensive than others. Some necessary regardless of approach taken. Some which can be viewed as incremental approaches--ends to the means. These approaches include the following:

Option A **- Fix Prosthetics Eligibility:** At least one aspect of the absurdities of VA eligibility (the crutches example) would be corrected by simply making a change in prosthetics eligibility. This minimal change is necessary, recommended, and should occur; but, it will only affect a small portion of the care now provided inappropriately on an inpatient basis. Therefore, this option should be considered as a necessary part to every approach discussed.

Option B-1 **- Permit Care to Be Provided in Appropriate Setting:** modification that grants VA the flexibility to provide veterans' health care in the most appropriate setting (as clinically determined) and to effectively manage that care across all settings is needed. This change would eliminate restrictions in law that only permit VA to provide outpatient care when it is needed to prevent hospitalization (in an emergent or near emergent situation), prepare for hospitalization or to complete an episode of treatment after hospitalization (the so-called "pre-, post-, and obviate" provision). It would also broaden the circumstances when other forms of non-institutional care (e.g., home health care, adult day care) may be provided. Given capacity and resource considerations, this option must also provide sufficient flexibility to the Secretary to prioritize access to care among veteran categories (e.g., service-connected vs. non-service connected). *N.B. Coupling this option with revenue enhancement opportunities for VA will help to ensure the broadest availability of VA services to veterans choosing such care.*

Option B-2 - Establish a 2-tier system of eligibility that would allow VA to treat Category A veterans without restrictions, but continue to treat other veterans with the restrictions that currently exist.

Option C - **Provide VA with Flexibilities to Compete and Cooperate:** VA needs substantial flexibility in areas such as contracting and human resources to enable it to function more like a business. VA needs to be able to structure and offer health plans, enroll veterans, and charge premiums, copays and deductibles when appropriate. Flexibilities in procurement and contracting will also permit VA to further improve customer service by extending veterans' access to care in their communities and to establish more rational sharing arrangements (with academic, community, military, and other federal providers) so as to ensure that care is available in the most cost-effective and desirable setting for veterans. VA medical centers should be able to structure agreements with health plans (e.g., Blue Cross/Blue Shield) that will include VA among the provider options for veterans enrolling in that health plan. Most of the changes that VA envisions under this option were included in the President's proposed Health Security Act. *N.B This option must be coupled with revenue enhancement provisions.*

Option D - **Form the VA Quasi-Governmental Corporation:** Faced with the difficulty of making a federal entity with all the concomitant governmental oddities, requirements, and inefficiencies look and act more like a business, the option of treating veterans health care delivery more like a quasi-governmental organization is in need of consideration. Such organizations, including non-profit governmental corporations, generally are structured to accomplish the organization's mission, respond to changing market conditions and have built-in flexibilities that are akin to the business environment. VA is currently required by Public Law 103-466 to contract with a non-Federal entity to study and report to the Congress by November 1995 on the feasibility and advisability of alternative organizational structures such as the establishment of a quasi-Government corporation.

Advantages/Disadvantages:
(Applicable to all options unless shown by exception.)

Advantages:

- Customer Friendly/Improves Customer Service
- Significantly enhances veterans' choices (Option C & D only)
- Improves quality of health care and patient management
- Eliminates costly, inappropriate care
- Permits necessary care in the appropriate setting (not applicable to Option A)
- Uses resources more effectively
- Consistent with industry trends
- Simplifies a government program for consumers and providers
- Permits VA to enter into agreements with health plans and other community providers improving access (Options C & D only)
- Has potential for improving veterans' access to institutional long term care (Options C & D only)

Disadvantages:

- Unknown effect on demand
- Potential for unmet consumer expectations (not applicable to Options C & D)
- For Option B-2, created a split system that will foster complaints for veterans not being treated with maximum flexibility. Also this will create additional burdens on clinicians making decisions.

Resource Implications:

Generally, these reforms will allow VA to shift its resources to provide care to veterans in more appropriate settings. Studies over the past ten years conducted by investigators both outside and within VA have been consistent in concluding that an average of between 40 and 50 percent of VA hospital admissions represent care that could be provided in a less intensive setting.

Further, through these approaches to reform, VA is seeking to improve its ability to effectively manage care and to participate in reasonable "business" arrangements to the benefit of the veteran customer. To varying degrees, we believe that these changes coupled with the shift to less intensive levels of care will enable us to more effectively meet the needs of current patients and to potentially add new workload within the level of our current appropriation.

Other Information: Demonstration (Pilot) Projects.

Particularly in the case of Options C & D, there are many issues which can only be addressed experientially. For example, it is virtually impossible to predict demand in these cases (and to some extent in the case of Option B as well) as there is no past experience which can be trended, extrapolated, or otherwise applied. Similarly, and directly related, are "cost" questions. Therefore, it may be appropriate/necessary to limit initial application of these reforms to selected VA locations on a pilot basis.

8. Enhancing Veterans' Health Care Choices

Currently, all veterans who would like to obtain care from the VA cannot. Only those with service-connected disabilities and low-income veterans are covered by the appropriation. Other sources of revenue are needed to cover the cost of services for higher-income, non-service connected veterans who would like to use VA health care. These veterans should be permitted to make that choice and to bring with them the revenues to cover the costs of the care. These other sources of revenue may include Medicare, other third-party insurers, and personal resources.

Discussion: Most higher-income, non-service connected veterans, as well as many current VA health system users, have some other kind of health care insurance coverage but would like to, or do, choose to come to the VA. Many more would like to do so but cannot be accommodated within the existing appropriation. Like any other community provider, VA should be able provide care to customers (veterans) choosing VA services, and then to recover and retain revenues from other sources. Other sources include Medicare, third- party insurers, and personal resources.

A. Medicare: Most veterans over age 65 are covered by the Medicare program. These veterans and their families have made contributions to Medicare throughout their working lives. Many of these veterans, particularly those who are not service-connected and have higher incomes cannot use their entitlement to gain entry into the VA health care system. By permitting these higher-income, non-service connected veterans to use their earned Medicare entitlement to pay for their access to VA care, their choices will be expanded. Also, if this choice is to enter into a VA managed care health plan (from a fee-for-service environment), the Medicare program goal of expanding use of managed care by the Medicare population will be furthered. Lastly, since VA has considerable experience in dealing with a high-risk population, we believe that opportunities would exist for the Medicare program as a whole to benefit from VA knowledge, experience and findings.

Option A1 - Permit VA to negotiate appropriate fee-for-service rates with HCFA for VA provider reimbursement of care provided to higher-income, non-service connected, Medicare-eligible veterans who do not choose to enroll in a managed care plan, but who would like to obtain care from VA. (This option could be extended to Medicare-eligible, *nonuser* Category A veterans for non-service connected care if current user, Category As (perhaps spanning 2-3 years) were grandfathered in under the appropriation.) VA would impose on those veterans the cost shares required by the Medicare program.

Historically, there has been considerable reluctance on the part of the Congress and the Health Care Financing Administration to permit Medicare reimbursement of VA. However, the President's Health Security Act did deem VA facilities to be Medicare providers and veterans' groups have long supported and actively sought such a provision. In part, the reluctance can be attributed to the considerable number of issues that must be resolved for a VA/HCFA arrangement to work effectively.

VA recognizes that these issues exist, but we believe that with the will to do so, there can be identified workable solutions that will benefit all concerned. VA would work with HCFA to negotiate a reimbursement arrangement for VA-provided, fee-for-service care. VA would expect to be reimbursed no more than other providers for the same services.

Option A2 - **Permit VA to function as a risk-contractor** to serve Medicare eligibles who are non-service connected, higher income, veterans and who choose to enroll with VA. VA and HCFA would negotiate appropriate capitated rates for veteran eligibles and would be authorized to negotiate and grant waivers, necessary and appropriate for VA when acting as a risk contractor.

VA would cover the same benefits as other Medicare risk contractors and would assure enrollees at least the same levels of quality care and access as other participating contractors. VA would expect to be reimbursed no more than other provider organizations. It is even possible that VA would be able to negotiate with HCFA a further discount on reimbursement rates by taking advantage of the VA system's economies of scale and possibly lower costs. Certainly, this represents potential savings to the Medicare Trust Fund. There is also merit to considering the benefits of expanding the Social/HMO (S/HMO)project to include VA to aid in addressing the growing national concern over long term care coverage and costs.

VA operates an integrated delivery system providing all levels of care. We are working to transform VA into a model integrated community-based system that effectively manages the care of our customers. Management changes now underway along with our proposal for eligibility reform will ensure that the VA system is able to accommodate the needs of the Medicare program and care for Medicare beneficiaries in an integrated seamless care system. Unlike many other Medicare risk contractors, VA *begins* with a clinical focus on geriatric care and significant experience in managing the link between acute and chronic care delivery systems. VA's learning curve as a risk contractor will be largely associated with administrative and operational matters.

Option A3 - Authorize VA and HCFA to conduct demonstration projects of Options A1 and/or A2. Establish timeframes for the duration of the projects and for reporting on findings and results by both VA and HCFA.

Option A4 - Authorize VA to participate as a Medicare ***Center of Excellence***. VA operates an integrated regional system of care in which specified procedures (e.g., rehabilitation, treatment for post-traumatic stress disorder and spinal cord injury care) are concentrated in a few hosptials. This system might be leveraged in the Medicare context by allowing VA to participate in Medicare's Centers of Excellence demonstration (i.e., a selected set of VA facilities would be available to provide a selected set of procedures to Medicare-eligible veterans.) Medicare would reimburse VA for patients referred to these centers.

Option A5 - Authorize a VA demonstration project permitting Medicare reimbursement for fee-for-service care provided to core veterans ***not*** currently using the system (i.e., beyond the number of veterans funded in the appropriation.)

B. Third-Party Insurers: The VA has the authority today to collect from third-party insurers for treatment of non-service connected conditions. However, all recoveries in excess of the Medical Care Cost Recovery (MCCR) program operating costs are returned to the Treasury.

Option B1 - Permit VA to retain a greater portion of third-party recoveries for the non-service connected care of Category A-veterans and all of the recoveries from higher-income veterans with insurance.

> ***Sub-Option B1a*** - Authorize a demonstration project in which a Veterans Integrated Service Network (VISN) would retain all of the third-party collections associated with treating new, higher-income, non-service connected veterans that have not previously used the VA for care. The collections would be used to pay the full cost of care for these veterans.

Option B2 - Establish a **gainsharing** program for third-party recoveries of VA. This program would provide financial incentive to VA facilities to increase collection levels because of the opportunity for additional returns from the invested funds. Gainsharing would invest recoveries back to Veterans Integrated Service Networks (VISNs) to determine appropriate allocation within the VISN for patient care improvements and refinement and improvement of collection operations. The components of VA's gainsharing proposal are as follows:

- Establish a collection threshold for the next five years in the President's Budget.
- Provide that collections would have to exceed the threshold before funds could be retained by VA.
- Permit VA to retain 100% of the funds exceeding the threshold.
- Permit VISNs to determine distribution of the gainsharing funds.

> ***Sub-Option B2a*** - Same as Option B2 with VA retaining 25% of the funds exceeding the threshold.

Option B3 - Permit VA to pilot in a state(s) a form of gainsharing that would permit VA to retain the recoveries attributable to a major insurer(s) (e.g., Blue Cross/Blue Shield) for veterans treated in that location by VA. Those dollars would constitute an "account" from which would be debited care received by any veterans using the primary care providers of that insurer throughout the state. This would vastly improve access to primary care for veterans.

C. Personal Resources: At present, VA is significantly restricted from collecting amounts that would constitute out-of-pocket expenditures by veterans. It is expected that the out-of-pocket expense to the veteran would be substantially less than that veteran would experience in the private sector.

Option C1 - Permit VA to set reasonable amounts of co-payments and to act like any other reputable provider in this regard. VA is currently restricted to a set amount as a co-payment for any outpatient service provided. Continuation of this and similar practices would be inconsistent with efforts to broaden the services provided in an outpatient setting.

Option C2 - Permit VA to collect the difference in the cost of care and the insured amount from any veteran. VA should be permitted to act like any other provider in this regard with respect to balance billing, at least with respect to care provided to Category C veterans.

Advantages/Disadvantages:

Advantages:

- Expands veterans' choices
- Capitalizes on VA expertise and experience with elderly and disabled populations
- Simplifies government programs for consumers
- Expands access to services for Federal beneficiaries - especially in rural areas
- Uses resources more effectively; takes advantages of economies of scale
- Consistent with industry practices
- Gives VA access to revenues beyond the appropriation, consistent with demand

Disadvantages:

- Unknown effect on demand
- Potential for unmet consumer expectations
- Capability to meet demand may be hampered by employment ceiling (FTE) restrictions
- Some waiver or modification of HCFA regulations needed (e.g., the 50/50 requirement, state approval and oversight requirements, et al)
- Option A4: may reinforce the concern of and/or further confuse veterans who cannot use Medicare to receive care from other VA facilities
- Option A5: establishes a system that would have VA suggesting that its responsibility for service-connected and low income veterans only extends to previous users; new Category users would be expected to bring Medicare reimbursment with them for care.

Resource Implications:

The outlays of the Medicare Trust Fund for care provided to VA current user Category C veterans would be offset by that amount in VA's discretionary account. Further, to the extent that the current user Category C veterans are also currently using Medicare for care outside of VA, the opportunity to unify that care under one provider

may represent a cost savings to Medicare because of efficiencies and improvements to the management of that patient's care.

Currently, HCFA is acutely aware of the apparent reluctance of Medicare beneficiaries to sign up for Medicare managed care plans in the private sector (6% enrollment rate). Having no reason to believe that the enrollment rate for the general Medicare population would be substantially different for veterans, we expect that the overall number of higher-income, non-service connected veterans who would enroll in a VA Plan would initially be relatively low (i.e., estimated in the 30,000 to 45,000 range) and could be accommodated within the existing VA infrastructure. Should our demand assumptions prove to be incorrect, VA would expect to have the option of limiting the number of enrollments, similar to other plans.

We have based our estimates of potential numbers of higher-income, non-service connected veterans who would enroll in a VA managed care plan on experience with past demand for care by this veteran cohort (i.e., VA's so-called 'Category Cs'), on what we know of enrollment levels in communities with Medicare managed care offerings, and on early survey indications from veterans who are 'never users' of VA.

Veterans, especially those with higher incomes, who are not using VA facilities today are generally covered by Medicare if they are over 65, by CHAMPUS, or by third-party insurance. If they are in need of care, they are obtaining it from the private sector. Because they are in higher-income brackets, out-of-pocket expenses are not a significant deterrent to their decision to obtain needed care from a private source. Thus, no new expenditures from Medicare would result from a Medicare reimbursement to the VA for these veterans.

The potential exists for some overall Federal savings through better utilization of existing federal health care resources and the possibility of negotiating lower reimbursement rates with Medicare.

Reasonable balance billing for costs associated with care of Category C insured veterans which is not offset by the third-party recovery could serve to reduce the cost to the appropriation for the care of these individuals. Co-payment is a practice that is generally accepted to have a moderating impact on the consumer which could offset some of the demand concerns associated with opening up access to VA outpatient care.

Other Information - Re: *Eligibility/Health Care Delivery Reforms and Demonstration Projects*

The reforms to VA eligibility and health care delivery must be accomplished in conjunction with effective implementation of these proposals.

We believe that the *Medicare proposals* for reimbursement merit serious consideration; however, we also recognize that there are many issues to be resolved if either option proposed in this paper is to be successful. Therefore, we recommend that,

at a minimum, VA be given the opportunity to further develop these proposals as demonstration projects/pilots (Option A3). With fairly liberal demonstration authority VA and HCFA have the opportunity to learn a great deal while testing the proposals.

VA has the advantages of an existing integrated delivery system, quality care, economies of scale, and substantial experience with an elderly and chronically-ill patient population. VA could bring managed care into rural communities where other risk contractors may not have shown an interest in being. Medicare has the potential for broadening use of managed care, learning more about risk adjusting for this population and about managing long-term care, and lessening costs. Additional veterans have the opportunity to choose VA health care and to use their earned Medicare entitlement for their provider of choice.

Finally, the *Gainsharing proposals* relative to Third-Party Reimbursement offer considerable potential for VA and in terms of overall budgetary impact and at a minimum should be considered for pilot testing.

9. Integrating, Consolidating, and Privatizing

Purpose: To define specific functions within the programs identified that may present positive opportunities toward the Reinventing Government initiative.

Background: VHA's primary mission is it will continue to provide health care to eligible beneficiaries. There are numerous support areas, such as those identified below, that are part of this endeavor. These areas present opportunities for increased efficiencies and cost savings. Several initiatives, are already underway such as facility integrations, service consolidations, service mergers, delegation of authorities, consolidated contracting (regional and national) and procurement streamlining. The potential exists for even greater efficiency and savings.

Discussion:

Textile Care (Laundry)

Consolidation/Integration

Both elements are included in the VHA Management Improvement Plan (MIP). Proposed are consolidations of 17 laundry facilities within the next three fiscal years and a System Wide Application Process (SWAP) (an Environmental Management Service proposal) which recommends construction of regional laundry facilities, in lieu of individual laundry facilities. In addition, 31 VA laundry operations have been consolidated since 1983. Potential savings include 60-93 FTEE and up to $2.6M over three fiscal years (FY 1995-97). Potential savings for FY 1995 alone include 20-34 FTEE and up to $961K.

Contract Out

Laundry services have been subject to the OMB Circular A-76 process since 1980 and in-house operations have proved cost effective under the provisions of 38 U.S.C. § 8110(c). With the suspension of these provisions by PL 103-446, more privatizing may occur. Cost comparisons, under A-76, need to be completed to accurately evaluate its impact. Based on the FY 1995 schedule to review A-76 activities, a total of 20 facilities with 534 FTEE will be reviewed in these activities. Contracting out laundry services will create major savings of FTEE; most salary costs will be shifted to contract costs, however a dollar savings may be 10-12%, or $2.7M-$3.2M. In addition, a majority of Laundry staff is counted in the veteran preference and minority employment categories.

Environmental Care (Housekeeping)

Employees operate within formal and informal 'matrix' organizational lines. Advantages to contracting this activity include elimination of direct labor FTEE; reduction of potential capital expenditures; minimization of labor/management issues; and reduction of support office requirements (fiscal, personnel, etc.) Disadvantages include an increase in operating costs; increased contract management workloads; and delay in adjusting

Construction

VA's construction program currently makes extensive use of private sector companies. Through these companies, the Office of Construction Management (CM) contracts for design and construction services. CM's project management services oversee some 4,100 such contract employees. Their role includes negotiating, executing, and administering contracts; reviewing contractor work products, and conducting onsite inspections of contractor performance.

VA has pilot tested contracting for Resident Engineer services rather than hiring VA personnel. Preliminary information demonstrates that use of these firms can reduce VA personnel, but presents substantial increases in cost and problems in project control. Additional testing of this approach is now underway.

VA is aggressively committed to streamlining its past standards to conform to community standards used by comparable private sector facilities. Those standards are created largely by voluntary consensus organizations, and members of VA staff participate in many of these bodies as required by OMB Circular A-119.

VA is changing its past, mandatory standards to guidelines and deleting, updating, simplifying, and rearranging the technical, engineering specific-discipline data into coordinated and user-friendly documents. These changes will reduce time and cost for design, construction and operation. Among the accomplishments already achieved are: Construction Standards-120 have already been reduced by half and 40 more are being studied for deletion; Standard Details-720 have already been reduced by 120 and another 60 are currently being studied for deletion; and Construction Master Specifications are being deleted wherever possible, updated to current industry norms and converted to metric.

Extensive contracting out of project management activities would entail the use of Construction Management firms. VA is presently testing the use of such firms on selected projects. It is estimated that contracting for functions provided by project managers and professional staff during design and construction would cost the VA 8-12% of the total project cost, an increase in cost of 4-6% over current expenses.

Medical Care Cost Recovery (MCCR)

MCCR was established for the purpose of identifying, billing and collecting reimbursements from third party insurers for the cost of health care services provided to veterans treated by the VA for non-service connected conditions. In the last two years, MCCR has collected $1.05B at a cost of $175 for each dollar recovered.

Recently, the General Services Administration negotiated national vendor contracts which would allow for the contracting out of certain health care cost recovery services. As evidenced by the GSA contract, vendors are willing to perform limited VA-type collection functions, but no combination of vendors performs all collection functions.

A staffing survey, commissioned by MCCR in 1993, indicated that contracting out MCCR functions could reduce the Federal work force by an estimated 1,000 FTEE and approximately $35M in salary costs. If no combination of vendors can perform all collection services required, the potential FTEE and dollar savings would have to be reduced substantially to provide the in-house staff to complete the collection process. Since MCCR employment is exempted from VA's FTEE ceiling, none of this reduction would benefit VA.

Cemetery Maintenance - National Cemetery System (NCS)

At this time, NCS has fifty-eight national cemeteries with space available for full burial operations, as well as fifty-six that are inactive or are with low burial rates. Currently, NCS fully contracts maintenance operations at 26 of the inactive or low burial rate cemeteries. As the interment rate of the aging and mostly WWII veteran population continues to rise, it is projected that by the year 2000, an additional ten cemeteries will close to full service. As more national cemeteries close to full service, the sites will not require full-time employees, thus the likelihood of NCS using full or selected contracting options of cemetery operations will increase where they prove feasible and cost effective. To date, the majority of national cemeteries employ service contracts at some level (e.g., trash disposal, rodent and pest control, and environmental compliance.)

Headstone/Marker Application Process - National Cemetery System (NCS)

Automating the headstone and application process would eliminate manual data input, reduce error rates, increase timeliness and allow for direct transmission of orders to the manufacturer. By retaining the activity in-house and automating the process, $200K per year would be saved, after start-up costs of $740K. Contracting out the entire application process, including mail operations, would reduce approximately 55 FTEE and save approximately $220K annually.

Other Support Areas and Approaches Considered:

VA Police: Current legal opinion states that only VA Police, not contract guards, may possess federal arrest authority on federal property. Current VA Police program costs are estimated to include 2,350 FTEE and $86.1M. With legislative action, federal arrest authority could be modified. Another obstacle to overcome is convincing local jurisdictions (city, county and state) to provide law enforcement on federal property. Historically, the local police have neither been able nor willing to provide the necessary presence. For contract guard services, the issue of effectiveness is also critical. Most satellite outpatient clinics currently use contract guard services and they are dissatisfied with the services provided. There is no data available on contracting the VA Police function. However, the A-76 process, applied to other activities, suggests potential savings of 10-12%, less the cost of staff to be retained for contract administration and monitoring. This issue can be developed further with appropriate legislation in place.

Canteen: The VCS operates on a self-sustaining basis with no direct appropriation of funds or FTEE. At the end of each fiscal year, VCS income (profit) from operations is

returned to the medical facilities in the form of capital improvements and support of patient and staff morale and recreation. Contracting out the Canteen function will not generate any FTEE savings. Expanding the Canteen to include some support functions such as Dietetics and Environmental Management (laundry) are options for further consideration. The immediate issue is a pending legislative initiative to make the Canteen Service into a Non-Appropriated Fund Instrumentality (NAFI). With approval of a NAFI, further review of these proposals may be warranted.

10. Simplifying the Means Test

Discussion: Medical care eligibility for some veterans is based on their income. The first time these veterans present to a VA medical center for care, they are asked 93 personal, financial questions which constitute a "means test." The "means test" is repeated yearly or if the veteran presents to another VA medical center. The answers to these questions are then entered into a computer system and used for determination of eligibility. To assure that the information which is provided is accurate, the provided information is compared to records from the Internal Revenue Service and the Social Security Administration. The comparisons have been authorized by law (PL 101-508) and are performed at the Income Verification Match Program in Atlanta, GA.

The current program deserves reinvention for the following reasons:

- o "welcoming" a patient to the hospital with 93 questions sends a strong message that the government is bureaucratic;
- o patients are asked to remember information which no one can remember accurately;
- o the essential portions of the information gathered is already being gathered by the government;
- o administering the "means test" wastes approximately 373,000 VA employee-hours and 373,000 veteran patient-hours per year;
- o the verification program sends a message to veterans that the government does not trust them;
- o a rapid and simple determination of eligibility could be designed which would meet the intent of the current "means test";
- o the reinvented determination of eligibility would save personnel time and money and enhance service to veterans;
- o the reinvented process would produce a government service which works better and costs less; and
- o the reinvented process could be applied government-wide to any programs which require means testing.

Proposed reinvention:

Patients who need an eligibility determination based on income would give their social security number to an authorized VA employee and would sign a statement similar to the following:

> "I hereby give VA and IRS permission to determine whether I am currently eligible for VA care based on my most recent tax return available from the IRS. The confidentiality of my tax return will be maintained by the IRS and the only information returned to this VAMC is whether or not I am eligible. I have no recent, significant changes in my income or net worth."

The authorized VA employee would then enter the social security number into the VA computer system. The Social Security numbers would be matched with the data base

obtained from IRS to apply a current test of eligibility to the most recent IRS "taxable income" for that veteran. An eligibility code (e.g.. A, B, or C) would be determined. This should be simple and automatic as the approval for credit card charges has become.

Advantages compared to current system:

- o quicker
- o simpler
- o more user friendly
- o less bureaucratic
- o wastes less time
- o will be required to continue to provide tax information.)

Disadvantages compared to current system:

- o none known.

Barriers to implementation:

- o will require legislation to amend 38 U.S.C. Section 1722 to allow VHA to determine financial eligibility for medical care using "taxable income"
- o will require cooperation from IRS
- o employee implications if Income Verification Matching Center is downsized or eliminated

Additional benefits:

- o similar "means testing" could be applied to other federal programs with additional savings and efficiencies

Resource implications:

- o savings of (approximately 280 FTEE and $10.5 million)
- o savings of FTEE plus dollars from Income Verification Matching Center.)
- o cost of relocation or severance for employees
- o cost of computers and software development for the means test

11. Enhancing VA/DoD Health Care Sharing and Integration

Background: VA is a single health care system composed of 173 medical centers and numerous other facilities. The FY 1994 medical care budget was $15.6B, and VA had approximately 891,000 discharges and 24 million outpatient visits. VA has a number of programs not found in the DoD system (i.e., nursing home care units, blind rehabilitation, SCI, readjustment counseling, etc.). Many VAMCs have significant medical school affiliations.

DoD's medical system is in reality four systems - Army, Navy, Air Force and CHAMPUS (Civilian Health and Medical Program for the Uniformed Services). Taken together, DoD's FY 94 health care budget was $9.6B for direct care, and another $3.3B for CHAMPUS. DoD provided 771,000 discharges and 1.2 million outpatient visits in FY 1994. There is evidence to suggest that (1) DoD's budget is understated by approximately $1B (due to indirect support from the rest of the DoD budget) and (2) the DoD direct care system is as much as 50 percent larger than required in order to meet its readiness mission. Taken together, the VA/DoD expenditures for health care approach almost $30 billion.

The missions of the two Departments are different. VA's mission is to provide quality health care to veterans, conduct education and training programs to enhance the quality of care to veterans, conduct medical research programs in connection with providing health care to veterans, and to serve as the primary contingency back-up to DoD of time or war or national emergency. DoD's primary mission is the security and defense of the country. In support of that, DoD's has a medical role to maintain the health and readiness of the active duty forces, and to provide immediate care to those injured in combat. Its associated mission is to provide health care to dependents of active duty personnel, retirees, and dependents of retirees. Both health care systems serve the military retiree population.

VA's 173 medical centers and DoD's 125 hospitals have many cooperative arrangements, but operate independently of each other. During FY 1994, 140 VA Medical Centers had 670 agreements with 140 DoD hospitals and clinics covering 4,170 shared services. VA's reimbursable earnings in FY 1994 from DoD from these agreements were $29.7 million while VA purchased $9.8 million from DoD. VA and DoD are operating joint venture hospitals at Albuquerque, New Mexico, and Las Vegas, Nevada, and six other joint ventures are in various stages of planning.

DoD is moving aggressively to implement a program called TRICARE. This program will move DoD in the direction of becoming a managed care system by (1) coordinating care among its three branches and CHAMPUS, and (2) offering beneficiaries a choice among fee-for-service, PPO, and HMO options. Under the HMO option, DoD will have both a well defined benefit and an enrolled population.

Discussion: DoD's primary mission is one of national defense; VA's is one of providing health care and benefits to America's veterans. Both systems provide direct health care to their beneficiaries. Furthermore, there is some overlap in the beneficiary population (i.e., retirees). Although a limited amount of resource sharing is taking place, it is

relatively small. No comprehensive review of how the two systems could best work together has been undertaken. Such a review could focus on how to improve services to the customer - through improved access, enhanced quality, and reduced cost - while maintaining the distinct missions and operations of two separate organizations.

For example, the review could consider such questions as:

- Could CHAMPUS beneficiaries be allowed to use any VA Medical Center and permit VA to bill for care through fiscal intermediaries?
- Could VA beneficiaries have access to DoD health care facilities?
- Could DoD beneficiaries have access to all VA Medical Centers under TRICARE?
- Could VA and DoD jointly offer HMO-type benefits to their customers?
- Could joint contracting for services under TRICARE provide benefits and savings to both systems?

As a first step in this initiative, the Vice President should task the Secretary of Veterans Affairs and the Secretary of Defense to jointly undertake a high-level review of how the two systems could best work together, and assess the potential for achieving substantial improvements through this effort. The results would have to show either a net savings, or be revenue-neutral with improved access and services. This effort is in keeping with the VA/DoD reinvention partnership.

Advantages:

The advantages of significantly improved co-ordination between the two systems would accrue primarily to the beneficiaries - more access points, less confusion over dual eligibility, and perhaps a more standardized federal benefits package. Other theoretical advantages would be better utilization of direct federal health care resources (i.e., providing more care within a given level of resources), and potential savings in contracting for care (i.e., one large contract could bring a better price than two smaller contracts). Depending on what arrangements were made, improved DoD access to VA's medical school affiliates might also be a potential benefit.

Disadvantages:

Significant concerns could be expected from both beneficiary populations, Congress, and probably from within both VA and DoD. Congress would include feared dilution of mission, reduced benefits, reduced funding, and "mainstreaming." The true difficulty associated with requiring two large organizations with very different cultures to work closely together should not be underestimated. Concerns might also be expressed that improved services to beneficiaries might be very limited, and that limited, if any, savings would be achieved from reducing the bureaucratic structures which lead and manage the two health care systems.

Resource Implications ($FTEE -- Cost/Savings): Savings in dollars and FTEE would depend on the actual recommendations. Benefits would come from improved service delivery, which does, in fact, have a high value for our customers.

Other Information: Other issues to consider include:

- whether to include IHS, Medicare, and other federal health care providers in review,
- the impact of VA's "eligibility reform" efforts on this proposal, and
- the need for whole-hearted commitment from both VA and DoD to make this review effective.

VBA – REENGINEERING GOVERNMENT – PHASE II

(dollars in thousands)

Option: Contracting Out Portfolio Loan Servicing/Accounting

	FY 1996 program levels in Budget	Estimated resulting levels for FY 1996	Estimated resulting levels for FY 1997	Estimated resulting levels for FY 2000	5–Year Cumulative (FY 1996–2000)
Discretionary Budget Authority	...	($3,580)	($7,393)	($7,983)	($34,340)
Discretionary Outlays	...	($3,580)	($7,393)	($7,983)	($34,340)
Mandatory Outlays	...	$3,800	$3,648	$3,192	$17,480
Governmental Receipts	...	...	...	...	...
FTE Changes	...	(85)	(171)	(171)	(171)

Option: Elimination of the Manufactured Home Loan Program

	FY 1996 program levels in Budget	Estimated resulting levels for FY 1996	Estimated resulting levels for FY 1997	Estimated resulting levels for FY 2000	5–Year Cumulative (FY 1996–2000)
Discretionary Budget Authority	...	...	...	...	...
Discretionary Outlays	...	...	...	...	...
Mandatory Outlays	...	...	($136)	($151)	($575)
Governmental Receipts	...	...	...	...	...
FTE Changes	...	...	...	...	...

Option: Consolidation of VA Insurance Activities

	FY 1996 program levels in Budget	Estimated resulting levels for FY 1996	Estimated resulting levels for FY 1997	Estimated resulting levels for FY 2000	5–Year Cumulative (FY 1996–2000)
Discretionary Budget Authority	...	...	($247)	($1,077)	($2,211)
Discretionary Outlays	...	...	($247)	($1,077)	($2,211)
Mandatory Outlays	...	...	...	...	...
Governmental Receipts	...	...	...	...	...
FTE Changes	...	...	(6)	(16)	(16)

Option: Education Program – Use of Electronic benefits transfer

	FY 1996 program levels in Budget	Estimated resulting levels for FY 1996	Estimated resulting levels for FY 1997	Estimated resulting levels for FY 2000	5–Year Cumulative (FY 1996–2000)
Discretionary Budget Authority	...	...	$1,500	($12,615)	($21,554)
Discretionary Outlays	...	...	$500	($12,615)	($21,554)
Mandatory Outlays	...	...	...	...	...
Governmental Receipts	...	...	...	...	...
FTE Changes	...	...	...	(240)	(240)

Total Veterans Benefits Administration

	FY 1996 program levels in Budget	Estimated resulting levels for FY 1996	Estimated resulting levels for FY 1997	Estimated resulting levels for FY 2000	5–Year Cumulative (FY 1996–2000)
Discretionary Budget Authority	...	($3,580)	($6,140)	($21,675)	($58,105)
Discretionary Outlays	...	($3,580)	($7,140)	($21,675)	($58,105)
Mandatory Outlays	...	$3,800	$3,512	$3,041	$16,905
Governmental Receipts	...	...	...	...	...
FTE Changes	...	(85)	(177)	(427)	(427)

REINVENTING GOVERNMENT, PHASE II
(dollars in thousands)

Option: Create VA/DoD Federal Health Care System 1/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996-2000)
Discretionary Budget Authority	. . .	. . .	. . .	. . .	. . .
Discretionary Budget Outlay	. . .	. . .	. . .	. . .	. . .
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes	. . .	. . .	. . .	. . .	. . .

Option: VA Health Care in Need of Reform 2/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996-2000)
Discretionary Budget Authority	. . .	. . .	. . .	. . .	. . .
Discretionary Budget Outlay	. . .	. . .	. . .	. . .	. . .
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes	. . .	. . .	. . .	. . .	. . .

Option: Retention of Funds 1/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996-2000)
Discretionary Budget Authority	. . .	. . .	. . .	. . .	. . .
Discretionary Budget Outlay	. . .	. . .	. . .	. . .	. . .
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes	. . .	. . .	. . .	. . .	. . .

Material on this page was developed in response to requirements of the Vice President's Reinventing Government initiative. As such, it is for discussion purposes only, and shall not be construed to represent the views or the policy of the Department of Veterans Affairs.

February 28, 1995

REINVENTING GOVERNMENT, PHASE II
(dollars in thousands)

Option: Privatize Support Functions 3/ 4/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996 -2000)
Discretionary Budget Authority	. . .	($8,858)	($6,830)	($6,203)	($35,483)
Discretionary Budget Outlay	. . .	($8,858)	($6,830)	($6,203)	($35,483)
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes	. . .	(2,427)	(3,750)	(8,510)	(8,510)

Option: Means Test Simplification 4/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996 -2000)
Discretionary Budget Authority	. . .	. . .	($10,540)	. . .	($10,540)
Discretionary Budget Outlay	. . .	. . .	($10,540)	. . .	($10,540)
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes	. . .	. . .	(280)	(280)	(280)

1/ No cost or FTE data available.

2/ Budget neutral - additional workload handled within available resources.

3/ All data is subject to A-76 cost comparison and other non-cost issues to be considered such as labor/management negotiations and Departmental socio-economic employment goals.

4/ All projected FTE and dollar savings in VHA programs to be re-directed to direct patient care needs.

February 28, 1995

REINVENTING GOVERNMENT, PHASE II
DETAIL
Privatize Support Functions
(dollars in thousands)

Laundry Consolidations a/ b/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996 -2000)
Discretionary Budget Authority	. . .	($1,099)	($564)	. . .	($1,663)
Discretionary Budget Outlay	. . .	($1,099)	($564)	. . .	($1,663)
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes	. . .	(73)	(93)	(93)	(93)

Privatize Laundries a/ b/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996 -2000)
Discretionary Budget Authority	. . .	($698)	($726)	. . .	($1,424)
Discretionary Budget Outlay	. . .	($698)	($726)	. . .	($1,424)
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes	. . .	(320)	(480)	(480)	(480)

Privatize Housekeeping a/ b/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996 -2000)
Discretionary Budget Authority	. . .	($2,926)	($3,046)	($3,152)	($15,711)
Discretionary Budget Outlay	. . .	($2,926)	($3,046)	($3,152)	($15,711)
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes	. . .	(540)	(1,080)	(2,600)	(2,600)

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February 28, 1995

REINVENTING GOVERNMENT, PHASE II
DETAIL
Privatize Support Functions
(dollars in thousands)

Privatize Dietetics a/ b/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996 -2000)
Discretionary Budget Authority	. . .	($2,203)	($2,272)	($2,439)	($11,629)
Discretionary Budget Outlay	. . .	($2,203)	($2,272)	(2,439)	($11,629)
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes	. . .	(514)	(1,028)	(2,570)	(2,570)

Privatize Engineering Functions (Grounds Maintenance, Transportation Units, Painting and Drafting) a/ b/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996 -2000)
Discretionary Budget Authority	. . .	($687)	($716)	($739)	($3,688)
Discretionary Budget Outlay	. . .	($687)	($716)	($739)	($3,688)
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes	. . .	(114)	(228)	(570)	(570)

Privatize Construction a/ b/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996 -2000)
Discretionary Budget Authority	. . .	$337	$350	$383	$1,803
Discretionary Budget Outlay	. . .	$337	$350	$383	$1,803
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes	. . .	(11)	(22)	(55)	(55)

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February 28, 1995

REINVENTING GOVERNMENT, PHASE II
DETAIL
Privatize Support Functions
(dollars in thousands)

Privatize Medical Care Cost Recovery (MCCR) a/ b/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996 -2000)
Discretionary Budget Authority	. . .	($3,000)		. . .	($3,000)
Discretionary Budget Outlay	. . .	($3,000)		. . .	($3,000)
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes	. . .	(600)	(600)	(600)	(600)

Modernize/Decentralize Headstone/Marker Application Process (NCS) a/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996 -2000)
Discretionary Budget Authority		$540	($180)		($360)
Discretionary Budget Outlay		$540	($180)		($360)
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes		(7)	(30)	(30)	(30)

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February 28, 1995

REINVENTING GOVERNMENT, PHASE II
DETAIL
Privatize Support Functions
(dollars in thousands)

Privatize VA Police a/ b/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996 -2000)
Discretionary Budget Authority	. . .	($221)	($240)	($256)	($1,474)
Discretionary Budget Outlay	. . .	($221)	($240)	($256)	($1,474)
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes	. . .	(141)	(282)	(705)	(705)

Privatize VCS Canteen) a/ b/ d/

	FY 1996 Program Levels in Budget	Estimated Resulting Levels for FY 1996	Estimated Resulting Levels for FY 1997	Estimated Resulting Levels for FY 2000	5-Year Cumulative (FY 1996 -2000)
Discretionary Budget Authority	. . .			. . .	
Discretionary Budget Outlay	. . .			. . .	
Mandatory Outlays	. . .	. . .	. . .	. . .	. . .
Governmental Receipts	. . .	. . .	. . .	. . .	. . .
FTE Changes	. . .	(180)	(360)	(900)	(900)

a/ All projected FTE and dollar savings in to be re-directed to direct patient care needs and other benefit delivery. Data is also subject to A-76 cost comparison on ohter cost analysis and other non-cost issues to be considered such as labor/management negotiations and Departmental socio-economic employment goals.

b/ Projected dollar savings are net of estimated separation costs.

c/ Projected dollar savings are net of estimated start-up costs.

d/ Budget neutral - self-sustaining.

NOTE: The savings are based on the assumption that contracting out will be successful 30% of the time and there will be a savings of 10% in those instances. The savings are not reflected in the FY 96 budget.

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February 28, 1995

Options Considered But Not Presented

Many possible recommendations were considered and discussed by the VA Reinvention Team and the Advisory Group. Some concern efforts already underway or completed. Others concern things mutually concluded as not being worth presenting as options. These include:

1. Transfer Federal Employees Government Life Insurance program to VA.

Analysis conducted by the OMB of this option concluded that only 16 FTE are used to administer this program and that costs may increase if this program were merged with VA insurance operations.

2. Consolidate VA Education Programs.

VA administers several education programs, each with different eligibility criteria and varying benefits. The possibility of consolidating the programs into one program was considered in order to streamline administration. Discussion of the magnitude of the problems with eligibility concluded that program benefit costs may increase and the disadvantages far outweigh the advantages.

3. Transfer Restored Entitlement Program to Social Security Administration.

This program restores payments to survivors of veterans who died on active duty or as a result of service-connected disabilities whose Social Security benefits were eliminated in 1981 upon the youngest child reaching age 18. Analysis determined that only 7 FTE currently administer this program which is already funded by DoD. The conclusion was that transferring this program would not be worthwhile.

4. Restructuring of Veterans Health Administration (VA Central Office and Field).

This option simply described reorganizations currently being proposed to Congress (field) or in final stages of approval in VA (Central Office). Although both reorganizations are expected to greatly improve the management of VA's health care system, neither will result in significant funding or FTE savings. Legislation is not required to implement these reorganizations but Congressional notification is required. It was concluded that these reorganizations did not warrant presentation as Phase II options.

5. Increase privatization of cemetery operations.

Cemetery operations are contracted out whenever it is cost beneficial and feasible. Full service contracts are in place at 24 closed and 2 less active cemeteries. Specific activities are contracted at all cemeteries. National Cemetery System will continue to consider contracting out whenever possible.

6. Reduction in Assistant Secretaries.

This item concerns the recent abolishment of one of VA's six Assistant Secretaries. This has been accomplished and VA expects savings of $882,500 for FY 1995 and 1996.

7. Restructuring of General Counsel field organization.

This item concerns a streamlining of the field organization of VA's Office of General Counsel that is included in the FY 1996 Budget Submission. No additional decisions are required.

Clinton Presidential Records
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This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Divider Title: **B**

Veterans Affairs NPR Options Paper

1. Eliminating the Manufactured Home Loan Program

This is a low volume program with a high subsidy cost. VA now insures less than $1 million of new mobile homes a year. Veterans desiring to finance a mobile home have the option of using FHA's Title I program.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = 0	
Discretionary	
Mandatory	$575

- Support

2. Two Part Study To Determine if VA Should Continue to:
1) Acquire/Manage Properties in Default *(Home Loan Program)*
2) Subsidize Loans to *General Public (Vendee)* for these Properties

No Savings Associated With This Proposal A Study Only

Under current policy, when a property is foreclosed, VA determines whether it is more beneficial for them to pay the amount of the guaranty or acquire and re-sell the collateral. If the property is acquired, VA extends the benefit of their guaranty to non-veteran purchasers. This study will look at whether VA should be in the business of acquiring and selling foreclosed property rather than simply paying the loss on the property if it is less than the guaranty amount. The study will also address whether it is appropriate for VA to offer favorable seller financing to non-veteran purchasers.

- Support "Study" in 2 parts - on a fast track
- This is an area outside the Department's mission
- VA's reasons for staying in business not compelling (needs good cost/impact)
- VA has 46 property management field stations (even though brokers sell properties)
- Vendee loans have higher default rate than original veterans' loans

3. Contracting Out Portfolio Loan Servicing and Accounting

This proposal would privatize the servicing and processing for VA home loan programs.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = 171	
Discretionary	$34,340
Mandatory	($17,480)

- Support

4. Privatizing Insurance Operations (A Study)

No Savings Associated With This Proposal A Study Only

This study will address whether it is more efficient for VA to privatize the administration of life insurance programs rather than doing the administration "in house."

- Support "Study" - on a fast track
- 51% of Insurance already privatized
- The administration of this 49% is more difficult but common in private sector
- Could reduce 400 FTE and associated overhead

5. Consolidate VA Insurance Activities

This proposal consolidates VA's St. Paul and Philadelphia insurance processing operations at the Philadelphia location. Philadelphia currently handles 86% of the insurance workload.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = 16	
Discretionary	$2,211
Mandatory	

- Support

6. Using Electronic Benefits Transfer for VA's Educational Program

This proposal would further automate the processing and payment of education benefits. Benefit checks would be replaced by electronic benefit transfers.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = 240	
Discretionary	$21,554
Mandatory	

- Support

7. Reforming Eligibility for VA Health Care

- Current eligibility rules distinguish between two kinds of veterans:
  - High priority "core" veterans (low income or service-connected disability)
  - Lower priority "non-core" vets (others) account for less than 5% of VA patients.
- Current inpatient covers mainly core vets (non-core when funding allows). Outpatient care eligibility is more restrictive, with VA unable to monitor chronic conditions of even most core veterans. Non-core vets are again treated as funding allows.
- Most VA options ***expand eligibility*** in the system to cover care for non-core vets in outpatient. We are concerned about the potential cost implications of such expansion. VA believes some of the eligibility reforms could save money, but admits this is highly uncertain. Thus, with respect to some of VA's proposals, we suggest pursuing demonstrations to ascertain the costs and benefits.
- We support ***Options 7.A (prosthetics eligibility) and 7.B-2*** eligibility reform that ***streamlines eligibility of services for the high priority core veterans that rely on the VA for their health care and does not allow for expansion of the types of veterans eligible to use care.***

Option 7.A: Modest reform of prosthetics eligibility.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = ?	
Discretionary	No Savings, but costs are probably insignificant.
Mandatory	

- Support.
- Would correct the most glaring weakness in current criteria.

***Option 7.B-1*:** Allows VA to provide comprehensive health care to all veterans, while retaining existing priority distinctions between core and non-core veterans. VA would expand access to its non-institutional long-term care programs.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = ?	
Discretionary	Unknown. HAS SIGNIFICANT COSTS.
Mandatory	

- We are concerned that this option would open system to all vets -- expanding the VA system -- with increases in utilization possibly exceeding savings from reduced inpatient costs, with potentially ***major costs.***
- Expansion of non-institutional geriatric care benefits would also have ***major costs.***

Option 7.B-2*:** Allows VA to provide comprehensive inpatient and outpatient care to 95% of its current users - the high-priority ***core veteran population. While we do not know the details of this option, it should be a cost-neutral, limited eligibility reform proposal that also includes reform of prosthetic eligibility.

5-YEAR OUTLAY SAVING ($ in 000s) FTE affected = ?	
Discretionary	Unknown. Could be cost neutral or have significant costs if suppressed demand for outpatient care.
Mandatory	

- This is the option recommended by the NPR Advisory Team becaus it is most consistent with VA's central mission in that it benefits current users of the system, the core veterans. You should know that it may encourage additional core veterans to use the VA system.
- Savings realized by reducing number of unnecessary admissions may be offset or eclipsed by increased costs resulting from additional outpatient utilization. There is, however, a ***possibility of significant costs*** depending on degree of suppressed demand for outpatient care.

***Option 7.C*:** Allows VA to operate like a private sector health plan: enroll core and non-core veterans, charge premiums, make it possible for VA to become a provider option for veterans enrolled in private health plans, etc.

5-YEAR OUTLAY SAVING ($ in 000s) FTE affected = ?	
Discretionary	Unknown. HAS SIGNIFICANT COSTS.
Mandatory	

- This is an expanded version of what VA would have become under the Health Security Act. It expands VA's mission and number of eligibles, transforming VA from a system that primarily treats core veterans into one that treats all veterans.
- This option would dramatically expand the VA health system and increase access for many core veterans. We are concerned that it would have ***major costs.***
- Would allow VA to compete for non-core veterans now treated in private sector.
- We support a pilot of an option to allow VA to serve more veterans who have third-party reimbursement (see option 8.B-1a). This would give VA experience with the changes it would need to make in enrollment, contracting with private payers, etc.

***Option 7.D*:** Makes VA a quasi-governmental corporation.

5-YEAR OUTLAY SAVING ($ in 000s) FTE affected = ?	
Discretionary	Unknown. HAS SIGNIFICANT COSTS.
Mandatory	

- VA is conducting a study of this option pursuant to Congressional direction. We do not have adequate information to assess this option at this time.

8. Enhancing Veterans' Health Care Choices

- VA's options are intended to increase the number of lower-priority, non-core veterans using the VA system (they currently represent less than 5% of users), and provide new sources of funding to cover the cost of their care.
- All of these options would allow VA to serve more lower-priority, non-core veterans currently treated by private providers.
- The Medicare option has been opposed by HHS in the past. We have not discussed this with HHS.
- ***We propose to conduct a demonstration that allows VA to receive Medicare funding to support programs in which the VA has a particular expertise (e.g., spinal cord injury) or to increase the number of core veterans using the VA (options 8.A-1, 8.A-4 and 8.A-5).***
- ***We support allowing VA to conduct a demonstration in which it would retain third-party collections for certain non-core veterans. We recommend permitting VA to keep third-party collections for treatment of service-connected disabilities. We would encourage VA to implement the gainsharing plan recommended in NPR1 (options 8.B-1a and 8.B-2a).***
- ***We support allowing VA to collect the full cost of care from non-core veterans (option 8.C-2).***

Medicare Reimbursement Options:

Option 8.A-1: Would permit VA to negotiate fee-for-service rates with HCFA for care provided to higher-income, non-service veterans, and potentially, core veterans that do not now use the VA health care system.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = ?	
Discretionary	VA estimates 5-year PAYGO costs of $802 million, with $618 million in discretionary savings.
Mandatory	

- We would support working with VA and HCFA to develop a demonstration to test this idea, given uncertainties about increased utilization and potential costs.
- VA would need to develop patient-based accounting or claims systems needed to accurately bill in a fee-for-service system.
- Entitlement offsets will be needed for <u>new</u> Medicare spending on the 28,000 to 56,000 "non-core" beneficiaries currently funded out of the VA appropriation, or the caps will need to be adjusted. VA has indicated that it would be willing to reduce discretionary appropriation by the amount of Medicare reimbursements.

Option 8.A-2: Would make VA a risk contractor for Medicare eligible, higher-income, non-service connected veterans who choose to enroll with VA.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = ?	
Discretionary	5-year PAYGO costs total $55 million, with $44 million in discretionary savings. OMB believes PAYGO costs will be much higher.
Mandatory	

- We believe this option deserves further study.
- VA does not have experience operating in a managed care environment, and would have to develop proper patient-based accounting or claims systems needed to establish capitated rates.

Option 8.A-3: Authorizes VA to conduct demonstration projects of options 8.A-1 and 8.A-2.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = ?	
Discretionary	Unknown PAYGO offset required.
Mandatory	

- We would support working with VA to study the feasibility of such demonstrations.

Option 8.A-4: Authorizes VA to participate as Medicare ***Centers of Excellence***. VA has certain specialties not commonly found in the private sector (e.g., rehabilitative care, treatment for post-traumatic stress disorder, or spinal cord injury care). Under this proposal, selected VA facilities would provide these procedures to Medicare-eligible veterans. Medicare would reimburse VA for patients referred to these centers. This proposal has been successful in saving Medicare significant amounts, while providing better services to beneficiaries.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = ?	
Discretionary	Insignificant PAYGO costs. Potential reimbursement to VA is $762 million
Mandatory	

- This is an NPR Advisory Team proposal

Option 8.A-5: Authorizes a VA demonstration project permitting Medicare reimbursement for fee-for-service care provided to ***core*** veterans ***not*** currently using the system (i.e., beyond the number of core veterans funded in the appropriation).

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = ?	
Discretionary	VA estimates potential Medicare reimbursements of more than $6 billion, with a potential increase in discretionary costs $2.3 billion. OMB believes this option is cost neutral.
Mandatory	

- This was an option suggested by the NPR Advisory Team. Our concept was to allow VA to use Medicare reimbursements to expand the number of core veterans they are able to treat. This idea requires further study.
- A limited demonstration project is proposed because the cost of extending this nationwide could prove insurmountable. Most Medicare-eligible vets do not use VA.
- Because the appropriation already covers the cost of all the anticipated number of core veterans expected to apply for VA care, it could be difficult for VA to develop a method for determining whether a core veteran's care is covered by the appropriation or should be paid by Medicare.

Third-Party Reimbursement Options:

Option 8.B-1: Would permit VA to retain a portion of the recoveries collected for care provided to core veterans and all of the recoveries associated with higher-income, non-service connected veterans.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = ?	
Discretionary	VA estimates PAYGO costs of $361 million.
Mandatory	

- Because of the PAYGO costs associated with this proposal, we propose instead option 8.B-1a.

Option 8.B-1a: Authorizes a demonstration project in which a Veterans Integrated Services Network (VISN) would retain all of the third-party collections associated with treating new, higher-income, non-service connected veterans that have not previously used the VA for care. The estimated collections -- $259 million over 5 years -- would be used to pay the full cost of care for these veterans.

5-YEAR OUTLAY SAVING ($ in 000s) FTE affected = ?	
Discretionary	...
Mandatory	...

- Support
- More acceptable version of Option 8.B-1. Will not require PAYGO offsets. Does not double-fund the cost of care.

Option 8.B-2: Would establish a gainsharing program in which VA would retain <u>all</u> reimbursements collected above a specified threshold.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = ?	
Discretionary	...
Mandatory	...

- We propose an alternative to this proposal, the proposal from NPR-1 (i.e., VA retains 25 percent of the collections above the baseline, with balance going to Treasury -- Option 8.B-2a).

Option 8.B-2a: As an incentive to increase collections, implement the gainsharing plan proposed in NPR1, but with a modest change to permit the Veterans Integrated Service Networks (VISNs), rather than individual facilities, to retain their share of additional collections. VISNs would retain 25 percent of the collections above the baseline.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = ?	
Discretionary	VA estimates $244.1 million in additional mandatory collections for Treasury.
Mandatory	

- Support
- Plan would ***both*** directly benefit VA and increase receipts to the Treasury's general fund.

Option 8.B-3: Would authorize a pilot to permit VA to retain the recoveries attributable to a major insurer (e.g., Blue Cross) in a particular state. VA would, in turn, use these funds to pay primary care providers of the same insurer for care provided to veterans throughout the state.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = ?	
Discretionary	VA estimates PAYGO costs of $48.2 million.
Mandatory	

- We are concerned about the potential PAYGO costs of this option and recommend options 8.B-1a and 8.B-2a instead.
- PAYGO offsets must be identified.
- Could double-fund the cost of care -- VA's budget currently includes contract money.
- Could increase discretionary costs. By using a private insurer's health network to expand the number of primary care access points available to veterans, VA could increase hospital utilization. The insurer's access points would act as a feeder system for VA's under-utilized hospitals, bringing more eligible veterans into the system.

Personal Resource Options:

Option 8.C-1: Would permit VA to set its own co-payment schedule, presumably to increase receipts from non-core veterans.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = ?	
Discretionary	...
Mandatory	...

- Co-pays are an effective way of managing utilization. Again, however, we suggest improving the system for the core vets first.

Option 8.C-2: Would permit VA to collect from higher-income, non-core veterans the difference in the cost of care and the amount paid by the insurer.

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = ?	
Discretionary	...
Mandatory	...

- Support

9. Integrating, Consolidating and Privatizing

- The services referenced here include food, housekeeping, laundry, engineering and maintenance, police, canteen, cemetery headstone marker applications, etc. The total cost impact that they submitted across all of these areas includes:

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = ?	
Discretionary	$35,483
Mandatory	...

- We strongly support this option.
- VA spends about $1.0 billion each year (with over 22,000 FTE) on these services, so ***we suggest greater savings could be achieved*** (see cost estimate).

10. Means Test Simplification

5-YEAR OUTLAY SAVINGS ($ in 000s) FTE affected = 280		
Department of Veterans Affairs	Discretionary	$10,540
	Mandatory	...
IRS	Discretionary	?
	Mandatory	
Total Government	Discretionary	?
	Mandatory	

- Support - Assuming that IRS concurs

11. Enhancing VA/DoD Health Care Sharing and Integration

- This proposal would have the VP task the Secretaries of DoD and VA to report on the feasibility of increasing sharing and integration of medical facilities.

No Savings Associated With This Proposal
A Discussion Only

- The NPR Advisory Team supports tasking VA and DoD to step up their work on coordination of services.
- DoD treats active duty (healthy and all social-economic groups) personnel in DoD facilities. Over 7 million retirees and dependents are treated on a space available basis but are mainly treated by the private sector through a self insured health plan (CHAMPUS). VA treats indigent vets and disabled vets mainly.

Department of Veterans Affairs
Reinventing Government - Phase II
(in millions of dollars)

	Discretionary Budget Authority						Mandatory Outlays 5 Year Total	Governmental Receipts 5 Year Total
	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	5 Year Total		
Freeze Discretionary BA at the FY 1996 level	19,245.0	19,245.0	19,245.0	19,245.0	19,245.0	96,225.0	110,400.0	3,094.0
FY 1996 President's Budget Discretionary BA	19,245.0	18,700.0	18,300.0	17,900.0	17,500.0	91,645.0	n/a	n/a
Minimum Savings Required (Budget less Freeze)	0.0	545.0	945.0	1,345.0	1,745.0	4,580.0	n/a	n/a
REGO Savings in the FY 1996 Budget (if applicable)							n/a	n/a
Other Savings Required								
Agency Recommendations								
1. Eliminating the Manufactured Home Loan Program							(0.6)	
2. Two Part Study in the Home Loan Program								
3. Contracting Out Portfolio Loan Servicing and Accounting		8.6	8.6	8.6	8.6	34.3	(17.5)	
4. Privatizing Insurance Operations (A study)								
5. Consolidate VA Insurance Activities		0.4	0.4	0.4	0.4	2.2		
6. Using Electronic Brnrfits Transfer for VA's Education Program		4.3	4.3	4.3	4.3	21.6		
7. Reforming Eligibility for VA Health Care								
7a. Modest Reform of Prosthetics Eligibility								
7b.1. Provide Comprehensive Care to All Veterans								
7b.2. Provide Comprehensive Care to Core Veterans								
7c. Provide VA w/ Flexibilities to Compete and Cooperate								
7d. Form the VA Quasi-Governmental Corporation								
8. Enhancing Veterans' Health Care Choices								
8a.1. Permit VA to negotiate Fee-for-Service Rates with HCFA		0.1	0.1	0.1	0.1	0.6	(0.8)	
8a.2. Make VA a Risk Contractor for Medicare		0.0	0.0	0.0	0.0	0.0	(0.1)	
8a.3. Authorize VA to Conduct Demonstration Projects								
8a.4. VA Participation in Medicare Centers for Exellence								
8a.5. Fee-for-Service Rates for Core Veterans Only								
8b.1. Allow VA to Retain a Portion of Third Party Recoveries							(0.4)	
8b.1a. Demo Project--VA Retains Collections of Non-Users								
8b.2. Gain Sharing Proposal - VA Retains 100% Above Baseline								
8b.2a. Gain Sharing Proposal - VA Retains 25% Above Baseline							0.2	
8b.3. VA Retains Recoveries Attrib. to a Specific Insurer							(0.0)	
8c.1. VA Sets its Own Co-payments								
8c.2. VA Collects Total Cost of Care								
9. Integrating, Consolidating and Privatizing		7.0	7.0	7.0	7.0	35.0		
10. Simplifying the Means Test		2.0	2.0	2.0	2.0	11.0		
11. Enhancing VA DoD Health Care Sharing/Integration								
Total Agency Recommendations		22.4	22.4	22.4	22.4	104.8	(19.1)	
Additional OMB/NPR Recommendations								
1. Consolidate VBA Regional Offices		500.0	500.0	500.0	500.0	2,500.0		
2. Inpatient/Outpatient Facility Reengineering		700.0	735.0	772.0	810.0	3,900.0		
Total, OMB/NPR Recommendations		1,200.0	1,235.0	1,272.0	1,310.0	6,400.0		

Note: Discretionary BA estimates are changes from a BA freeze at the FY 1996 level. Mandatory outlay estimates are changes from Current Services published in the FY 1996 President's Budg

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THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

TELEFAX TRANSMISSION MEMO

ATTENTION: Jennifer O'Connor

ORGANIZATION: _____

TELEFAX NO.: 456-6704

FROM: **Robert L. Jones, Special Assistant to the Secretary (00F)**

ORGANIZATION: Department of Veterans Affairs

TELEFAX NO.: (202) 273-4876, Office No. (202) 273-4836

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NO. OF PAGES TO FOLLOW: _____

DATE: _____

MESSAGE: _____

Jennifer, Lynn, Steve

Reference the memo on the Interagency Policy Group meeting - March 2 at 10:00 am. is fine for me.

I believe it is extremely important that we have a draft report of action/results concerning the issues raised by the groups in October. The IAVPWG is being looked at by the veterans and the media as an accomplishment of the administration. We need to demonstrate progress.

Item 1. Short term issues

The Department of Labor Veterans Advisory Committee has met and is chaired by Mr. Drach of the Disabled American Veterans. The committee identified issues and began to task organize. Secretary Reich visited with the committee at its initial meeting.

Item 4.

The VSO/Mil. Coalition meetings with OMB were favorably received and provided an excellent forum for the groups to express their budget concerns and for OMB to clarify the administrations position on budget decisions. The Military Coalition meeting held after the budget had been finalized did not prompt any changes in the Defense budget but clearly indicated that there continues to be concern for military family/retiree benefits such as access to quality health care and quality of life, impact of the draw down on readiness of active and reserve forces and HCFA reimbursement for medical care given to Medicare beneficiaries.

Item 4 Long term issues

There has been a series of interagency (VA,DOL,HUD) meetings to address the issue of how to better coordinate programs and services for the homeless veteran population. At the sub cabinet level over a dozen meetings have occurred, the last in December 1993. HUD and VA have a support housing program that provides 2000 veteran priority Section 8 housing vouchers through HUD and the VA provides case management. DOL has the homeless veteran Reintegration program and is working at the staff level to obtain additional program support (read dollars) from HUD. HUD believes essentially that to break the cycle of homelessness the individual needs housing. VA and DOL believe that the cycle is broken through training and employment. HUD believes that they do not have the authority to negotiate or to feed funds to DOL for their program. DOL (OASVETS) has not been able to gain internal support to advance the issue. Recommend that the White house Interagency Veterans Policy Group forward this issue to the Interagency Council for the

Homeless and recommend that it be an agenda item at their next meeting o/a march 15, 1995.

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