

“TO CARE FOR HIM WHO SHALL HAVE BORNE THE BATTLE:” EXPANDING THE CHOICE CARD PROGRAM TO PROVIDE FOR THOSE WHO SERVE

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I. INTRODUCTION

America and other nations have long revered the idea that those who serve in wars are eligible for health and financial benefits, and that the families of those who died in war should receive help as well. The belief that injured or disabled veterans should be cared for first appeared in the United States in 1636 at Plymouth Colony.¹ After fighting against Native Americans in the Pequot War, the Pilgrims passed a law declaring the colony would take care of those who had been injured during the fight.² Various other financial and personal incentives were common to soldiers by the time the Declaration of Independence was drafted in 1776.³ The Continental Congress provided pensions to those injured during the Revolution, and the government introduced several other benefits to veterans by World War I.⁴

Recently, healthcare for veterans has been subject to controversy. Rumbblings of trouble came to a head in 2014 when whistleblowers released information to CNN that a Phoenix Veteran’s Administration (VA) hospital manipulated reports, hid long wait times for appointments, and allowed dozens of veterans to die while waiting for care.⁵ This sparked similar allegations

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1. *History*, DEP’T OF VETERANS AFFAIRS, http://www.va.gov/about_va/vahistory.asp (last visited Nov. 9, 2015) [hereinafter VA HISTORY].

2. *Id.*

3. *Id.*

4. *Id.*

5. Scott Bronstein, Drew Griffin, & Nelli Black, *VA Deaths Covered Up to Make Statistics Look Better, Whistle-Blower Says*, CNN.COM (June 24, 2014), <http://www.cnn.com/2014/06/23/us/phoenix-va-deaths-new-allegations/index.html>; see also Scott Bronstein & Drew Griffin, *A Fatal Wait: Veterans Languish and Die on a VA Hospital’s Secret List*, CNN.COM (Apr. 23, 2014), <http://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/> (describing “an

from dozens of VA facilities nationwide and placed the VA healthcare system in the spotlight.⁶

In response, Congress passed the Veterans Access, Choice, and Accountability Act (Choice Act) in August 2014.⁷ The Choice Act made structural changes to VA and Veteran's Health Administration (VHA) in an attempt to address the problems that caused the 2014 controversy.⁸ Among other provisions, the Choice Act introduced a pilot program called the Choice Card Program, which allows qualified veterans to receive healthcare services at non-VA facilities.⁹ This bi-partisan effort from Congress was an attempt to improve the accessibility of healthcare for veterans. However, Congress's intentions to improve the healthcare system for all veterans have not been fulfilled, as VHA has erected barriers to veterans seeking medical care under the Program.

If Congress and other American leaders truly want to provide for veterans and honor their service to the nation, they should overhaul VHA and the Choice Card Program. While keeping the Program's goal of providing efficient and quality healthcare to veterans, VHA should abandon most of its small clinics and instead focus its attention on its system of large hospitals that are most qualified to treat health problems that are common to veterans.¹⁰ The Choice Card Program should allow a veteran seeking less intensive or serious treatment to go to a local, private clinic for free or low charge. VHA should seize the opportunity to save money by allowing veterans to go to private clinics, which have an incentive to provide efficient and cost effective services. Furthermore, VHA would better serve veterans by focusing on the unique needs of individuals who have served. With these changes, VHA would have the opportunity to provide the best care possible to those who need it.

Even if Congress decides not to overhaul the Choice Card Program and VHA, lawmakers should not let the Choice Card Program expire when the pilot program terminates in 2017. Instead, they should extend the program and

elaborate scheme designed by Veterans Affairs managers in Phoenix who were trying to hide that 1,400 to 1,600 sick veterans were forced to wait months to see a doctor.”).

6. OFFICE OF THE INSPECTOR GENERAL, VETERANS HEALTH ADMINISTRATION INTERIM REPORT – REVIEW OF PATIENT WAIT TIMES, SCHEDULING PRACTICES, AND ALLEGED PATIENT DEATHS AT THE PHOENIX HEALTHCARE SYSTEM, at i (May 28, 2014), <http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf>. This interim report was produced at the request of various politicians and state officials.

7. Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, § 707, 128 Stat. 1754 (2014).

8. *Id.*

9. *Id.* at § 101(f)(3)(E).

10. Health problems veterans commonly face include musculoskeletal injuries and pain, prosthetics, PTSD and other mental health problems, chemical and physical exposures, including sand, dust, agent orange, etc., noise exposure, and traumatic brain injuries. See generally Maureen Salamon, *After the Battle: 7 Health Problems Facing Veterans*, LIVE SCIENCE (Nov. 11, 2010), <http://www.livescience.com/8916-battle-7-health-problems-facing-veterans.html>; DEP'T OF VETERANS AFFAIRS, *Public Health*, <http://www.publichealth.va.gov/index.asp> (last visited Nov. 9, 2015) (describing health problems common associated with military service, and noting health risks from being stationed in various parts of the world.).

expand its provisions to truly provide veterans with access, choice, and accountability of their healthcare.

This paper will discuss the history of healthcare for veterans and provide a brief summary of the events that led to the calls for reform of VHA. Then it will examine the provisions of the Choice Act, including the Choice Card Program. The Choice Card Act has been subject to changes and criticism, some of which will be addressed below. Finally, this paper will discuss two solutions to address the insufficiencies in the Choice Card Program. First, VA could address the current problems in healthcare by making drastic changes, including scaling back its smaller clinics, restructuring the Choice Card Program to allow veterans to have a primary care physician outside of the VA, and focusing on its larger hospitals with more intensive care. A second option is that VA could instead make changes to the Choice Card Program, such as altering its eligibility requirements and extending the time frame so that the program does not end in 2017.

While there are advantages and disadvantages to both options, an overhaul of the Choice Card Program—and, therefore, a dramatic overhaul of VHA’s organization and structure—is likely the best long-term solution for the veterans healthcare system. The biggest barrier VHA would face in order to accomplish reorganizing the system is funding. Most of the solutions VHA could implement would take a much larger allocation of the federal budget than it currently receives. With the various ways to reform VHA, Congressional oversight is absolutely crucial for the continued success and accountability of veterans’ health care.

II. BACKGROUND

VHA, the largest of the three subdivisions that make up VA, has its roots in the Civil War.¹¹ On March 4, 1865, just weeks before the Civil War ended, President Lincoln gave his second inaugural address on the steps of the capitol.¹² He spoke sadly of the devastation and destruction that the country was experiencing during the war, and he proceeded to call upon the nation, saying, “Let us strive to finish the work we are in, to bind up the nation’s wounds, to care for him who shall have borne the battle and for his widow, and his orphan, to do all which may achieve and cherish a just and lasting peace among ourselves and with all nations.”¹³ This call prompted the first VHA facility for injured Civil War soldiers to open in 1866.¹⁴ By 1929, 11 locations had been established in the eastern United States.¹⁵

Today’s VHA has expanded greatly from those 11 locations. VHA has become one of the largest healthcare systems in the U.S., with 9.11 million

11. VA HISTORY, *supra* note 1.

12. Abraham Lincoln, President of the United States, Second Inaugural Address (March 4, 1863), http://avalon.law.yale.edu/19th_century/lincoln2.asp.

13. *Id.*

14. VA HISTORY, *supra* note 1.

15. *Id.*

enrolled veterans.¹⁶ In the last few decades, VHA has seen a dramatic increase in the number of veterans seeking treatment due to the U.S.'s involvement in the Middle East.¹⁷ Because of advancements in safety technology, medicine, injury treatment, and transportation, a higher percentage of veterans are returning home alive than ever before.¹⁸ This high number of returning veterans means that more veterans need medical treatment, and the demand for VHA services has risen at a higher rate than the government's allocated budget.¹⁹ Many VA health facilities have struggled to accommodate the increased need.²⁰ VHA locations across the country saw waiting lists grow longer and fewer veterans were receiving care.²¹

After the whistleblower's allegations of mismanagement at the Phoenix VA hospital,²² whistleblowers from the Atlanta VA Hospital claimed employees falsified wait times and alleged maladministration and wait times caused several deaths.²³ Also under fire was the Pittsburg VA Hospital, where hospital officials knew water in the building tested positive for *Legionella* bacteria, which causes Legionnaires' Disease, but did little to prevent the impending outbreak.²⁴ At the end of the outbreak, six patients' deaths were attributed to the Legionnaires' Disease, and 22 others were ill.²⁵ Similar incidences were reported all over the country,²⁶ which caused "questions about the VA's integrity [to run] all the way up to the secretary's office."²⁷ Initial

16. NAT'L CTR. FOR VETERANS ANALYSIS AND STATISTICS, DEPARTMENT OF VETERANS AFFAIRS STATISTICS AT A GLANCE (Aug. 2015), http://www.va.gov/vetdata/docs/Quickfacts/Stats_at_a_glance_08_27_15.pdf.

17. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-15-290, HIGH RISK SERIES: AN UPDATE, 27 (2015), <http://www.gao.gov/products/GAO-15-290>.

18. Rajiv Chandrasekaren, *A Legacy of Pain and Pride*, WASH. POST (Mar. 29, 2014), <http://www.washingtonpost.com/sf/national/2014/03/29/a-legacy-of-pride-and-pain/>.

19. *Assessing the Promise and Progress of the Choice Program: Hearing before the House Veterans' Affairs Committee*, 114th Cong. 1 (May 13, 2015) (statement of Joseph Violante, National Legislative Director, Disabled American Veterans), available at <https://www.dav.org/wp-content/uploads/Violante20150513.pdf> [hereinafter *Assessing the Promise*].

20. *Id.* at 2.

21. *Id.* See also Bronstein, Griffin, & Black, *supra* note 5 and accompanying text; OFFICE OF THE INSPECTOR GENERAL, *supra* note 6 and accompanying text.

22. See Bronstein, Griffin, & Black, *supra* note 5 and accompanying text; OFFICE OF THE INSPECTOR GENERAL, *supra* note 6 and accompanying text.

23. See generally *Timeline of VA Health-Care Scandal*, THE ARIZ. REPUBLIC (May 9 2014, 9:33 PM), <http://www.azcentral.com/story/news/arizona/politics/2014/05/10/timeline-road-va-wait-time-scandal/8932493/> (providing a timeline and overview of the VA healthcare scandal) [hereinafter *Timeline*].

24. Elaine Quijano, *PA. VA Hospital Knew of Legionella Problem Before Patient's Death*, CBS NEWS (Jan. 11, 2013, 6:30 PM), <http://www.cbsnews.com/news/pa-va-hospital-knew-of-legionella-problem-before-patients-death/>.

25. Jennifer Janisch, *VA Hospital Knew Human Error Caused Legionnaires' Outbreak*, CBS NEWS (Mar. 13, 2014, 6:21 PM), <http://www.cbsnews.com/news/va-hospital-knew-human-error-caused-legionnaires-outbreak/>.

26. *Timeline*, *supra* note 23.

27. Phillip Carter, *How to Fix the VA*, SLATE (May 30, 2014, 6:59 PM), http://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html.

investigations revealed that these practices were not new—instead, they were part of “a systemic, years-long problem.”²⁸ Top administrators then—VA Secretary Eric Shinseki and VHA Under Secretary for Health Dr. Robert Petzel—VHA’s highest-ranking official—resigned amid the allegations.²⁹

VA launched various committees to investigate the claims, and an internal audit confirmed what the whistleblowers alleged—too many veterans were left waiting much longer than reported and many never received the care they needed.³⁰ The report found many VA health clinics falsified reports to make patient wait times appear shorter, and 13% of scheduling staff indicated that they received instructions from supervisors to change dates in the scheduling system to show more favorable results.³¹ For example, the Phoenix VA facility reported an average wait time of 24 days, but in reality, veterans were waiting close to four months for an appointment.³² The results showed that the stated goal of a 14-day wait time was unattainable, largely due to lack of providers and limited support staff.³³ The report also indicated that employees thought that the scheduling process was “overly complicated” and resulted in veterans having to wait months for care.³⁴

While there were a lot of systemic issues within VA, three large forces contributed to the VHA scandal of 2014. First was the increased need for services and therefore the inability to meet goals.³⁵ Second, administrators and high-level employees likely desired to make wait times look more favorable because of the availability of performance-based bonuses.³⁶ As a striking example, in the months following the Legionnaires’ Disease outbreak at the Pittsburgh VA facility,³⁷ an official who oversaw the hospital received a

28. Michelle Ye Hee Lee, *No, The VA Has Not Fired 60 People for Manipulating Wait-Time Data*, WASH. POST (Feb. 18, 2105), <https://www.washingtonpost.com/news/fact-checker/wp/2015/02/18/no-the-va-has-not-fired-60-people-for-manipulating-wait-time-data/>.

29. OFFICE OF THE PRESS SECRETARY, STATEMENT BY THE PRESIDENT (May 30, 2014, 11:17 AM), <https://www.whitehouse.gov/the-press-office/2014/05/30/statement-president>. See generally *Veterans Secretary Eric Shinseki Resigns After Report*, BBC NEWS (May 30, 2014), <http://www.bbc.com/news/world-us-canada-27640375>.

30. DEP’T OF VETERANS AFFAIRS, ACCESS AUDIT: SYSTEM-WIDE REVIEW OF ACCESS (2014) [hereinafter ACCESS AUDIT], <http://www.va.gov/health/docs/VAAccessAuditFindingsReport.pdf>; see also Tom Cohen, *Audit: More Than 120,000 Veterans Waiting or Never Got Care*, CNN POLITICS (June 10, 2014, 7:09 AM), <http://www.cnn.com/2014/06/09/politics/va-audit/> (describing the results of VA’s Access Audit and the consequences of its implications).

31. ACCESS AUDIT, *supra* note 30, at 4.

32. *Timeline*, *supra* note 23.

33. *Id.* at 3–4.

34. *Id.* at 3.

35. See *supra* notes 16–21 and accompanying text; see *infra* notes 64–67 and accompanying text.

36. Dustin Racioppi, *Report: VA Gave \$100M in Bonuses as Vets Awaited Care*, USA TODAY (June 11, 2014, 8:10 AM), <http://www.usatoday.com/story/news/nation/2014/06/11/va-waiting-lists-bonuses/10315455/> (describing another reason why VHA employees may have been falsifying data on reports—their bonuses were tied to performance.).

37. See *supra* notes 24–25 and accompanying text.

\$63,000 performance bonus.³⁸ Finally, the VHA scandal was influenced by a lack of funding.³⁹ Three groups—Disabled American Veterans (DAV), Paralyzed Veterans of America, and Veterans of Foreign Wars—co-author a document called “The Independent Budget.”⁴⁰ This document, prepared annually, is created to provide Congress with their policy, legal, and budgetary recommendations for the coming fiscal year.⁴¹ Representatives from Disabled American Veterans (DAV) noted that year after year, the budgetary recommendations they provided were not requested by VA, and were therefore not provided by Congress.⁴² Motivated by those financial incentives and other internal pressures, VHA staff and administrators produced documents that portrayed wait times at VHA facilities inaccurately and more favorably to compensate for the long wait times at clinics.⁴³ This falsified and misleading information lead to disastrous results all over the country.⁴⁴

III. A CALL FOR CHANGE: CONGRESS INTRODUCES THE CHOICE ACT AND THE CHOICE CARD PROGRAM

After compiling results from investigations, reports, hearings, and an FBI investigation, Congress took action. The Veterans Access, Choice, and Accountability Act (Choice Act) was enacted August 7, 2014.⁴⁵ The final draft of the Choice Act—negotiated by Senator Bernie Sanders and Senator John McCain—passed easily through both chambers.⁴⁶ Overwhelming bipartisan support for the Choice Act and the insistence to reform the VA healthcare system is a testament to how important this issue is to Congressional leaders.

The Choice Act aims to establish clear goals to ensure accountability

38. Janisch, *supra* note 25.

39. *Assessing the Promise*, *supra* note 19 at 1 (“we have no doubt that the principle reason veterans were put on waiting lists was the mismatch between funding available to VA and demand for health care from VA by veterans, a phenomenon that is hardly new. In fact, this mismatch has been regularly reported to Congress by [Disabled American Veterans], our partners in the Independent Budget (IB) and others for more than a decade.”).

40. *Budget Recommendations for FY 2017 and FY 2018*, THE INDEP. BUDGET, <http://docs.house.gov/meetings/VR/VR00/20160210/104383/HHRG-114-VR00-20160210-SD003.pdf>.

41. *Id.*

42. *Assessing the Promise*, *supra* note 19 at 2. (“In fact, in the prior 10 VA budgets, the amount of funding for medical care requested by the Administration and ultimately provided to VA by Congress was more than \$7.8 billion less than the amounts we recommended. Over the past five budgets, the IB recommended \$4 billion more than VA requested and Congress approved. For this fiscal year, FY 2015, the IB had recommended over \$2 billion more than VA requested or Congress appropriated.”).

43. *See generally* Carter, *supra* note 27 (“Key among these was the finding that the actual VA primary care wait times in Phoenix averaged 115 days—more than four times the VA’s previously reported average of 24 days.”).

44. *See* Racioppi, *supra* note 36 and accompanying text; *See Timeline*, *supra* note 23.

45. Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, § 707, 128 Stat. 1754 (2014).

46. *See generally All Actions: H.R. 3230—Veterans Access, Choice, and Accountability Act of 2014*, CONGRESS.GOV, <https://www.congress.gov/bill/113th-congress/house-bill/3230/all-actions/> (last visited Oct. 23, 2016) (tracking the actions the bill took before becoming a law).

throughout VA—from individual VHA locations all the way to officials in its Washington, D.C. office. The Act contains a firing provision that allows the Secretary of Veterans Affairs to fire high-ranking executives for poor performance and misconduct.⁴⁷ It also limits performance-based bonuses in an attempt to cut down on the pressure to falsify information to give an illusion of better outcomes.⁴⁸ The Choice Act provided funding that allowed VHA to hire more staff, provide additional training for employees, open more locations, and extend clinic hours.⁴⁹ It introduced mobile medical centers to further serve veterans.⁵⁰ Additionally, medical services were extended to cover military sexual trauma during active or inactive duty, requiring reports to Congressional leaders about progress made in treatment of sexual trauma.⁵¹

Perhaps most notably, the Choice Act introduced a three-year pilot program—the Choice Card Program. This program allows veterans to utilize healthcare services from non-VA providers in certain circumstances.⁵² If a veteran has been waiting more than 30 days for VA medical care (or has a projected wait time of over 30 days), or if a veteran lives more than 40 miles away from a VA medical care facility⁵³, the veteran is eligible for the Choice Card Program.⁵⁴

Procedurally, scheduling an appointment under the Choice Card Program is complicated. If the veteran knows that he or she is eligible to receive non-VA healthcare services, he or she still must make the appointment through the VA scheduler. To receive healthcare at VA facilities, the veteran calls the scheduler to request an appointment.⁵⁵ If the wait time is over 30 days, the

47. Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, § 707, 128 Stat. 1754 (2014).

48. *Id.* at § 705.

49. *Id.* at § 303.

50. *Id.* at § 204.

51. *Id.* at §§ 401–03.

52. *Id.* at § 101.

53. See *Veterans Choice Program: Access Health Care Closer to Home*, U.S. DEP'T VETERANS AFF., <http://www.va.gov/opa/choiceact/#> (describing a VA policy that allows a veteran to otherwise qualify if he or she does not meet the 40-mile distance requirement, but rather if he or she meets an exception from a list of 'excessive travel burdens.' If any of the following situations apply, the veteran is qualified for the program: "The Veteran resides in a location other than Guam, American Samoa, or the Republic of the Philippines and needs to travel by air, boat, or ferry to the VA medical facility closest to his/her home. The Veteran faces an unusual or excessive burden traveling to a VA medical facility based on geographic challenges, environmental factors, or a medical condition. The Veteran resides in a State or a United States Territory without a full-service VA medical facility that provides hospital care, emergency services and surgical care having a surgical complexity of standard, and resides more than 20 miles from such a VA facility.") [hereinafter ACCESS CLOSER TO HOME].

54. *Id.*

55. *Id.* ("If you are a distance-eligible Veteran call 1-866-606-88198 to confirm eligibility and ensure the care needed is covered by VA. When you call, you will be asked for: your first and last name, your full address, the name of your preferred community physician. Unfortunately, not all physicians will be eligible to participate so if your preferred physician is not available, we will recommend other physicians in your area. If you are a wait list-eligible Veteran, you will receive a phone call from a VA partner (a non-VA phone number) to help set up your appointment.").

scheduler notifies the veteran that he or she is eligible to receive treatment at a non-VA facility.⁵⁶ The scheduler also provides a list of third-party providers in the community that are covered under this program.⁵⁷ The scheduler then contacts the third-party provider to schedule an appointment for the veteran.⁵⁸ The process is the same for veterans who live 40 miles away from a VA healthcare facility or face a travel burden as approved by VA.⁵⁹

IV. CURRENT AND POTENTIAL PROBLEMS

Since the Choice Act's August 2014 enactment, some initial problems arose that led to barriers for many veterans. Some of the largest barriers stemmed from the eligibility requirements. First, the Act initially restricted eligibility to only veterans enrolled in VA healthcare by August of 2014.⁶⁰ If the veteran enrolled after August of 2014, they were required to have served active duty in a combat area within five years of their enrollment date.⁶¹ This meant that a veteran could not drop his or her current healthcare plan to take advantage of the Program unless they have served in a combat role very recently, and excluded veterans who have long since completed their years of service.⁶² This provision served a purpose—to control costs, especially during the first few stages of implementation.⁶³

After the Program was up and rolling, this required enrollment date of August 2014 was lifted so all veterans are eligible if they are enrolled in VA health care.⁶⁴ Before this program, veterans may have purchased private insurance because of the systemic problems within VHA. Because they were not enrolled in VA health care as of August 2014 or have not served in active duty within five years of their enrollment date, those veterans were not able to take advantage of the Program. VHA has been plagued by years of long wait times, the spreading of disease, and an inability to provide necessary treatment in a timely manner. Veterans should not be penalized for seeking healthcare elsewhere when VHA was not historically meeting their needs, and lifting this enrollment restriction was a good step toward ensuring all veterans have access to the care they need.

Second, veterans whose eligibility hinges on a 30-day wait time have no

56. *Id.*

57. *Id.*

58. *Id.*

59. ACCESS CLOSER TO HOME, *supra* note 53.

60. Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 101(b)(1)(A), 128 Stat. 1754 (2014).

61. *Veterans Choice Program: 101 For Veterans*, U.S. DEP'T OF VETERANS AFFAIRS, https://commissiononcare.sites.usa.gov/files/2016/01/20151006-05N-Veterans_Choice_Program_Toolkit_for_Outreach_Partners.pdf.

62. *Id.*

63. *Id.*

64. *VA Makes Enhancements to the Veterans Choice Program*, U.S. DEP'T OF VETERANS AFFAIRS (December 1, 2015), <https://www.va.gov/opa/choiceact/documents/FactSheets/VCP-Leg-Changes-Fact-Sheet.pdf>.

way of knowing of their eligibility prior to calling VA to schedule an appointment. With the current scheduling process, it is the scheduler's responsibility to inform the veteran that he or she is eligible for non-VA care.⁶⁵ Because veterans who are eligible due to waiting lists are not eligible all the time, they must rely on VA schedulers. If the scheduler does not alert the veteran of the ability to see another provider, he or she might be out of luck. Additionally, when scheduling appointments with non-VA providers, VA schedulers unnecessarily play middleman.⁶⁶ Making an appointment with a non-VA provider could be a simple process that the veteran could handle alone, but is not able to with the current system. This reliance on the VA scheduler is unnecessary and adds time to the process. Instead, veterans should be able to make appointments with non-VA providers on their own, with the outside provider billing VA afterwards.⁶⁷

Third, the Choice Act's distance requirements are narrowly construed.⁶⁸ When the Choice Act was implemented, the 40-mile requirement was calculated "as the crow flies" by drawing a straight-line measurement from the veteran's home to the nearest facility.⁶⁹ An "as the crow flies" measurement does not take road and highway access into consideration, and, as a result, many veterans—particularly those residing in rural areas—had to drive farther than 40 miles.⁷⁰ As of May 2014, 24% of veterans live in rural areas.⁷¹ Additionally, 36% of veterans who have service-connected disabilities reside in rural areas.⁷² These rural veterans were more likely to be negatively affected by this system of measuring. This eligibility factor was revised and codified in April 2015.⁷³ Now, VA measures the shortest route a veteran must drive to the nearest VA facility.⁷⁴ This change alone almost doubled the number of eligible veterans—a sign that the program is needed in rural areas

65. See generally ACCESS CLOSER TO HOME, *supra* note 53 and accompanying text (showing the process for making a non-VA appointment through the VA scheduler).

66. *Id.*

67. See *infra* notes 87–89 and accompanying text.

68. Adam Smeltz, *Lawmakers press Veterans Affairs for improved access to rural healthcare*, PITTSBURGH TRIBUNE-REVIEW (Mar. 1, 2015), <http://triblive.com/usworld/nation/7867243-74/care-veterans-veteran?printerfriendly=true#axzz3kiQV0eo>.

69. Jacqueline Kilmas, *VA to Change Choice Card's 40-Mile Criteria to Driving Distance, not Straight Line*, THE WASH. TIMES (Mar. 24, 2015), <http://www.washingtontimes.com/news/2015/mar/24/va-change-choice-card-40-mile-criteria-driving-dis/>.

70. *Id.*

71. VHA OFFICE OF RURAL HEALTH, FACT SHEET: INFORMATION ABOUT THE VHA OFFICE OF RURAL HEALTH AND RURAL VETERANS, (May 2014), http://www.ruralhealth.va.gov/docs/factsheets/ORH_General_FactSheet_2014.pdf [hereinafter RURAL FACT SHEET]. Additionally, almost 60% of Iraq and Afghanistan veterans live in a non-urban setting, and are disproportionately at a disadvantage for access to quality healthcare. Chandrasekaren, *supra* note 18.

72. RURAL FACT SHEET, *supra* note 71.

73. See 38 C.F.R. § 17.1510(e) (2015).

74. *Id.*

and that veterans need better access to healthcare.⁷⁵

However, altering the distance qualifications did not alleviate all problems with access. The driving distance only measures the distance from the veteran's home to the "the closest VA facility—including Community-Based Outpatient Clinics and VA Medical Centers"⁷⁶ that has a full time primary care physician on staff.⁷⁷ The veteran may be within 40 miles of some sort of VA clinic, but that facility may not have the specialty care that they need. "That means a veteran may have to travel farther to get specific care, like mental health services."⁷⁸ This is a huge barrier for veterans seeking specialty care, and "choice should not be denied those who reside within 40 miles of a VA clinic that doesn't provide needed care."⁷⁹ The distance requirement needs to be further altered so that veterans truly have access to the care that they need.

Additionally, the Act does not address current emergency care procedures. While emergency care is governed by a different statutory provision⁸⁰, the Choice Act would have been the perfect platform to change the way VHA handles emergency care. With only 121 VA emergency departments around the country, many veterans are left without a VA emergency room near them.⁸¹ These veterans in emergency situations are left with no other option than to go to a local, non-VA emergency room. The process for being reimbursed for emergency care for both service-connected and nonservice-connected conditions at non-VA hospitals is unsurprisingly also complicated,⁸² especially for nonservice-connected conditions.⁸³ These provisions should be addressed to ensure veterans can receive emergency care without resulting in complicated reimbursement procedures.

Finally, enrollment in the Choice Card Program is lower than originally anticipated.⁸⁴ This could be the result of a few things. First, this could be an indication that not enough veterans are aware of the program, as described

75. Smeltz, *supra* note 68.

76. *Veterans Choice Program: Questions and Answers*, U.S. DEP'T OF VETERANS AFFAIRS, <http://www.va.gov/opa/choiceact/faqs.asp>.

77. *VA Makes Enhancements to the Veterans Choice Program*, U.S. DEP'T OF VETERANS AFFAIRS (December 1, 2015), <https://www.va.gov/opa/choiceact/documents/FactSheets/VCP-Leg-Changes-Fact-Sheet.pdf>.

78. Kilmas, *supra* note 69; *See infra* notes 96–109 and accompanying text (discussing the prevalence of PTSD and depression, the importance of treating mental health, and the long-range effects of non-treatment).

79. Tom Philpott, *Caution Flag up on More Easing of 'Choice Card' Usage*, HERALD NET (Apr. 8, 2015, 4:02 PM), <http://www.heraldnet.com/article/20150410/NEWS01/150419971>.

80. *See* 38 U.S.C. § 1725 (2015).

81. Press release, VA Announces Changes to Emergency Care Payment Policy, U.S. DEP'T OF VETERANS AFFAIRS (Jan. 12, 2012, 8:00 AM), <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2245>.

82. *See* 38 U.S.C. § 1725 (describing procedures for a veteran to be reimbursed for non-VA emergency care).

83. *See id.* at §§ 1725–35. There are eight requirements that have to be met in order for VA to retroactively approve of nonservice-connected care in an emergency room.

84. *Assessing the Promise*, *supra* note 19 at 3–4.

above. However, low enrollment could also indicate success of the Act overall. The budget increases stemming from the Choice Act allow for longer hours and more staff at many VHA locations, the addition of mobile health units, and funding for new and expanded facilities. The increased capacity may have cut down on wait times and the number of veterans who need to seek outside treatment.⁸⁵ Therefore, low enrollment in the Choice Card Program could be a sign that the other provisions of the Choice Act are working.

Problems with the Act, including those briefly described above, continue to place barriers to healthcare for veterans seeking quality attention. Because of these problems, changes are still needed to satisfy Congress's intent behind the Act. "When Congress passed the Veterans Choice Program, we intended the program to be widely available to ensure that all veterans receive timely access to medical appointments," said Rep. Julia Brownley.⁸⁶ While the Program has helped many veterans, Congress can continue to improve the Program by streamlining the scheduling process and expanding Program eligibility.

The implementation of the Choice Card Program has not lived up to the goals and ideations of those who created it. An overhaul of the VA healthcare system is the best opportunity to allow veterans to seek quality and accessible healthcare and would help serve the changing veteran population. At the very least, changes to the Choice Card Program will give more veterans opportunities to receive treatment.

V. OPTION ONE: OVERHAUL VHA AND THE CHOICE CARD PROGRAM

An overhaul of VHA and the Choice Card Program could give veterans better access to healthcare. To do so, VHA should do three things. First, it should simplify the process for veterans to make an appointment. Second, it should use the Choice Card Program to allow veterans to visit approved walk-in clinics or primary care providers, especially for routine or minor care, such as colds and sinus infections. Third, cutting back on minor and routine care will allow VHA to focus on larger hospitals, increase focus on treating mental health, and specializing in other health problems common to veterans. This would require radical structural transformations to VHA's hospitals and clinics, but would ultimately benefit veterans by providing true access to medical care.

A. *Simplify the Scheduling Process*

The entire process to receive healthcare is currently very complicated for veterans. However, the scheduling and billing processes can be streamlined, and therefore much more simple than the current process: "Patient is seen by

85. *Id.*

86. Patricia Kime, *VA Choice Program's Distance Rule to be Revised*, MILITARY TIMES (Mar. 24, 2015), <http://www.militarytimes.com/story/military/benefits/health-care/2015/03/24/va-choice-40-miles/70340582/>.

private doctor, private doctor treats patient, doctor sends bill to government, government pays doctor.”⁸⁷ A streamlined, less complicated process will allow easier communication and understanding, especially among veterans seeking care from non-VA healthcare providers. In the same way that Medicaid and Medicare provide healthcare benefits without running their own facilities, VA could eliminate their smaller outpatient facilities and set up a billing system similar to that of Medicaid and Medicare.⁸⁸ The difference would be that VA would still run hospitals and could focus on conditions that are common amongst veterans.⁸⁹ As previously discussed, VHA could put itself in a situation to be best suited to understand and treat common mental and physical health concerns that veterans face.⁹⁰ Simplifying the scheduling and billing process would be beneficial to veterans by providing them with an efficient and hassle-free way to see a health care provider.

B. Allow Veterans to Visit Approved Walk-In Clinics or Primary Care Providers

Overcrowding and longer-than-anticipated wait times show VA facilities are having trouble keeping up with demand.⁹¹ VA waiting rooms do not need to be inundated with veterans who require medical care that can easily be taken care of at a walk in clinic or primary care physician’s office. For example, veterans who have a cold, need allergy medication, or have a sore back should be able to go to an approved primary care provider location instead of scheduling an appointment at a VA facility. This would allow VHA to clear up waiting rooms, shorten wait times, and provide more intensive and focused care for veterans with more serious medical needs. It would also be more convenient for veterans to receive routine medical care at their local, neighborhood facility. The Choice Card Program should be altered to allow veterans to have an approved primary care practice or walk-in clinic that they can go to for small or common medical needs.

Allowing veterans to visit approved walk-in clinics or primary care physicians may bring a healthy dose of competition to VHA. A common criticism of government agencies is that they have little incentive to be efficient and cost effective because they have no direct competitors, and VHA is no different. This does not mean VHA should be shut down altogether and fully privatized. However, VHA would benefit from some influence and pressure from the private sector to lower costs and provide competitive services. By overhauling the Choice Card Program, more veterans would be able to access the private healthcare market for their routine appointments.

87. Col. Jack Jacobs, U.S. Army (Ret.), *Want to Fix VA Health Care? Get Rid of It*, NBC NEWS (May 16, 2014), <http://www.nbcnews.com/storyline/va-hospital-scandal/want-fix-va-health-care-get-rid-it-n106601>.

88. *Id.*

89. *See supra* note 10.

90. *See id.*; *See also infra* notes 93–95 and accompanying text.

91. *See supra* notes 20–44 and accompanying text (discussing the scandal and controversy that came to light in 2014).

Because the private sector is a for-profit sector, providers have an incentive to provide quality care more efficiently. With no competition, VA officials are not held as accountable as providers in the private sector. If a private citizen does not like a particular health clinic, he or she can choose to not seek care there, therefore allowing the competitiveness of the private sector to run efficiently. Veterans do not have that choice if they are limited to VA facilities.

C. Shift Focus to Hospitals that Treat Medical Issues Common to Veterans and Increase Attention to Mental Health

If VHA scaled back on the sheer number of VHA operated clinics, as discussed above, VHA could focus on more specialty care, mental health treatment, and inpatient hospital services through its existing network of hospitals. With this overhaul, veterans will be better served with the issues that they commonly have.⁹² VA commonly sees individuals with war-related health problems, such as traumatic brain injuries, prosthetics, and chemical and physical exposures, and will be able to focus on developing treatment for them.

Scaling back VHA infrastructure is more logical than building it up, especially with the current demographic of veterans. The influx of veterans and increased demand for care seems to be temporary. In 2014, 9.4 million veterans—almost half of the total 19.3 million total United States veterans—were 65 years of age or older.⁹³ Largely expanding VHA-owned facilities and pouring money into them is not necessary, as this increased need for VHA services is expected to wane as the generations of WWII, Korea, and other older veterans continue to disappear.⁹⁴ “The demographic changes within the veterans community suggest the VA is seeing its peak demand now, from young and old veterans alike. Building permanent VA infrastructure may not make as much sense as leveraging private providers, contractors, and nonprofit organizations to serve veterans.”⁹⁵

Slowly shedding itself of the smaller outpatient clinics could provide VHA with a great opportunity to serve veterans by focusing on the larger hospital facilities. These facilities could receive more attention, potentially expanding specialties and adding to services provided. This plan would allow VA to focus on specialty care while also allowing veterans to seek healthcare at a facility that is convenient to them. In the event that a VA hospital is faced with a specialty need that it cannot handle or if a veteran faces accessibility or travel burdens, the veteran should receive a voucher to receive treatment at a hospital that is able to provide the level of care needed.

Mental health in America has been thrust onto center stage in the last decade, and rates of trauma and mental illness are higher among veterans than

92. See *supra* note 10 and accompanying text.

93. U.S. CENSUS BUREAU, *FFF: Veteran's Day 2015: Nov. 11, 2015* (Nov. 4, 2015), <http://www.census.gov/newsroom/facts-for-features/2015/cb15-ff23.html>.

94. Carter, *supra* note 27.

95. *Id.*

the civilian population.⁹⁶ War and warfare strategy have changed a lot over the years, and veterans are serving longer amounts of time through multiple tours. “Of those deployed to Iraq, 47 percent were sent on two or more deployments, and 29 percent—more than a half-million service members—spent two years or more in the strife-torn country.”⁹⁷ Veterans are coming home physically and mentally scarred, and are more in need of medical attention than ever before. The Kaiser Family Foundation and the Washington Post conducted a survey of opinions of post-9/11 veterans.⁹⁸ Of those polled, more than half indicated that they struggle with physical or mental health problems related to their service.⁹⁹ Additionally, 58% of post-9/11 veterans believe that VA is failing to meet their needs.¹⁰⁰

While not unique to veterans, Post Traumatic Stress Disorder (PTSD) occurs at a higher rate in veterans than the general public.¹⁰¹ One study found that 18.5% of Operations Enduring Freedom and Iraqi Freedom veterans meet criteria for either PTSD or depression,¹⁰² and an estimated 30% of Vietnam veterans have experienced PTSD.¹⁰³ It is noteworthy that mental health problems frequently lead to chronic physical health problems: “Among service members previously deployed to Iraq and Afghanistan who are not seeking treatment, an estimated 5 to 20 percent have PTSD. Individuals with PTSD are more at risk for cardiovascular disease, high blood pressure, and dementia.”¹⁰⁴ Because of these increased risks, VHA and civilian medical systems alike may be handling two or more chronic health problems later on in a veteran’s life.¹⁰⁵ This has significant implications for VHA and health care providers, who will

96. *Removing Barriers to Mental Health Services for Veterans*, AM. PUB. HEALTH ASS’N, (Nov. 18, 2014), <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

97. Chandrasekaren, *supra* note 18; *See After the Wars—Post-Kaiser survey of Afghanistan and Iraq war veterans*, WASH. POST (Oct. 20, 2014), https://www.washingtonpost.com/page/2010-2019/WashingtonPost/2014/03/30/National-Politics/Polling/release_305.xml [hereinafter *Post-Kaiser Study*].

98. *Post-Kaiser Study*, *supra* note 97.

99. *Id.* *See also* Chandrasekaren, *supra* note 18 (describing the results of the Washington Post-Kaiser Family Foundation Study’s questions on the mental health and emotional needs of veterans).

100. *Post-Kaiser Study*, *supra* note 97. Additionally, 56% rated the job the government is doing in meeting the needs of current veterans as “not so good” or “poor.”

101. 7-8% of the general population experiences PTSD, as compared to an estimated 11-20% of veterans. *How Common is PTSD?*, U.S. DEP’T OF VETERANS AFFAIRS, PTSD: NAT. CTR. FOR PTSD, <http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp> (last visited Feb. 3, 2017) [hereinafter *PTSD*].

102. This is approximately 300,000 veterans. TERRY TANIELIAN ET AL., RAND CORPORATION, *INVISIBLE WOUNDS: MENTAL HEALTH AND COGNITIVE CARE NEEDS OF AMERICA’S RETURNING VETERANS* (2008), http://www.rand.org/pubs/research_briefs/RB9336/index1.html [hereinafter *RAND Study*].

103. *PTSD*, *supra* note 101.

104. Terri Tanielian & Rajeev Ramchand, *The Long Tail of War*, U.S. NEWS AND WORLD REPORT: POLICY DOSE (June 4, 2015), <http://www.usnews.com/opinion/blogs/policy-dose/2015/06/04/veterans-battle-mental-health-issues-after-iraq-and-afghanistan>.

105. *Id.*

be treating these veterans for multiple health-related issues, potentially for years to come. By dealing with some of these mental health problems earlier, health care providers may be able to prevent other health problems down the road, substantially improving the lives of veterans while simultaneously reducing costs.

By treating more individuals for PTSD and depression, there could be long-term savings for the community as a whole.¹⁰⁶ When an individual suffers from various health problems, not only does it affect their physical and mental health, but it affects various other areas of their lives and interactions with the community. These health problems can turn external and “can affect workplace productivity, causing increased absenteeism and job loss, and lead to housing instability and homelessness.”¹⁰⁷ Further, veterans with PTSD or who have suffered from traumatic brain injuries are also more likely to struggle with relationships and substance abuse, which undoubtedly affects those around them.¹⁰⁸ Therefore, it is advantageous for VA to commit to treating veterans for the mental health problems they commonly face.

The psychological problems many veterans face can be gripping and life threatening in themselves. Fifty percent of post-9/11 veterans reported that they know a fellow service member who has attempted to commit or has committed suicide.¹⁰⁹ With a proper focus on mental health, VHA can work to bring that number down. The reorganization of VHA and VHA facilities would allow the opportunity to provide veterans with increased mental health services.

VI. OPTION TWO: AMEND THE CHOICE CARD PROGRAM

While an overhaul of the current system is likely the best choice to initiate a total reform of veterans’ healthcare, it may be too complicated for lawmakers to accomplish in one fell swoop. If that is the case, lawmakers should not be content with the current Choice Card Program in place and should take action to remedy its flaws. Three changes to the Choice Card Program could allow veterans ample opportunity to receive quality, timely care: elimination of the current sunset provision on the pilot program, extension of the eligibility requirements to allow more veterans to take advantage of the program, and expansion of the network of approved third-party providers.

106. RAND Study, *supra* note 102 (“Direct costs of treatment are only a fraction of the total costs related to mental health and cognitive conditions. Far higher are the long-term individual and societal costs stemming from lost productivity, reduced quality of life, homelessness, domestic violence, the strain on families, and suicide. Delivering effective care and restoring veterans to full mental health have the potential to reduce these longer-term costs significantly.”).

107. Tanielian & Ramchand, *supra* note 104.

108. *Id.*

109. *Post-Kaiser Study*, *supra* note 97.

A. Eliminate the Expiration Date

While the Choice Card Act does not create a perfect health care system, Congress should not let the Choice Card Program expire after its three-year trial run. Currently, as the Choice Card Program is a pilot program, it has an end date of 2017 or earlier if the allocated funds run out.¹¹⁰ Ending this program would be a major step backwards for expanding veterans' access to healthcare services.

Senator McCain proposed the Permanent Choice Card Program Act in August 2015. In the bill, Sen. McCain seeks to eliminate the ending date for the pilot program, making it a permanent option for veterans. "I urge my colleagues to support the Permanent VA Choice Card Act and make sure that no veteran is ever again denied the care they so desperately need."¹¹¹ The bill was introduced to the Senate in August of 2015 and is in the first phase of the legislative process.¹¹² Whether or not this provision passes, legislatively eliminating the expiration date is vital in ensuring this important program continues to serve our veterans.

B. Extend Eligibility

The Choice Card Program's eligibility should be extended so that more veterans are eligible. To be eligible, the veteran must meet one of the following requirements: the veteran must live 40 miles away from a VA healthcare facility¹¹³ or have a wait time of over 30 days.¹¹⁴

The biggest barrier to eligibility, and arguably the one that causes the most confusion, is the distance requirement. An issue that has revealed itself under the Choice Card Program's eligibility factors is that some veterans may live within 40 miles of a VA health facility, but not one that provides the level of care they need.¹¹⁵ Lawmakers should change the distance requirement to make veterans eligible when they are not within 40 miles of a facility that can provide the level of care needed. This would fix the barrier that some veterans may face if they are within 40 miles of a VA facility, but it is only a small clinic or an outpatient center that cannot accommodate the veteran's physical or mental health needs. The 40-mile distance requirement is an issue for many veterans, but with a slight change, more veterans will be able to access the level of care they need. This would fulfill Congress's intentions of providing quality, timely care for veterans at a VA facility whenever possible.

110. Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 Stat. 1754, 1788-90 (2014).

111. Patricia Kime, *VA Choice would expand under McCain proposal*, MILITARY TIMES (Aug. 8, 2015), <http://www.militarytimes.com/story/military/benefits/veterans/2015/08/07/va-choice-would-expand-under-mccain-proposal/31282197/>.

112. Permanent Department of Veterans Affairs Choice Card Act of 2015, 114 S. 1991 (2015).

113. ACCESS CLOSER TO HOME, *supra* note 53.

114. Veterans Access Choice and Accountability Act of 2014, 128 Stat. 1754 § 101(b).

115. See *supra* note 76-79.

Another prong of eligibility could be added to include coverage during times when a veteran needs emergency care. It should not be a complicated process for a veteran to be reimbursed for emergency care.¹¹⁶ The last thing anyone, including a veteran, should have to worry about on the way to an emergency room is how much it will cost and what kind of hoops he or she will have to go through to get their care covered by VA. By amending the Act to cover more emergency care situations, lawmakers will provide security and peace of mind to veterans during a time when they need care the most.

C. Expand the Network to Provide True Choice

For the Choice Card Program to be successful, VA needs to continue to expand the network of approved third party care providers. With high demands for healthcare services and an increasing veteran population, VA facilities will continue to experience strain.¹¹⁷ The best way for veterans to truly have access and choice in their medical care is to provide alternative options when the VA system is backlogged. The Choice Card Program's current system of sending a veteran to an approved third-party provider helps alleviate the demand on VA. However, to fully alleviate the pressure, more private providers should be encouraged to go through the approval process to become part of the network. Veterans in rural areas may be eligible for the Choice Card Program, but are finding that there are few approved non-VA providers in their area.¹¹⁸ Providers, especially ones in rural areas or areas not near a VA facility, should be encouraged to participate so veterans have options. They cannot participate, though, if they are not aware of the Program and their potential role.

Ultimately, VA should reach out to community providers and showcase the Program as an opportunity for private practitioners. For veterans to truly have choice and access to health care, the Program needs maximum participation from quality health care providers.

VII. PROBLEMS LEFT TO BE ADDRESSED

This paper proposes radical changes, and the financial challenges of restructuring VHA are significant and should not be ignored. Limited funding is a major barrier to providing veterans, and the entirety of the United States population, frankly, with access to quality and effective medical care. It would potentially take hundreds of pages to propose the avenues to properly allocate that money. However, it is important to note how much the federal

116. See *supra* note 80–83 and accompanying text; see also Press release, *supra* note 81.

117. Mark K. Matthews, *Veterans wrestle with new VA Choice Card effort to reform care*, THE DENVER POST (Nov. 5, 2015), http://www.denverpost.com/politics/ci_29076063/veterans-wrestle-new-va-choice-card-effort-reform (“[U]se of outpatient care has risen steadily—the VA expects more than 101 million outpatient visits in 2016, an increase of 2.8 million from 2015.”).

118. Patricia Kime, *Murray calls for overhaul of VA Choice program*, MILITARY TIMES (Oct. 23, 2015), <http://www.militarytimes.com/story/veterans/2015/10/23/murray-calls-overhaul-va-choice-program/74390536/>.

government currently spends on veterans health care. In 2015, the federal government allocated \$56 billion dollars to VA medical programs and VA health care.¹¹⁹ While this is seemingly a huge number, it only makes up 1.4% of the \$3,901 billion federal budget. While financial constraints are certainly a concern, a relatively low percentage of the budget is being spent on VA and VHA health care programs. It is not idealistic to think that a few billion more dollars could be allocated to veterans, and make a large impact on the availability of health care services.

Medicaid is not a perfect program, either, and if VHA builds a new program that mirrors Medicaid's blueprint, it will have similar problems. In 2014, Merritt Hawkins conducted a survey that exposed patient wait times and rates of Medicaid/Medicare acceptance in 15 cities in the country.¹²⁰ Boston had the highest cumulative average wait time for an appointment with a physician at 45.5 days.¹²¹ Dallas had the shortest wait time, at 10.2 days.¹²² Boston had the highest rate of Medicaid acceptance at 73%, and Dallas's acceptance rate was 23%.¹²³ The average acceptance rate across the 15 cities was 46%, which is down 10% from Merritt Hawkins's 2010 survey.¹²⁴ There are a variety of circumstances that may affect the rate that physicians accept Medicaid, but it can be largely due to the lack of economic incentives.¹²⁵ Additionally, there are many administrative requirements that may influence physicians into opting out of accepting Medicaid as a form of payment.¹²⁶

Currently, many providers do not accept Medicaid as a form of payment. Many walk-in clinics also are limited in what types of payments and insurance they accept. This could be a problem for VA Choice Card coverage, as it is quite possible that participants in the Choice Card Program may have trouble getting coverage at smaller clinics. This is especially problematic at walk-in

119. In 2015, the federal government spent \$3,901 billion dollars. \$68.4 billion dollars was awarded to VA, with \$56 billion dollars being allocated to medical care. OFFICE OF MGMT. & BUDGET, EXEC. OFFICE OF THE PRESIDENT, FISCAL YEAR 2015 BUDGET OF THE UNITED STATES GOVERNMENT, 174 (2014), <https://www.gpo.gov/fdsys/pkg/BUDGET-2015-BUD/pdf/BUDGET-2015-BUD.pdf#page=174> [hereinafter 2015 UNITED STATES BUDGET].

120. *2014 Survey: Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates*, MERRITT HAWKINS 3–4, <http://www.merrithawkins.com/uploadedFiles/MerrittHawkins/Surveys/mha2014waitsurvPDF.pdf> [hereinafter HAWKINS Survey].

121. *Id.*

122. *Id.*

123. *Id.*

124. *Id.*

125. HAWKINS Survey, *supra* note 120 at 26 (“In some cases, reimbursement rates provided by Medicaid to particular specialists may be below their cost of providing services. If not actually below costs, Medicaid reimbursement often is relatively low compared to that offered by other payers, and therefore busy physicians may have no economic incentive to see Medicaid patients.”).

126. *Id.* (“In other cases, the process of billing for and receiving Medicaid payment can be problematic and some physicians choose to avoid it.”); See also Elizabeth Renter, *You've Got Medicaid—Why Can't You See the Doctor?*, U.S. NEWS AND WORLD REPORT: HEALTH (May 26, 2015), <http://health.usnews.com/health-news/health-insurance/articles/2015/05/26/youve-got-medicaid-why-cant-you-see-the-doctor>.

clinics and in rural areas, which are arguably some of the most convenient places for veterans with remedial health care needs could seek care. VHA could see a similar problem if providers and clinics refuse to accept a new VA program-type payment. This problem would have to be addressed when VA looks to expand the network of approved and participating providers.¹²⁷

Regardless which action is taken, either a total overhaul of the way VHA functions or amending the Choice Card Program, there is a need for accountability. The Choice Act requires VA and VHA to prepare reports for Congress and other officials detailing the results and progression in various areas.¹²⁸ Congress should enact legislation that ensures the continuation of these reports and updates to hold VA accountable. By implementing changes, gone will be the days of falsifying documents, lying to administrators, and covering up shortfalls in the VA healthcare system. Instead, annual reports to Congress will allow an open line of communication between VA officials and policy makers to address underperformances and weaknesses within the healthcare system. Forced accountability and communication will ensure that the allocated budget is being used appropriately and will provide the best opportunity for veterans' healthcare to continue to improve. Improvements in VHA should not only come following a scandal, and a scandal like the one seen in 2014 should never be seen again. With continued oversight and increased accountability, it will not.

While these problems and barriers should not be overlooked, the importance of providing timely and quality medical care for United States veterans outweighs any difficulties it will take to make meaningful institutional changes. Veterans have given up enough—proper health care should not be another thing they have to sacrifice.

VIII. CONCLUSION

There were times when everyone's father, brother, uncle, and grandfather wore a uniform, but gone are the days when everyone knew someone serving. Unfortunately, this means that veterans no longer have a personal connection with a large portion of the American public. We should not let this influence our level of commitment to veterans and to veteran's healthcare. The Choice Act provides our veterans with the opportunities they need to attain quality health care services, from the VA and from non-VA providers.

Again, the lower-than-expected enrollment numbers are not something to worry about. In a perfect world, VHA would have the capacity to handle all of the services that our veterans need and there would be no need for the Choice Card Program. At this point, unfortunately, that is not the case. But with a better-allocated VHA, adequate support staff, and increased awareness of VHA's services, veterans will have the best chance at receiving sufficient

127. *See supra* Part VI(C).

128. *See, e.g.*, Veterans Access Choice and Accountability Act of 2014, Pub. L. No. 113-146, §§ 101(q), 202(b)(3), 204(b), 301, 403, 128 Stat 1754 (2014).

healthcare. The aim of the Choice Card Program, for now, should be to help as many veterans as possible and alleviate the barriers they experience to receiving healthcare. However, besides the Choice Card Program, the other provisions of the Choice Act are also helping reduce the number of veterans who are experiencing difficulties with VHA. Even if enrollment in the program decreases, it should be taken as a sign that the provisions of the Choice Act are achieving their purpose and providing veterans with better access to healthcare.

Whether through an overhaul of the VHA system or from minor changes and expansions in the existing Choice Card Program, veterans deserve true access and choice to the healthcare that was promised to them during the Civil War. Regardless of which route lawmakers decide to take, continued oversight and true accountability are crucial to improvement. When wait times at VA facilities are too long or when a VA facility cannot accommodate a veteran's special needs, he or she should be able to go to a non-VA facility for treatment.

Regular or preventative care allows individuals to stay healthier, saves time, and can add years of quality life.¹²⁹ Seeing a doctor regularly increases the chances of seeing subtle symptoms and catching diseases or illnesses at a time when they are more easily treated.¹³⁰ Additionally, by taking preventative care measures, the health care system as a whole will benefit.¹³¹ The system will be less crowded, allowing time, money, and resources to be spent more effectively than if people do not take preventive health measures.¹³²

Our veterans have provided indescribable benefits to our country through service and sacrifice, and "the nation has a solemn obligation to take care of its veterans and to honor them for their service and sacrifice on behalf of the United States."¹³³ Veterans' healthcare needs a long-term solution, not a pilot

129. *The Importance of Preventative Care*, UNITED HEALTHCARE, <http://www.uhc.com/health-and-wellness/family-health/preventive-care> (last visited Feb. 3, 2014) (defining preventative care as care that "focuses on maintaining your health, and establishing your baseline health status. This may include immunizations, vaccines, physical evaluations, lab work, x-rays and medically appropriate health screenings."); *Preventative Health Care*, CENTERS FOR DISEASE CONTROL AND PREVENTION, <http://www.cdc.gov/healthcommunication/toolstemplates/entertainmenttips/preventivehealth.html> (last visited June 12, 2013) ("The right preventive care at every stage of life helps all Americans stay health, avoid or delay the onset of disease, keep diseases they already have from becoming worse or debilitating, lead productive lives, and reduce costs.").

130. *Preventative Health Care*, *supra* note 129 ("Chronic diseases, such as heart disease, cancer, and diabetes, are responsible for 7 of every 10 deaths among Americans each year and account for 75% of the nation's health spending. These chronic diseases can be largely preventable through close partnership with your healthcare team, or can be detected through appropriate screenings, when treatment works best.").

131. *Preventative Health Care Helps Everyone*, WORLD RESEARCH FOUND., <http://www.wrf.org/preventive-healthcare/preventive-healthcare.php> (last visited Feb. 3, 2017).

132. *Id.* ("On the other hand, if too many people wait too [long] to get treated (when the illness or injury is most like more serious), the burden becomes much greater on the system overall, and the quality of everyone's health care suffers and medical expenses rise. The inevitable result will be higher health costs, higher health insurance premiums, poorer medical services for each individual, and a highly-taxed medical system.").

133. 2015 UNITED STATES BUDGET, *supra* note 119, at 128.

program or a program designed to cover up a scandal. The Choice Card Program, as it now stands, has a sunset provision that is coming up quickly. Lawmakers need to continue to fight for the healthcare needs of the nation's veterans. Supporting the provisions of the Choice Act and expanding veterans' options is essential in improving healthcare for veterans. VHA has implemented some transformations, but Lincoln's words from 1865, "to care for him who shall have borne the battle," call for more. In order to fulfill Lincoln's echoing statement, and to truly care for those who have battled for the United States, veterans need access, choice, and accountability in their healthcare services.