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Health Care for Veterans: Answers to Frequently Asked Questions

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SUMMARY

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Health Care for Veterans: Answers to Frequently Asked Questions

The Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), operates one of the nation's largest integrated health care delivery systems. The VHA estimates that, in FY2020, it would provide care to about 6.29 million unique veteran patients, employing a staff of about 343,000 full-time equivalent employees, with an appropriation request of approximately $80.93 billion. VA health care is a discretionary program; therefore, the provision of health care is dependent on available appropriations.

Eligibility and Enrollment

Not every veteran is automatically entitled to medical care from the VA. Veterans must meet basic eligibility requirements for enrollment.

Eligibility for VA health care is based primarily on veteran status resulting from military service. Generally, veterans must also meet minimum service requirements; however, exceptions are made for veterans discharged due to service-connected disabilities, members of the Reserve and National Guard (under certain circumstances), and those eligible under special treatment authorities, such as Camp Lejeune veterans.

In the enrollment process, the VA categorizes veterans into eight priority categories, based on factors such as service-connected disabilities, income, and combat veteran status (among others). The VA may limit enrollment based on the availability of funds—an authority provided by Congress. Some veterans without service-connected disabilities and whose attributable income exceeds established means tests cannot enroll in the VA health care system. Dependents, caregivers, and survivors of certain veterans are eligible for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), which reimburses non-VA providers or facilities for their medical care.

Medical Benefits

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

For female veterans, the VA provides gender-specific care, such as gynecological care, breast and reproductive oncology, infertility treatment, maternity care, and care for conditions related to military sexual trauma. Under current regulations, the VA is not authorized to provide, or cover the costs of, in vitro fertilization, abortion counseling, abortions, or medication to induce abortions. However, as authorized by the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2019 (P.L. 115-244), the VA may provide fertility counseling and treatment using assisted reproductive technology or adoption reimbursement to certain veterans.

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

Under certain circumstances, the VA authorizes care to eligible veterans to receive care in the community. Under provisions of the VA MISSION Act of 2018 (P.L. 115-182, as amended), on June 6, 2019, the VA launched the new Veterans Community Care Program (VCCP). In addition, starting June 6, 2019, veterans can access urgent, nonemergency care in the community within VA's contracted network of providers.

Costs to Veterans and Health Insurance Coverage

In general, veterans do not pay for care related to service-connected conditions. Moreover, veterans with service-connected disabilities rated 50% or greater are exempt from any copayments. Although enrolled veterans do not pay premiums for VA care, some veterans are required to pay copayments for medical services and outpatient medications related to the treatment of nonservice-connected conditions. Copayment amounts vary by priority category and type of service. The VA has the authority to bill most health care insurers for nonservice-connected care; any insurer's payment received by the VA is used to offset "dollar for dollar" a veteran's VA copayment responsibility. The VA is statutorily prohibited from receiving Medicare payments (with a narrow exception).

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Introduction

The Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), operates one of the nation's largest integrated direct health care delivery systems. The VHA estimates that, in FY2020, it would provide care to about 6.29 million unique veteran patients.[1] In the same year, VHA estimates employing a staff of about 343,000 full-time equivalent employees[2] at approximately 1,420 VA sites of care,[3] with an appropriation of approximately $80.93 billion.[4]

For other health care programs that are publicly funded—for example, Medicare, Medicaid, and the Children's Health Insurance Program (CHIP)—private providers in private facilities deliver most of the health care services. In contrast, the VA health care system could be categorized as a veteran-specific national health care system, in the sense that the federal government owns a majority of its health care delivery sites, employs the health care providers, and directly provides the majority of health care services to veterans.[5]

It should be noted that VA health care is *not* a health insurance plan similar to what many individuals or employers purchase in the private health insurance market, nor does it have the same health insurance plan characteristics, such as coinsurances, deductibles, and premiums.[6]

This report provides responses to frequently asked questions about health care provided to veterans through the VHA. It is intended to serve as a quick reference for easy access to information. Where applicable, it provides the legislative background pertaining to the question. Throughout this report, VA and VHA are used interchangeably to refer to the VA health care system.

The report discusses three broad topics: (1) eligibility and enrollment (including how they differ), (2) medical benefits, and (3) the cost of care and the VA's authorities to bill and collect from a third-party when a veteran has other health insurance or another source of payment.

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[1] Department of Veterans Affairs, *FY2020Congressional Submission, Medical Programs and Information Technology Programs,* Vol.2 of 4, March 2019, p. VHA-27.

[2] Department of Veterans Affairs, *FY2020 Congressional Submission, Budget in Brief*, March 2019, p. BiB-10.

[3] Ibid. p. BiB-11. (Sites of care used in this calculation are VA hospitals, community living centers, health care centers, community-based outpatient clinics (CBOCs), other outpatient service sites, and dialysis centers.)

[4] Department of Veterans Affairs, *FY2020 Congressional Submission, Supplemental Information &Appendices*, Vol 1 of 4, March 2019, p. Supplemental Information-1.

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

[6] *Coinsurance* is a form of medical cost-sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid. A *deductible* is a fixed dollar amount during the benefit period—usually a year—that an insured person pays before the insurer starts to make payments for covered medical services. A person enrolled in a private health insurance plan must pay a fee (*premium*), typically on a monthly basis, to maintain coverage under the plan. For more information on health insurance, see CRS Report RL32237, *Health Insurance: A Primer*.

Eligibility

Are All Veterans Eligible for VA Health Care?

In general, not all veterans are eligible to receive VA health care services. To be eligible, veterans must meet both basic and more specific criteria.

Generally, a veteran has to meet *three* basic criteria to be eligible for VA health care.[7] A veteran must (1) meet the statutory definition of a "veteran," meaning an "individual who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable"[8] (see text box for definitions of military discharges); (2) meet the statutory definition of "active duty," meaning full-time duty in the Armed Forces, other than active duty for training;[9] and (3) have served a minimum period of 24 months of continuous active duty.[10]

Some veterans may meet the eligibility requirements listed above but, due to the discretionary nature of VA health system funding, may not be allowed to enroll in the system.[11] (See the "Enrollment in the VA Health Care System" section below.)

Descriptions of Military Character of Discharge

- **Honorable discharge** applies when the quality of a servicemember's service generally has met the standards of acceptable conduct and performance of duty for military personnel, or is otherwise so meritorious that any other characterization would be clearly inappropriate
- **General (under honorable) discharge** applies when a servicemember's service has been honest and faithful. Characterization of service as general (under honorable conditions) is warranted when the positive aspects of a servicemember's conduct or performance of duty outweigh negative aspects of the servicemember's conduct or performance of duty as documented in their service record.
- **Other-than-honorable discharge** applies when separation is based on a pattern of behavior that constitutes a significant departure from the conduct expected of servicemembers, or when separation is based on one or more acts or omissions that constitute a significant departure from the conduct expected of servicemembers. Factors that may lead to such a discharge include the use of force or violence to produce serious bodily injury or death; abuse of a special position of trust; disregard by a superior of customary superior-subordinate relationships; acts or omissions that endanger the security of the United States or the health and welfare of other servicemembers; and deliberate acts or omissions that seriously endanger the health and safety of other persons.
- **Bad-conduct discharge** applies only to enlisted persons and may be adjudged by a general court-martial and by a special court-martial. A bad-conduct discharge is less severe than a dishonorable discharge and is designed as a punishment for bad conduct rather than as a punishment for serious offenses of either a civilian or military nature. It is also appropriate for an accused servicemember who has been repeatedly convicted of minor offenses and whose punitive separation appears to be necessary.
- **Dishonorable discharge** applies only to enlisted persons and warrant officers who are not commissioned and may be adjudged only by a general court-martial. A dishonorable discharge may be adjudged for any offense in which a warrant officer who is not commissioned has been found guilty. It is reserved for those who should be separated under conditions of dishonor, after having been convicted of offenses typically recognized in civil jurisdictions as felonies, or of offenses of a military nature requiring severe punishment.

Source: CRS, adapted from the Department of Defense, *Enlisted Administrative Separations,* DOD Instruction 1332.14, effective April 12, 2019 and the *Manual for Courts-Martial United States* (2019 edition).

[7] Department of Veterans Affairs, Veterans Health Administration, *Eligibility Determination*, VHA DIRECTIVE 1601A.02, November 21, 2018.

[8] 38 U.S.C. §101(2).

[9] 38 U.S.C. §101(21).

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

[11] Department of Veterans Affairs, "Enrollment-Provision of Hospital and Outpatient Care to Veterans Subpriorities of Priority Categories 7 and 8 and Annual Enrollment Level Decision," 68 *Federal Register* 2669, 2003.

In addition to the general eligibility criteria above, Congress has enacted several measures to grant limited eligibility to certain categories of veterans for specific conditions or specific services under special treatment authorities. For example, the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154) authorized the VHA to provide hospital care and medical services, for certain specified conditions, to certain veterans who served at the Marine Corps base at Camp Lejeune, North Carolina, during a specific period of time. Moreover, the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2018 (P.L. 115-141, as amended), provided eligibility for mental health care and behavioral health services to certain veterans with other-than honorable (OTH) discharges. These specific eligibilities, among others, are discussed in the questions and answers below.

Is Eligibility Different for Members of the Reserves?

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

Members of the Reserve components may be eligible for VA health care based on veteran status (i.e., previous military service) or service-connected disability. (See text box on service-connected disability.) Reservists achieve veteran status and are exempt from the 24-month minimum duty requirement (described above) if they (1) were called to active duty, (2) completed the term for which they were called, and (3) were granted a discharge under conditions that were other than dishonorable.

What Is a Service-Connected Disability?

In general, a service-connected disability means that a disease or injury resulting in a disability, based on all the evidence, was incurred in the line of duty during military service. If the disabling condition was preexisting, then such disability was aggravated during such service.[12] A veteran's military service need not have been during combat or a period of war.

Currently, there are five ways to establish that a disability is service-connected:

- Through direct service connection—that is, the facts, shown by evidence, establish that a particular injury or disease resulting in a disability was incurred while in service in the Armed Forces.[13]
- Through aggravation during service—that is, a preexisting injury or disease is considered to have been aggravated while in service in the Armed Forces.[14]
- Through proximity—that is, a disability is proximately due to, or the result of, a service-connected disease or injury considered to be service-connected.[15] An example would be a veteran developing cardiovascular disease due to a service-connected amputation of a lower limb.
- Through a finding that the disability was caused by medical care or vocational rehabilitation provided by the VA—that is, a disability caused by VA-provided medical care or vocational rehabilitation is treated as if it were service-connected.[16]
- Through the application of statutory presumptions—that is, certain diseases as established by law or regulation are considered to have been incurred in or aggravated by service in the Armed Forces, even without evidence of such a disease during the period of service.[17]

[12] 38 U.S.C. § 1110, 1131; 38 C.F.R. § 3.303(a)

[13] 38 C.F.R. § 3.303.

[14] 38 C.F.R. § 3.306.

[15] 38 C.F.R. § 3.310.

[16] 38 C.F.R. § 1151.

[17] 38 C.F.R. § 3.307.

The VA evaluates a disability based on a schedule (VA Schedule for Rating Disabilities, VASRD) of ratings (based on average impairment of earning capacity) and assigns ratings from 0% to 100% based on the severity of the disability. Ratings are assigned in 10% increments.[18] When a veteran has more than one service-connected disability, the VA uses a formula to determine the combined rating of disability.[19]

Members of the Reserve components may be granted service connection for any injury they incurred or aggravated in the line of duty while participating in inactive duty training sessions, annual required training sessions, or active duty for training.

Injuries incurred during transfer from or to any of the above training sessions may also be granted as service-connected disabilities.[20] In addition, Reserve component members who experience a heart attack, cardiac arrest, or stroke during training may have those medical events established as service-connected conditions.[21]

Is Eligibility Different for Members of the National Guard?

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

Similar to regular active duty servicemembers, members of the National Guard may be eligible for VA health care based on veteran status (i.e., previous military service) or service-connected disability.[22]

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

In contrast to when called to active duty by a federal executive order, National Guard members are not granted service connection for any injury, heart attack, cardiac arrest, or stroke that occurs while performing duty ordered by *a governor for state emergencies or activities*.[23]

Is Eligibility Different for Veterans Who Served on Active Duty at Camp Lejeune?

Certain veterans who served on active duty for a period of no fewer than 30 days between August 1, 1953, and December 31, 1987, and who worked or lived at Camp Lejeune are eligible to receive health care for certain medical conditions.

The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154), as amended by the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235, Division I, Title II, Section 243), established a presumptive service connection for veterans' health care for one or more of 15 diseases and health conditions that may be associated with exposure to trichloroethylene (TCE), tetrachloroethylene (PCE), vinyl chloride, and other

[18] 38 C.F.R. Part 4

[19] 38 C.F.R. §4.25

[20] For members of the Reserves, service connection may be granted for injuries, but not for diseases.

[21] 38 U.S.C. §101(24); 38 C.F.R. §3.6(a).

[22] Ibid.

[23] 38 C.F.R. §3.6(c).

contaminants discovered in drinking water supplies at Camp Lejeune, North Carolina. Veterans and their family members who worked or lived at Camp Lejeune for no less than 30 days (consecutive or nonconsecutive) from August 1, 1953, to December 31, 1987, generally are eligible for VA health care services under this law.[24] Eligible veterans and family members can receive free care for any of the 15 covered illnesses or conditions.[25] To be eligible, a veteran or former reservist or member of the National Guard (1) must have been stationed at Camp Lejeune, or traveled to Camp Lejeune as part of his or her professional duties, and (2) must have served on active duty[26] for at least 30 (consecutive or nonconsecutive) days during the period beginning on August 1, 1953, and ending on December 31, 1987.[27]

Are Former Servicemembers with Discharges Characterized as Under Other–Than-Honorable (OTH) Conditions Eligible for VA Health Care?

Under certain circumstances, a former servicemember found to be dishonorably discharged for VA purposes may be eligible for VA health care services.

To be eligible for VA health care, a veteran generally has to meet certain criteria, which includes a discharge or release from active service under conditions other than dishonorable.[28] A discharge that is characterized by the Department of Defense (DOD) as an honorable discharge or general under honorable conditions, with some exceptions, qualifies veterans for VA health care services.[29] If the discharge is under OTH conditions, administrative discharge, or is a punitive bad conduct discharge (BCD), the VA is required to make a character of discharge (COD) determination on a case-by-case basis to determine eligibility.[30] Generally, when a former servicemember with an OTH or BCD discharge applies for health care services, the VHA forwards the request for an eligibility determination by submitting VA Form 20-0986 to the Veterans Benefits Administration (VBA) Regional Office (RO).[31] COD determinations result in one of three potential outcomes:

1. *Honorable for VA purposes*, meaning that the veteran qualifies for all veterans benefits, including health care benefits, provided that other eligibility criteria (such as minimum active duty service requirements) are met.

[24] 38 U.S.C. §1710(e)(1)(F); 38 U.S.C. §1787; and 38 C.F.R. §17.400.

[25] A covered illness or condition incudes any of the following: esophageal cancer; lung cancer; breast cancer; bladder cancer; kidney cancer; leukemia; multiple myeloma; myelodysplastic syndromes; renal toxicity; hepatic steatosis; female infertility; miscarriage; scleroderma; neurobehavioral effects; and Non-Hodgkin's lymphoma (38 C.F.R. §17.400).

[26] As defined in 38 U.S.C. §101(21).

[27] As originally enacted, P.L. 112-154 specified January 1, 1957, as the beginning date of eligibility. The Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235, Division I, Title II, Section 243), amended P.L. 112-154 to change this date to August 1, 1953, based on more current information suggesting that the contaminated water supplies may have been in use earlier than previously thought.

[28] 38 U.S.C. §101(2); 38 C.F.R. §3.1(d).

[29] This applies unless the separation reason is explained in the DD-214 form (Certificate of Release or Discharge From Active Duty) as a bar to benefits under 38 U.S.C. 5303(a).

[30] Adjudication Procedures Manual M21-1, Part III, Subpart v, Chapter 1, Section B - Statutory Bars to Benefits and Character of Discharge (COD).

[31] Department of Veterans Affairs, Veterans Health Administration, *Eligibility Determination*, VHA DIRECTIVE 1601A.02 November 21, 2018.

2. *Dishonorable for VA purposes, but eligible to receive health care services*, meaning that the veteran is eligible to receive health care only for service-connected or service-aggravated disabilities or conditions.[32]
3. *Dishonorable for VA purposes due to a statutory bar to VA benefits*, meaning that the veteran is not eligible for service-connected disability compensation or health care services. In essence, the VA is barred from providing any benefit or service to the former servicemember.[33]

Are There Special Eligibility Rules for Those Seeking Mental Health Care Services from the VA?

Certain former servicemembers with mental or behavioral health care needs, including risk of suicide or harming others, are eligible for an initial mental health assessment and subsequent mental health services, even if they were discharged from the military service under other-than-honorable (OTH) conditions. In addition, former servicemembers may qualify for emergency mental health care services.

Section 258 of the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act of 2018 (P.L. 115-141, as amended by P.L. 115-182 and P.L. 115-251) authorized the VA to provide an initial mental health care assessment and subsequent mental or behavioral health care services to certain former servicemembers, including those who served in the reserve components and who meet each of the following criteria:

- *Conditions of discharge*: the veteran served on active duty and was discharged or released under a condition that is not honorable (but not a dishonorable discharge), or was discharged by court-martial (i.e., those with a dishonorable discharge or a discharge by court-martial would not be eligible for mental health care services from the VA).
- *Duration of service*: the veteran served for a period of more than 100 cumulative days.
- *Conditions of service*: the veteran (1) was deployed in a theater of combat operations, in support of a contingency operation, or in an area at a time during which hostilities occurred, including by controlling an unmanned aerial vehicle (UAV) from a location other than such theater or area; or (2) was the victim of a physical assault of a sexual nature, a battery of a sexual nature, or sexual harassment.
- *Not currently enrolled* in VA's health care system.[34]

Those veterans with an OTH administrative discharge and who meet the above criteria are not required to enroll in VA's health care system, to meet the minimum active duty service

[32] 38 C.F.R. §3.360. If the outcome is dishonorable for VA purposes, but the veteran is eligible for health care services, the VBA RO must prepare a rating decision addressing service connection for treating only specific service-connected disabilities or conditions. A rating decision is "a record purposes document detailing the formal determination made by the RO rating activity regarding one or more issues of benefit entitlement. The rating decision states the decisions made and provides an explanation supporting each decision." (Adjudication Procedures Manual, M21-1, Part III, Subpart iv, Chapter 6, Section C - Completing the Rating Decision Narrative).

[33] Adjudication Procedures Manual, M21-1, Part III, Subpart v, Chapter 7, Section A - Eligibility for Hospital, Nursing Home, Domiciliary, and Medical Care.

[34] 38 U.S.C. §1720I.

requirements, or to pay any copayments for mental and behavioral health care services included under VA's standard medical benefits package.[35]

Emergency Mental Health Care Under Humanitarian Care Provisions

The Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (P.L. 107-135) provided the Secretary broad authority to furnish hospital care or medical services in emergency situations to any individual regardless of veteran status. This authority is generally referred to as the *humanitarian care authority*. Furthermore, the Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016 (P.L. 114-315) requires VA emergency departments to, at minimum, screen individuals for a medical emergency. If the facility determines that a medical emergency exists, the facility will provide care to stabilize the individual's emergency condition.[36] The individual is generally billed for any emergency services provided.[37]

A former servicemember with a bad conduct or dishonorable discharge who is in distress and in need of emergency mental health services may be provided services under humanitarian care provisions.[38] Former servicemembers can access the VA system by calling the Veteran Crisis Line[39] or by visiting a VA emergency room, urgent care center, or VA medical center.

On March 7, 2017, during a hearing before the House Veterans Affairs Committee, VA Secretary Dr. David Shulkin announced his intention to expand urgent mental health care services to former servicemembers with OTH administrative discharges. Under this initiative, effective July 5, 2017, a former service member with an OTH administrative discharge with an urgent mental health need qualifies for a 90-day episode of care, which includes inpatient, residential, or outpatient care.[40] This initiative provides care beyond the requirement to stabilize the patient under humanitarian care provisions. During this 90-day period, the VBA may have time to complete a character of discharge determination and notify the VHA of the former servicemember's discharge status. The initiative also allows an additional 90 days of treatment to be authorized upon request to the Chief Medical Officer for the Veterans Integrated Service Network (VISN).[41]

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[35] Department of Veterans Affairs Veterans Health Administration, *Eligibility Determination*, VHA DIRECTIVE 1601A.02 November 21, 2018.

[36] Department of Veterans Affairs Veterans Health Administration, *Eligibility Determination*, VHA DIRECTIVE 1601A.02, November 21, 2018, and 38 U.S.C. §1784A.

[37] 38 U.S.C. §1784.

[38] Department of Veterans Affairs Veterans Health Administration, *Eligibility Determination*, VHA DIRECTIVE 1601A.02, November 21, 2018. p. 17.

[39] In 2007, VHA established a suicide crisis hotline. It was initially called the National Veterans Suicide Prevention Hotline. In 2011 its name was changed to the Veterans Crisis Line (VCL). In addition to calling, veterans could chat and text and connect with a counselor. See https://www.veteranscrisisline.net/Default.aspx.

[40] Memorandum from Deputy Under Secretary for Health for Operations and Management (1ON) to Network Directors (10N1-23) and Network Mental Health Leads (10N1-23), *Eliminating Veteran Suicide: Emergency Services for Other Than Honorable*, June 26, 2017.

[41] The VA health care system is divided into administrative regions, called 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. For more information, see CRS In Focus IF10555, *Introduction to Veterans Health Care*.

Eligibility Based on Presumption of Mental Illness or Psychosis

Certain veterans, including those with an OTH administrative discharge, may qualify for free care under presumptions of eligibility for psychosis[42] or mental illness other than psychosis to treat those conditions. Former servicemembers who meet either of the two presumptive criteria do not have to meet the minimum active duty service requirements, and they are not required to pay any copayments for the treatment of covered conditions.

Under the presumptive eligibility for psychosis, a former servicemember must have served on active duty during World War II, the Korean conflict, the Vietnam era, or the Persian Gulf War and developed an active psychosis (1) within two years after discharge from active duty and (2) before specific statutory dates associated with the war or conflict in which the servicemember served, as follows:

- World War II: before July 26, 1949.
- Korean conflict: before February 1, 1957.
- Vietnam era: before May 8, 1977.
- Persian Gulf War: before the end of the two-year period beginning on the last day of the Persian Gulf War.[43]

Under the presumptive eligibility for mental illness other than psychosis, a former servicemember must have served on active duty in the Persian Gulf War and developed an active mental illness other than psychosis (1) within two years after discharge and (2) before the end of the two-year period beginning on the last day of the Persian Gulf War.[44]

Are Veterans' Family Members Eligible for VA Health Care?[45]

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

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) pays for health care services to dependents and survivors of certain veterans. It is primarily a fee-for-service program that reimburses the cost of medical care provided by non-VA providers or facilities. On May 5, 2010, President Barack Obama signed into law the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163), which expanded the CHAMPVA program to include the primary family caregiver of a post-9/11 veteran who has no other form of health

[42] "Psychosis is a range of symptoms that includes experiencing hallucinations and/or delusions. It is seen most commonly in schizophrenia, schizoaffective disorder, and bipolar disorder." Source: Jared Bernard et al., *A Clinician's Guide to Psychosocial and Psychotherapeutic Interventions for Veterans with Psychosis*, VA South Central Mental Illness Research, Education and Clinical Center (SC MIRECC), https://www.mirecc.va.gov/VISN16/docs/psychotherapy-for-psychosis-clinician-brochure.pdf.

[43] 38 U.S.C. §1702 and 38 C.F.R. §17.109. The Persian Gulf War is defined as "the period beginning on August 2, 1990, and ending on the date thereafter prescribed by Presidential proclamation or by law." 38 U.S.C. § 101(33). No end date has yet been prescribed. Generally, to qualify for eligibility, a veteran must have been on active military duty service in Southwest Asia during the Gulf War (Operation Desert Shield, Operation Desert Storm, Operation Iraqi Freedom [OIF], and Operation New Dawn [OND], including service in one or more of the following areas: Iraq, Kuwait, Saudi Arabia, the neutral zone (between Iraq and Saudi Arabia), Bahrain, Qatar, the United Arab Emirates, Oman, and the waters of the Persian Gulf, Red Sea, Arabian Sea, and Gulfs of Aden and Oman (Department of Veterans Affairs, Veterans Health Administration, *Gulf War Registry*, VHA DIRECTIVE 1325, June 1, 2017).

[44] 38 U.S.C. §1702 and 38 C.F.R. §17.109. See note above.

[45] For more information, see CRS Report RS22483, *Health Care for Dependents and Survivors of Veterans*.

insurance, including Medicare and Medicaid.[46] Health care services covered by the act include counseling, training, and mental health services for the primary family caregiver.

The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act; P.L. 115-182, as amended) further expanded eligibility for the CHAMPVA program to include the primary family caregiver of a pre-9/11 veteran.[47] This expansion is currently being implemented in two phases, each of which requires the implementation of new information technology. Under the first phase, veterans with serious service-connected injuries incurred on or before May 7, 1975, will qualify for benefits over a two-year period beginning on the date when the VA certifies to Congress that it has fully implemented the information technology system required for the program. Under the second phase, those with serious service-connected injuries incurred between May 7, 1975, and September 11, 2001, will qualify for benefits two years after the implementation of the first phase.

Enrollment in the VA Health Care System

Once a Veteran Meets the Basic Eligibility Criteria, Is Enrollment in the VA Health Care System Guaranteed?

Generally, after a veteran meets the basic eligibility criteria of veteran status and minimum active duty requirements (as described in the preceding section), the veteran must qualify for enrollment based upon service-connected disability, income, and other factors, such as being a former prisoner of war (POW) or being awarded the Medal of Honor or Purple Heart.

Eligibility for and enrollment in VA health care has evolved over time. Various eligibility laws enacted since the 1920s created a complex structure of eligibility criteria that ultimately led to the Veterans' Health Care Eligibility Reform Act of 1996 ("Eligibility Reform Act," P.L. 104-262), which created the modern enrollment system in use today.

Prior to the 1996 reform, veterans with service-connected conditions or lower incomes generally had access to VA health care.[48] Furthermore, eligibility criteria had been designed to limit access to care, because the provision of care was based on available budgetary resources. A National Academy of Sciences report from 1977 stated that

> [t]he public policy rationale for the VA hospital system assumes two broad categories of eligible veterans: those who have a service-connected disabilities and those who do not. The VA hospital system was initially justified (and the substantial continuing investment in VA facilities and resources has been provided by the Congress) on the grounds that the facilities were (and continue to be) necessary to provide health care to veterans with service-connected disabilities. Eligible veterans without service-connected disabilities were to be treated only if spare capacity were available after the needs of veterans in the highest-priority eligibility category were met. The elaborate structure of eligibility rules enacted by the Congress was designed to control access to facilities. That structure rests on

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

[47] For more information on expansion of the Comprehensive Assistance of Family Caregivers, see CRS Report R45390, *VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act; P.L.115-182).*

[48] Commission on Care, *Final Report of the Commission on Care*, Washington, DC, June 30, 2016, p. 162.

> the implicit assumption that VA facilities have insufficient capacity to meet the needs of all eligible veterans who may apply for care.[49]

According to the General Accounting Office (GAO, now called Government Accountability Office):

> The complex eligibility provisions that have developed over many decades are often ill-defined and confusing—which ultimately creates frustration for veterans and VA staff. Veterans are often uncertain about which services they are eligible to receive and what right they have to require VA to provide them. VA physicians are likewise frustrated by requirements that they determine, before treatment can be provided, whether a condition is related to a service-connected disability or whether, if left untreated, the condition would require immediate hospitalization.
>
> Unlike public and private health insurance, VA cannot offer well-defined benefits or guarantee the availability of covered services. Further, because provision of VA care is contingent upon available resources, whether a veteran receives care can depend on where and when the veteran seeks care. To add to veterans' confusion, VA medical centers use different methods to ration care when funds are not sufficient to meet demand. Because of these problems, veterans may be unable to obtain needed health care services from VA facilities.[50]

Although the Eligibility Reform Act refers to "eligibility reform" in both its title and legal provisions, in practice, the legislation did not significantly alter the eligibility criteria described in the preceding section of this report.[51] The act did, however, require the VHA to manage the provision of hospital care and medical services through an enrollment system based on prioritization and available resources.[52] As stated in the report language accompanying the act,

> [t]he Act would direct the Secretary, in providing for the care of 'core' veterans, to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment system would operate.[53]

Taking these issues into consideration, the Eligibility Reform Act established two broad mutually exclusive categories of eligibility: [54]

1. Veterans who meet one or more of the following criteria:

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[49] U.S. Congress, House Committee on Veterans' Affairs, *Health Care for American Veterans*, committee print, prepared by National Academy of Sciences, National Research Council, 95th Cong., 1st sess., June 7, 1977, H. Prt. 95-36 (Washington: GPO, 1977), p. 23.

[50] U.S. General Accounting Office, *VA Health Care: Issues Affecting Eligibility Reform Efforts*, GAO/HEHS-96-160, p. 6. (On July 7, 2004, the GAO's legal name was changed from the General Accounting Office to the Government Accountability Office.)

[51] Although the Veterans' Health Care Eligibility Reform Act of 1996 did not alter basic eligibility for a veteran to receive care, it did place inpatient and outpatient care on the same statutory footing so that the VA can provide needed care in the most medically appropriate setting. (Source: Kenneth W. Kizer et al., "Reinventing VA Health Care, Systematizing Quality Improvement and Quality Innovation," *Medical Care*, vol. 28, no. 6, pp. 1-8.)

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

[53] Ibid., p. 6.

[54] U.S. Congress, House Committee on Veterans' Affairs, *Veterans Eligibility Reform Act of 1996*, report to accompany H.R. 3118, 104th Cong., 2nd sess., H.Rept. 104-690, p. 5.

- veterans with service-connected disabilities;[55]
- veterans who are former prisoners of war;
- veterans exposed to certain toxic substances and environmental hazards, such as Agent Orange;
- veterans whose attributable income and net worth are not greater than an established "means test"; or
- veterans of World War I.

2. Veterans who do not meet any of the above criteria (i.e., veterans with no service-connected disabilities, who are not former prisoners of war, who were not exposed to certain toxic substances and environmental hazards, or with attributable incomes above an established "means test," and were not veterans of World War I).

Since the law's enactment, the enrollment categories have been amended through both statutory and regulatory changes.[56] (For the current priority enrollment categories, see the **Appendix**.)

The Eligibility Reform Act provided clear intent that the provision of health care to veterans depends on available resources. The committee report accompanying it states that the provision of hospital care and medical services would be provided to "the extent and in the amount provided in advance in appropriations Acts for these purposes. Such language is intended to clarify that these services would continue to depend upon discretionary appropriations."[57]

Beginning on October 1, 1998, the VA started enrolling eligible veterans in the VA health care system. Unless otherwise exempt, veterans are required to enroll in the VA health care system to receive inpatient hospital and outpatient medical care.[58]

Are Some Veterans Unable to Enroll Despite Meeting Basic Eligibility Criteria?

Under current regulations, veterans who do not have a compensable service-connected disability or meet other eligibility factors, and whose household incomes exceed both the VA national means test and a geographical-based means test, are currently not allowed to enroll in the VA health care system.[59]

Generally, veterans with no service-connected conditions or other eligibility factors (as described above) may only qualify based on their gross household income (income of the veteran, spouse, and dependent children) and deductible expenses income for the previous calendar year. If a veteran's household income is *above* the VA National Means Test (NMT; see **Table A-2**) and the geographical income limits established by the U.S. Department of Housing and Urban

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

[56] 38 U.S.C. §1705 and 38 C.F.R. §17.36.

[57] U.S. Congress, House Committee on Veterans' Affairs, *Veterans Eligibility Reform Act of 1996*, report to accompany H.R. 3118, 104th Cong., 2nd sess., H.Rept. 104-690, p. 5.

[58] 38 C.F.R. §17.36(a).

[59] 38 C.F.R. §17.36.

Development (HUD) for the fiscal year that ended on September 30 of the previous calendar year (known as the Geographical Means Test [GMT]), based on the area that the veteran resides, then the veteran is not eligible to enroll.

The Eligibility Reform Act stipulated that medical care to veterans be furnished to the extent that appropriations are made available by Congress on an annual basis. Based on this statutory authority, the Secretary of Veterans Affairs announced on January 17, 2003, that the VA would suspend enrolling veterans without service-connected disabilities and with incomes above the GMT.[60] Those who enrolled in the VA health care system prior to January 17, 2003, were not affected by this suspension.

The Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (P.L. 110-329) was enacted on September 30, 2008. The accompanying report language stated that funding "has been provided ... to support increased enrollment for Priority 8 veterans whose income exceeds the current veterans means test and geographic means test income thresholds by 10 % or less."[61] The act provided $375 million for FY2009 to fund increased enrollment. On January 21, 2009, the VA issued regulations indicating its plans to enroll new veterans who meet the expanded means-test thresholds.[62] The VA began enrolling new veterans on June 15, 2009.[63]

Are There Different Enrollment Criteria for Returning Combat Veterans?

Veterans returning from a current combat theater of operations are allowed to enroll in VA health care for five years from the date of their most recent discharge or release without having to demonstrate a service-connected disability[64] or satisfy a means-test requirement. Veterans who enroll under this extended enrollment authority continue receiving health services after the five-year eligibility period ends.

Combat zones are designated by executive order from the President, which generally sets specific dates to establish the beginning and end period for each combat zone. Eligiblity for this enhanced enrollment provision can be established through one of three means:

1. A certificate of release of discharge form active duty (DD-214) containing notations of service in a designated theater of combat operations;
2. receipt of a combat related medal; or
3. proof of receipt of hostile fire, imminient danger pay, or combat tax exemption.[65]

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[60] Department of Veterans Affairs, "Enrollment—Provision of Hospital and Outpatient Care to Veterans Subpriorities of Priority Categories 7 and 8 and Annual Enrollment Level Decision; Final Rule," 68 *Federal Register* 2670, January 17, 2003.

[61] P.L. 110-329, U.S. Congress, House Committee on Appropriations, *Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009*, committee print, 110th Cong., 2nd sess. (Washington: GPO, 2008), p. 750.

[62] Department of Veterans Affairs, "Expansion of Enrollment in the VA Health Care System," 74 *Federal Register* 3535-3540, January 21, 2009.

[63] Department of Veterans Affairs, "Expansion of Enrollment in the VA Health Care System," 74 *Federal Register* 22832-22835, May 15, 2009.

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

[65] Department of Veterans Affairs, Veterans Health Administration, *Health Care Benefits for Combat Theater Veterans*, VHA DIRECTIVE 1606(1), June 22, 2015, A-2.

Generally, returning combat veterans are assigned to Priority Category 6, unless they are eligible for a higher priority category, and are not charged copays for medication or treatment of conditions that are potentially related to their combat service. At the end of the five-year period, veterans enrolled in Priority Category 6 may be reenrolled in Priority Category 7 or 8, depending on their service-connected disability status and income level, and may be required to make copayments for nonservice-connected conditions. The above criteria also apply to National Guard and Reserve personnel who were called to active duty by federal executive order and who served in a theater of combat operations after November 11, 1998.

In 2007, the National Defense Authorization Act (NDAA), FY2008 (P.L. 110-181), created the current five year period of enrollment eligibility for veterans who served in a theater of combat operations after November 11, 1998. Prior to enactment of the FY2008 NDAA, returning combat veterans were granted a two year period of enrollment eligibility.[66] The most recent discharge date is used for those servicemembers who are called to duty multiple times.

If returning veterans do not enroll during the five-year window (from the most recent date of discharge), future enrollment applications will be evaluated according to the priority category classifications described in the **Appendix**. For this reason, the VA encourages veterans to take advantage of the enhanced enrollment period.

How Do Veterans Enroll in VA Health Care?

A veteran may apply for enrollment at any time of year by submitting an enrollment application (online, in person, by mail, or by telephone) to a VA health care facility.[67]

Veterans must enroll in VA health care by completing and submitting the VA's application for health benefits (VA Form 10-10EZ).[68] The application form requests information about the veteran's military service, demographics, and (as applicable) financial status. Veterans can apply for enrollment through many avenues:

Online. Veterans may fill out and submit their benefit application electronically through the VA website.[69] After completing the application online, the veteran will receive a message confirming that the application has been submitted. If the veteran has been recently discharged, the VA will gather the required service information.

[66] Congress established a special period of enrollment eligibility for VA health care in 1998 and expanded it in 2007. In 1998, Congress—responding to growing concern over Persian Gulf War veterans' undiagnosed illnesses—passed the Veterans Programs Enhancement Act of 1998 (P.L. 105-368). The act entitled veterans who served on active duty in a theater of combat operations during a period of war after the Persian Gulf War to enroll in VA health care during a two-year period following the date of discharge. The Clay Hunt Suicide Prevention for American Veterans Act (P.L. 114-2) authorized an additional one-year period of eligibility to enroll for those veterans who were discharged from active duty after January 1, 2009, and before January 1, 2011, but who did not enroll during the five-year period of post-discharge eligibility. This one-year period began on February 12, 2015, the enactment date of the Clay Hunt Suicide Prevention for American Veterans Act. It ended on February 12, 2016. Expanded eligibility under the act was established in response to concerns that the five-year special eligibility period was not an adequate amount of time for veterans seeking mental health treatment. U.S. Congress, Senate Committee on Veterans'Affairs, *Clay Hunt Suicide Prevention for American Veterans Act*, report to accompany H.R. 203, 114th Cong., 1st sess., April 23, 2015, S.Rept. 114-34 (Washington: GPO, 2015), p. 9.

[67] Veterans who meet the basic eligibility requirements may apply for enrollment into VA health care. For additional information, see https://www.va.gov/health-care/apply/application/introduction.

[68] VA Form 10-10EZ is available at https://www.va.gov/health-care/how-to-apply/.

[69] To apply online, see https://www.va.gov/health-care/how-to-apply/.

In person. Veterans may apply for health care services at their local VA health facility. State departments of veterans affairs can assist veterans with in-person applications. Veterans typically receive their enrollment notification letters in the mail in less than one week.

By mail.[70] Veterans who choose to mail their enrollment forms may download the form from the VA's website or pick one up at their local VA health facility.

By telephone. At present, veterans can complete and submit their enrollment application over the telephone. Beginning March 15, 2016, all veterans who served in a theater of combat operations after November 11, 1998, and who were discharged or released from active service on or after January 28, 2003, could apply for enrollment over the telephone.[71] For other veterans, applications for enrollment over the telephone began on July 15, 2016.[72]

How Does the VA Process Applications?

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

Veterans designate which VA medical center or outpatient clinic they prefer, with the exception of four medical facilities.[73] If veterans choose to have their applications processed through their local VA health facility, the staff will process the applications using the Veterans Health Information Systems and Technology Architecture (VistA). VistA is an integrated electronic health record system that the VA uses to record the care it provides; it also includes administrative tools.

If veterans choose to have a Health Eligibility Center (HEC) process their applications, the center staff do so using the Workload Reporting and Productivity (WRAP) tool. HEC staff uses the WRAP tool to maintain and distribute health applications to reviewers, along with supporting documentations.[74] The flowchart in **Figure 1** depicts how the VA processes health care applications.

[70] Applications are mailed to Health Eligibility Center, 2957 Clairmont Road, Suite 200, Atlanta, GA 30329.

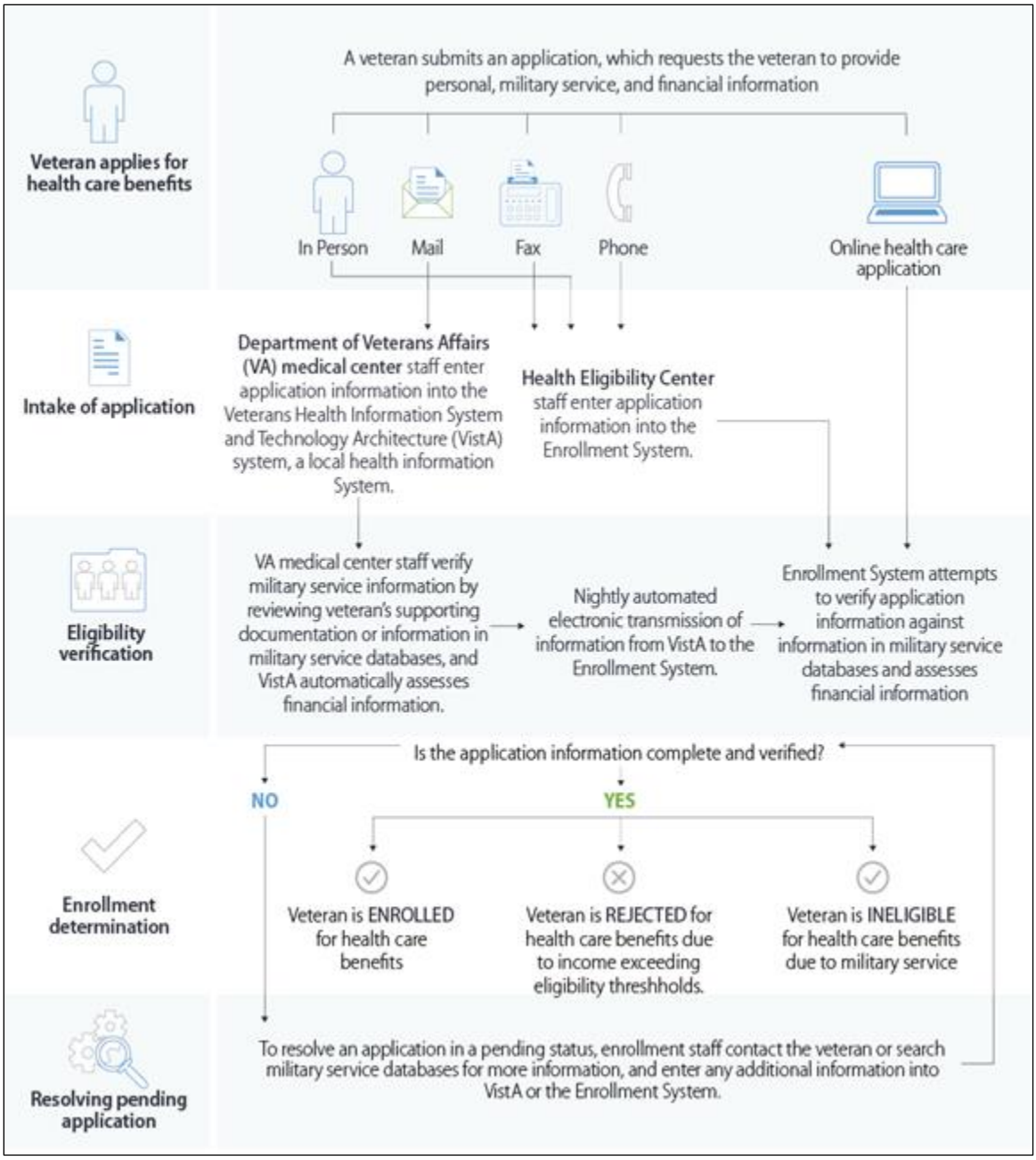
[71] Department of Veterans Affairs, "Telephone Enrollment in the VA Healthcare System," 81 *Federal Register* 13994 - 13997, March 16, 2016.

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

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

[74] VA Office of Inspector General, Veterans Health Administration, *Review of Alleged Mismanagement at the Health Eligibility Center*, 14-01792-510, September 2, 2015, p. 13, http://www.va.gov/oig/pubs/VAOIG-14-01792-510.pdf.

Figure 1. VA Health Care Enrollment Process



Source: Figure prepared by CRS based on figure titled "Key Steps for Veterans Health Administration's (VHA) Enrollment Processes, as of June 2017" in U.S. Government Accountability Office, *VA Health Care: Opportunities Exist for Improving Implementation and Oversight of Enrollment Processes for Veterans*, GAO-17-709 VA, September 2017, p. 7.

What Happens After Veterans Receive Their Enrollment Notification Letters?

Veterans who are accepted into the VA health care system and placed into a priority category are considered enrolled.[75]

Veterans who are approved to receive medical benefits may schedule their first VA health care appointment after receiving their approved enrollment notification letter. Once approved, veterans will receive a personalized Veterans Health Handbook through the mail.[76] This handbook details each veteran's individual medical benefits, copay status, and Enrollment Priority Category assignment. Veterans found by the VA to be ineligible for medical benefits may appeal the decision. Unenrolled veterans will receive letters explaining why they are unable to receive medical benefits; the letters provide instructions for appealing the VA's decision.

Once enrolled in the VA health care system, veterans retain that status unless they formally request to disenroll.[77] "Enrolled veterans may seek care at any VA facility without being required or requested to reestablish eligibility for VA health care enrollment purposes."[78]

Veterans may cancel their health care enrollment with the VA at any time. Applications for reenrollment are accepted at any time by the VA. "Acceptance for future VA health care enrollment will be based on eligibility factors at the time of application, which may result in a denial of enrollment."[79]

Are There Categories of Veterans Who Are Not Required to Enroll in the VA Health Care System?

Although most eligible veterans must be enrolled in the VA health care system to receive VA health care, some categories of eligible veterans are exempt from this requirement.[80]

Any veteran who falls into one of the following categories is not required to apply for enrollment in the VA's health care system but is entitled to full health care benefits:

- A veteran with a service-connected disability rated at 50% or more. (Percentages of disability are based on severity; those with a rating of 50% or more are placed in Priority Category 1).
- A veteran with a service-connected disability seeking care for that service-connected disability only.

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

[76] Enrollees can access an online version of the Veterans Health Benefits Handbook in addition to receiving a mailed copy. For additional information, see https://www.va.gov/healthbenefits/vhbh/.

[77] Certain VA officials are authorized to cancel a veteran's enrollment, subject to an appeals process, if the official determines that the veteran is no longer in a priority category that is eligible for enrollment (38 C.F.R. §17.36(d)(5)(ii)). See the **Appendix** for priority categories that are not currently eligible for enrollment.

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

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

[80] 38 C.F.R. §17.37.

- A veteran who has been discharged from military service for less than one year with a disability that the military determined was incurred or aggravated in the line of duty, but that has not yet been rated by the VA.
- A veteran who is disenrolled, but has a compelling medical need to complete a course of VA treatment started when the veteran was still enrolled in the VA health care system.
- A veteran participating in VA's vocational rehabilitation program under certain criteria.
- A veteran who seeks care for psychosis or mental illness other than psychosis based on a diagnosis.
- A Commonwealth Army veteran or new Philippine Scout.

Medical Benefits

What Are the Standard Medical Benefits?

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

The VA's standard medical benefits package promotes preventive and primary care and offers a broad spectrum of inpatient, outpatient, surgical, and preventive health services. (See **Figure 2**.)

Does the VA Provide Gender-Specific Services for Women?[81]

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

The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) authorized the VA to provide certain health care services to a newborn child of a female veteran receiving maternity care furnished by the VA. Health care for the newborn is authorized for a maximum of seven days after the birth of the child if the veteran delivered the child in a VA facility or in another facility pursuant to a VA contract for maternity services.[82]

Under current regulations, the VHA does not provide abortions, abortion counseling, or medication to induce an abortion (e.g., mifepristone, also known as RU-486).[83]

[81] For more details, see CRS In Focus IF11082, *Veterans Health Administration: Gender-Specific Health Care Services for Women Veterans*.

[82] 38 U.S.C. §1786.

[83] 38 C.F.R. §17.38; and Department of Veterans Affairs, Veterans Health Administration, *Health Care Services for Women Veterans*, VHA DIRECTIVE 1330.01(2), February 15, 2017. It should be noted that medically necessary procedures for the management of a miscarriage are provided under the medical benefits package.

Figure 2. Standard VA Medical Benefits: Covered and Not Covered

Overall Covered Services	Covered Preventive Care Services	Non-Covered Services
• Medical, surgical, and mental health care, including care for substance abuse • Prescription drugs, including over-the-counter drugs, and medical and surgical supplies available under the VA national formulary system • Durable medical equipment and prosthetic and orthotic devices, including hearing aids and eyeglasses (subject to limitations) • Home health services, hospice care, palliative care, and institutional respite care • Noninstitutional adult day health care and noninstitutional respite care • Complementary and alternative medicine (CAM) therapies	• Periodic medical exams • Health and nutrition education • Maintenance of drug-use profiles, monitoring, and education • Preventive services for mental health and substance abuse • Vaccinations against infectious diseases • Prevention of musculoskeletal deformity or other gradually-developing disabilities of a metabolic or degenerative nature • Genetic counseling for disease inheritance • Routine vision testing and care services • Periodic re-examination of members of high-risk groups for selected diseases, sensory organs decline	• Abortions and abortion counseling • In-vitro fertilization • Drugs, biologicals, and medical devices not approved by the Food and Drug Administration (FDA) [with exceptions] unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption • Gender alterations • Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give such care or services • Membership in spas and health clubs; cosmetic surgery (plastic surgery) that is not medically necessary

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

Does the VA Provide Infertility Services to Veterans?

The VA does provide infertility services to veterans.

The VA provides infertility services to both service- and nonservice-connected veterans. Covered infertility services for both female and male veterans are illustrated in **Table 1**. The VA is not authorized to provide or cover the cost of in vitro fertilization (IVF) or other assistive reproductive technologies (ART). There is a narrow exception to this policy, which allows the VA to provide IVF services to veterans and their spouses if a service-connected disability results in the inability of the veteran to procreate without the treatment.[84] This exception is authorized on an annual basis through appropriations acts.[85] Such services and benefits may be provided in a

[84] 38 C.F.R. § 17.380.

[85] This policy has been authorized in appropriations acts since FY2017. Section 260 of the Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, and the Zika Response and Preparedness Act (P.L. 114-223) permitted the VA to use funds from the Medical Services account for this purpose for FY2017. Section 236 of Division J of the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2018 (P.L. 115-141), continued this policy for FY2018 and FY2019. Section 235 of the Energy and Water, Legislative Branch, and Military Construction and Veterans Affairs Appropriations Act, 2019 (P.L. 115-244), allows the VHA to use FY2019 appropriations and FY2020 advance appropriations to continue providing IVF

manner similar to those described in a memorandum issued by the Assistant Secretary of Defense for Health Affairs ("Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members," dated April 3, 2013), along with guidance issued by the Department of Defense (DOD). The VA is exempt from DOD requirements applicable to the duration of embryo cryopreservation and storage.[86] The VA is not authorized to cover gestational surrogacy treatment or costs associated with sperm or oocyte donation.[87]

Additionally, on an annual basis appropriations acts have authorized the VA to use funds to reimburse veterans for adoption expenses incurred by a veteran with a service-connected disability that results in the inability of the veteran to procreate without the use of fertility treatment.[88] Reimbursement is capped at $2,000 per adopted child for an eligible veteran or for two eligible veterans who are spouses. No more than $5,000 can be paid to an eligible veteran in any calendar year regardless of the number of children they adopt.[89]

Table 1. Infertility Services Offered by the VA

Diagnosis and Treatment for Female Veterans	Diagnosis and Treatment for Male Veterans
Diagnostic Tests: • Laboratory blood testing: follicle stimulating hormone (FSH); thyroid stimulating hormone (TSH) • Genetic counseling and testing • Pelvic and/or transvaginal ultrasound • Hysterosalpingogram • Saline-infused sonohysterogram	Diagnostic Tests: • Laboratory blood testing: serum testosterone, FSH, LH, estradiol • Semen analysis • Genetic counseling and testing • Transrectal and/or scrotal ultrasonography • Post-ejaculatory urinalysis
Treatments: • Surgical correction of structural pathology • Reversal of tubal ligation • Intrauterine insemination (IUI) • Medication for ovulation induction (e.g., clomiphene) • Injectable gonadotropin medications • Hormonal therapies (e.g., controlled ovarian hyperstimulation) • Additional hormonal therapies as approved by VA Pharmacy Benefits Management • Oocyte cryopreservation for medically indicated conditions	Treatments: • Evaluation and treatment of erectile dysfunction • Surgical correction of structural pathology • Vasectomy reversal • Hormonal therapies (e.g., clomiphene citrate, human chorionic gonadotropin, phosphodiesterase type 5 medications, testosterone) • Sperm retrieval techniques • Sperm cryopreservation for medically indicated conditions • Ejaculation techniques (e.g., electroejaculation, vibratory stimulation)

Source: Prepared by CRS based on U.S. Department of Veterans Affairs, Veterans Health Administration, *Infertility Evaluation and Treatment*, VHA DIRECTIVE 1332, June 2017.

services to certain veterans and their spouses.

[86] Department of Veterans Affairs, "Final Rule-Fertility Counseling and Treatment for Certain Veterans and Spouses," 84 *Federal Register* 8254 - 8257, March 7, 2019.

[87] Department of Veterans Affairs, Veterans Health Administration, *Infertility Evaluation and Treatment*, VHA DIRECTIVE 1332, June 2017.

[88] This policy has been authorized in appropriations acts since FY2017. The Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, and the Zika Response and Preparedness Act (P.L. 114-223) first authorized reimbursement for adoption expenses. Section 236 of Division J of the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2018 (P.L. 115-141), continued this policy for FY2018 and FY2019, and Section 235 of the Energy and Water, Legislative Branch, and Military Construction and Veterans Affairs Appropriations Act, 2019 (P.L. 115-244), continues this policy for FY2019 and FY2020.

[89] 38 C.F.R. § 17.390.

Does the VA Provide Dental Care?

Eligibility for dental care differs significantly from eligibility requirements for medical care. The scope of dental services is generally narrow except in cases where a veteran has a service-connected dental condition, is a former prisoner of war, or has a service-connected disability rated 100%.

The VA outpatient dental program categorizes enrolled veterans into classes that are distinct from the priority categories that enrolled veterans are placed in for medical care. The classes form the basis for the scope of dental treatment provided. **Table 2** describes the eligibility criteria and scope of treatment for VA-provided dental care.

Table 2. Eligibility Criteria and Scope of Treatment for VA Dental Care

Classification	Eligibility Criteria	Scope of Treatment Provided
Class I	Veteran has a service-connected compensable (i.e., disability compensation is paid) dental condition.	Any dental care and service needed regardless of relation to service-connected condition.
Class II	Veteran has a service-connected noncompensable dental condition (i.e., not subject to disability compensation) shown to have been in existence at the time of discharge or release from active duty service, which took place after September 30, 1981, if [a] • the veteran served at least 180 days (or 90 days if a Veteran of the Gulf War era); • the veteran's DD214[b] does not bear certification that the veteran was provided, within 90 days immediately prior to discharge or release, a complete dental examination (including dental x-rays) and all appropriate dental treatment indicated by the examination to be needed; and • application for treatment is received within 180 days of discharge.	A one-time course of dental treatment of the service-connected noncompensable dental condition.
Class II(a)	Veteran has a service-connected noncompensable dental condition or disability determined as resulting from combat wounds or service trauma.	"Any dental care necessary to provide and maintain a functioning dentition. A Dental Trauma Rating (VA Form 10-564-D) or VA Regional Office Rating Decision letter (VA Form 10-7131) identifies the tooth/teeth/condition(s) that are trauma rated."
Class II(b)	Veteran is enrolled and may be homeless and receiving care for a period of 60 consecutive days in specified settings stipulated at 38 U.S.C. §2062.	A one-time course of dental care that is determined clinically necessary to relieve pain, to help the veteran gain employment, or to "treat moderate, severe, or severe and complicated gingival and periodontal pathology."
Class II(c)	Veteran is a former prisoner of war (POW).	Any dental care and service needed regardless of relation to service-connected condition.

Classification	Eligibility Criteria	Scope of Treatment Provided
Class III	Veteran has a dental condition clinically determined by VA to be aggravating a disability or condition from an associated service-connected condition or disability. [c]	Dental care and services to treat such dental condition.
Class IV	Veteran whose service-connected disabilities have been rated at 100% or who is receiving the 100% rating by reason of individual unemployability.	Any dental care and service needed regardless of relation to service-connected condition.[d]
Class V	Veteran is actively engaged in a vocational rehabilitation program (38 U.S.C. Chapter 31).	Dental treatment clinically determined to achieve specific objectives.[e]
Class VI	Veteran is receiving VA care or is scheduled for inpatient care and requires dental services for "a dental condition complicating a medical condition currently under treatment."	Outpatient dental care that is clinically necessary to treat "a dental condition complicating a medical condition currently under treatment."

Source: Table prepared by CRS based on 38 C.F.R. §§17.160 – 17.166; Department of Veterans Affairs, Veterans Health Administration, *Eligibility Determination*, VHA Directive 1601A.02, November 2018; and Department of Veterans Affairs, Veterans Health Administration, *Veterans Health Administration Dental Program*, VHA Handbook 1130.01, February 2013.

Notes:

a. P.L. 84-83, enacted on June 16, 1955, amends veterans' eligibility for outpatient dental services. This amendment makes veterans who have noncompensable dental conditions determined by the Veterans Benefits Administration (VBA) before 1955 ineligible for Class II outpatient dental treatment.

b. When servicemembers separate from active military service, they receive a certificate of release or discharge from active duty, known as a DD-214. The DD-214 provides the member and the service with a concise record of a period of service with the Armed Forces at the time of the member's separation, discharge, or change in military status (reserve/active duty). In addition, the form serves as an authoritative source of information for both governmental agencies and the Armed Forces for purposes of employment, benefit, and reenlistment eligibility, respectively.

c. A dental condition that may be caused by a mental condition (e.g., bruxism caused by post-traumatic stress disorder) is not eligible under Class III.

d. Veterans who receive disability compensation based on a 100% temporary rating, such as extended hospitalization for a service-connected disability, convalescence or prestabilization, are not eligible for comprehensive outpatient dental services based on this temporary rating.

e. The objectives consist of "(1) making possible [veteran's]entrance into a rehabilitation program; (2) achieving the goals of [the veteran's] vocational rehabilitation program; (3) preventing interruption of [the veteran's] rehabilitation program; (4) hastening the return to a rehabilitation program if [the veteran is]in interrupted or leave status; (5) hastening the return to a rehabilitation program of a veteran placed in discontinued status because of illness, injury or a dental condition; (6) securing and adjusting to employment during the period of employment assistance; or (7) enabling [the veteran] to achieve maximum independence in daily living." (Source: Appendix B VHA Directive 1601A.02, November 2018.)

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

The VA Dental Insurance Program (VADIP) is a pilot program that provides premium-based dental insurance coverage through which eligible individuals may choose to obtain dental insurance from a participating insurer.[90]

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

The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) authorized the VHA to conduct a three-year pilot program to assess the feasibility and advisability of providing private, premium-based dental insurance coverage to eligible veterans and certain survivors and dependents.[91] The three-year pilot program ended in January 2017. The Department of Veterans Affairs Dental Insurance Reauthorization Act of 2016 (P.L. 114-218) extended the VADIP until December 31, 2021. The VHA contracts with qualified dental insurance carriers that provide dental insurance and administer all aspects of the dental insurance plan.

The VADIP is available to CHAMPVA beneficiaries and veterans enrolled in VA health care. Dependents of veterans who are not eligible under CHAMPVA are not eligible for VADIP. Participation in VADIP does not affect eligibility for other VA dental services.[92]

Does the VA Provide Hearing Aids and Eyeglasses?

Generally, the VA provides audiology and eye care services (including preventive care services and routine vision testing) for all enrolled veterans. The VA does not provide hearing aids or eye glasses for normally occurring visual or hearing impairments.[93]

The VA provides hearing aids and eyeglasses to any veteran who meets one or more of the following circumstances:[94]

- has any compensable service-connected disability;
- is a former prisoner of war (POW);
- was awarded a Purple Heart;
- is receiving compensation for an injury, or an aggravation of an injury, that occurred as the result of VA treatment;
- is receiving an increased pension based on being permanently housebound and in need of regular aid and attendance;
- has hearing or vision impairment resulting from diseases or the existence of another medical condition for which the veteran is receiving VA care or services, or which resulted from treatment of that medical condition (e.g., stroke, polytrauma, traumatic brain injury, diabetes, multiple sclerosis, vascular disease, geriatric chronic illnesses, toxicity from drugs, ocular photosensitivity from drugs, cataract surgery, and/or other surgeries performed on the eye, ear, or brain resulting in a vision or hearing impairment);

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

[92] 38 C.F.R. §17.169. For more information on the VA Dental Insurance Program (VADIP), see http://www.va.gov/healthbenefits/vadip/.

[93] According to the VA Directive: "normally occurring visual and hearing impairments are not considered as deficiencies of activities of daily living, as usually defined. Normally occurring impairments are not the same as age-related impairments from disease conditions or disorders (such as age-related macular degeneration, age-related cataract, etc.) that may result in significant functional impairment, including low vision and blindness, adversely impacting activities of daily living" (Department of Veterans Affairs, Prescribing And Providing Eyeglasses, Contact Lenses, and Hearing Aids, VHA Directive 1034(1), April 22, 2014.)

[94] 38 C.F.R. §17.149, and Department of Veterans Affairs, Prescribing And Providing Eyeglasses, Contact Lenses, and Hearing Aids, VHA Directive 1034(1), April 22, 2014.

- has significant functional or cognitive impairment evidenced by deficiencies in the ability to perform activities of daily living;[95] or
- has hearing and/or vision impairment severe enough that it interferes with his or her ability to participate actively in medical treatment and to reduce the impact of dual sensory impairment (combined hearing and vision loss).

Does the VA Provide Long-Term Care?[96]

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

The Veterans Millennium Healthcare and Benefits Act (P.L. 106-117) requires the VA to provide nursing home services to all enrolled veterans who are 70% or more service-connected disabled, or 60% or more service-connected disabled and unemployable and in need of such care, or who are service-connected for a condition that makes such care necessary.[97] The VA provides short- and long-term nursing care, respite, and end-of-life care through three different settings: (1) Community Living Centers (CLCs) located on VA medical campuses, (2) contracted care in Community Nursing Homes (CNHs), and (3) the State Veterans Nursing Home (SVNH) program.

Does the VA Provide Support to Caregivers of Disabled Veterans?

The VA provides extensive caregiver support and assistance through the Program of General Caregiver Support Services and the Program of Comprehensive Assistance for Family Caregivers.[98] The VA is in the process of expanding eligibility for caregiver assistance.

The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) required the VA to establish caregiver support services to veterans. The VA established two programs: the Program of General Caregiver Support Services and the Program of Comprehensive Assistance for Family Caregivers. In addition, the VA maintains a caregiver support phone line and staffs each VA medical center with at least one caregiver support coordinator.[99]

The Program of General Caregiver Support Services (PGCSS) is available to caregivers of enrolled veterans of all eras. The program provides education, training, and technical support; telehealth services; respite care; and counseling. To be eligible for these services, a veteran must be enrolled in the VA health system and need personal care services because the veteran is either:

- unable to perform one or more activities of daily living; or
- needs supervision or protection based on symptoms or residuals of neurological or other impairment or injury.

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

[96] For more information, see CRS Report R44697, *Long-Term Care Services for Veterans*.

[97] 38 U.S.C. §1710A.

[98] 38 C.F.R §71

[99] U.S. Department of Veterans Affairs, Veterans Health Administration, *Caregiver Support Program*, VHA DIRECTIVE 1152(1), June 2017.

There is no application or clinical evaluation required to obtain benefits under the PGCSS. Individuals receiving services and benefits under this program are referred to as "general caregivers."

The Program of Comprehensive Assistance for Family Caregivers (PCAFC) is available to family caregivers of veterans and certain servicemembers who were seriously injured in the line of duty on or after September 11, 2001. These veterans or servicemembers are commonly referred to as "post-9/11 veterans." Eligibility for the program requires, at a minimum, six months of continuous and approved caregiver support that is in the best interests of the veteran or servicemember based on either of the same criteria listed above for the PGCSS program or a 100% service-connected disability rating with special monthly compensation that includes aid and attendance allowance.

The PCAFC requires an extensive application process and clinical evaluation. Individuals granted services and benefits under this program are referred to as "family caregivers." A family caregiver may be designated as either a primary or secondary family caregiver for purposes of the program. This designation confers different services and benefits. Primary family caregivers are eligible for additional services and benefits not available to secondary family caregivers.

Table 3 lists the services and benefits available under the two caregiver support programs (i.e., the Program of General Caregiver Support Services and the Program of Comprehensive Assistance for Family Caregivers) and designates which of the three categories of caregiver status (i.e., general caregiver, secondary family caregiver, or primary family caregiver) are eligible for the specific service or benefit. The table is organized from the general caregiver category, which confers the least amount of services and benefits, to the primary family caregiver category, which confers the most amount of services and benefits.

Table 3. Service and Benefit Eligibility for Veteran Caregiver Programs, by Caregiver Status

Benefit	Explanation of Service or Benefit	General Caregiver	Secondary Family Caregiver	Primary Family Caregiver
Program of General Caregiver Support Services (PGCSS)				
Caregiver Support Line	Licensed professionals staff the support line to connect caregivers with VA services. The support line also offers monthly telephone education groups.	X	X	X
Caregiver Support Coordinator	A licensed professional who administers the VA caregiver programs and provides support to caregivers by matching them with services. There is a coordinator at each VA medical center.	X	X	X
Peer Support Mentoring	Caregivers can participate in peer support as both mentors and mentees. This is usually a six month program, but one-time support is also available.	X	X	X
Education, Training and Technical Support	The VA provides online and in-person education and training offerings to caregivers. The VA will also make referrals to non-VA community services.	X	X	X

Benefit	Explanation of Service or Benefit	General Caregiver	Secondary Family Caregiver	Primary Family Caregiver
Telehealth	Telehealth enables physicians and nurses to monitor a veteran's medical condition remotely using home monitoring equipment. This is an indirect benefit to caregivers.	X	X	X
Counseling	Counseling services are provided to a caregiver if the VA medical professional caring for the veteran determines that the services would further the objectives of the veteran's medical treatment.	X	X	X
Respite Care	Allows a home health aide to go to a veteran's home to provide personal care services or take a veteran to a program while the caregiver takes a break. The respite care must be medically and age appropriate.	X	X	X
Program of Comprehensive Assistance for Family Caregivers (PCAFC)				
Primary Care Team Support and Monitoring	Ongoing monitoring of a veteran's overall health and well-being and adequacy of care and supervision being provided.	NE	X	X
Mental Health Services	These services include individual and group therapy, individual counseling, and peer support groups. These services are limited to outpatient care only.	NE	X	X
Beneficiary Travel	Travel reimbursement during the period in which a veteran is traveling to and from medical examination, treatment or care, and for the duration of such examination.	NE	X	X
Stipend	A monthly stipend payment paid directly to the primary family caregiver.	NE	NE	X
Civilian Health and Medical Program (CHAMPVA)	Health insurance program where primary family caregivers obtain medical care from private health care providers.	NE	NE	X

Source: Prepared by Congressional Research Service based on Title 38 C.F.R. §§71.40 and 71.50 as well as VHA Directive 1152(1).

Notes: X = Eligible. NE = Not eligible. VA = Department of Veterans Affairs. The statutory authority for all services and benefits under the PGCSS and PCAFC is 38 U.S.C. §1720G.

The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act; P.L. 115-182 as amended by P.L. 115-251), expanded eligibility for the Program of Comprehensive Support for Family Caregivers to include pre-9/11 veterans. The expansion is contingent on the implementation and certification of a new information technology system for the program. Once the system is certified, the VA is authorized to enroll pre-9/11 veterans in two phases: first veterans with service-connected injuries incurred on or before May 7, 1975, then veterans with service-connected injuries incurred between May 7, 1975, and September 11, 2001.

Does the VA Pay for Medical Care in the Community?

Under certain circumstances, the VA pays for care in the community to eligible veterans.

The VA MISSION Act established the permanent Veterans Community Care Program (VCCP), replacing the Veteran's Choice Program (VCP) and the traditional community care program. [100] The VCCP program was launched on June 6, 2019. To be eligible for care under VCCP, a veteran must be enrolled in the VA health care system, or not enrolled in the VA health care system but entitled to hospital care, medical services, and extended care services. Once these criteria are met, the veteran has to meet one of the following six criteria:[101]

1. The veteran needs a service that is not available at the veteran's regular VA medical facility.
2. The veteran resides in U.S. state or territory without a full-service VA medical facility (i.e. Alaska, Hawaii, New Hampshire, and the U.S. territories of Guam, American Samoa, Northern Mariana Islands, and the U.S. Virgin Islands).
3. The veteran was eligible under the distance criteria under the Veterans Choice Program (VCP) on the day before the VA MISSION Act was enacted into law (June 6, 2018), and continues to meet the distance criteria, and either lives in one of the five states with the lowest population (i.e., North Dakota, South Dakota, Montana, Alaska, Wyoming) or received care between June 6, 2017, and June 6, 2018, and requires care before June 6, 2020.
4. The veteran meets specific access standards for average drive time or appointment wait-times, as follows.
   - Average drive time to a specific VA medical facility:
     - 30-minute average drive time for primary care, mental health, and noninstitutional extended care services (including adult day health care).
     - 60-minute average drive time for specialty care.
   - Appointment wait time at a specific VA medical facility:
     - 20 days for primary care, mental health care, and noninstitutional extended care services, unless the veteran agrees to a later date in consultation with a VA health care provider.
     - 28 days for specialty care from the date of request, unless the veteran agrees to later date in consultation with a VA health care provider.
5. The clinician agrees that it is in the veteran's best medical interest to be referred to a community provider.
6. The veteran needs care from a VA medical service line that VA determines is not provider care that complies with VA's quality standards (to be implemented after June 2019).

[100] On June 6, 2018, President Trump signed into law the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act; P.L. 115-182). The Department of Veterans Affairs Expiring Authorities Act of 2018 (P.L. 115-251), enacted on September 29, 2018, made amendments to the VA MISSION Act. For additional information, see CRS Report R45390, *VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act; P.L.115-182)*

[101] 38 U.S.C. §1703 and 38 C.F.R.§17.4000.

If a veteran meets one of the six criteria, the VA authorizes care through the VA Community Care Network (CCN) of health care facilities and providers or at Department of Defense medical facilities, Indian Health Service medical facilities, any Federally Qualified Health Center (FQHC), or any other health care provider that meets criteria established by the Secretary.

Does the VA Pay for Care for Veterans Abroad?

The VA may pay for hospital care and outpatient services related to a service-connected disability or rehabilitation to any eligible veteran outside of the United States, without regard to the veteran's citizenship.[102]

The VA provides limited health care benefits to veterans residing or traveling outside the United States through the Foreign Medical Program (FMP). Under current law, the VA is authorized to provide hospital care and medical services to an eligible veteran outside the United States only if the VA "determines that such care and services are needed for the treatment of a service-connected disability of the veteran or as part of a rehabilitation program under chapter 31 [Vocational Rehabilitation and Employment (VR&E) program] of this title [38 U.S.C.]."[103]

Under the FMP, the VA pays the allowable amount for hospital and outpatient care. Veterans may generally select any health care provider. Claims for payment or reimbursement of services under the FMP must be submitted to the FMP office in Denver, CO. For care provided in Canada, claims must be submitted to Veterans Affairs Canada, Foreign Countries Operations Unit.[104]

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

The VA may pay for emergency[105] care provided to enrolled veterans by non-VA providers based on several factors, such as whether the care is for a service-connected condition or not.

Prior to the passage of the Veterans' Emergency Care Fairness Act (P.L. 111-137), the VA did not reimburse for emergency treatment for nonservice-connected conditions if the veteran had third-party insurance that paid any portion of the costs associated with that treatment.[106] This included minimal insurance coverage, such as health coverage through an automobile insurance policy. The act required the VA to reimburse a veteran for the portion of the emergency care expenses not covered by a health plan contract, such as private health insurance. Following passage of the act,

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[102] With a few exceptions, a veteran's citizenship status generally is not a prerequisite for veterans' benefits and services under the laws administered by the Secretary of Veterans Affairs. As stated elsewhere in this report, generally, to qualify for veterans' benefits and services, veterans must demonstrate their status as a "veteran." Under current law, this means "a person who served in active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable." (38 U.S.C. §101(2)).

[103] 38 U.S.C. 1724(b)(1); 38 C.F.R. §17.35.

[104] For more information see, the FMP Guide, https://www.va.gov/COMMUNITYCARE/docs/pubfiles/programguides/FMP_Guide.pdf#.

[105] According to the Department of Veteran Affairs, "a medical emergency is an injury, illness or symptom so severe that without immediate treatment, you believe your life or health is in danger. If you believe your life or health is in danger, call 911 or go to the nearest emergency department (ED) right away." Department of Veteran Affairs, *Emergency Medical Care*, Fact Sheet 20-02, April 2018, https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/FactSheet_20-02.pdf#. Accessed on April 15, 2019.

[106] U.S. Congress, House Committee on Veterans' Affairs, *Amending Title 38, United States Code, to Expand Veteran Eligibility for Reimbursement by the Secretary of Veterans Affairs for Emergency Treatment Furnished in a Non-Department Facility, and for Other Purposes*, committee print, 111th Cong., 1st sess., 111-55, pp. 2-3.

the VA interpreted it in such a way that it continued to deny reimbursement for nonservice-connected emergency care when the veteran had partial coverage under a health plan contract.

In response, to this statutory interpretation by the VA, Richard W. Staab, filed a lawsuit against the VA. In *Staab v. McDonald*, the U.S. Court of Appeals for Veterans Claims (CAVC) found that the act does require reimbursement in cases where a veteran has partial coverage under a health plan contract. In response to this CAVC ruling, the VA issued new regulations to implement the *Staab* decision pertaining to emergency care reimbursement for nonservice-connected care.[107] However, under this new regulation, the VA stated that it "will not reimburse a veteran…for any copayment, deductible, coinsurance, or similar payment that the veteran owes the third party or is obligated to pay under a health-plan contract."[108]

Once again, in response to this new regulation Amanda Jane Wolfe and Peter E. Boerschinger filed a lawsuit against the VA stating that, in general, the new regulation is inconsistent with Congressional intent in passing the Veterans' Emergency Care Fairness Act. On September 9, 2019, CAVC ruled that VA's new regulations is contrary to the Veterans' Emergency Care Fairness Act and that the VA should pay deductible or coinsurance payments for which the veteran is responsible under a health plan contract [109] As of the date of this report, the VA has not publicly indicated whether it will appeal this ruling or promulgate new regulations.

Table 4 lists certain criteria that veterans must meet to be reimbursed for emergency services received from non-VA health facilities. (It should be noted that this table is based on regulations prior to the *Wolfe v. Wilkie* ruling.)

Table 4. VA Regulations for Reimbursement for Emergency Care

The VA is required to pay or reimburse veterans for medical expenses incurred at non-VA facilities when the following conditions apply:	
Emergency Care for a Service-Connected Condition	**Emergency Care for a Nonservice-Connected Condition**
To be reimbursed under 38 U.S.C. §1728, a veteran must meet each of the following criteria: • Emergency care or services were rendered in a medical emergency of such nature that delay would have been hazardous to life or health; • Emergency care or services were rendered to a veteran for an adjudicated service-connected disability, or for a nonservice-connected disability associated with and held to be aggravating a service-connected disability, or for any disability of a veteran who has a total disability permanent in nature from a service-connected disability, or for any illness, injury, or dental condition of a veteran who is participating in a vocational rehabilitation program and who is medically determined to be in need of hospital care or medical services; and	**To be reimbursed under 38 U.S.C. §1725, a veteran must meet each of the following criteria:**[a] • The emergency care or services were provided in a hospital emergency department or a similar facility that provides emergency care to the public; • The claim for payment or reimbursement for the initial evaluation and treatment was for a condition of such a nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health; • A VA or other federal facility/provider was not feasibly available and an attempt to use them beforehand would not have been considered reasonable by a prudent layperson; • At the time the emergency care or services were furnished, the veteran was enrolled in the VA

[107] For additional information, see "Reimbursement for Emergency Treatment," 83 *Federal Register* 974, January 9, 2018.

[108] 38 C.F.R. § 17.1005(a)(5).

[109] *Wolfe and Boerschinger v. Wilkie* , Vet. App. No. 18-6091.

The VA is required to pay or reimburse veterans for medical expenses incurred at non-VA facilities when the following conditions apply:	
• VA or other federal facilities were not feasibly available, and an attempt to use them beforehand would not have been reasonable, sound, wise, or practical.	health care system and had received medical services from the VHA within the 24-month period preceding the furnishing of such emergency treatment; • The veteran was financially liable to the provider of emergency treatment for that treatment; • The veteran had no coverage under a health plan contract that would fully cancel the medical liability for the emergency treatment; • If the condition for which the emergency treatment was furnished was caused by an accident or work-related injury, the claimant had exhausted without success all claims and remedies reasonably available to the veteran or provider against a third party for payment of such treatment; and the veteran had no contractual or legal recourse against a third party that could reasonably be pursued for the purpose of extinguishing, in whole or in part, the veteran's liability to the provider; and • The veteran is not eligible for emergency treatment reimbursement under 38 U.S.C. §1728.

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

Notes:

a. These criteria are based on regulations prior to the *Wolfe and Boerschinger v. Wilkie* ruling on September 9, 2019.

Does the VA Pay for Urgent Care?

The VA MISSION Act authorized a new benefit for eligible veterans to obtain urgent care through certain community providers.

The VA MISSION Act of 2018, as amended, required the VA to implement a new benefit for covered veterans to obtain urgent care through eligible entities and providers.[110] The benefit went into effect on June 6, 2019. Under the program, a veteran is eligible to receive limited, nonemergent (nonlife-threatening) health care services at qualified urgent care facilities and walk-in retail health clinics. To be eligible, a veteran must be enrolled in the VA health care system and must have received VA care in the past 24-months preceding the episode of urgent or walk-in care.[111] Eligible veterans needing urgent care must obtain care through facilities that are part of the VA's contracted network of community providers.[112] These facilities typically post information indicating that they are part of VA's contracted network. It is important to note that if an eligible veteran receives urgent care from a *noncontracted* provider or receives services that

[110] 38 U.S.C. §1725A.

[111] A veteran would meet this requirement under any of the following situations: "Care provided in a VA facility, care authorized by VA performed by a community provider, care reimbursed under VA's Foreign Medical Program (38 U.S.C. 1724) or an emergency treatment authority (38 U.S.C. 1725 or 1728) or care furnished by a State Veterans Home" (Department of Veterans Affairs, "Urgent Care," 84 *Federal Register* 26014, June 5, 2019).

[112] https://vaurgentcarelocator.triwest.com/.

are *not* covered under the urgent care benefit, the veteran may be required to pay the full cost of such care.[113] Certain veterans are required to pay copayments for care obtained at a VA-contracted urgent care facility or walk-in retail health clinic. Contracted clinics cannot bill a veteran for any copayment amount at the time of service (see **Table 5**). Veterans required to pay copayments under this benefit are billed by the VA separately.

Table 5. Urgent Care/Walk-In Care Copayments

Priority Category	Copayment Amount
Priority Categories 1-8	if the visit is only for immunization against influenza (flu shots): $0 copay
Priority Categories 1-5	First three visits per calendar year: $0 copay
	Fourth and subsequent visits per calendar year: $30 per visit
Priority Category 6	Care related to special treatment authorities: • First three visits per calendar year: $0 copay • Fourth and subsequent visits per calendar year: $30 per visit
	Care not related to special treatment authorities:[a] $30 per visit
Priority Categories 7-8	$30 per visit

Source: 38 C.F.R. §17.4600 and Department of Veterans Affairs, *Veteran Community Care – Urgent Care,* Fact Sheet, May 2019.

a. Special treatment authorities include care related to Agent Orange exposure, service in Camp Lejeune, ionizing radiation, and Project 112/SHAD and Military Sexual Trauma (MST), among others.

Costs to Veterans and Private Health Insurance

Do Veterans Have to Pay for Their Care?

Whether a veteran is required to pay for VA health care services or not depends primarily on (1) whether the condition being treated is service-connected, and (2) the veteran's enrollment priority category.[114]

Veterans who are enrolled in the VA health care system do not pay any premiums; however, some veterans are required to pay copayments for medical services related to the treatment of a nonservice-connected condition. **Table 6** summarizes which priority categories are charged copayments for inpatient care, outpatient care, outpatient medication, and long-term care services. Only veterans in Priority Category 1 (those who have been rated 50% or more service-connected or awarded the Medal of Honor) and veterans who are deemed catastrophically disabled by a VA

[113] Department of Veterans Affairs, *Veteran Community Care – Urgent Care*, Fact Sheet, May 2019.

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

provider are never charged a copayment, even for treatment of a nonservice-connected condition.[115]

For veterans in other priority categories, the VHA has four types of nonservice-connected copayments for which veterans may be charged: outpatient, inpatient, extended care services, medication copayments.[116] (The cost of outpatient medication is discussed in the subsequent section.) Veterans in all priority categories are not charged copayments for a number of outpatient services, including publicly announced VA health fairs, screenings and immunizations, smoking and weight loss counseling, telephone care, laboratory services, flat film radiology, and electrocardiograms.

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

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

The VHA bills private health insurers for medical care, supplies, and prescriptions provided to veterans for their nonservice-connected conditions. Although the VA cannot bill Medicare, it can bill Medicare supplemental health insurance carriers for covered services.[117] Veterans are not responsible for paying any remaining balance of the VA's insurance claim that is not paid or covered by their health insurance carrier. Any payment received by the VA is used to offset "dollar for dollar" a veteran's VA copayment responsibility.[118]

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[115] The manner in which the VA determines that a veteran is catastrophically disabled is established in regulation. The determinations are based on clinical criteria rather than (as was formerly the case) medical codes, which change over time. For more information, see 38 C.F.R. 17.36, and Department of Veterans Affairs, Veterans Health Administration, *Catastrophically Disabled Veteran Evaluation, Enrollment, and Certain Copayment Exemptions*, VHA Directive 1630(1) Transmittal Sheet, Washington, DC, May 7, 2015, pp. T-1.

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

[117] 38 U.S.C. §1729.

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

Table 6. Copayments for Health Care Services (CY2019)

U.S. Dollars

Priority Category	Outpatient Services (per visit)				Inpatient Services						Long-Term Care Services (Daily Max)							
	Basic Care		Specialty Care		First 90 days of care during a 365-day period		Each additional 90 days during a 365-day period		Daily Per Diem Charge		Nursing Home Care/ Inpatient Respite Care/ Geriatric Evaluation		Adult Day Health Care/ Outpatient Geriatric Evaluation/ Outpatient Respite Care		Domiciliary Care		Spousal Resource Protection Amount	
	SC	NSC	SC	NSC	SC	NSC	SC	NSC	SC	NSC	SC	NSC	SC	NSC	SC	NSC	SC	NSC
1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4[a]	0	0	0	0	0	0	0	0	0	0	0	Up to 97	0	0	0	Up to 5	0	126,420
5	0	0	0	0	0	0	0	0	0	0	0	up to 97	0	up to 15	0	up to 5	0	126,420
6[b]	0	15	0	50	0	0	0	0	0	0	0	up to 97	0	up to 15	0	up to 5	0	126,420
7	0	15	0	50	0	273	0	136	0	2	0	up to 97	0	up to 15	0	up to 5	0	126,420
8	0	15	0	50	0	1,364	0	682	0	10	0	up to 97	0	up to 15	0	up to 5	0	126,420

Source: CRS summary based on U.S. Department of Veterans Affairs, "2019 Copayment Rates" (IB 10-430), https://www.va.gov/healthbenefits/resources/publications/IB10-430_copay_rates_2018_dec.pdf (dated January 2019).

Notes: SC = service-connected; NSC = nonservice-connected.

a. The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163P.L. 111-163) exempted veterans determined by the VA to be catastrophically disabled from inpatient, outpatient, medication, and noninstitutional extended care services copayments.

b. Priority Category 6 are veterans claiming exposure to Agent Orange; veterans claiming exposure to environmental contaminants; veterans exposed to ionizing radiation; combat veterans within five years of discharge from the military; veterans who participated in Project 112/SHAD (Shipboard Hazard and Defense); veterans claiming military sexual trauma; Camp Lejeune veterans receiving VA-provided health care for one of the 15 identified illnesses or conditions; and veterans with head and neck cancer who received nasopharyngeal radium treatment while in the military. Such veterans are subject to copayments when their treatment or medication is not related to their exposure or experience. The initial registry examination and follow-up visits to receive examination results are not billed to the health insurance carrier and are not subject to copayments. However, care provided that is not related to exposure, if it is nonservice-connected, will be billed to the insurance carrier and copayments can apply.

Do Veterans Have to Pay for Their Medications?

Some veterans are required to pay copayments for each 30-day supply of medication provided on an outpatient basis. Veterans do not pay copayments if they have a service-connected disability rating of 50% or higher, have a Medal of Honor, are former POWs, are catastrophically disabled, or if the medication is for a service-connected disability.[119]

The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) authorized the VA to charge most veterans $2 for each 30-day supply of medication furnished on an outpatient basis for treatment of a nonservice-connected condition. The Veterans Millennium Health Care and Benefits Act of 1999 (P.L. 106-117) authorized the VA to increase the medication copayment amount and to establish annual caps on the total amount paid, to eliminate financial hardship for veterans enrolled in Priority Categories 2 through 6.

For many years since then, through rulemaking, the VA gradually increased the copayment amount by tying it to any increase in the prescription drug component of the Medical Consumer Price Index (CPI-P). In January 2006, the copayment amount increased to $8 and the annual cap on Priority Categories 2 through 6 increased to $960. The VA generally charged a flat copayment amount of $8 for all medications provided on an outpatient basis. As the prices based on the drug component of the CPI-P began to increase beyond $8, the VA, through a series of rulemakings, froze the copayment amount at $8 and the cap at $960 to alleviate any financial hardship for certain veterans. Starting on July 1, 2010, the VA allowed the copayment amount to increase to $9 for veterans in Priority Categories 7 and 8. On January 1, 2013, the VA froze the copayment amount at this rate for veterans in these priority categories. There was no copayment cap established for these veterans.

In January 2016, the VA proposed regulations to change the flat rate medication structure and institute a new tiered copayment structure that would vary depending upon the class of medication.[120] These new regulations went into effect on February 27, 2017.[121]

Veterans are charged copays for each medication per supply up to 30 days. Veterans pay a $5 copay for tier 1 or preferred generics, an $8 copay for tier 2 or nonpreferred generics, and an $11 copay for tier 3 or brand-name medications (see **Table 7**).

Veterans enrolled in Priority Categories 2 through 8 have a $700 calendar-year cap on the amount that they can be charged for these copayments.[122] After reaching the $700 cap during the calendar year, a veteran may continue to receive medications without making any copayments. Veterans who are unable to pay the VA's copayment charges may submit requests for assistance, including waivers, hardships, compromises, and repayment plans.[123]

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[119] For more information, see Department of Veterans Affairs, Medication Copayments, *Facts You Should Know*, IB10-971, revised April 2019, https://www.va.gov/healthbenefits/resources/publications/IB10-971_medication_copayment_brochure_english.pdf (accessed July 12, 2019).

[120] Department of Veterans Affairs, "Proposed Rule - Copayments for Medications Beginning January 1, 2017," 81 *Federal Register* 196, January 5, 2016.

[121] Department of Veterans Affairs, "Final Rule - Tiered Pharmacy Copayments for Medications," 81 *Federal Register* 89383 - 89391, December 12, 2016.

[122] CRS summary based on U.S. Department of Veterans Affairs, "2019 Copayment Rates" (IB 10-430), https://www.va.gov/healthbenefits/resources/publications/IB10-430_copay_rates_2018_dec.pdf (dated January 2019).

[123] U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Identifying the Causes of Inappropriate Billing Practices by the U.S. Department of Veterans Affairs*, 111th Cong., 1st sess., October 15, 2009 (Washington: GPO, 2010), p. 43. For additional information, see https://www.va.gov/healthbenefits/cost/

The VA has developed criteria for determining tier 1 medications, and each year it identifies a subset of multisource medications as tier 1 medications.[124] In addition to being FDA-approved and available from multiple sources, tier 1 medications must

- cost the VA $10 or less for a 30-day supply;
- be available on the VA national formulary;
- be among the top 75 most commonly prescribed medications; and
- be primarily used to either treat or manage a chronic condition, or to reduce the risk of adverse health outcomes secondary to the chronic condition.

Topical creams, treatments for musculoskeletal conditions, antihistamines, steroid-containing medications, and antibiotics primarily used for short periods to treat infection cannot be considered for tier 1 status.

Table 7. Outpatient Medication Copayments

Priority Category	Medication Tier	Up to a 30 day supply per medication
2 through 8[a]	Tier 1 medications (preferred generics)[b]	$5
	Tier 2 medications (nonpreferred generics and some over-the-counter medications)[c]	$8
	Tier 3 medications (brand-name)	$11

Source: Department of Veterans Affairs, *Medication Copayments, Facts You Should Know*, IB10-971, revised April 2019, https://www.va.gov/healthbenefits/resources/publications/IB10-971_medication_copayment_brochure_english.pdf.

Note: For veterans in Priority Categories 2-8 the annual outpatient prescription medication copayment is capped at $700.

a. Veterans enrolled in Priority Category 1 do not pay copayments for outpatient medication.

b. A list of tier 1 medications is available at http://www.pbm.va.gov/PBM/Tiered_Copay/Tier_1_CO-PAY_MEDICATION_LIST.pdf.

c. A list of tier 2 and 3 medications is available at https://www.pbm.va.gov/PBM/Tiered_Copay/TierCopayExcelPPSN.xlsx.

Can Veterans Who Receive Health Care from the VA for Service-Connected Conditions Contribute Toward Health Savings Accounts (HSAs)?[125]

Provided veterans meet certain eligibility criteria, they may contribute toward health savings accounts.

financialhardship.asp.

[124] Department of Veterans Affairs, "Tiered Pharmacy Copayments for Medications Update," 84 *Federal Register* 15044, April 12, 2019.

[125] This section was written by Ryan J. Rosso, CRS Analyst in Health Care Financing. For more information on health savings accounts (HSAs), see CRS Report R45277, *Health Savings Accounts (HSAs)*, by Ryan J. Rosso.

The Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (P.L. 114-41) expanded the ability of veterans who receive care from the VA for service-connected disabilities to contribute toward health savings accounts. This change went into effect January 1, 2016.

HSAs are one way individuals can pay for unreimbursed medical expenses (deductibles, copayments, and services not covered by health insurance) on a tax-advantaged basis.[126] Only eligible individuals can establish and fund HSAs. To be eligible, one must be covered under an HSA-qualified high-deductible health plan (HDHP),[127] cannot have disqualifying coverage,[128] and cannot be claimed as a dependent on a different taxpayer's return. In general, an individual's eligibility to contribute to an HSA is determined on a monthly basis.

Prior to 2016, receiving care from the VA limited veterans' ability to contribute to HSAs. Veterans who were otherwise eligible to contribute to an HSA would not be considered eligible to contribute to their HSA in any month in which they received care from the VA in the preceding three months.[129]

Under P.L. 114-41, individuals who are otherwise eligible to contribute to an HSA are no longer prohibited from contributing to an HSA merely because they receive medical care from the VA for a service-connected disability.

Can the VA Bill Private Health Insurance?

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

To help defray the cost of delivering medical services to veterans, the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), enacted into law in 1986, gave the VHA the authority to bill some veterans and most health care insurers for nonservice-connected care provided to veterans enrolled in the VA health care system.[130] This law also established means-testing for veterans seeking care for nonservice-connected conditions.[131] Congress authorized the VHA to collect reasonable charges for medical care or services (including the provision of prescription drugs) from a third party to the extent that the veteran or the provider of the care or services would be eligible to receive payment from the third party for (1) a nonservice-connected disability for which the veteran is entitled to care (or the payment of expenses of care) under a health plan contract;[132] (2) a nonservice-connected disability incurred as a result of the veteran's employment and covered under a worker's compensation law or plan that provides

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

[127] A qualified high-deductible health plan (HDHP) has a minimum deductible and an annual out-of-pocket limit. For 2019, the minimum deductible is $1,350 for single coverage and $2,700 for family coverage. The 2019 annual out-of-pocket limit is $6,750 for single coverage and $13,500 for family coverage. Internal Revenue Service (IRS), *Internal Revenue Bulletin: 2018-21*. For additional information, see https://www.irs.gov/irb/2018-21_IRB.

[128] Individuals generally cannot have any other health coverage that is not an HSA-qualified HDHP. However, some types of health coverage are allowable to establish and contribute to an HSA. Such coverage includes, but is not limited to, property insurance, hospital indemnity insurance, insurance for a specified disease or illness, and coverage for dental care, vision care, or long-term care. 26 U.S.C. §223(c)(1).

[129] Internal Revenue Service, Health Savings Accounts – Additional Qs&As, Notice 2004-50, August 16, 2004.

[130] Veterans' Health-Care and Compensation Rate Amendments of 1985 (P.L. 99-272).

[131] Prior to this, veterans signed a form under oath stating that they were unable to pay for hospitalization.

[132] 38 U.S.C. §1729(a)(2)(D), and 38 C.F.R. §17.101(a)(1)(i).

reimbursement or indemnification for such care and services;[133] or (3) a nonservice-connected disability incurred as a result of a motor vehicle accident in a state that requires automobile accident reparations (no fault) insurance.[134] Similarly, the VHA can receive payments from Medicare supplemental coverage plans (also known as medigap policies, which are private insurance plans that may pay medical expenses not paid by Medicare) for nonservice-connected conditions for which the veteran receives care at VHA facilities.

The VHA will not recover or collect charges from third-party private health insurers or the veterans for care or services provided to veterans who receive care under special statutory treatment authorities (e.g., exposure to tactical herbicides during the Vietnam era, ionizing radiation, and certain chemical and biological weapons testing; for conditions attributable to service in the Southwest Asia theater during the Persian Gulf War; and for certain veterans at Camp Lejeune during specified periods of time).[135] In other words, the VA provides full coverage without cost-sharing.

Veterans are not responsible for paying any remaining balance of the VA's insurance claim not paid or covered by their health insurance plan. This means that the VA does not "balance bill" the veteran[136] Moreover, any payment received by the VA is used to offset "dollar for dollar" a veteran's VA copayment responsibility.[137]

Can the VA Bill Medicare?

The VA is statutorily prohibited from billing Medicare[138] in most situations. In addition, veterans are responsible for paying all Medicare premiums, deductibles, and co-insurance. The VA has no authority to reimburse VA-enrolled Medicare beneficiaries for expenses they incur to obtain care under Medicare.[139]

In general, Medicare is prohibited from reimbursing the VA for any services unless

- the provider is determined by the Secretary of Health and Human Services (HHS) to be providing services to the public as a community institution or agency;
- the provider is providing services through facilities operated by the Indian Health Service (IHS);[140] or
- the services were provided in an emergency (in a hospital setting).

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[133] 38 U.S.C. §1729(a)(2)(A), and 38 C.F.R. §17.101(a)(1)(ii).

[134] 38 U.S.C. §1729(a)(2)(B), and 38 C.F.R. §17.101(a)(1)(III).

[135] 38 C.F.R. § § 17.101(a)(9).

[136] Balance billing is when a health care provider bills a consumer for charges (other than cost sharing) that exceed the health insurance plan's payment for a covered service. (See CRS In Focus IF10263, *Balance Billing in Private Health Insurance Plans*.)

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

[138] "Medicare is a federal insurance program that pays for covered health care services of qualified beneficiaries." For more information, see CRS Report R40425, *Medicare Primer*.

[139] 42 U.S.C. §1395y(a)(3)).

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

In addition, Medicare is prohibited from making payments to any federal health care provider who is obligated by law or contract to render services at public expense.[141] Therefore, the VHA is statutorily prohibited from receiving Medicare payments for services provided to Medicare-covered veterans.[142] This statutory prohibition applies to Medicare Part C (Medicare Advantage Plans) as well.

Although the legislative history does not indicate congressional intent for this, in United States v. Blue Cross & Blue Shield of Maryland, Inc., the majority opinion stated that "a safe assumption to be drawn from the exclusion of Medicare [from paying for health care services provided through other federal entities] is that Congress wanted to avoid the unnecessary transfer of federal funds from Medicare to the VA when the money is all coming out of the same coffer."[143]

It should be noted that there is a narrow exception to this statutory prohibition of Medicare reimbursing the VHA. Under current law, the VHA can be reimbursed by Medicare (notwithstanding any condition, limitation, or other provision in title XVIII of the Social Security Act) when the VA provides services to Medicare-covered individuals who are not eligible for care under Title 38, *U.S. Code* (U.S.C.), Chapter 17,[144] and who are afforded VA care or services under a "sharing" agreement.[145] A sharing agreement is a written contract that allows the VHA to buy, sell, or exchange health care resources and services with non-VA facilities. The VHA may enter into noncompetitive sharing agreements with affiliated institutions (e.g., affiliated medical schools—affiliated with VHA under 38 U.S.C. §7302) and other entities associated with these affiliated institutions (e.g., university hospitals).

[141] 42 U.S.C. §§1395f(c), 1395n(d), and 1395f(a).

[142] 42 U.S.C §1395f(c), and 38 U.S.C. §1729(i)(1)(B)(i).

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

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

[145] 38 U.S.C. §8153(d).

Appendix. VA Priority Categories and Their Eligibility Criteria

The VA classifies veterans into eight enrollment priority categories based on an array of factors, including (but not limited to) service-connected disabilities or exposures,[146] prisoner of war (POW) status, receipt of a Purple Heart or Medal of Honor, and income. The criteria for each priority category are summarized in **Table A-1.**

The eight priority categories fall into two broad groups. The first group is composed of veterans with service-connected disabilities or with attributable incomes below the VA's National Means Test (NMT) threshold. These veterans are regarded by the VA as "high-priority" veterans, and they are enrolled in Priority Categories 1-6. Veterans enrolled in priority categories 1-6 include the following:

- veterans in need of care for a service-connected disability;
- veterans awarded the Purple Heart or Medal of Honor;
- veterans who have a compensable service-connected condition;
- veterans whose discharge or release from active military, naval, or air service was for a compensable disability that was incurred or aggravated in the line of duty;
- veterans who are former POWs;
- veterans who have been determined by the VA to be catastrophically disabled;
- veterans of World War I;
- veterans who were exposed to hazardous agents (such as Agent Orange in Vietnam) while on active duty; and
- veterans who have an annual income below VA's National Means Test (NMT) threshold (see **Table A-2**).

The VA considers applicants' gross household income (earned and unearned) and deductible medical expenses for the previous year to determine their specific priority categories and whether they have to pay copayments for nonservice-connected care.[147] In addition, veterans are asked to provide the VA with information on any health insurance coverage they have, including coverage through employment or through a spouse. The VA may bill these payers for treatment of conditions that are *not* a result of injuries or illnesses incurred or aggravated during military service (i.e., not service-connected).

The second group of veterans is composed of those who do not fall into one of the first six priority categories—primarily veterans with nonservice-connected medical conditions and with

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

[147] To align the VA's health care program with other federal health care programs' financial assessment requirements, effective January 1, 2015, the VA stopped collecting veterans' net worth information for purposes of financial assessment for health benefits. According to the final rule published in the *Federal Register*, "by eliminating the requirement to have veterans report net worth information VA will be able to use established practices with the Internal Revenue Service and Social Security Administration to verify veterans' reported annual income far more efficiently. Since this process can be done without requiring a collection of information with the Veteran, this policy has eliminated the significant burden on veterans to report their net worth, and it also eliminated the need for VA to use resources to verify that information" (Department of Veterans Affairs, "Final Rule-Removing Net Worth Requirement from Health Care Enrollment," 84 *Federal Register* 24032 - 24034, May 24, 2019).

incomes above the VA-established means test threshold (see **Table A-2**). These veterans are enrolled in Priority Categories 7 or 8.[148]

Table A-1. VA Priority Categories and Placement Criteria

A veteran is placed in the highest priority category for which the veteran meets at least one criterion

Priority Category	Enrolled Veteran Placement Criteria
1	• Service-connected disabilities rated 50% or more disabling; • Determined by VA to be unemployable due to service-connected conditions; or • Awarded the Medal of Honor.[a]
2	• Service-connected disabilities rated 30% or 40% disabling
3	• Former Prisoners of War (POWs);[b] • Awarded the Purple Heart;[c] • Discharge from the military was for a disability that was incurred or aggravated in the line of duty; • Service-connected disabilities rated 10% or 20% disabling; or • Awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation."
4	• Receiving aid and attendance or housebound benefits; or • Determined by the VA to be catastrophically disabled.
5	• Nonservice-connected disabilities and noncompensable service-connected disabilities rated 0% disabled with an annual income below VA's National Means Test (NMT) thresholds;(a veteran must have a household income below both the VA's NMT and Geographic Means Test (GMT) thresholds); • Receiving VA pension benefits; or • Eligible for Medicaid benefits.
6	• Compensable service-connected disability rated 0% disabling; • Exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; • Participation in Project 112/SHAD[d]; • Service in the Republic of Vietnam between January 9, 1962, and May 7, 1975; • Active duty service at Camp Lejeune for at least 30 days between August 1, 1953, and December 31, 1987; or • Service in a theater of combat operations after November 11, 1998, and discharged from active duty on or after January 28, 2003 (these veterans are placed in Priority Category 6 for five years post discharge. At the end of the five year period, veterans are assigned to the highest priority category for which they qualify).
7	• Gross household income below geographic income limits and agreement to pay copayments.

[148] The VA considers a veteran's gross household income (both earned and unearned income, as well as his/her spouse's and dependent children's income) for the previous year. Earned income is usually wages received from working. Unearned income includes interest earned, dividends received, money from retirement funds, Social Security payments, annuities, and earnings from other assets. The number of persons in the veterans' family will be factored into the calculation to determine the applicable income threshold. 38 C.F.R. §17.36(b)(7).

Priority Category	Enrolled Veteran Placement Criteria
8	• Gross household income above the established VA means test thresholds and geographic income limits and agreement to pay the applicable copayments; and • Subpriority a: noncompensable service-connected rated 0% (i.e., the disability is not severe enough to be compensated) and enrolled as of January 16, 2003, and who has remained enrolled since that date and/or place in this subpriority due to changed eligibility status; or • Subpriority b: noncompensable service-connected rated 0% and enrolled on or after June 15, 2009, whose income exceeds the current VA's National Means Test (NMT) and Geographic Means Test (GMT) thresholds by 10% or less; or • Subpriority c: Nonservice-connected and enrolled as of January 16, 2003, and who has remained enrolled since that date and/or place in this subpriority due to changed eligibility status; or • Subpriority d: Nonservice-connected and enrolled on or after June 15, 2009 whose income exceeds the current VA means test threshold or geographic income limits by 10% or less; or • Subpriority e (*currently not eligible for enrollment*): noncompensable service-connected rated 0% and not meeting the criteria above; or • Subpriority g (*currently not eligible for enrollment*): Nonservice-connected and not meeting the criteria above. (VA has not established Subpriority f).

Source: Prepared by CRS based on information from Department of Veterans Affairs, Veterans Health Administration, *Eligibility Determination*, VHA DIRECTIVE 1601A.02, November 21, 2018.

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

a. Veterans in receipt of the Medal of Honor are in Priority Category 1. This change occurred with the enactment of the Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016 (P.L. 114-315) on December 16, 2016.

b. Veterans who are former POWs are placed in Priority Category 3. This change occurred with the enactment of the Former Prisoner of War Benefits Act of 1981 (P.L. 97-37) on August 14, 1981.

c. Veterans in receipt of a Purple Heart are in Priority Category 3. This change occurred with the enactment of the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) on November 30, 1999. .

d. Project 112 and Project SHAD were chemical and biological weapon experimentation projects conducted between 1962 and 1973.

Table A-2. National Income Thresholds for CY2019

(Based on attributable income for 2018)

Veterans with—	Free VA prescriptions and travel benefits for veterans with incomes (annual VA pension rate) of—	Free VA prescriptions and travel benefits for veterans with VA pension with aid and attendance incomes of—	Free VA prescriptions and travel benefits for veterans with VA pension with housebound benefit incomes of—	Free VA health care for veterans with incomes of—	Enrollment in Priority Category 8 for veterans with incomes of—[a]
No dependents	$13,535 or less	$22,577 or less	$16,540 or less	$33,632 or less	$36,995 or less
1 dependent	$17,724 or less	$26,766 or less	$20,731or less	$40,359 or less	$44,395 or less
2 dependents	$20,037 or less	$29,079 or less	$23,044 or less	$42,672 or less	$46,939 or less
3 dependents	$22,350 or less	$31,392 or less	$25,357 or less	$44,985 or less	$49,484 or less
4 dependents	22,663 or less	$33,705 or less	$27,670 or less	$47,298 or less	$52,028 or less
For each additional dependent, add:	$2,313	$2,313	$2,313	$2,313	$2,313

Source: Table prepared by CRS based on information from the Department of Veterans Affairs. https://www.va.gov/healthbenefits/apps/explorer/AnnualIncomeLimits/LegacyVAThresholds?FiscalYear=2019.

Notes: For geographic means test (GMT) variations, see https://www.va.gov/healthbenefits/resources/gmt..

a. The Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (P .L. 110–329), provided funding within the medical services account to increase the enrollment of Priority Category 8 veterans whose incomes exceed the current VA's National Means Test (NMT) and Geographic Means Test (GMT) thresholds by 10% or less. The VA issued regulations and began enrolling these veterans effective June 15, 2009. (Department of Veterans Affairs, "Expansion of Enrollment in the VA Health Care System," 74 *Federal Register* 22832, May 15, 2009).

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