STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ON
THE BUDGET MODELING AND METHODOLOGIES USED BY THE DEPARTMENT OF VETERANS AFFAIRS

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Mr. Chairman and Members of the Committee:

Thank you for this opportunity to participate in this important hearing to examine the budget modeling and methodologies used by the Department of Veterans Affairs (VA) in developing and forecasting veterans' health care costs and utilization projections for future years. The American Legion welcomes this chance to address its approach to health care modeling for VA.

The American Legion continues to advocate for adequate funding levels to ensure America's veterans receive the health care and benefits they have earned through their honorable service to this country. With young service members currently deployed to more than 130 countries, it is the responsibility of this Committee to ensure VA is indeed capable of meeting its obligation to provide for timely access to services for America's veterans that choose VA as their preferred health care provider. The American Legion commends the Committee for holding this hearing to discuss this important matter.

Former British Prime Minister William Gladstone once said, "*Budgets are not merely affairs of arithmetic, but in a thousand ways go to the root of prosperity of individuals, the relation of classes, and the strength of kingdoms.*"

The basic difference between The American Legion's Department of Veterans Affairs' (VA's) budget recommendation and the President's VA budget request and the congressional VA budget is The American Legion's is demand-driven, whereas the other two are budget-driven. In fact, The American Legion's recommendations are probably more consistent with VA's initial submission to the Office of Management and Budget (OMB) before the initial "pass-back."

Mr. Chairman, of all of the budget modeling and methodologies available, the congressional budget process is the least effective in properly funding VA. Will Rogers said, "*The budget is a mythical bean bag. Congress votes mythical beans into it, and then tries to reach in and pull real beans out.*"

VA's Office of the Assistant Secretary for Management is staffed with very competent professionals. However, Members of Congress and the American taxpayers are not getting their

money's worth because the best product, the true budgetary needs of VA, is submitted to the Office of Management and Budget (OMB).

What Congress and the American people see is a skewed budget recommendation that meets the President's budget needs rather than the actual needs of VA; therefore, an inaccurate and unprofessional product. It is a challenge for Congress to build a good budget when even national priorities are tainted to meet artificial, bureaucratic, and political parameters.

Clearly, if Congress and the American people were allowed to see the initial budget recommendation, rather than the watered-down version, everyone involved in the budgetary process could work towards a solid product – supported by the President, Congress, and the American people. Nobody wants to shortchange America's heroes and their families.

For a moment, let's assume that the President's budget request accurately reflects VA's needs:

- Why is "timely access" a problem?
- Why are eligible veterans being denied enrollment?
- Why are third-party collections inadequate?
- Why create "an annual enrollment fee" for certain veterans?
- Why increase co-payments for certain veterans?
- Why do claims take so long to be processed?
- Why are there waiting lists for VA nursing homes?
- Why are there hiring freezes throughout VA?
- Why is medical inflation within VA viewed differently than medical inflation in the rest of the health care industry?

The American Legion believes the underlying answer to each of these questions is an inadequate funding paradigm. The American Legion does not advocate simply "throwing money at the problem" without any accountability; however, we do believe VA needs the fiscal resources to operate the very best system possible. Good budgeting should not be the homogeneous allocation of inadequate funding, but rather a solid statement of national priorities. Maintaining a strong national defense is a top national priority, while VA is clearly an end-product of winning wars and maintaining peace.

It is the hope of The American Legion that eligible Members of Congress would want to seek their health care first from VA medical facilities rather than the Department of Defense or the private sector.

Clearly, there is a tremendous difference in the budgetary modeling and methodology between VA and DoD medical care. In the VA health care delivery system, not all veterans have equal access standards to quality health care, regardless of their willingness to pay. Currently, new Priority Group 8 veterans – those most likely to have resources and third-party insurance coverage – are denied enrollment regardless of their honorable military service in combat or peacetime.

Within DoD medical care, all eligible beneficiaries are welcomed to enroll and have equal access to timely health care within their assigned region. Active-duty service members are primarily

taken care of within the Military Treatment Facilities (MTFs), while all other beneficiaries may be treated in MTFs or civilian health care facilities based upon their contracted health care provider's decision.

Likewise, trying to compare the enrollment fees for TRICARE Prime beneficiaries and proposed enrollment fees for Priority Group 7 and 8 veterans is an awkward and inaccurate comparison. All TRICARE Prime beneficiaries enjoy the same priority for care; whereas, Priority Group 7 and 8 veterans are at the end of the prioritization list for care and may very well exceed VA's own acceptable access standards.

The American Legion also recognizes that most military beneficiaries with veterans' status have earned the right to use both health care delivery systems. The decision is normally based on individual health care needs – for example, long-term care or other specialized care not available through DoD, TRICARE, or TRICARE for Life. However, there are recently separated military retirees (since January 2003) in Priority Group 8 that are currently denied enrollment in VA. To gain access, these veterans would have to be specifically referred to VA by TRICARE for Life via some kind of sharing agreement.

The American Legion's Budget Methodology

The American Legion's budget recommendations are based on both internal and external factors:

- Internal Factors

1. **A System Worth Saving** – findings from on-site visits to local VA medical facilities. The American Legion has spent a great deal of time, energy, and effort to get an "up close and personal" view of a patient's experiences throughout the VA health care system. Preparation of this annual report is based on actual site visits to VA medical facilities. During these visits, both "official" and "unofficial" information is collected and documented. Clearly, there are problems – some fiscal and others managerial – but each problem can be resolved. In most cases, there are no "cookie-cutter" solutions, but there are two unquestionable trends – funding and staffing shortfalls.

2. **CARES Task Force** – reports from local veterans' advocates closely monitoring activities, situations, and observations at local VA medical facilities. The American Legion created a CARES Task Force to work with VA personnel and other stakeholders during the entire life of the CARES study. This group of Legionnaires will continue to monitor the CARES process throughout the implementation phase. They continue to provide valuable input and assessments – such as reports of budgetary shortfalls in FY 05 and anticipated budgetary cuts in FY 06.

3. **Formal network of service-officers --** The American Legion's network of dedicated service-officers, at both the local and state level, have plenty of daily contact with veterans seeking assistance. Too often these service-officers see veterans experiencing major obstacles in receiving their earned benefits. Sometimes they need help with disability claims, while others need health care assistance, especially VA's specialized

services. Again, these service-officers report of problems encountered in assisting veterans in need.

4. **Formal network of homeless veterans' program advocates and providers** -- The American Legion has a formal network of homeless veterans' program advocates that share information of the challenges faced by homeless veterans they assist.

5. **Information from other advocacy organizations** -- The American Legion works closely with a number of veterans' and military service organizations, health care professional organizations, and other such advocacy groups. We share information and observations with regard to not only VA funding, but services provided and the quality of health care delivered.

6. **Information from informed government sources** -- through close association with numerous government agencies and officials, a great deal of information – official and unofficial – is collected by not only The American Legion's professional staff, but also Legionnaires actively engaged within their local community. Such information like OMB's "spring guidance" to all Federal budget offices and the Bureau of Labor Statistics' medical inflation rates are extremely useful.

- External Factors

1. **The President's Task Force to Improve Health Care Delivery For Our Nation's Veterans report** -- among the numerous findings of this Presidential Task Force was the mismatch between demand for services and available resources. Even the Task Force could not agree on "the best solution," but unanimously agreed that the issue needed immediate attention. As a result, several bills have been introduced offering possible solutions. The American Legion has joined ranks with 9 other major veterans' service organization in support of a full funding formula approach that would remove VA medical services from the annual discretionary appropriations process, such as Medicare, Social Security, VA compensation and pension, et al.

2. **President's budget request --** provides a great deal of facts, figures, and statistics from the Office of the Assistant Secretary for Management. Although this document fails to reflect the "true" budgetary needs of VA and we disagree with many of its VA legislative initiatives contained therein, it reflects changes in funding, workloads, staffing, services, and other extremely useful information. The American Legion testifies before a joint session of the Veterans' Affairs Committees each fall with the goal of impacting the President's budget request as it is being crafted for presentation in February.

3. **Budget Resolution** -- provides The American Legion with the views and estimates of the Veterans' Affairs Committee, as well as the leadership of both sides of the aisle. The 5 or 10-year projections provide valuable insight.

4. **Annual VA appropriations** – serves as the platform for building the next fiscal year recommendations. Unfortunately, for the last three years, this bill has been a part of an omnibus appropriations bill enacted well into the new fiscal year. Clearly, this adversely impacts the long-range planning efforts of local VA medical center directors, medical researchers, as well as VISN Directors.

The American Legion's Health Care Modeling

In the late 1980s, The American Legion was deeply concerned with the health care delivery problems faced by veterans and military beneficiaries. Within VA, service-connected disabled veterans, economically disadvantaged veterans, and Civilian Health and Medical Program for VA (CHAMPVA) eligible beneficiaries were the only individuals with complex access standards to an inpatient-oriented health care delivery system. Military beneficiaries had to navigate an extremely costly and inefficient Civilian Health and Medical Care for Uniformed Services (CHAMPUS) program that failed to provide timely access. The American Legion believed there was a better way to meet the health care needs of America's veterans and their families. After much deliberation, The American Legion offered to Congress a new health care model for VA health care delivery in the 21st Century, it was called the GI Bill of Health.

Fundamentally, the GI Bill of Health called on Congress to create an integrated health care delivery system accessible to all veterans and their eligible family members. Building on VA's current infrastructure and contracting authority, VA would build a network of qualified health care providers working with its medical school affiliations; the military health care system; Public Health Service, to include Indian Health Services; the Federal Employee Health Benefit Program; and the Centers of Medicare and Medicaid Services (CMS); and contracted health care providers.

The GI Bill of Health called on the Veterans Health Administration (VHA) to establish an enrollment process accessible to all veterans and their eligible family members. Also, VHA would develop defined health benefit packages for basic care, comprehensive care, and specialized services.

Congress would authorize the creation of a Veterans Health Plan Fund to serve as a repository for all appropriated dollars (mandatory and discretionary), premiums, co-payments, coinsurance, deductibles, and third-party reimbursements. Funds would be expended for the timely delivery of health care services.

- **Mandatory vs. discretionary funding**. The American Legion points out that Title 38, United States Code (USC), clearly identifies priority veterans, non-priority veterans, and dependents of veterans. Congress mandates the Secretary of Veterans Affairs to provide health care services to certain priority veterans and dependents of veterans at no cost to the beneficiary. All other veterans and dependents should be required to cover the cost of their health care services through premiums, co-payments, or third-party reimbursements.

  The American Legion believes the funding needed to provide the care required to those priority veterans and dependents of veterans should be guaranteed (mandatory funding).

However, this does not relieve Congress of its responsibilities of appropriating discretionary appropriations for other VHA costs, such as medical facilities, medical administration, homeless veterans, and other such discretionary programs.

- **Medicare reimbursements**. Under current law, VA is prohibited from billing Medicare for the treatment of nonservice-connected medical conditions of enrolled Medicare-eligible veterans. Medicare eligibility is not a criteria for enrollment in the VA health care delivery system; therefore, VA is funded to treat Medicare-eligible veterans. When Medicare is listed as the veteran's health insurance provider, VA should be authorized to bill CMS for the treatment of allowable nonservice-connected medical conditions just as any other health care provider (just like DoD's TRICARE for Life or PHS' Indian Health Services).

- **Third-party reimbursement offsets**. Third-party reimbursements are essential for VA to meet its budgetary requirements. The current practice of offsetting third-party collections from the discretionary appropriations puts each VA medical facility in the "red" pending future collections. As previously mentioned, VA's inability to collect from CMS is a major obstacle since over half of VA's enrolled patient population is Medicare-eligible. In addition, VA's current Medical Care Collection Fund's inability to achieve the projected collection goal is unacceptable and must be corrected.

- **Enrollment**. Enrollment is a critical element of the GI Bill of Health because it identifies not only who is enrolled, but more importantly, how that medical care will be paid for. For priority veterans and dependents of veterans, they will identify VA as the primary payer and any third-party insurers. Military beneficiaries would identify DoD and any third-party insurers. Non-priority veterans and dependents of veterans would identify their third-party insurers. For veterans and dependents with no third-party insurers, VA should be authorized to offer premium-based health benefit packages (similar to TRICARE or FEHBP).

- **Defined health benefit packages**. The GI Bill of Health called for defined benefits packages so that veterans and dependents would understand health care services available to them under each benefit package. VA would offer a basic plan, comprehensive plan, and specialized services plan(s). At enrollment, each enrolled veteran or dependent would be placed in the appropriate health benefit plan(s).

- **Timely access standards**. Under the GI Bill of Health, all veterans would be subject to VA's own timely access standards. To achieve this objective, VA will have to closely monitor appointments and patient populations. With VA's transformation to integrated care, the number of outpatient clinics has grown dramatically. With the addition of a more diverse patient population with a significant increase in women and children, VA will need to adjust its own health care professional staffing and contracted services.

- **Availability of services**. The GI Bill of Health emphasizes the timely delivery of quality health care in the most appropriate setting. This philosophy is consistent with the overall objective of the Capital Assets Realignment for Enhanced Services (CARES) program. Throughout the 1990s in the midst of VA's transformation, hundreds of community-based

outpatient clinics were opened to move health care delivery closer to where veterans lived. The American Legion believes VA should collaborate with other Federal health care providers where opportunities expanding VA health care services may be practical, especially in rural areas. Working in close co-ordination with DoD's Base Realignment and Closure Commission, the availability of military medical facilities destined for closure many present opportunities for future community based outreach clinics, especially if there is a large military retirement community in the catchment area.

- **VERA formula**. One of the major problems with the current Veterans Equitable Resource Allocation (VERA) formula is that it ends at the VISN rather than the facility levels. This flawed process allows the VISN director to withhold resources that were allocated based on the criteria determined by the individual medical facilities within the VISN. Allocated dollars should not be held in reserve accounts – each facility should receive its earned allocation.

Conclusion

Mr. Chairman and Members of the Committee, The American Legion's Medical Care Modeling is designed to:

- Enable the Veterans Health Administration to provide timely access to quality health care for all enrolled patient population;
- Assure all enrolled patients identify means of payment for their health care treatment;
- Assure adequate funding through Federal appropriations (both direct and discretionary), co-payments, premiums, and third-party reimbursements from Federal and private health insurers;
- Assure all service-connected disabled veterans have timely access to quality health care for treatment of their service-connected condition at no cost to the veteran;
- Increase the number of access points for VA health care services;
- Assure all enrolled patients are assigned to the appropriately defined health benefits package(s);
- Eliminate unnecessary, duplicative, or contradictory regulations that would hamper timely access to quality health care services;
- Expand the diversity of VA patient population; and
- Continue to honor the military service of those enrolled veterans, survivors, and other family members.

Mr. Chairman, VA, Congress, and The American Legion share the same goal – meeting the needs of America's veterans and by working together, we can achieve that goal. This concludes my testimony and I appreciate this opportunity to present The American Legion's approach to health care modeling.