

Asset and Infrastructure Review (AIR) Act of 2017

Analysis by

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Analysis

The AIR bill's goals of achieving structural efficiencies and saving taxpayer money without sacrificing high-quality healthcare for veterans are laudable and timely. However, the opposite result is more likely -- **increased cost to taxpayers and compromised quality of care for veterans**. Closing down Veteran Health Administration (VA) facilities would leave veterans to fend for themselves in the fragmented Veterans Choice Program (VCP) system. The extra costs associated with outsourced care would drain the VA of needed funding for staffing and services. The bill would accelerate the privatization of veterans' health care and threaten the long-term viability of the VA, closely adhering to the recommendations advocated in the 2016 "Strawman proposal." ⁱ

More specifically:

Increases Costly Use of Veterans Choice Program

- This bill differs in important ways from the Department of Defense's Base Realignment and Closure (BRAC) process that it is modeled after. If three military bases are consolidated into two, the DoD saves expenses of operating the 3rd base when all of the servicemembers are redistributed and absorbed by the two receiving bases. This veterans' Asset and Infrastructure Review process is fundamentally different. If three facilities were consolidated into two, the veterans receiving care at the 3rd facility would NOT go to the other VAs. In nearly all cases, the other facilities are too far away. In the few densely populated areas where another VA is within reasonable distance, there is little capacity to absorb the redistributed veterans. The veterans enrolled at the closed facility **would immediately – and permanently -- be pushed into the VCP**.
- Independent reviews forecast that granting **unfettered Choice options for veterans would vastly increase, not decrease, costs**. There are two main reasons for this budget-busting impact. (1) There are nearly as many "eligible" or "enrolled" veterans who do not use the VA as those who do. Without a local VA, all of them would be folded into VA-subsidized Choice care, and outlays will skyrocket. See Appendix below for explanation. (2) Managing the care veterans receive in the community would require contracting with a third party administrator, adding more costs, and as we have seen with the current Choice program, more inefficiencies. If these

projections are correct, then the bill's costs significantly exceed the CBO \$3.8 billion cost estimate (as well as their additional \$7.5 billion cost for facility leasing).

- The impact would not be felt merely in the locales where VA facilities are shut. **It will take money out of the entire VA system, leaving less available to preserve VA's capacity to offer care.** Most likely, benefits would be cut.
- Although purportedly a cost-saving measure, there is nothing in the bill that prohibits the closure or realignment of facilities when doing so would increase overall long-term costs.

Accelerates Privatized Veterans Health Care

- The Commission's processes will begin three years from now. But immediately, the bill allocates \$2.1 billion for provision of clinical care via the VCP. No money is allocated for VA care. (\$500,000 is allocated for minor construction and non-recurring maintenance projects.) **This is an unmistakable message that continued expansion of privatized veterans care, and diminished VA-delivered care, is the intention of the bill.**
- **This is a cannibalizing process, whereby in order for one facility to improve, another has to be closed or realigned.** Once a facility closes and outsourced care in the community is paid, it is unclear that much will be left for other facilities improvements.
- The VA can hand over a facility's deed to a private entity (even for free), as long as the entity complies with environmental restoration requirements. There are no restrictions on what's done with the property once it is environmentally cleared. **The entity can turn right around and re-open the facility to provide private care for veterans, paid for by the VA.**
- The bill explicitly denies Congresspersons' ability to represent the veterans and constituents in their communities. There can be no motions to reconsider or amend the Commission recommendations. **At a more stealth level, Congress can cede the process of dismembering the VA to a proxy committee and then claim that they had no responsibility for closures and privatization.**
- Given the current administration's commitment to shrinking government and transferring government obligations and accountability to the private sector, **it is highly likely that the administration will fill the Commission with healthcare executives who have a huge stake -- and a conflict of interest -- in VA privatization. These inordinately powerful commissioners make the final set of recommendations, and it takes only five members to decide the fate of the veterans' healthcare system.** While three seats are reserved for recognized Veteran Service Organization members, even if they voted as a bloc their votes will have little to no influence on the outcome.

Eliminates Veterans Option of Superior VA Care

- The bill ignores that veterans emphatically prefer the VA system and its facilities to be improved, not dismantled. **Where a VA facility is closed, veterans who want VA care will no longer have that choice.**
- It ignores that **community clinicians lack the military and veteran cultural competence, the special clinical competence, or the access to a sophisticated array of therapeutic resources pertinent to military service health vulnerabilities.** Care in the community rarely includes VA's primary care – mental health integrated approach so essential with this population.
- **It leaves veterans to fend for themselves** in a chaotic private healthcare system. For those veterans who rely on VA's veteran-centered care, there is no substitute.

The Commission on Care Final Report ⁱⁱ warned that closing VA facilities would reduce the choices available to veterans, and offered a **win-win alternative solution that would ensure veterans continue to receive VA care at facilities that are underutilized without added expense to taxpayers.** It suggested (p. 161) “allowing veterans’ family members and currently ineligible veterans to purchase VA care through their health plans in areas where VA hospitals and other facilities might otherwise need to close... Participating VA facilities will be able to retain any ‘profit’ associated with treatment of new users without offset.” The Final Report noted that this plan has many potential benefits:

- optimizing patient safety, productivity, and cost-effectiveness by ensuring sufficient patient volumes in currently under-utilized facilities,
- preserving mission critical veterans’ programs that would otherwise need to be terminated in many parts of the country,
- optimizing the integration of VHA and non-VHA care within communities,
- providing a public option for health care to a wider range of veterans as well as non-veterans in communities where health care choices are currently limited,
- bringing in new sources of revenue to contribute to the funding for veterans’ healthcare.

We support this forward-thinking, no-cost recommendation.

It is impossible to overstate the concern that a Commission that favors the increased privatization of government services combined with less regulation and accountability for the private sector will produce a situation in which veterans receive lower quality and less integrated care at a much higher cost in money and suffering.

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APPENDIX

There are four overall categories of U.S. veterans in terms of eligibility to use the Veterans Health Administration (VA) for their healthcare. The table below shows the size of each category and how each would be affected by the AIR bill.

Category of veteran	Approximate % of total veterans	Veterans authorized for VCP under current law	Veterans authorized for VCP if AIR bill passes
A. Eligible, enrolled, and used the VA in the last year	31	Yes ¹	Yes ²
B. Eligible, enrolled, but didn't use the VA in the last year	12	No	Yes
C. Eligible for VA, but not enrolled	14	No	Yes ³
D. Not eligible for VA	43	No	No
Total	100		

¹If VA cannot provide timely, convenient care

²For nearly all veterans in this category

³Once the veteran enrolls

Implications for each category of veteran

After the AIR Commission closes a local VA facility, care that was being delivered at the VA will move to the community, the amount of paid care will vastly increase and overall costs will skyrocket.

- The cost for category A veterans' care will increase in two ways. Any treatment (for example, an organ transplant) that costs more to render in the community than in the VA increases outlays. Second, switching to a fee-for-service model of reimbursement incentivizes more utilization than in the current VA managed-care model
- The health care received by veterans in category B, which under current law is not paid by VA, would be authorized for paid VCP-care.
- Veterans in category C, whose health care is also not currently covered by the VA, would be authorized for paid VCP-care as soon as they enroll.
- Although not every veteran in category B or C would elect to get services from a VCP provider, an appreciable number will do so, especially in urban areas. These changes will astronomically increase the overall expense to taxpayers, since presently the VA pays for none of the care received by category B and C veterans.

The likely way that Congress would offset these budgetary problems would be severe cuts in VA services and benefits.

ⁱ <http://3mc77e18jo7n1uk8m71my8ml.wpengine.netdna-cdn.com/wp-content/uploads/2016/04/Proposed-Strawman-Assessment-and-Recommendations.pdf>

ⁱⁱ https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf