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IN FOCUS

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Introduction to Veterans Health Care

The federal government's role in providing health care to the nation's veterans can be traced back to World War I. The veterans' health care system was first developed when Congress passed P.L. 65-326 in 1919 and authorized the Public Health Service to provide needed care to veterans injured or sick as a result of military service (today known as a service-connected disability)—a disability that is incurred or aggravated during active military, naval, or air service. In 1924, with the passage of the World War Veterans Act (P.L.68-242), veterans with no service-connected disability "financially unable to pay" for care were also given access to Department of Veterans Affairs (VA) health care, thus creating a safety net mission. Congress has enlarged the scope of VA's health care mission and has enacted legislation expanding benefits, new programs, and services. This In Focus briefly outlines the mission, eligibility and enrollment requirements, health care delivery system, and funding for veterans health care. Selected trends in enrollment and budget are provided as well.

Mission of the VA Health Care System

The VA provides health care and health-related services through the Veterans Health Administration (VHA). Its primary mission is to provide health care services to eligible veterans and some family members. The VHA is also statutorily required to conduct medical research, to train health care professionals, to serve as a contingency back up to the Department of Defense (DOD) medical system during a national security emergency, and to provide support to the National Disaster Medical System and the Department of Health and Human Services (HHS) as necessary (38 U.S.C. §§7301-7303; §8111A; §1785).

Eligibility and Enrollment for Care

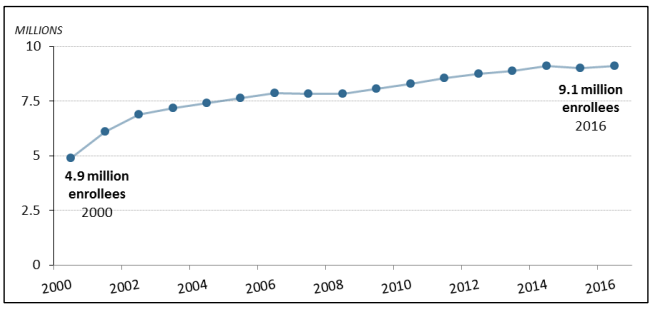
Not all veterans are eligible to receive care, and not every veteran is automatically entitled to medical care from the VHA—the system is neither designed nor funded to care for all living veterans (*The Journal of Law, Medicine & Ethics*, Volume 36, Issue 4, p.680, Winter 2008). Eligibility for veterans health care has evolved over time, and laws governing eligibility have been amended by Congress many times. The last major eligibility amendments occurred in 1996 with passage of the Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262). This law established two eligibility categories and required the VHA to manage the provision of hospital care and medical services through an enrollment system based on a system of priorities.

The first eligibility category is veterans with service-connected disabilities, Medal of Honor recipients, Purple Heart recipients, former prisoners of war, veterans exposed to toxic substances and environmental hazards such as Agent Orange, and veterans whose attributable income are equal to or below an established "means test." The second eligibility category is veterans with no service-connected disabilities but who also have attributable incomes above an established means test. Once veterans are determined to be eligible for care in VHA, veterans are required to formally enroll in the VHA health care system in order to receive services and are placed in one of eight priority groups based on the first or second eligibility category. Once a veteran is enrolled, the veteran remains in the system and does not have to reapply for enrollment annually. Enrolled veterans do not pay any premiums, deductibles, or coinsurance for their care. Some veterans are required to pay co-payments. In contrast, major medical insurance plans typically have premiums, deductibles, and co-payments.

Trends in Enrollment

As required by the Veterans' Health Care Eligibility Reform Act of 1996, VHA began formally enrolling veterans for the first time in FY1999. As shown in **Figure 1** just over 4.9 million veterans (19% of all veterans) were enrolled in the VHA in FY2000; by FY2016, that number was estimated to have increased 86%, to 9.1 million enrollees. This increase is due, in part, to factors such as enrollment of newer veterans from Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND), a larger number of female veterans, and economic conditions, among other factors.

Figure 1. VHA Enrolled Veterans, FY2000 to FY2016

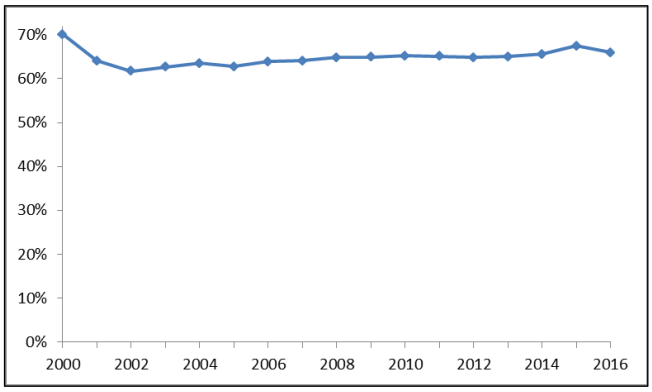


Source: Chart prepared by CRS based on VA enrollee numbers in the Department of Veterans Affairs budget justifications

Note: FY2000-FY2015 numbers are actual; the FY2016 number is an estimate.

In a given year, not all enrolled veterans receive their care from the VA—either because they do not need services or because they have other forms of health coverage such as Medicare, Medicaid, or private health insurance. **Figure 2** shows the percentage of enrollees who are unique patients in a given year. Generally, around two-thirds of enrollees in a given year are VHA patients and receive some or all of their health services from VHA.

Figure 2. VHA Patients as a Percentage of VHA Enrollees, FY2000-FY2016



Source: Chart prepared by CRS based on VA enrollee and patient numbers in the Department of Veterans Affairs Budget Justifications.

Notes: FY2000-FY2015 numbers are actual; the FY2016 number is an estimate.

VA Health Care System

Once veterans are eligible and enrolled, they receive their care directly through a large integrated health care system. VHA is the largest integrated health care system in the United States, with over 1,700 sites of care, including medical centers, community based outpatient clinics (CBOCs), nursing facilities, and Vet Centers. To administer this large system, the VHA has divided the country into Veterans Integrated Service Networks (VISN), based on geography. There are currently 18 VISNs, which vary regarding the number of sites of care, the types and number of facilities, and the geographic size of the network's region. Each VISN has a VISN Director, who has oversight of the VA facilities within that VISN and directly supervises the facility director at each facility. Although policies and guidelines are developed at VA headquarters to be applied throughout the VHA health care system, management authority for basic decisionmaking and budgetary responsibilities are delegated to the VISNs.

It should be noted that compared with the predominant health care financing and delivery model in the United States—where there is a payer for health care services (e.g., Medicare or private health insurance plan), a provider (e.g., hospital, physician), and a recipient of care (the patient)—the VHA operates under a very different model. It is not a health insurance financing program that provides reimbursement to providers for all or a portion of a patient's health care costs. VHA is primarily a direct provider of care; VHA owns the hospitals and employs the clinicians. Nevertheless, VHA does pay for care in the community under certain circumstances, as authorized (38 U.S.C.§1701 note;38 U.S.C.§1703;38 U.S.C.§1703 note; 38 U.S.C.§8153; 38 U.S.C.§8111;38 U.S.C.§1725; and 38 U.S.C.§1728).

Health Care Services

All enrolled veterans are eligible for a standard medical package, which includes a full range of health care, gender-specific medical services, prescription drugs, long-term care, and social support services. The medical package provides benefits generally not found in private health insurance plans, such as travel reimbursement for medical appointments, family caregiver stipends, homeless veterans programs, and dental care (38 C.F.R. §17.38).

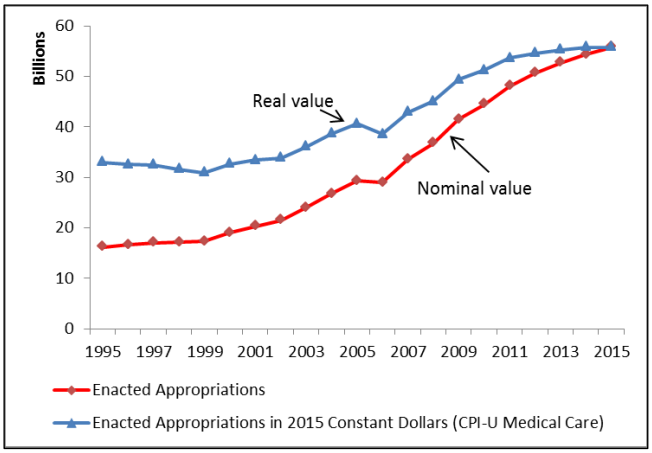
VHA Health Care Appropriations

Congress annually provides discretionary appropriations to fund VA health care and support services for enrolled veterans. In addition to annual discretionary appropriations, Congress has provided VHA the authority to bill some veterans and most health care insurers for nonservice-connected care provided to enrolled veterans to help defray care costs.

Trends in Appropriations

In FY2017, Congress provided $64.59 billion (not shown in **Figure 3**) for VHA—without research and collections amounts—and in FY1995 this amount was $16.22 billion (in nominal dollars). Between FY1995 and FY2005, VHA's appropriations grew in real terms by 2% on average; between FY2005 and FY2015, it grew by 4% on average. Overall from FY1995 to FY2015, VHA's appropriations in real terms grew by about 2.8% on average, from about $33 billion to $55 billion (**Figure 3**).

Figure 3. VHA Appropriations, FY1995-FY2015



Source: Chart prepared by CRS based on enacted appropriation figures provided by VA Office of Budget.

Notes: VHA medical care appropriations include funding for the medical services, medical administration, and medical facilities accounts, and exclude medical and prosthetic research funding and medical care collections.

CRS Products

CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by Sidath Viranga Panangala

CRS Report R44625, *Department of Veterans Affairs FY2017 Appropriations*, by Sidath Viranga Panangala

CRS Report R44301, *Veterans' Medical Care: FY2016 Appropriations*, by Sidath Viranga Panangala

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