FUNDING THE U.S. DEPARTMENT OF VETERANS AFFAIRS OF THE FUTURE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

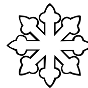
ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

APRIL 29, 2009

Serial No. 111–16

Printed for the use of the Committee on Veterans' Affairs



U.S. GOVERNMENT PRINTING OFFICE

49–914 WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON VETERANS' AFFAIRS

BOB FILNER, California, *Chairman*

CORRINE BROWN, Florida
VIC SNYDER, Arkansas
MICHAEL H. MICHAUD, Maine
STEPHANIE HERSETH SANDLIN, South Dakota
HARRY E. MITCHELL, Arizona
JOHN J. HALL, New York
DEBORAH L. HALVORSON, Illinois
THOMAS S.P. PERRIELLO, Virginia
HARRY TEAGUE, New Mexico
CIRO D. RODRIGUEZ, Texas
JOE DONNELLY, Indiana
JERRY MCNERNEY, California
ZACHARY T. SPACE, Ohio
TIMOTHY J. WALZ, Minnesota
JOHN H. ADLER, New Jersey
ANN KIRKPATRICK, Arizona
GLENN C. NYE, Virginia

STEVE BUYER, Indiana, *Ranking*
CLIFF STEARNS, Florida
JERRY MORAN, Kansas
HENRY E. BROWN, JR., South Carolina
JEFF MILLER, Florida
JOHN BOOZMAN, Arkansas
BRIAN P. BILBRAY, California
DOUG LAMBORN, Colorado
GUS M. BILIRAKIS, Florida
VERN BUCHANAN, Florida
DAVID P. ROE, Tennessee

MALCOM A. SHORTER, *Staff Director*

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

April 29, 2009

	Page
Funding the U.S. Department of Veterans Affairs of the Future	1

OPENING STATEMENTS

Chairman Bob Filner	1
Prepared statement of Chairman Filner	44
Hon. Steve Buyer, Ranking Republican Member	2
Prepared statement of Congressman Buyer	44
Hon. Harry E. Mitchell, prepared statement of	45

WITNESSES

Congressional Research Service, Library of Congress, Sidath Viranga Panangala, Analyst in Veterans Policy	24
Prepared statement of Mr. Panangala	58
U.S. Department of Health and Human Services, Jessica Banthin, Ph.D., Director of Modeling and Simulation, Center for Financing, Access, and Cost Trends, Agency for Health Care Research and Quality	25
Prepared statement of Dr. Banthin	60
U.S. Government Accountability Office, Randall B. Williamson, Director, Health Care	27
Prepared statement of Mr. Williamson and Ms. Irving	62
U.S. Department of Veterans Affairs, Hon. Eric K. Shinseki, Secretary	34
Prepared statement of Secretary Shinseki	68

Harris, Katherine M., Ph.D., Study Director, Review and Evaluation of the VA Enrollee Projection Model, RAND Corporation	22
Prepared statement of Dr. Harris	53
Partnership for Veterans Health Care Budget Reform:	
Joseph A. Violante, National Legislative Director, Disabled American Veterans	4
Prepared statement of Mr. Violante	45
Steve Robertson, Director, National Legislative Commission, American Legion	6
Prepared statement of Mr. Robertson	49
Carl Blake, National Legislative Director, Paralyzed Veterans of America	8
Prepared statement of Mr. Blake	51

SUBMISSION FOR THE RECORD

Coalition of Former VA Officials, joint statement	71

MATERIAL SUBMITTED FOR THE RECORD

Post-Hearing Questions and Responses for the Record:	
Hon. Bob Filner, Chairman, Committee on Veterans' Affairs to Hon. Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs, letter dated May 13, 2009, and VA responses	73

FUNDING THE U.S. DEPARTMENT OF VETERANS AFFAIRS OF THE FUTURE

WEDNESDAY, APRIL 29, 2009

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:06 a.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Snyder, Michaud, Herseth Sandlin, Hall, Halvorson, Perriello, Teague, McNerney, Walz, Adler, Buyer, Stearns, Moran, Brown of South Carolina, Boozman, Bilirakis, and Buchanan.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. Good morning. This session of the House Committee on Veterans' Affairs is called to order.

We thank all of you for being here and I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks.

Hearing no objection, so ordered.

We are going to try to move a little faster this morning because we will have votes in about an hour. Let me just say this is obviously a very important hearing. The power of the purse is the most important power Congress has and our budget must reflect our goals and our responsibilities.

Veterans are a high priority in our thinking and in our budget. Having a budget is fine, as all of the veterans' groups will tell us, but if it's not a timely budget, it throws everything into turmoil. Nobody can plan, nobody can hire, and nobody knows what to do. In fact, over the last 20 years, I think, the U.S. Department of Veterans Affairs (VA) budget has been enacted before the start of the fiscal year only four times.

Advance funding is the mechanism by which we hope to get control over that. Senator Akaka and I have introduced legislation to accomplish this, and many Members of this Committee support the House Bill, H.R. 1016.

We want to hear today from interested parties about how we make this process work, any problems with advance funding and how we might deal with these problems. We look forward to trying to get this done through this Committee as soon as we can.

I yield to Mr. Buyer for an opening statement.

[The prepared statement of Chairman Filner appears on p. 44.]

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Before I go to opening statement, I have a question for the Chairman. It has been a custom of this Committee, and most Committees of Congress, to have Members of the President's Cabinet as the first witness to testify. Recognizing that the Secretary is a representative of the President, he is, in fact, the President's agent at this hearing here today. And given that each branch is co-equal in our respect and mutual respect between the Legislative, the Judiciary and the Executive Branch, I believe the Secretary should be accorded the respect that he is due.

The question for the Chairman is, is today's order of witnesses, which places the Secretary on a third panel, considered exception to the usual practice?

The CHAIRMAN. Would you have Mr. Buyer's light on because this is part of his opening statement, please. He he seems to be representing his party well in obstructing things, as usual.

As you know, the Chairman sets the agenda, and I will be happy to answer it when your opening statement is through.

Mr. BUYER. I'd like to make a motion, given that I have the time. I move that the current Panel Number 3 be made Panel Number 1 and move Panel Number 1 to Panel Number 2 and move current Panel Number 2 to Panel Number 3. This is my motion.

The CHAIRMAN. Any second? Motion dies for lack of a second.

Mr. BUYER. I have a motion to—I make a motion——

The CHAIRMAN. The motion is out of order. The Chairman sets the agenda for the meeting.

Mr. BUYER. I control the time. I control the time.

I control the time.

I ask for regular order. I ask for regular order. I asked for regular order. This is my time. This is my time.

The CHAIRMAN. And your motion is out of order.

Mr. BUYER. I have a second motion. I make a motion to move the current Panel Number 3 to Panel Number 1. I move for the current Panel Number 1 to Panel Number 2 and move the current Panel Number 2 to Panel Number 3.

The CHAIRMAN. The motion is out of order.

Mr. BUYER. It is not out of order.

The CHAIRMAN. The motion is out of order. Do you want your time or not?

Mr. BUYER. Would the Chairman cite the rule? I would like a parliamentary inquiry to cite the rule as to how the motion would be out of order.

The CHAIRMAN. Because the Chairman sets the agenda. It is not subject to your——

Mr. BUYER. But the Chairman cannot make up the rules. Will the Chairman—will Counsel please advise? Parliamentary inquiry. Would the Counsel please advise as to why this would be out of order?

The CHAIRMAN. Mr. Buyer, let me——

Mr. BUYER. No, no, no. This is a parliamentary inquiry.

The CHAIRMAN. Mr. Buyer, let me say something about your issues here, which I take—you were Chairman for 2 years. You ran the Committee and the agenda the way you wanted. We thought

it was wrong, but you did it. I have watched for 16 years in this Committee, both under Republican and——

Mr. BUYER. Is this on my time?

The CHAIRMAN [continuing]. Both under Republican——

Mr. BUYER. I reclaim my time. I reclaim my time. I reclaim my time. You can say what you want.

The CHAIRMAN. Your time has expired.

Mr. BUYER. I have 2—I would say to my colleagues here, and this is ridiculous. I have 2 minutes and 42 seconds on my time.

The CHAIRMAN. Mr. Buyer, Mr. Buyer, Mr. Buyer——

Mr. BUYER. No, this is my time.

The CHAIRMAN. You may finish your time.

Mr. BUYER. Here is what is challenging. Here is what is challenging, to those who are listening. I equally have listened to you belittle two prior Secretaries, and now you are demeaning this President's Secretary by what you are doing here today and I am very bothered by it. I asked and made sure that Kingston Smith would talk to Malcom Shorter to make sure that this type of embarrassment would not occur.

And you know what, my friends out here, representatives of the veterans service organizations (VSOs), they pride themselves equally with regard to values and virtues and respect. And this town works when you have mutual respect.

Now, General Shinseki, now Secretary Shinseki, he is not going to get involved in this. Why? Because he is a gentleman. And so when you say, well, Mr. Secretary, I want you to be on the third panel, you know what he's going to say? I will be wherever I think I need to be.

But what is important, I believe, for us, is to make sure that that we treat Secretaries with the respect for which they are accorded, and I was hopeful that in fact, would have happened here today. And so I am greatly disappointed, greatly disappointed, but not surprised, that once again you would attempt to manipulate the rules and make things up as you go. That is really unfortunate.

What those of us here on the Committee have done is, we have worked very hard so that we work between each other and we have respect with each other.

But I am stunned that you would treat Secretary Shinseki in such a manner. And you know what? The Secretary has an excellent working relationship. He stepped off like he should, and he built rapport with the veteran service organizations.

So you set the stage here today to sort of imply that, here is a Secretary, we are going to put him on the third panel, he is going to sit there, he is going to listen to the first two panels. What? The implication or the inference is that the Secretary doesn't listen to the veteran service organizations? That is false because he has already met and meets regularly with them. So you don't set that stage.

The Secretary is doing exactly what the Secretary should be doing.

So does form and procedure and rules matter? Absolutely. And that is why I asked, very politely here, that the Secretary be placed on the first panel.

You are absolutely right. You can run things the way you want to run things. I just believe that you are setting the wrong perception and implication out there.

This is a Secretary that listens. He has met with every Member of this Committee. He moves out smartly. He wants to do the right thing by our soldiers and dependents and the disabled and the families, but you are setting the wrong tone and that is the reason I was politely asking for this replacement.

[The prepared statement of Congressman Buyer appears on p. 44.]

The CHAIRMAN. Thank you, Mr. Buyer.

The first panel consists of representatives of various veteran service organizations representing the Partnership for Veterans Health Care Budget Reform. Joe Violante is the National Legislative Director of the Disabled American Veterans (DAV). Steve Robertson is the Director of the National Legislative Commission of the American Legion. Carl Blake is the National Legislative Director of the Paralyzed Veterans of America (PVA).

As you know, you will be recognized for 5 minutes each. Your written statements will be made part of the record. We look forward to your testimony. We thank you for getting this coalition together and making sure that the Hill and the Nation understand what is at stake here.

Mr. Violante.

STATEMENTS OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS, ON BEHALF OF THE PARTNERSHIP FOR VETERANS HEALTH CARE BUDGET REFORM; STEVE ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, AMERICAN LEGION, ON BEHALF OF THE PARTNERSHIP FOR VETERANS HEALTH CARE BUDGET REFORM; AND CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA, ON BEHALF OF THE PARTNERSHIP FOR VETERANS HEALTH CARE BUDGET REFORM

STATEMENT OF JOSEPH A. VIOLANTE

Mr. VIOLANTE. Thank you, Mr. Chairman and Members of the Committee. Thank you for holding this hearing today and for inviting the Partnership for Veterans Health Care Budget Reform to testify.

The Partnership includes the American Legion, AMVETS, Blinded Veterans Association, Disabled American Veterans, Jewish War Veterans, Military Order of the Purple Heart, Paralyzed Veterans of America, Veterans of Foreign Wars and Vietnam Veterans of America.

Mr. Chairman, it has been over 18 months since I testified before this Committee at a hearing on this same subject: how to provide sufficient, timely and predictable funding for veterans health care programs. Then, as had been our position for many years, the Partnership focused on mandatory funding.

However, at that hearing I told the Committee this: "If the Committee chooses a different method for effecting this change, we will examine that proposal to determine whether it meets our three es-

sential standards for reform—sufficiency, predictability and timeliness of funding for VA health care. If that alternative fully meets those standards, our organizations will enthusiastically support it."

Well, you did, we have, it does, and we do. That is, you did introduce new legislation, H.R. 1016, the Veterans Health Care Budget Reform and Transparency Act, that supports advanced appropriations (AA). The Partnership was honored to work with you and Chairman Akaka in developing that proposal. The new legislation does meet our goals and the Partnership does enthusiastically support it.

Mr. Chairman, we applaud Congress for the significant funding increases that have occurred in recent years and the President's 2010 budget request.

However, for too long the VA health care system has had to struggle with the budgets that were too little and too late. In 2001, VA health care funding began to fall significantly behind the demand for services, straining VA's ability to provide treatment and leaving 250,000 veterans waiting 6 months or longer for doctor's appointments.

In 2002, VA placed a moratorium on marketing and outreach activities. In 2003, then Secretary Principi cut off enrollment of new Priority Group 8 veterans. In 2004, Secretary Principi told this Committee that VA's fiscal year 2005 budget request was cut $1.2 billion by the Office of Management Budget (OMB). In 2005, Secretary Nicholson admitted that VA's budget request for fiscal year 2005 and 2006 were insufficient.

And while we appreciate Congress completing the VA's appropriations on time last year, that was only the third time in two decades. Unfortunately, VA officials have become accustomed to continuing resolutions (CR) in emergency supplemental appropriations. This has created a feast-or-famine mentality, wherein VA managers hoard money in the beginning of the year and spend money unnecessarily at the end. No private-sector business, especially a health care system, would operate effectively without knowing what its budget will be until months after the start of the fiscal year and neither can VA.

To resolve these problems, the Partnership believes that the proposal most likely to lead to sufficient, timely, and predictable funding is H.R. 1016.

We thank you, Mr. Chairman, for working with the Partnership and Chairman Akaka in developing this legislation, and we are pleased that these bills have significant bipartisan support, 97 cosponsors in the House and 41 in the Senate.

In addition to the Partnership, this legislation is endorsed by the Independent Budget, the Military Coalition and the American Federation for Government Employees.

Advance appropriations have also been endorsed by a Coalition of Former VA Senior Officials, including former Secretary Principi. I have a statement from this coalition and ask unanimous consent that it be made part of the record.

The CHAIRMAN. So ordered.

[The prepared statement of the Coalition of Former VA Officials appears on p. 71.]

Mr. VIOLANTE. We recently met with President Obama, who told us in a private meeting, and then reiterated before the cameras, that he fully intends to keep his campaign promise on advance appropriations.

President Obama said the following: "The care that our veterans receive should never be hindered by budget delays.

I have shared this concern with Secretary Shinseki and we have worked together to support advance funding for veterans' medical care."

The Senate included advance appropriations in their budget resolution, and Chairman Spratt and Chairman Conrad have reached agreement to keep advance appropriations in the final 2010 budget resolution.

H.R. 1016 is a common sense solution to a longstanding problem. Advance appropriations will not add one more dollar to the Federal deficit or national debt.

Mr. Chairman, we look forward to enactment of this legislation so that we can finally guarantee veterans' health care funding will be sufficient, timely and predictable.

My colleagues will now address the details of your legislation, and we look forward to answering any questions the Committee may have of us. Thank you.

[The prepared statement of Mr. Violante appears on p. 45.]

The CHAIRMAN. Thank you, Mr. Violante.

Mr. Robertson.

STATEMENT OF STEVE ROBERTSON

Mr. ROBERTSON. Thank you, Mr. Chairman, Mr. Buyer, and other Members of the Committee for allowing the American Legion to participate in this hearing.

From the very beginning, our goal has been a shared goal by the Partnership, and that is to provide sufficient, timely and predictable funding. We have worked with you and developed a piece of legislation that we believe is a solution to our problems.

Historically, advance appropriations has been used to make program functions more effectively better rely on the funding cycles with program recipients and provide insulation from annual partisan political maneuvering.

By moving advance appropriations, veterans' health care programs can benefit from these three elements. The problem the Partnership is trying to address is the annual discretionary appropriations not always being available to VA on October 1st. This delay in the timely and predictable provisions of medical funds means that the VA health care system administrators are cautious in decisions that they have to make concerning hiring of medical personnel, procurement of new equipment, supplies and services, and the construction and maintenance of VA medical facilities, until those funds are actually appropriated and gets to them.

While Congress has taken—made great strides to increase funding during the past several years, it has been the potential for significant—there is still the potential for significant delays in the VA funding process.

The core problem in the timing, a timely funding of VA medical care is the inherent volatile nature of the annual appropriations

process. Due in large part to the current medical care funding process used to approve annual discretionary appropriations, it is clearly flawed, and the Partnership has looked for a new way to address this issue.

That approach, clearly to us, is advanced appropriations. We believe that it will stabilize the VA medical care funding and provide the funds truly in a timely and predictable manner.

Congress will still have its discretionary authority to approve and oversee these funds. Because medical care discretionary appropriations will be decided 1 year in advance, VA medical programs could be more closely monitored to make sure the funding levels are sufficient. More importantly, the VA medical care would be available on October 1st of every year.

If advanced appropriations for VA medical care were adopted by Congress, VA administrators would have 1 year in advance of when that appropriations is due to be able to plan accordingly, to deliver quality medical care services to all enrolled veterans who need it.

Most importantly, advanced appropriations allows Congress to improve its oversight responsibilities over VA medical care because VA administrators will be held more accountable due to the fact that they should be able to make better use of these resources.

Advanced appropriations is a technique already used by Congress for many years to approve authority for 1 year in advance of certain government programs, such as the Low-Income Housing Energy Assistance Program and Section 8 housing.

Although Congress has provided advanced funding for these programs for a variety of public policy reasons, it does not provide advanced appropriations for timely and predictable provisions for VA medical care. We would like to see this changed.

As a Nation at war and with the economic difficulties we face today, now is the time to enact this critical legislation. As you and your colleagues consider the conference report for S. Con. Res. 13, the Budget Resolution for 2010, we are pleased to see advanced appropriations for VA medical care included in that Congressional blueprint.

The Partnership supports that provision in S. Con. Res. 13. Advanced appropriations will increase budget flexibility for Congress to provide sufficient funding. If faced with unforeseen medical circumstances that dictate changing the funding amount, clearly advanced appropriations fully addresses two of the three prongs of our sufficient, timely and predictable medical care funding, while helping to create an environment that is more likely to produce sufficient funding.

Mr. Chairman, the Partnership welcomes the opportunity to continue to work with you and your colleagues toward enactment of the budget reform that will achieve sufficient, timely and predictable annual discretionary appropriations for VA medical care.

Thank you. That concludes my testimony.

[The prepared statement of Mr. Robertson appears on p. 49.]

The CHAIRMAN. Thank you, Mr. Robertson.

Mr. Blake.

STATEMENT OF CARL BLAKE

Mr. BLAKE. Chairman Filner, Ranking Member Buyer, Members of the Committee, on behalf of the Partnership, I would like to thank you for the opportunity to testify today.

As already mentioned, the Partnership's goal for VA health care system is to ensure sufficient, timely, and predictable funding.

While much of the attention during the debate of this legislation has been focused on the advanced appropriations aspect, we believe that the second part of the proposal is equally important.

To ensure sufficiency of the VA health care budget, section 4 of H.R. 1016 would require VA's internal budget model to be shared publicly with Congress to provide accurate estimates for VA health care funding as determined by a U.S. Government Accountability Office (GAO) audit before political considerations take over the process.

In recent years, VA developed its new methodology to estimate its resource needs for veterans' health care through the Enrollee Health Care Projection Model, or the "Model."

Developed in collaboration with a leading private-sector actuarial firm, Milliman, Inc., over the last several years the Model has substantially improved VA's ability to estimate its budgetary needs for future years. The Model has been thoroughly reviewed by the Office of Management and Budget and approved for use in developing VA's budget.

We recognize that the Model itself directly accounts for approximately 86 percent of the real costs to the VA to provide services in a given year. The remainder of the budget needed by the VA primarily goes to long-term care, approximately 10 percent for nursing home and non-institutional care, as well as some smaller programs that make up approximately 4 percent.

The Partnership also recognizes that the biggest argument against relying on the Model for budget forecasting is the impact unforeseen events, such as exceedingly large numbers of new enrollments or catastrophic events might have on the budget. For instance, the report released on April 3rd, 2009, by the Congressional Research Service (CRS) titled, "Advance Appropriations for Veterans' Health Care: Issues and Options for Congress," addresses this concern directly.

The report specifically states that, "It is reasonable to assume that future year budget projections could have variances that could create budget shortfalls if there are unanticipated shocks to the model." We see this as simply a statement of the obvious since this point is true even under the current budget process.

The Partnership does not believe that the advanced appropriations proposal somehow changes the actions that Congress would take under these circumstances. There seems to be an assumption that if our entire proposal were to be enacted, that Congress would no longer have or choose not to use its authority to provide emergency supplemental appropriations when warranted.

The Partnership would also like to point to the detailed analysis of the Enrollee Health Care Projection Model conducted by the RAND Corporation. Ultimately, we believe that the most important point of the RAND study is that compared to traditional models, the current specification offers the benefit of a substantially more

flexible and detailed platform from which to plan the VA's appropriations request, monitor budget execution and assess system performance. If the outcomes of the model were shared publicly, Congress would have better information in order to develop its own appropriations plan for the VA.

The Partnership simply believes that the outcomes of the Model better reflect the needs of the VA health care system than any other model currently used.

Mr. Chairman, we look forward to working with the Committee to ensure that your legislation, H.R. 1016, is advanced and ultimately enacted. We appreciate the opportunity to lay out our proposal in detail and we would be happy to take any questions that you or the Members of the Committee might have. Thank you.

[The prepared statement of Mr. Blake appears on p. 51.]

The CHAIRMAN. Thank you all for your testimony.

Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman, Mr. Ranking Member, for having this hearing today. I think it is very important. I have always been a strong supporter of making sure that we have adequate funding for the VA, but also that that funding comes on time, and there has been a problem over previous years as the panel had alluded to earlier, as far as getting the budget on time.

I have been very used to dealing with 2-year budgets serving in the Maine legislature and chairing the Appropriation Committee and it works very well. But my question is, when you look at the Model that the VA puts forward, currently there's a lag in that Model. And by having advanced appropriations, that will add another year in that lag as far as adequately reflecting what the budget should be within the VA.

And I heard Mr. Blake mention in his testimony the fact that, yes, even if we do advanced funding, we probably will have to come back and make some adjustments in the following Congress.

Do you feel comfortable—and I will ask each of you—do you feel comfortable with advanced funding, that additional year lag, that we can make adjustments down the road to take care of that, or other ways that we might be able to look at that model to make sure that it accurately reflects what is really happening within the VA system?

Mr. VIOLANTE. Mr. Chair, that is a question that we have considered, and we do feel comfortable. We believe that in the beginning there may be some things that need to be ironed out, and that is why we have asked or that the bill contains a review by GAO to make sure that the numbers that are going in are accurate. And we think as time progresses and with all these numbers being looked at, both forward and backward, that we will get a good estimate in the very near future.

If immediately something needs to be done to correct it, we would hope that Congress would take steps either during the normal budget process or in a supplemental. But we do feel comfortable that this model will work for 2 years out.

Mr. ROBERTSON. Mr. Chairman, we have looked at this as nothing new, as nothing new. If these numbers were used in the reg-

ular process that we are using right now and they were inaccurate, we would go back and fix it.

So it is not like we are chiseling this on a tablet somewhere and bringing it down and giving it to you. It is a flexible document. And all the tools that the Congress has to make adjustments in the appropriations, that are given out, whether they are advanced appropriations, whether they are supplemental appropriations, whether they are continuing resolution, are still there.

I agree with Joe. The more people looking at the Model and making evaluations of it, I think, the better fine tuned we can make it.

Mr. BLAKE. I guess I couldn't say much more than what they have said, Mr. Michaud, except to say that you sort of imply that the assumption would be that emergency supplemental appropriations and things like that would become part of the normal process, and that is not necessarily what we are advocating for. We believe if we can get this right, there should not be the need for that kind of activity.

I think the point that we tried to make in our testimony about emergency supplemental is, the intent of something like that is when things like a shock to the system, as outlined by the CRS Report, occur, that is the reason for that being a tool that the Congress has.

I would also point to the fact that in the RAND study, they do have a conclusion in there that they believe that this model is good for short-term budget planning. Now, obviously that opens up a big question about what constitutes short-term budget planning. Two years? We feel pretty comfortable and we have discussed that that probably falls within that window.

Now whether that applies to 5—and 10—year budget projections out, I am not sure that we have the same fate.

Mr. MICHAUD. As you know, I am a cosponsor of Chairman Filner and Chairman Akaka's legislation dealing with advanced funding and look forward to moving that legislation forward. My second question is, do you feel it would be easier to have a more accurate account for advanced funding appropriation for the VA system if, in fact, the VA and the U.S. Department of Defense (DoD) moves more rapidly with a seamless transition, electronic medical records and other information that the VA needs? Do you think that would be extremely helpful, as well, when you look at the accuracy issue?

Mr. VIOLANTE. It would definitely be helpful and we appreciated the President back on April 9th when he came out with Secretary Shinseki and Secretary Gates to announce that will be happening and that definitely will help alleviate a lot of problems.

Mr. ROBERTSON. It will also give you a look ahead that will be much better as to what population you may be receiving in the next year. And I think the most important thing that a lot of people overlook is we will all be working off the same numbers. Everybody will be working off the same numbers. It won't be your Committee having one set of numbers, our organizations having another set of numbers, and the Secretary having another set of numbers. We will all be working off the basic core package.

Mr. BLAKE. Mr. Michaud, I would like to make one other comment, too. There's another recommendation that is part of this that

the VA has made or a plan going forward that I think is critical to this, and that is this idea that when a servicemember takes the oath and becomes a servicemember, they then are enrolled into a system where they never leave the DoD and then they have to get back in to VA a different way so that they are always a one and the same system. I think it makes it better to track these people going forward and you can keep a better—you get a better idea of trends as it relates from the beginning of military service all the way through.

It creates a different aspect, but it is certainly something we support.

Mr. MICHAUD. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

Let me just say that, Mr. Robertson, let us say we did this advanced appropriation with the Department of Defense. Would you think that that would be a good idea, to have advanced appropriations for Navy, Army, Navy and Marine Corps?

Mr. ROBERTSON. Would I think it would be good to make the entire budget advanced appropriations?

Mr. STEARNS. I am talking for the Department of Defense. If we took a segment. For example, as I understand it, this advanced appropriations account would account for 43 percent of the total VA budget, 85 percent of the total VA discretionary account. So we are talking about almost half of the VA budget being funded through AA.

Mr. ROBERTSON. I think you would have a very good argument if the DoD budget wasn't usually the first one that's adopted. I don't think the DoD appropriations or the DoD supplemental requests are ever delayed over, you know, 6 or 7 months. That is what maintains——

Mr. STEARNS. Well, no. Sometimes the DoD is delayed, we have to do an emergency appropriation supplemental. It's constant, you know, dealing with Afghanistan and the Iraq war. We had the same problem with late appropriations and these people didn't have money.

So I mean, if your argument is strong here, then I am just curious if you feel it should be applied to the Department of Defense.

Mr. ROBERTSON. I do not think that the Department of Defense has suffered in decisionmaking process due to delays like the VA has on the medical care side of it.

Mr. STEARNS. Isn't it true that by doing this, this will be the first time in the Federal budget that we are giving advance appropriations for health care? We are not doing it for Medicare or Medicaid. I mean——

Mr. ROBERTSON. Those are mandatory programs, sir, and they are automatic.

Mr. STEARNS. I know. But we are not doing advanced appropriations like we are requesting here.

Mr. ROBERTSON. It is an automatic, sir. It is effective October 1st.

Mr. STEARNS. Would you rather have that automatic, rather than the advanced appropriations?

Mr. ROBERTSON. Sir, that is what we initially pushed for and was turned away from by Congress. Congress has asked us to give them a discretionary appropriations that they can continue to work with.

Mr. STEARNS. If we have advance appropriations, what about the flexibility for the Secretary of Veterans Affairs? Doesn't he lose some of the flexibility he needs when he looks at—I mean, we have talked about—Mr. Blake talked about the RAND study. We also have input from the GAO that indicated the provision of advance appropriations would use up discretionary budget authority for the next year and would so limit Congress' flexibility to respond to changing priorities and needs. The longer projection period increases the uncertainty of the date and projection used.

And in addition to Congress losing flexibility, the Secretary of Veterans Affairs loses his flexibility. So what would you say to that? There is no flexibility provided.

Mr. BLAKE. Mr. Stearns, could I answer that question?

Mr. STEARNS. Sure.

Mr. BLAKE. First, I would say that I don't believe the Secretary would lose any flexibility. What we are proposing doesn't in some way change the authorities that the Secretary has and how he spends his money, whether he can transfer funds around. And ultimately, the money will become available for all of the accounts in the VA on the same day, assuming that all of the other accounts not governed by advanced appropriations are approved before October 1st.

My understanding of the GAO findings, which I think you referred to their testimony that was submitted for the hearing today which was, I just glanced over it before we began this morning, I think that their finding is targeted more at their concern about the flexibility Congress would have, and my sense of reading that suggests that by moving this into an advanced area, it is removed from the current budget debate and it is a pot of money that the Congress no longer has to manipulate in some fashion to address other priorities or not that they may have.

Mr. STEARNS. Mr. Blake, let me just read. "In January 2009 the GAO found that the VA's assumptions about the costs of providing long-term care appear unreliable given that assumed costs increases were lower than VA's recent spending experience and guidance provided by the Office of Management and Budget."

So they are pretty clear. They don't think that the projections are reliable and with that, in fact, if you have advance appropriations, then you have assumptions that are based upon unreliable data.

Mr. BLAKE. Well, to your point, Mr. Stearns, the projections they refer to, refer to the long-term care piece of the VA, which is actually not governed by the Model itself. And that is something we see as a problem. I even mentioned it in my written statement. And I won't argue with you. I agree. If there is an area where they have clearly manipulated and made false assumptions, it is in how they planned their long-term care.

I think in recent past we have seen that the VA has wanted to get out of the business of institutional long-term care, and I think their assumptions reflect that.

Mr. STEARNS. Mr. Blake, they also moved not just to long-term. They said they had a report that indicated that the VA underesti-

mated the cost of serving veterans returning from military operations in Iraq and Afghanistan.

So it is not just in the long-term. It is a consistent pattern that they found unreliability of the data. And so that is why—you know, we are all on the same team here, you know. I think, as serving on the Veterans Committee almost 20 years, that I would like to have that flexibility and be able to come out and help when there is unreliable data.

But now, subject to what the GAO found and the RAND study, the flexibility is gone from Congress, gone from the Secretary of Veterans Affairs, and based upon unreliable data, not what I said, what the GAO said.

Mr. ROBERTSON. Mr. Stearns, if I may, with advanced appropriations, the Secretary would still go through the regular appropriations process and if he felt that the appropriation level for the next year was too high, he could state that from the very beginning of the budget process with the President's budget request.

But, secondly, which I think is a very important point, is that you are making an—or that report is making an assumption that the Model that was used was what was advanced by the Administration, and I don't think that is always the case. I think the Model may have had higher numbers or better predictions. It just, when it was passed back through the OMB process, it may have been skewed.

Mr. STEARNS. Thank you, Mr. Chairman.

Mr. VIOLANTE. If I could just answer that also. I mean, Steve is right. If you look at that report, it talks about the fact——

Mr. STEARNS. The GAO report or the RAND report?

Mr. VIOLANTE. Yes. The GAO report. That, you know, VA compared projected costs to the anticipated requests, not based on the needs.

And the other thing about this legislation, it does not require Congress to use the numbers that the Model puts forth. I mean, everyone has flexibility. The idea was to have this Model made available so everyone would know what the needs are.

I mean, Congress may not agree with those needs, and Congress can add more or subtract money from that. This legislation does not bind you to the VA's model.

Mr. STEARNS. Thank you.

Mr. Chairman, that would make a good question for the Secretary of Veterans Affairs when he comes up.

The CHAIRMAN. Thank you, Mr. Stearns.

Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman and Ranking Member and thank you to each of you, once again, for all you do for our veterans. Maybe I will have to take responsibility for the black cloud that entered here, both literally and as I got soaked on the way, and figuratively as I couldn't find my caffeine and everything else went wrong today. The one thing I could count on, though, was coming here on this important issue. And I think moving in a positive manner to kind of break this jinx I have been under, I am going to speak heresy here because I'm trying to figure it out on the flexibility side of this, too.

I think we do this thing right because many of us feel this gives the flexibility to the Secretary and to his managers. With those of us who have been out there and watched the decisions that have to be made by hospital administrators on cutting back nurses and care at the last minute and then maybe being able to rehire them back down the road or different things that were going on. I think the potential lies here to get efficiencies out of the system so that we may deal with the issue of rescissions of money coming back. Now, wouldn't that be odd?

If we were able to get the system to where it was functioning correctly and if we do this right, we shouldn't always have to. And I am glad that you brought this up, Carl, focusing on this, because I, too, want to make sure. And I think Mr. Stearns brings up a valid point on allowing that flexibility.

But the way I understand it is, if the budgeting processes are more in the hands—with advance appropriations—of the Secretary and of his managers who know how to deliver the care, I think we have got a much better chance of coming to the number of what it actually takes to care for our veterans and get it back.

Would you agree with that, that that is the point we are trying to get to, that this doesn't necessarily just mean more money, faster money? It means the correct amount of funding at the right place and right time to deliver the care.

Mr. VIOLANTE. You are exactly right. And that is what we are trying to do with this legislation, is to get to that point where we know what the needs are, not what the government wants to spend on veterans.

Mr. ROBERTSON. This is the old "garbage in, garbage out." If you don't have good data to start with, if we are operating off of five or six or ten or fifteen different proposals, then how do we know which one is the best one? If we have a good model that the taxpayers are paying for, why aren't we all using it? Why aren't we all working off the same sheet of music and coming up with the best plan possible? And it does provide, I think, a tremendous amount of flexibility.

And you are exactly right. If I was a brandnew researcher coming out of a medical school, which system am I going to go to? One that doesn't know when its budget is going to be approved and how much they are going to have to operate their system?

If I am uncertain of what the fate is of the VA medical care system, I need to go someplace else where I have a little more security.

Mr. BLAKE. I agree wholeheartedly with you, Mr. Walz. I mean, even in our statement we make the point that we're not suggesting that we just want increased budgets year after year after year.

If ultimately we get this right and it is reflected that—I mean, I think we all know that the patient population of the VA is actually slowly decreasing, or at least the growth of it is, and the discussion about the World War II generation and once it is gone will have a significant impact on the utilization in VA.

And so, we recognize that fact and we accept that. And so the impact that will have on the budget, if it drives the budget down some, so be it. We just want to get it right.

Mr. WALZ. Again, I think my colleague from Florida brought up an interesting point in asking about other appropriations. I think there is a valid argument to be made there and I think, Steve, you are right about this, that others didn't have to do it and there might be a difference in appropriating a building or something, as opposed to the care of one of our warriors. I understand that is a pretty strong moral argument.

But I do think that what the President's talked about and what his Secretaries are talking about is a total change in efficiencies and transparencies, how we do this. I have worked in organizations. I am not talking about putting government on auto pilot. What I am talking about is our responsibilities to get that out. The Secretary's responsibility is his managers are better at understanding how to deliver that. Our job is to provide oversight. I worked in school systems where every single year we got pink slipped as a way to just assume, we didn't know if we were going to have the money to have you back, so everybody got laid off automatically, and you got hired back on again in the fall until you received quite a bit of seniority.

That created massive problems in how to figure things out. It created a sense of, in the organization, no sense of consistency, and the morale in the organization was hurt by that lack of understanding of what was coming. So I think there is—we are not going to talk about intangibles. We are going to measure them, we are going to show, we are going to provide how this works.

But I think the proposal is solid. I have supported it. I think you have thought through some of the difficulties. And I think this discussion further on how we make government more efficient is warranted, so I yield back my time, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Walz.

Mr. Moran.

Mr. MORAN. Mr. Chairman, thank you. I would yield my time to the gentleman from Florida who has additional requests or questions. Thank you.

Mr. STEARNS. I thank my distinguished colleague.

Mr. Chairman, I thought I might just continue this GAO discussion with Mr. Blake and Mr. Robertson and just to have them aware of what the conclusions are.

I think my colleague mentioned a little bit about putting this whole thing on auto pilot, and I think that's obviously a concern when we want to have flexibility for both the Secretary and as publicly elected Members of Congress, why wouldn't I want to get involved with priorities here.

And I feel, Mr. Robertson, by this advance appropriations proposal, I am giving up a little bit. And he used the word "auto pilot," and I am just going to use his word to say that, you know, we are tying up Members of Congress from having the flexibility we need, not to mention the Secretary of Veterans Affairs.

Let me just read, if you would allow me to read from their concluding comments of this recent testimony that the GAO did. Now, lots of times if you are, you know, people quote OMB and they say, oh, that is the White House. And then if your party's in power and GAO is quoted and you say, well, that is Congress and that is your party. But I mean, this is the GAO today, and I think most of us

respect, regardless of what party we are, we respect what the GAO has to say.

I will read a little bit of what they said. “Providing advanced appropriations will not mitigate or solve the problem, which is noted above, regarding data calculations or assumptions in developing the VA health care budget. Nor will it address any link between cost, growth and program design. Congressional oversight will continue to be critical.” So you don’t want to tie our hands here so that we don’t have this flexibility.

“If the VA is to receive advance appropriations”—this is the GAO we are talking about, for health care—“the amount of discretionary spending available for Congress to allocate to other Federal activities in that year will be reduced. In addition, providing advance appropriations for health care, VA health care, will not resolve the problems we have identified in the VA’s budget formulation.”

Mr. ROBERTSON. Mr. Stearns, are they basing this on all of the other advance appropriations that have been awarded for over the years? Is that a problem that is common amongst all the other Federal programs that receive advanced appropriations, that it is running amuck? Because if we have got that many programs that are receiving advanced appropriations, that they are basing this on, because we haven’t ever done this as a VA appropriation. So my question is, is this report being based upon their experience with——

Mr. STEARNS. No.

Mr. ROBERTSON [continuing]. Other advance appropriation——

Mr. STEARNS. I am told by Counsel it is not based upon that. In fact, there is not as many advanced appropriation programs as you indicated. So Counsel is telling me “no,” that is not true.

So, I mean, the fundamental question is that the three of you have to, in your conscience, think about if what you are asking based upon the GAO’s finding, going to tie our hands and in the area where you want to have this improved health care, will not resolve the problems because you are advancing money and no one knows, based upon the data that is provided, that it is going to do the job.

So, I mean, this is just sort of a general comment. I mean, you are welcome to comment, but I am just reading from the GAO report and not having had a lot of experience, frankly, so I can’t even answer your question, if it is legitimate, whether advanced appropriations have worked or not. I mean, that is a good question. I think myself and Counsel should——

Mr. ROBERTSON. Mr. Stearns, with all due respect, when Mr. Buyer was Chairman and he called up the question about how the methodology was being determined by all of the groups and everybody else, we all had to lay our cards out on the table, it was clear that we weren’t doing it right, with the way the process was going. The data was clearly well outdated. I mean, they didn’t even take into consideration we were in a war.

So how did we fix it then? We made the adjustments. We got the additional appropriations. The President came back with a new budget request and they fixed the problem.

When you do advanced appropriations, it is the exact same thing. The money is not spent. It is out there on the wall. If we determine

between now and when that appropriation goes into effect that it is inaccurate, we still have the vehicles to correct it.

You have a rescission process. If the bill goes into effect and the money is appropriated, you can go back and take money back if you feel it is inaccurate.

So I hate this thought that this is automatic pilot. It is not. It is still subject to review.

Mr. STEARNS. Well, let me just conclude, Mr. Robertson, can you cite an example where Congress has taken money back? I will give you 230 years of history.

Mr. ROBERTSON. I will be glad to show you my tax return.

[Laughter.]

Mr. STEARNS. Okay. Well, you are the only one.

Mr. ROBERTSON. Talking current receipt.

Mr. STEARNS. Well, in my 20 years of Congress, I have never seen Congress take back money, so if that is a new era, I am looking forward to it.

The CHAIRMAN. The President has made decisions all along, Mr. Stearns.

Mr. STEARNS. Yeah, well, I am not thinking in the way he is thinking. To see government, Congress, come back and take money back. But in all defense of what you are talking about, you know, the current budget and appropriations process is not perfect up here. That is for sure and we are sometimes just as unreliable as anybody. So thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mrs. Halvorson.

Mrs. HALVORSON. Thank you, Mr. Chairman. Thank you all for being here. I have an Advisory Committee for Veterans and I just met with them on Saturday and we had a lot of discussion over health care. In fact, my district, the most calls we get are from veterans and people who feel that their health care needs are not being satisfied, and the smooth transition that we need to see from the Department of Defense into the Department of VA.

But Mr. Robertson, you make a very, very good point. Just because you have an advanced budget, doesn't mean you spend it. And I am really concerned, from spending a lot of years in State government, the fact that you hoard all your money in the beginning because you don't know what is going to come up and then you spend it needlessly because if you don't spend it, you are not going to get it next year.

And that is why we have got to remember, what I am hearing, and I may be new and I am trying to keep this simple, but what I am hearing is we are putting politics before the health of our veterans, and we need to put the health of our veterans and veterans first.

Where, if it is going to help the health of our veterans to have an advanced appropriation, I think no matter what, we should be doing that. But for Congress to say they want more control, but that hurts our veterans, I think that is absolutely ridiculous. We should be putting the flexibility in the hands of the Secretary so that our veterans are the ones that are taken care of, because any time Congress wants to pull that back and make sure that it is more efficient, they can.

So my question to you is, if we have an advanced appropriation, is it going to help take care of our veterans better? And any one of you can answer or all of you can.

Mr. VIOLANTE. Definitely. I mean, we wouldn't be supporting it if we didn't believe that this will benefit veterans getting proper timely quality health care. And I think the statement I asked to be introduced into the record from former VA personnel, including Former Secretary Principi, Deputy Secretaries Hershel Gober and Gordon Mansfield, and almost two dozen other directors, indicate that the biggest problem they have is not knowing what they are going to get and when they are going to get it.

And what happens is—and we have talked to a number of directors—when they get their budget 3 months late, what happens is, they can't hire the doctors at that time. They have to contract out, which then costs them more money.

So I think, all in all, advance appropriations will solve a lot of problems.

Mr. ROBERTSON. And ma'am, we are all held responsible. Our organizations, I can speak for the American Legion. I can't speak for my partners, but I have a true feeling that it is the same. If it was wrong, if it was doing—if advanced appropriations hurt the veterans community, we would be the first ones up here yelling and screaming, "Stop the wagon, stop the wagon." But right now, we feel that this is the best approach, short of mandatory funding, to be able to make sure that we are getting timely, sufficient and predictable revenue.

Mr. BLAKE. You know, Mrs. Halvorson, the irony of this is everyone, I think, deep down believes that there is a need for some kind of funding reform in the VA health care system. Mandatory funding was simply, it just didn't have the—there was no will to support it.

Mrs. HALVORSON. Right. Okay, I'll talk to you somewhere else.

Mr. BLAKE. Because of PAYGO considerations and other things, because it would become a mandatory program. And I'm not sure that we necessarily have had any time to really digest this. I think we believe that this is better because this proposal actually answers a number of the concerns raised by mandatory funding as it relates to Congress and its actions.

But I think that this will simply be, allow the VA to be more efficient. And if we can get to the bottom line so that the VA, it would provide better care in a timely manner, then so be it.

Mrs. HALVORSON. Well, and to me, that is better care, more efficiency, transparency, timely manner. To me, that is what it is all about. And I also want to congratulate Secretary Shinseki for sitting here through all the panels and for being on the third panel because I have been through a lot of Committee hearings where they sit through the first panel and leave.

You know, congratulations, Secretary, for wanting to hear what we on the Committee also are asking because this is so important to us.

And you know, we have created a lot of veterans and it is up to us to make sure we take care of them, and I haven't seen that happening. You know, this is very personal. You know, I have a father, a husband and a son all serving or who have served. And you

know, I congratulate all of you for wanting to come to us to make sure that this is a priority. So I yield back. Thank you.

The CHAIRMAN. Thank you, Mrs. Halvorson.

Mr. Buchanan.

Mr. BUCHANAN. I don't have anything.

The CHAIRMAN. Mr. Bilirakis?

Mr. BILIRAKIS. No questions.

The CHAIRMAN. Mr. Teague?

Mr. TEAGUE. Yes. I just want to say, you know, that definitely I am in support—well, first, thank you, Mr. Chairman and Ranking Member, I am sorry.

But I do want to say that I am in support of advance appropriations and that is why I wrote two letters of support. I think that the fact that we allow these gaps to happen in the coverage of our veterans is wrong because they never let the gaps occur in their protection of us. I think it is an embarrassment and I definitely want us to fix it. Thank you.

The CHAIRMAN. Thank you, Mr. Teague.

Mr. Buyer.

Mr. BUYER. What I am going to try to do here is, what I was doing is looking at the legislation and then listening to your testimony, is your testimony relying upon what is in H.R. 1016?

Mr. VIOLANTE. Yes.

Mr. BUYER. The advance appropriation relies upon the enrollee model. Do you have the confidence in its planning and predictability?

Mr. VIOLANTE. We believe the model is good, that there are, as we have seen from numerous reports, there are problems with some of the information that goes in, and it is our hope that with GAO looking at it, constant look back at this situation or looking at it beforehand, that we get this refined.

The model is good. It is what goes into it, that's the problem—or what happens with OMB when those numbers come out.

Mr. BLAKE. Mr. Buyer, I would like to make one comment along that line, too. I think the problem is, we don't know what the model in its first form puts out as a projected need. We don't believe, I think as a Partnership, that what ultimately gets submitted as the President's budget request on the first Monday in February, reflects what is the initial projection of the model. There are too many other political and policy considerations that get added in after that point that I think lead to what we see in February and begin the debating process.

So if we had the opportunity to at least see that first, we could make a better judgment and a better decision.

Mr. BUYER. I am going to embrace what my friend, Steve, just testified to Mr. Stearns, when reflecting upon the past years when we looked at the model and it was the inputs and now we have RAND's analysis of the enrollee model, and says it is a pretty good model with regard to the short term, but with regard to long-term predictability, it gets a little fuzzy. It is harder. It gets a little more difficult. Those are my words, but that is kind of what RAND is saying to us.

So with regard to our level of confidence in the predictability for longer term, I think we have to acknowledge that is where we have

to continue our oversight, if this is the pathway that we want to take.

Would you concur with that, Mr. Violante?

Mr. VIOLANTE. Again, it is not defined what short term and long terms is in that report, and I would say that 2 years out is not long term. But, yes, the further out you get, the more unreliable anything will be.

Mr. BUYER. All right. So then I will take it that you also concur with RAND's review and evaluation of the current model.

With regard to the accounts, if we are going to use the word "flexibility," and that's what's sort of being danced around here by the panel and by different questions, the flexibility isn't necessarily there in the legislation itself. I mean, I went and grabbed the legislation; I went and looked at it. And it applies to specific line-item appropriation accounts, and so excluding out of this would be your research——

Mr. ROBERTSON. Construction.

Mr. BUYER [continuing]. Your construction. And the one that was really bothersome that we better take a good look at is information technology (IT), because I don't know how the Secretary can really do his job with regard to the IT architecture when you have medical IT also. I mean, it is all synergistically intertwined and I think we are going to need to give the Secretary some of that "flexibility" we are talking about. We may need to make some amendments to this legislation to make sure the Secretary is able to move necessary dollars among accounts.

You know, we do that with regard to the Department of Defense. How challenging it would be for the Secretary to have been the Chief of Staff of the Army with the ability to move funds among accounts and work with the Appropriations Committee, but then not be able to do that in the VA.

So I think if truly our interests then are serving the veterans and making sure appropriate dollars are where they need to be, we should look at some discretionary authorities to the Secretary. Would you agree?

Mr. BLAKE. Mr. Buyer, I don't think we would have any argument with that. I mean, we are interested in ensuring that the legislation accomplishes the best possible outcome and ultimately meets our goals as the Partnership.

I wouldn't argue that necessarily all of the programs in the VA wouldn't benefit from advanced appropriations. However, there are no other programs in the VA that have something like the Enrollee Health Care Projection Model to rely upon in determining its resource needs and outcomes.

And as far as—and as far as the——

Mr. BUYER. Well, let us explore the IT issue because this would be very challenging for the Secretary for medical IT and equipment. Concur?

Mr. ROBERTSON. And I think the other thing that is important is, as Mr. Stearns pointed out, that it is such—by the time you get your comp and pen appropriations and the medical care appropriations, there is only a small portion left of the VA budget. Hopefully that would be an incentive to get the budget through by October 1st. That maybe the advanced appropriation would be the driving

stimulus to get the rest of the package done in a more timely manner.

What has happened in the past, we have had many bills that have been agreed to by the House and the Senate, have been agreed to by the President. It just never got out of Congress over to the White House because of the other appropriations that were attached to it. That is what we are trying to get away from. And if this helps us achieve that goal, even more the better.

The CHAIRMAN. Thank you, Mr. Buyer.

We thank you for being here.

Mr. Stearns, if I may, I think the issues you raise are a little bit of a "red herring" in that nothing changes from the way we do it now, except that it is a year further out. If the model is bad, it is a model that is bad for this year, next year and every year.

We are discussing the exact same issue, the exact same situation and we have a chance to change it just like we do now. I don't find any of your concerns really applicable because we are just discussing fiscal year 2011's budget right now instead of fiscal year 2010's budget. We are going through with the same oversight, the same flexibility, and the same process. If the model is wrong, it is going to be wrong even if we were doing it last year.

So I understand your concerns but I don't think it really would affect the working of this Congress.

Mr. STEARNS. Would the gentleman yield?

The CHAIRMAN. Yes.

Mr. STEARNS. Let's say that it passes and we are the next year out and we find there is a problem, how do we go about changing it?

The CHAIRMAN. The same way we would change it if it was this year's budget. A couple of years ago, the VA came back to us and said that we didn't calculate it right in the current year. We had to pass a supplemental. The same thing can happen at any point in our appropriations cycle now.

Mr. STEARNS. Now, let's take the opposite, that they have leftover funds. Can we get them back? How do we get them back?

The CHAIRMAN. There are provisions for both—the President, by the way, has enormous rescission authority which has been used. You said earlier that you don't know when it has been used. Presidents have used rescission authority numerous times.

Mr. STEARNS. So third year, then, he would use his rescission authority because of the second year to get that money back?

The CHAIRMAN. No, the rescission can happen in the existing situation. It doesn't take away any of the tools that we have now. Nothing has changed, except the fact that a medical director in Florida knows what is coming and can plan his or her activities.

Mr. STEARNS. I will just conclude and thank you for the time, Mr. Chairman. This is from the RAND study, "The longer the period of time between the baseline year and the budget planning year, the higher the risk that past budgets do not reflect the resources required by the VA to achieve its . . ."

The CHAIRMAN. No question. The model could be wrong for this year, but we are balancing two things—the fact that they cannot count on a budget now, and the uncertainty of a timely budget.

So which one is more important to look at now? I think the fact that any medical director in Florida or San Diego cannot hire, cannot plan, and cannot assure anything that is going on in their own hospital when the budget is 5 months late. Is that better or worse than that our estimates may be off because we did it at the current estimate? That is what we have to balance.

Mr. STEARNS. No, and I see your point there.

The CHAIRMAN. I apologize for downgrading your point.

Mr. STEARNS. No, no, no, I see your point. I just question, I think our big issue is the flexibility.

The CHAIRMAN. I think we have the same flexibility either way.

Mr. STEARNS. Anyway.

The CHAIRMAN. Thank you, Panel 1. We will start with Panel 2 where we have a Senior Economist for the RAND Corporation, the Congressional Research Service and a representative for the Agency for Health Care Research and Quality.

I'll just proceed in the order that I have, unless you have a different intention.

Katherine Harris is a Senior Economist for the RAND Corporation, so some of your concerns, Mr. Stearns and others, can be dealt with.

Ms. Harris.

STATEMENTS OF KATHERINE M. HARRIS, PH.D., STUDY DIRECTOR, REVIEW AND EVALUATION OF THE VA ENROLLEE PROJECTION MODEL, RAND CORPORATION; SIDATH VIRANGA PANANGALA, ANALYST IN VETERANS POLICY, CONGRESSIONAL RESEARCH SERVICE, LIBRARY OF CONGRESS; JESSICA BANTHIN, PH.D., DIRECTOR OF MODELING AND SIMULATION, CENTER FOR FINANCING, ACCESS, AND COST TRENDS, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ), U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS); RANDALL B. WILLIAMSON, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; ACCOMPANIED BY SUSAN J. IRVING, DIRECTOR, FEDERAL BUDGET ANALYSIS, STRATEGIC ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF KATHERINE M. HARRIS, PH.D.

Dr. HARRIS. Thank you, Chairman Filner and Ranking Member Buyer. Today I will discuss findings from RAND's recent evaluation of the VA's Enrollee Health Care Projection Model. First, I will summarize findings from our evaluation, discuss the model support for advanced appropriations and discuss our recommendations for improving the model.

To support budgeting and planning for its broad mission, the VA relies on a complex forecasting model to project demand for VA health care 20 years into the future. The VA uses the third-year estimates in formulating its annual budget request.

I refer you to my written testimony for a short overview of how the model works.

The VA asked RAND to work in conjunction with an independent actuary to review the validity and accuracy of the model. Our evaluation found that the model is useful for short-term budget plan-

ning. And compared to methodologies used in the past, the model offers the VA a high degree of flexibility and detail in planning its budget.

However, we also found that the model may yield misleading forecasts when used for longer-term strategic planning and analysis. This is because the model structure does not account for key drivers of the future demand for VA care and the costs of providing it. These longer term applications would require measures of costs, the costs of providing care that are independent of the current appropriation, information about VA's capability to expand its capacity to meet future demand and information about factors driving veterans' reliance on VA facilities.

In the absence of such information, model forecasts rely on a number of unrealistic and untested assumptions. For example, the model assumes that unit costs do not vary with changes in treatment capacity that are likely to occur over time. This is akin to assuming that the VA pays for care on a fee-for-service basis similar to Medicare.

Finally, we found that the model's complexity limits its transparency and tractability. This complexity stems from two sources. The first is a series of major adjustments to commercial utilization benchmarks that are undertaken in order to equate a commercially enrolled population with enrolled population and veterans. Second, the model calibrates these adjusted benchmarks back to actual VA workload data. These calibrations embed past VA appropriations and model forecasts. Past appropriations may or may not be an accurate reflection of enrollee demand for VA care.

Advanced appropriation would, in essence, link the time horizon over which the model forecast resource requirements from 3 years to 4 years. Under advanced appropriation, the fiscal year 2009 model baseline would inform the 2013 budget request.

The expanded time period between budget planning and the time the spending actually occurs makes it even more imperative that the VA have robust budget planning tools at its disposal.

Because past budgets are key drivers of the model short-term forecasts, the longer the period of time between the baseline year and the budget planning year, the higher the risk that past budgets do not reflect the resources required by the VA to achieve its mission.

We made recommendations for improvement in three areas. First, to provide more tractable and transparent support for short-term planning, the VA should consider simplifying the model to rely more exclusively on its own administrative workload data.

Second, to enhance the model's ability to inform long-range planning, the VA should consider modifying subcomponents to allow more robust forecasting of demand for and the cost of providing care for veterans in a changing policy environment.

Fortunately, the model is structured in such a way to allow modifications to support longer term planning and policy analysis, applications without disrupting its usefulness for short-term budget planning.

Finally, the VA should also consider other improvements, which include making the documentation more approachable and complete, the involvement of a wider range of expertise in developing

the model, and periodic review of the model by independent experts.

Thank you for your time and I am happy to answer any questions.

[The prepared statement of Dr. Harris appears on p. 53.]

The CHAIRMAN. Thank you, Ms. Harris.

Mr. Panangala is an Analyst in Veterans Policy for the Congressional Research Service. You have 5 minutes, sir.

STATEMENT OF SIDATH VIRANGA PANANGALA

Mr. PANANGALA. Chairman Filner, Ranking Member Buyer, and distinguished Members of the Committee. My name is Sidath Panangala from the Congressional Research Service.

I am honored to appear before the Committee today. As requested by the Committee, my testimony will highlight some of the issues that are discussed in our report entitled, "Advance Appropriations for Veterans' Health Care: Issues and Options for Congress." As a supplement to my testimony, I have included this report for the record. CRS takes no position on any of the legislative proposals to authorize advance appropriations that fund certain accounts of the Veterans Health Administration (VHA).

I will begin by briefly providing an overview of VHA's current budget formulation process and the current appropriations process for health care programs.

Historically, the major determinant of VHA's budget size and character were the number of staffed beds, which was generally controlled by Congress. The preliminary budget estimate, to a large extent, was based on funding and activity of previous years. VHA developed the system-wide workload estimates by type of care, using forecasts submitted by the field stations.

In 1996, Congress enacted the Department of Veterans Affairs and Housing and Urban Development Independent Agencies Act requiring VHA to develop a plan for allocation of health care resources to ensure that veterans eligible for medical care who have similar economic status and eligibility priority have similar access to such care, regardless of where they reside.

We also had the Health Care Eligibility Reform Act 1996, which established an enrollment system. As part of those requirements, VHA began to establish the Demand Model in 1998. The model has evolved over time and develops estimates of future veteran enrollment, enrollees' expected utilization of health care, and the costs associated with that utilization. A detailed description has been given in our report and in the RAND Corporation study as well.

VHA's budget request is formulated using this Enrollee Health Care Model to estimate the demand for medical services among veterans in future years. Each year, through the annual appropriations process, then Congress appropriates funds to these accounts that comprise medical services, medical support and compliance, medical facilities, and prosthetic research.

One proposal that has been discussed in the past few months is to provide more predictability in funding for the VHA in the future is the use of advanced appropriations for certain medical care accounts.

An advanced appropriation provides funding that is budget authority to an account one fiscal year or more ahead of schedule. So if in an annual appropriations act, let us say 2010, has authority to provide to an account in fiscal year 2011 or a later fiscal year, that would be considered an advanced appropriation.

Let me highlight two potential implementation issues that were discussed in our report. One concern that has already been discussed is the impact of funding based on this model. GAO, in a recent testimony, and I quote, "The formulation of VHA's budget is by its very nature challenging, and is based on assumptions and imperfect information on health services VHA expects to provide." End of quote.

The RAND Corporation also found that while the model projects reasonably for the future enrollment estimates in a stable environment, it has also found that we have no understanding of the future specificity of explicit scenarios regarding the relationship and the utilization in future years. Under such findings, it is reasonable to assume that future year budget projections could have variances that could create budget shortfalls if there are unanticipated shocks to the system.

Just to give an example of this is when you have, for example, there is a concern in Congress what happens if a lot of people start losing health care due to unemployment and loss of jobs, because of current economic conditions, would the VA be able to anticipate that burden coming into the VA.

Another issue that has already been raised is the IT issue. There are some options that Congress might want to decide on long-term financing of VA health care and one option might be the creation of an independent entity modeled on the lines of the Medicare Payment Advisory Commission (MedPAC).

Congress established MedPAC in 1997 to advise Congress on issues affecting the Medicare program. MedPAC is tasked to analyze access to care, quality of care, and other issues affecting Medicare. The Commission meets publicly, discusses Medicare issues and policy questions and then develops and approves its reports and recommendations to Congress. Such a program for VHA might independently analyze issues facing VHA and advise Congress on funding for both short and long-term issues affecting VA health care. It could bring transparency to the VHA's funding process and create credibility, particularly among key constituency groups. This could, in turn, provide an added layer of transparency and accountability to VHA's budget process.

This concludes my statement. I would be pleased to answer any questions the Committee may have. Thank you.

[The prepared statement of Mr. Panangala appears on p. 58.]

The CHAIRMAN. Thank you, sir.

Jessica Banthin is the Director of Modeling and Simulation for the Center of Financing, Access and Cost Trends with the Agency for Health care Research and Quality.

STATEMENT OF JESSICA BANTHIN, PH.D.

Dr. BANTHIN. Good morning, Mr. Chairman.

The CHAIRMAN. Please tell us what your agency does.

Dr. BANTHIN. I am the Director of the Division of Modeling and Simulation. I head a small group of economists that develops micro-simulation models related to health care.

Good morning, Mr. Chairman and Members of the Committee. Thank you for the opportunity to testify before the Committee on the issue of long term projection models. I would ask that my written testimony be made part of the official record.

The CHAIRMAN. That is ordered. Thank you.

Dr. BANTHIN. I want to mention that the Agency for Health care Research and Quality has benefited from extensive collaboration with the Department of Veterans Affairs in areas of health services research, patient safety, and quality of care. We consider the VA an important partner in improving health care.

At AHRQ we have extensive experience developing sophisticated health care models based on household survey data. For example, we have developed a simulation model that estimates the number of eligible uninsured children in the U.S. and can be used to project enrollment in Medicaid and the Children's Health Insurance Program. The model has also informed outreach efforts to increase enrollment of eligible children. Details about this model are included in my written testimony.

I have had the opportunity to review the RAND report on the VA Enrollee Health Care Projection Model. The VA Model includes three major components; an enrollment model, a utilization model, and a unit cost model.

The RAND report draws a distinction between actuarial models that are based on historical trends and economic models that incorporate behavioral parameters. There are caveats to all long-term projection models.

Mr. Chairman, the long-term projection of costs and utilization is very difficult because of the number of factors that affect use of health care services. Factors include unpredictable changes in both the demand for and the supply of various services.

For example, technological change can yield new treatments for medical conditions and improved diagnosis of ailments. Changes in the prevalence of disease can affect the demand for care.

When AHRQ publishes micro-level projected health care expenditure data, we refrain from applying complex models and behavioral assumptions. Instead, we rely on publicly available projections from census data regarding demographic changes, and from Centers for Medicare and Medicaid Services (CMS) regarding aggregate health expenditure growth. We project expenditures using this relatively conservative approach that is more aligned to actuarial methods.

AHRQ-projected expenditure data are publicly available, so that modelers can then use these data as a baseline from which to develop more complex economic simulation models that incorporation various behavioral parameters. These more complex models are critical for policy analysis, and this is one of the primary benefits of developing models with behavioral parameters, but their long-term accuracy in projecting expenditures is very hard to gauge.

Programs, such as the VA, face several challenges in projecting utilization and costs for its patient population when there is limited information on other non-program sources of care that patients may access. This issue is more pronounced for patients under age

65 without Medicare claims data to examine. To the extent that the VA patient population is unique and differs from the commercially insured population, such data limitations present additional challenges in projecting future utilization and costs.

In particular, it is important to account for illness severity or morbidity when projecting costs. Morbidity is a strong predictor of both enrollment and use of services. This can be measured with clinical measures but can also be accounted for with simpler survey-based measures of patient reported physical and mental health status, functional status, and work disability. These patient reported measures have strong predictive power in many economic models of demand for care.

In conclusion, I want to emphasize that there are caveats associated with all long-term projection models, whether they use actuarial or economic methods.

In addition, the accuracy of all projection models depends critically on available data. Without sufficient data there may be areas in the models that rely on best guesses rather than solid information.

As most modelers know, long-term projection models can constantly be improved and enhanced. This is usually an ongoing process. The VA Enrollee Health Care Projection Model is a very sophisticated model that benefits each year from better information on the current veteran population.

Mr. Chairman, this concludes my prepared testimony. Thank you, and I would be happy to answer any questions.

[The prepared statement of Dr. Banthin appears on p. 60.]

The CHAIRMAN. Thank you.

Mr. Williamson, Director of the Health Care Team for the VA–DoD Health Care Issues with GAO and he is accompanied by Susan Irving who is the Director of the Federal Budget Analysis and Strategic Issues.

STATEMENT OF RANDALL B. WILLIAMSON

Mr. WILLIAMSON. Thank you, Mr. Chairman. We are pleased to be here today as the Committee considers potential changes in how funds are appropriated for VA health care programs.

With me today is Susan Irving, Director of Federal Budget Analysis from our Strategic Issues Team. Together, we will address VA's budget challenges and offer views on advanced appropriations for VA.

By its very nature, VA's budget formulation is challenging since it is based on assumptions and imperfect information, which is further complicated in the changing environment VA faces in the differing veteran populations it serves.

In 2006 and 2009, we issued reports that examined some of the challenges VA faces in budget formulation, including obtaining sufficient data for useful budget projections, making accurate calculations, and making realistic assumptions. For example, our 2006 report on VA's overall health care budget found that VA underestimated the cost of serving veterans returning from military operations in Iraq and Afghanistan, in part because estimates for fiscal years 2005 were based on data that largely predated the Iraqi conflict.

Earlier this year we again reported on budget formulation issues for the long-term care portion of VA's budget which is formulated separately from VA's budget projection model.

Specifically, in its 2009 budget request VA may have made unrealistic assumptions about the cost of both its nursing home and non-institutional long-term care and workload projections for non-institutional care. To its credit, VA has implemented a number of recommendations to address past budget issues, but continued vigilance is necessary.

Turning now to the issue of advanced appropriations for VA. There are a number of important considerations in deciding on changes in the appropriations cycle. As a first step, it is critical to understand the true nature of the problems that exist in terms of how and to what degree circumstances surrounding the current budget approach have impacted VA's past ability to provide quality health care to veterans.

Also important is to consider the current flexibility that VA already has. For example, VA carries over as much as $600 million annually and has authority to move funds among its health care accounts, both of which can provide flexibility to respond to changing circumstances.

Any proposals to change the appropriation cycle should be considered in the context of the budget structure and the Congressional budget process, including budget controls, as well as the impact on Congressional flexibility and oversight.

One issue relates to the impact on Congress' ability to consider competing demands for Federal funds and the allocation of resources among other critical areas, such as national defense, homeland security, energy and natural resources, education and public health.

Currently, the Congress sets totals for its discretionary spending for 5 years to the Congressional Budget Resolution. A provision for advanced appropriations would pre-commit or use up some of next year's discretionary budget authority, thereby limiting flexibility to deal with changing priorities and reducing the amount available for other high priorities.

A related issue is a potential impact on Congressional oversight. Given the challenges VA faces in formulating its health care budget and the changing nature of health care, proposals to change that cycle deserve careful scrutiny. Providing advanced appropriations will not solve the problems we have previously reported regarding the data used or the calculations made during budget formulation. Continued Congressional oversight will be critical.

On another matter, H.R. 1016 would require GAO to conduct a study of the adequacy and accuracy of the budget projections made by VA's Enrollee Health Care Projection Model and report at the same time as our President's budget is submitted in 2011, 2012 and 2013, indicating whether the President's budget request for VA health care funding is consistent with estimating expenditures under the model.

We do not think it is feasible for GAO to conduct a study because of formidable challenges in obtaining, evaluating and reporting detailed information about the model and information concerning the

President's budget submissions for VA health funding as they are being developed as the bill suggests.

Instead, GAO would be pleased to work with Members of the Committee to develop a request for that work in a timely manner that would inform Congressional deliberations over VA's budget and address issues of particular relevance and interest to the Committee at that time.

Mr. Chairman, that concludes my remarks. We will be happy to answer any questions that you or other Members have.

[The prepared statement of Mr. Williamson and Ms. Irving appears on p. 62.]

The CHAIRMAN. We thank you so much. We are in the process of three votes. We will recess for 25 minutes and return as quickly as we can. Thank you.

[Recess.]

The CHAIRMAN. I apologize for the recess. Of course, we don't have control over when the votes are, and I thank you for your patience.

I would just like to make a few comments, and anybody can respond if they want.

Number one, it seems to me that to use the argument of a bad model against advance funding is not meaningful. If the formula is bad, it is a bad formula and you deal with it. If we defined the formula as being accurate for 2 years, then your formula is good. If the formula is bad and doesn't cover the first year, why is that any different than the second? It makes it that much less certain.

I don't believe that if we have a bad model, we've got to correct the model and not argue that against advanced funding.

Second, I am not sure where the line is in any of your testimonies between short term and long term. Why not appropriate a month in advance because we don't know 2 months out, or a day in an advance or an hour in advance? Why don't we have hourly funding because the model loses its certainty. Where in that spectrum does it become completely unhelpful?

Third, just as a policy issue, it seems to me that we have to balance against uncertainty in the funding in the current process. Uncertainty in the model can be corrected as we go along. Uncertainty in the process can't. If you are 6 months late, nothing can make up for that. So as a policy issue, I think we have to make those balances.

If anybody wants to comment on any of those points, I would be happy to hear from you.

Ms. HARRIS. Thank you. I would like to start by saying I think we all see—I speak for myself, but I think in general—there is a disconnect between the advanced appropriation issue and the delayed appropriation and the budgeting tools that the VA uses in formulating its budget.

But I think what is important is that good budgeting tools are important under any circumstance and incrementally more important the farther out the appropriation is.

I don't have a figure for you at what time the short run becomes the long run. If the model is used in a stable policy environment, that short run could last 3 to 5 years or even longer. If there is a dynamic unstable policy environment, the long run could be right

now, particularly if you think that the current VA budget isn't adequate to meet demand for care.

The CHAIRMAN. But they are separate issues. I mean——

Ms. HARRIS. I think under any circumstance you might want to improve the——

The CHAIRMAN. The model.

Ms. HARRIS [continuing]. Robustness of the model.

The CHAIRMAN. Any other comments on that?

Ms. IRVING. Mr. Chairman, I think I would say they are separable, but not unrelated issues, which I think was your point. I think some of the disconnect in the conversation is, in part, what is the presumption about the amount, about what advance funding represents. That is, some of the conversation seemed to imply that it was rather like going to biannual budgeting as the State of Maine does, in which you would, in effect, in the fiscal year 2010 process appropriate a full fiscal 2010 appropriation and then advance appropriate the full fiscal year 2011—a full year under the same structure that Congress provided.

In that case, I think the longer lead time between the preparation of the budget submitted and the effective date of that budget becomes a bigger issue.

On the other hand, the presumption could be that this is more like a downpayment; a CR is a downpayment. If it is sort of like we are going to advance appropriate some money "in case," you know, just to alleviate—concern since the agencies have not, in fact, had a funding gaps—then the issue of the uncertainly of the model may be much less important. It is still important in the way you described it in terms of for 1 year, but the lead time issue becomes different.

So I think the question of what is the plan and what is the intent about the share and the scope of the advance appropriation becomes very critical for the importance of the uncertainty of the model, for the flexibility in the budget debate for the next year, and for all of those kinds of issues. That is something that only Congress can decide.

The CHAIRMAN. Thank you.

Mr. Michaud, any questions?

Mr. MICHAUD. No questions.

The CHAIRMAN. Mr. Snyder?

Mr. SNYDER. To GAO, and this H.R. 1016, you made a comment in your written statement, I think, that you did not think you could comply with one of the requirements of the bill that GAO does a study on the ability of the accuracy of the budget projection. Would you comment on that, why you don't think that you all would not be able to comply with that?

Mr. WILLIAMSON. Yes. Two points to really consider there. One is that H.R. 1016 contemplates that information on VA's budget, health care budget, would be available to us at the time that budget's being developed. And typically OMB and the Executive Agencies have resisted giving us that kind of information, especially while the budget is undergoing development. So it would require extensive and lengthy negotiations with OMB and the Executive Agencies to get that. That is the first point.

The other point relates to the enormity of that study and what it would involve. As others of my colleagues have discussed, that is a very complex tool that has been developed and maintained by Milliman and Co., Incorporated. And it contains output from three separate submodels used as part of that. It contains, literally hundreds of data points, calculations, assumptions and to do that and deal with that would require very much considerable resources. So for those two reasons, we just don't think it is feasible.

I think, though, there are some acceptable alternatives. We have in the past looked at particular critical assumptions and cost drivers that go into the model and we can still do that.

We could also, and we have used this in the past simply, and it is more doable, we can look back at what happened versus what was enacted, and use, you know, the reasons, if there was any gaps that exist, whatever those reasons are, we can then apply to making improvements to either the model or the future budget process.

But that is much more feasible than the mandate currently states.

The CHAIRMAN. Thank you.

Mr. Buyer.

Mr. BUYER. I would like to thank CRS for your report, and I would also like for you to help clarify what I think are some use of clumsy language. The reason I choose the word "clumsy language," is that many terms are being used interchangeably among my comrades back in Indiana.

So if you could please help explain, I would like for the record, the difference between an advanced appropriation, forward funding and advanced funding. What are the true differences between them as a finance model?

Mr. PANANGALA. Thank you, Ranking Member Buyer, for that question. Let me just start out by saying I am not an expert in the budget process, but I will just reiterate some of the things that I have highlighted in the thing, and I guess others in the panel may want to jump in and provide some examples as well.

An advance appropriation is an appropriation of new budget authority. That is, authority provided by Federal law for outlays, for the agencies to enter into outlays, that becomes available 1 or more fiscal years beyond the fiscal year for which the Appropriation Act was passed.

So, for example, if you take the following language in an appropriations bill. For 2010, it would provide an advanced appropriation for fiscal 2011 for medical services, and let us assume $30.8 billion.

Mr. BUYER. I only have a limited amount of time.

Mr. PANANGALA. Right.

Mr. BUYER. Give me the definitions without the——

Mr. PANANGALA. An advanced funding is a budget authority that you provide in an appropriation act to obligate or to disburse funds from its succeeding years' appropriation.

And a forward funding is a budget authority that is made for obligation beginning in the last quarter of the fiscal year for financing ongoing activities, especially for grant programs and education. So that is sort of the general definition or differences between the three.

Mr. BUYER. All right. Thank you.

Ms. IRVING. Mr. Buyer——

Mr. BUYER. One of the questions I have is to the GAO. Is there a constitutional question if the President's prerogative is to propose and to execute and GAO then is an arm of the Congress, as proposed in this legislation, it is asking GAO to make a judgment. And you are an extensive arm of the Congress as laying responsibility right in your lap. Is there a constitutional question?

Ms. IRVING. Mr. Buyer, I think that I would probably wish I had Counsel with me. But, in general, we would assert that there are not limits to our ability to access that data. We often, through comity, reach agreements with the Executive Branch on behalf of the Congress of what makes sense for us to do and what not.

I also point out that one of the things, as my colleague mentioned about the mandate is that you lock into law the scope of the study. Whereas, suppose instead you wanted to focus on something in particular? That doesn't answer your particular question.

Mr. BUYER. You are auditors.

Ms. IRVING. Yes, sir.

Mr. BUYER. So as auditors you look backward, right?

Ms. IRVING. Well——

Mr. BUYER. And this is asking you to look forward. So do you have the expertise to be able to do what is asked in this bill?

Ms. IRVING. I will answer part of this question and then defer to Mr. Williamson, but we do a great deal forward-looking work. In fact, my area where we do the long-term budget simulations and work with our programmatic colleagues on what we think is likely, something is likely to do.

As to the programmatic expertise to do this particular kind of work, I——

Mr. WILLIAMSON. Well, typically we look backward and we also do real-time auditing where we are in there as things are happening. But again, when you have a very sensitive situation like we have here, where the budget is being developed at the same time that we would be in there, it is very unusual. Again, OMB and Executive Agencies resist that kind of thing, particularly as it is ongoing.

Mr. BUYER. That is why I asked is there a constitutional question here about your involvement in the Secretary and the President's business.

Ms. IRVING. One of the interesting things——

Mr. BUYER. Wait, hold on.

Ms. IRVING. Oh, I am sorry.

Mr. WILLIAMSON. I don't know if it is a constitutional question. It is a very practical question. We think—we believe we have access to that data, so in that regard it is probably not a constitutional question.

Mr. BUYER. Right.

Mr. WILLIAMSON. But I am not——

Mr. BUYER. Will you have your counsel provide input to us on separation of powers issue?

Mr. WILLIAMSON. Sure.

[The GAO subsequently provided the following information:]

Section 4 of H.R. 1016[1] requires GAO to conduct a study of the adequacy and accuracy of budget projections made by the Enrollee Health Care Projection Model and determine whether the President's requests for VA health care funding are consistent with expenditures estimated under the Model. Section 4 requires GAO to report to the Committees on Veterans' Affairs, Appropriations, and Budget of the House of Representatives and the Senate no later than the date on which the President's budget requests are submitted in 2011, 2012, and 2013. As discussed below, we do not believe that section 4 implicates the constitutional principle of separation of powers.

The Supreme Court's 1986 decision in *Bowsher v. Synar*[2] is particularly instructive with respect to the role of the Comptroller General and executive branch functions. In that case, the Court considered the Comptroller General's responsibilities under the Balanced Budget and Emergency Deficit Control Act 1995 (act).[3] The act required the Comptroller General to report to the President on deficit estimates and spending reductions in Federal programs designed to achieve target deficit levels, and further required the President to reduce spending in accordance with the Comptroller General's reports. The Court held that the provisions requiring the President to reduce spending consistent with the Comptroller General's reports violated the principle of separation of powers.[4] It explained that by placing responsibility for execution of the act in an officer subject to removal only by Congress, Congress had in effect retained control over the execution of the act and unconstitutionally intruded into the executive function.

Section 4 of H.R. 1016 does not provide GAO with authority or control over Executive Branch powers or functions. Notably, unlike the provisions at issue in *Bowsher v. Synar*, section 4 does not require the President or any other Member of the Executive Branch to act in accordance with GAO's report, such as by requiring the President to adjust his requests for funding based on GAO's findings about the relationship between the requests and the Enrollee Health Care Projection Model. To the contrary, section 4 merely directs GAO to study the President's requests for VA health care funding and report to identified Congressional Committees on its findings. GAO does not believe this provision implicates the principle of separation of powers.

Although we do not believe that section 4 of H.R. 1016 presents separation of powers issues, we do question whether GAO could conduct the required studies due at or before the date the President's budget request is submitted to Congress because of challenges in obtaining, evaluating, and reporting on the relevant budgetary and technical information. Section 4 contemplates that information regarding the President's requests for VA health care funding would be available to GAO as they are developed. While GAO has a broad statutory right of access to agency records under section 716(a) of title 31, United States Code, Executive Agencies have consistently resisted making detailed information about the development of the President's budget available to GAO.[5] In light of the extensive negotiations typically required to resolve requests for this type of information, as well as the need for timely information for Congressional deliberations on VA funding, GAO believes that a requirement like that contained in section 4 is inadvisable.

Mr. BUYER. Thank you. I yield back.

The CHAIRMAN. Thank you, Mr. Buyer.

---

[1] H.R. 1016 was introduced on February 12, 2009, and referred to the Committee on Veterans' Affairs.

[2] 478 U.S. 714 (1986).

[3] Pub. L. No. 99–177, §§ 251, 252, 99 Stat. 1038, 1063–1078.

[4] 478 U.S. at 732–34.

[5] Executive Agencies often assert that information related to the development of the President's budget is deliberative or "pre-decisional" in nature. While, under certain circumstances, the Comptroller General may be precluded under section 716 from pursuing a judicial remedy for an agency's failure to disclose records covered by the deliberative process privilege, the provision is not triggered by a mere assertion that records are "pre-decisional." Section 716 does not bar GAO from pursuing such information unless the President or the Director of the Office of Management and Budget first certifies that (1) the record could be withheld from disclosure under the Freedom of Information Act exemptions for records covered by the deliberative process privilege or compiled for law enforcement purposes and (2) that disclosure reasonably could be expected to impair substantially the operations of the Government.

We thank you for your expertise and your thoughtful testimony. We will excuse Panel 2 and call the Secretary of the VA up for the last panel.

Thank you. Mr. Secretary, you are accompanied by Patricia Vandenberg, the Assistant Deputy Under Secretary for Health for Policy and Planning with the VHA. We thank you for being here and for listening to the earlier testimony. I know you agree with me that that informs your ability to testify and makes this a more meaningful dialog. You are recognized, sir.

STATEMENT OF HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PATRICIA VANDENBERG, MHA, BSN, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND PLANNING, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Secretary SHINSEKI. Thank you, Mr. Chairman, Chairman Filner, Ranking Member Buyer, and distinguished Members of the Committee. I am please to be joined today, and the Chairman has already introduced her, but let me do that again.

Patricia Vandenberg is our Assistant Deputy Under Secretary for Health at our Veterans Health Administration.

What that really means is that she is the person I rely on to have oversight over this modeling process that we have been discussing this morning.

We thank you for this opportunity to discuss advance appropriations and the requirement to project VA future budgetary needs.

It has been a very busy 3 months at VA for this new Secretary, as we have begun laying the groundwork for fulfilling the President's charter to us of establishing a vision for transforming this VA into a 21st century organization.

Earlier this month, the President announced the joint VA–DoD initiative requiring both of us to work together to create a virtual lifetime electronic record for members of our armed forces, one that will stay with them throughout their service in uniform and to the date that the VA lays them to rest.

In making that announcement, the President repeated his concern that caring for veterans should never be hindered by budget delays. I share the President's concern as well as his support for advanced appropriations as a way to ensure uninterrupted care. In particular, we support the overall intent that is covered in H.R. 1016 and are committed to working with the Congress to provide veterans with care they expect and deserve.

Having lived with continuing resolutions in another life, I know how disruptive they can be, especially in the case of health care and other services and benefits provided to veterans. Implementing an advance appropriations mechanism is not without challenges. However, VA has had considerable success recently in predicting future needs using its Enrollee Health Care Projection Model, developed in 1998 with the help of Milliman, Incorporated, the largest health care actuarial practice in this country.

Over the last 11 years, VA and Milliman have continued to improve the model with periodic updates. We have developed a strong partnership that has resulted in a credible, in my opinion, credible

modeling tool. VA has guided the overall development of the Model and ensures that it meets the needs of its stakeholders. VA program staff provide expertise on the unique needs of veterans that resides within the VA, that knowledge, patterns of practice in the VA health-care system, and how the system is expected to evolve over the next 20 years. Milliman brings specialized actuarial expertise, access to extensive amounts of non-VA health-care data and excellent research to the overall modeling effort and we think that this marriage between both, our historical database and what they bring to the table, creates a very strong and robust model.

This partnership with Milliman has enabled VA to develop a robust model that produces thorough and accurate projections of demand for health services for enrolled veterans. In the last 5 fiscal years, the average variance between the model's projection of enrollees and the actual enrollee population was .54 percent under forecast. In other words, slightly more veterans, half of one percent, enrolled than were projected to do so.

For the same 5 years, the average variance between the VA model's projection of veteran patients and actual patients was 1.7 percent over forecast. In other words, slightly fewer patients were actually treated than were projected.

The VA model is used to develop most, but not all, of VA's health care budget, about 84 percent. Sixteen percent of our health care budget is developed through alternative models and estimations.

All such models and estimations are based on assumptions about the future. Any advanced appropriations mechanism should provide some flexibility for budgetary adjustments in a following year, a year two for example, in order to account for factors that could not have been foreseen by year one assumptions.

Finally, close consultation between the Administration, the Congress, the VSOs and other stakeholders, some who appeared on panels here this morning, is necessary to make advance appropriations work. I believe today's hearing recognizes that necessity.

I value the opinions of others who work with us in ensuring that our modeling process is first rate and I welcome the testimony of today's previous panels. I look forward to hearing the Committee's views on advanced appropriations and I am prepared to answer your questions.

Thank you, Mr. Chairman.

[The prepared statement of Secretary Shinseki appears on p. 68.]

The CHAIRMAN. Thank you, Mr. Secretary, and again we appreciate your first 100 days. I know you have been constrained in that only two of your appointees have been confirmed by the Senate.

Secretary SHINSEKI. They have.

The CHAIRMAN. There are another nine or ten to go? We look forward to you being fully staffed and taking full reins of the job. We appreciate what you have done so far.

Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman. I too want to thank you, Mr. Secretary, for all that you have done so far and all that you are planning on doing to make sure that our veterans receive adequate, timely health care and have access to that health care as well, especially in the rural areas.

I am also very appreciative of the fact that you and the Administration are looking forward to working with Congress for some type of advanced funding mechanism. H.R. 1016 might not be perfect, but I think it is a good basis for us to move forward. I think all too often people are skeptical of change and are unwilling to think outside the box and do things differently.

I am convinced, however, having talked to former VA officials that have to deal with budgets, budgets that have been delayed 2, 3, 4, 5, 6 months, that we can do things differently and we can improve on the process that is currently there.

And at the same time, with that improvement, I think we actually can save money. All too often if budgets are not approved come October 1st, it forces the VA—having talked to former VA officials—to make decisions that might not be cost effective decisions that they have to make just to live within the budget continuing resolution that is provided to them from Congress.

So I just want to let you know, Mr. Secretary, that I will work with you and the Administration to move forward and make changes within H.R. 1016 if changes have to be made, which I think they probably should. And I would just ask you, is there anything in particular, under H.R. 1016, that is causing you some problems or how might we be able to address it a little differently than what is currently presented in that piece of legislation?

Secretary SHINSEKI. Thank you for this opportunity.

However the final legislation is worded, I would hope that in a follow on year there is a mechanism of some kind that would allow us, all of us, to be able to adjust, for the unforeseen, which, you know, whether it is an outbreak of swine flu, as we are currently contending with, there will be the unexpected and the unknowns, and so flexibility to accommodate that, and even flexibility to accommodate misreads by us in how we put the assumptions in. We have gotten a lot better at that. We have very much narrowed those issues and, over time, improved performance.

I would say that that would be one interest. Another one would be to work closely with you all to ensure that when we talk about those three categories that would fall under advance appropriations—medical services, medical support and compliance, medical facilities, as was indicated earlier here in some discussion—that anymore IT is very much integrated into those activities and that we should be sure that that is also how we parse that to ensure that that is included so that our plans to provide services, health care services and community-based outpatient clinics (CBOCs) or open new CBOCs, are not hindered by an inability to have that kind of flexibility.

Mr. MICHAUD. Have you looked or have you talked to former VA employees or existing VA employees who have been there for a length of time as far as how much more cost effective this might be for advance funding? Have you had any discussions internally about that as of yet?

Secretary SHINSEKI. I am not aware that we have had those discussions, but to be sure, those discussions will take place. We are beginning now to look at our ability to look beyond the first year and see just how accurate our models are.

This model looks out 20 years. And all of us would say 20 years is probably not worth looking at. Year one has been the focus. We looked at year two and looked backward to compare how the year two projections compare with what would have been the model suggestion. The correlation is pretty close. So I defer again to RAND and GAO's stated comfort in the short term for the model's being useful.

Mr. MICHAUD. Once again, thank you very much, Mr. Secretary, and I also want to thank all the employees that work at VA. You do a phenomenal job with the resources that you are provided in taking care of our veterans. So thank you and your employees as well.

Secretary SHINSEKI. Thank you. Thank you very much.

Mr. MICHAUD. I yield back, Mr. Chairman.

The CHAIRMAN. Mr. Walz?

Mr. WALZ. Thank you, Mr. Chairman.

Mr. Secretary, again, thank you for being here and more importantly, thank you for all of your years of service. And I am always reminded, and folks have told me to tell you this when I see you, thank your wife for letting you come back again to do this, how important that is.

Ms. Vandenberg, thank you for choosing to serve our veterans. It is truly important.

A couple of things. First of all, the announcement on the 9th of April was incredibly heartening for many of us, especially that I think we are looking at the full spectrum of how to make the system more efficient, how to come together to get this right. The seamless transition and uniform enrollment is another big piece we will be working simultaneously on, but I really do get it and believe it is going to get us there.

I think it is important that we do remember here and we see some of the issues coming up and we hear support for this or we hear some of the legitimate concerns that we want to air. This is not a VA issue, a weakness there. It is not our veterans demanding something above and beyond. It is Congress' failure to get done by the 1st of October. That is where all of the problems start.

And I wish there were another mechanism. I have suggested that if our appropriations are not done by October 1, they start reducing pay daily and see how quickly things get done. It is the nature of a deliberative body to wait until the last minute, but that last minute does have huge repercussions.

So I wish there were a better way to be able to do this. I sure do not want to inhibit in any way your flexibility, Mr. Secretary, and your staff's flexibility. That is absolutely paramount. And one of the things you are most known for is your frankness and directness on this.

Are we missing anything here that is going to be a problem? I know the modeling issue got—and all we can count on is exactly what you said. It was a question I was going to ask where RAND says the model is somewhat uncertain. All models are to a certain degree.

Are we missing something here that could cause us problems on this from your perspective that you want us to really, really keep

in mind? I know it has kind of been asked before, but any frank assessment? Because our goal here is to make this work.

Secretary SHINSEKI. I would just remind that this model is intended to run based on assumptions that we input into it and run clean, and then it produces outcomes that we use to inform the budgeting process. So we are talking about a modeling process that is expected to inform the budgeting process. And my interest is keeping this process essentially designed to do what it is supposed to do. So that with that information, now we can decide how much risk we want to take in any given budget or sets of years of budgets.

If this process isn't allowed to do that, we will never know where risk resides in this. We will take at good faith that these are good numbers and we won't know until it is too late. So my hope is that in working with the Congress and working with the VSOs and other people who do modeling, is to have an open and transparent understanding of the process, but let the process run, and then we can decide to do what it is we need to do with the results.

And hopefully, it will inform a very good budgeting process where decisions can be made about how much risk to take. We don't want to take risk in the modeling process. That ought to be allowed to be a clean run.

If I have a concern, it is that we missed this opportunity to separate those two pieces here, and I would ask for just the opportunity to be able to express even stronger feelings about why that is important. And we in VA will commit to sharing as much visibility as we can of this process. All the people can develop the same trust and confidence in this model as we have and I have in the last 3 months in sitting with the experts who are taking me through it.

I think those would be the two issues I would offer. One is looking for help in ensuring that this process is allowed to run. We can discuss the assumptions and why they go in and talk about it, but once run, it can then be allowed to inform the budgeting process and then we will make as much transparency as we can.

A certain piece of this is proprietary to Milliman so, you know, they own it. But all the inputs and the outputs, we can look at very closely.

Mr. WALZ. Well, I truly appreciate it, and I guess our bottom line is, and it may be too early to tell, the intent of this is plain and simple, to give you another tool to provide quality care and hopefully in an efficient manner, and that anything in this process that is leading us away from that, well, we need to be aware of and switch directions, so I very much appreciate it. I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Walz.

I just want to remind everyone as we talk about modeling and all the expertise that several years ago we had a budget that did not assume a that war was going on. That says to me that if you don't have accurate data, it doesn't make any difference anyway.

Mr. Hall.

Mr. HALL. Thank you, Mr. Chairman.

Mr. Secretary, welcome back. It is good to see you. I bring you greetings from Sheriff Don Smith from Putnam County, New York,

and his wife who send their best. And thank you, again, for your service to our country.

Some of the VSOs we have heard from have worried that in the past, the VA has had a pattern of hoarding funds until the end of the fiscal year and then spending them needlessly or inefficiently because they know if they don't spend it, the money won't be available in the next budget year. That is something I saw when I served in local and county government that different agencies would do.

If we do advanced appropriations for VA, what can you do or what can we do to prevent that from happening?

Secretary SHINSEKI. Well, part of the process here, in response to Congressman's Walz's question, last question, what I am trying to assure or what I am trying to develop is confidence in the model. What I would also like to do is work with you to develop your confidence in me in making the right calls, and the example you cited would be something I would look at.

In the last 12 weeks we have canceled or deferred about $18 million worth of things we didn't have to do, and that is just business the way I am use to doing it and I will take on this issue that you have mentioned. I do not have particulars on it. I don't doubt that some of that goes on, but I will get to the bottom of it.

Mr. HALL. I am sure you will be watching it, sir. I also wanted to mention that we had a hearing in the Subcommittee on Disability Assistance on my bill, H.R. 952, the "COMBAT PTSD Act." In the course of that hearing, Director Mayes' remark that you or the President had asked, the Department to try to move in a regulatory fashion to provide some of the same goals, to achieve the same goals that this legislation would achieve, that being a presumed stressor for PTSD if a service man or woman comes back from Iraq or Afghanistan or whatever conflict and is diagnosed. They can't just say they have it, but they have to actually have the diagnosis of the symptoms that make up post-traumatic stress.

And in the course of that hearing, it was related by some VSO reps as well as VA witnesses that in the early 'eighties a similar decision was made regarding Agent Orange. That Vietnam era exposure to Agent Orange was initially dealt with on a one case at a time basis, trying to link the individual veteran to an exposure being sprayed in a field, or having a barrel break open in a truck that one was driving or something that you could draw a direct line to. And it turned out to be inefficient and cause more person hours to be expended, and at the same time delay the claim from being expedited.

So as a result, as you know, there has been a blanket presumption that if you served in Vietnam and you come down later with prostate disease or with diabetes, or certain diseases that are known to be caused by Agent Orange, that that automatically would be presumed to be caused by your service there.

There seems to be somewhat of a parallel between that and the current conflicts and PTSD and I was just curious, in terms of budgeting, whether you thought that there was something to that and whether you would look into it as regards to either a regulatory fix or the bill that I am talking about.

Secretary SHINSEKI. Mr. Hall, I am part of the Vietnam generation. I do know the history of Agent Orange, 40 years. I also know the history of Gulf War illness, 20 years. We are where we are and my interest for this current generation of young Americans is to understand whether we have to follow the same scientific method that we followed in both of these examples for the last several decades, which is collection of data, the writing of professional papers, sharing opinions, and at some point decisions get to be made about individual cases or individual disabilities.

The scientific process is important. It is a part and parcel of a lot of things we do, and there is great faith in its veracity. But I would say in my experience, that it does not favor the veteran because we come to those conclusions over time after we have arrived at convincing evidence that there is a connection. And I think, you know, part of my responsibility here is to look at whether there is another way of doing this.

The veterans, about 3 years, you know in a Vietnam, gathered around reunion tables as their units gathered, and they all compared notes and they could figure out something wasn't right. They came to those conclusions without that scientific collection, but they had the evidence that was important to them. That is, they didn't grow up in any place together, except they served in the same unit, in the same location and, you know, the conclusions were——

So I think, you know, we have a responsibility to look at the process that we have lived with and ask whether that is the right process. I have asked whether that is the right process, so that some future Secretary is not sitting here 20 or 40 years after Afghanistan and Iraq and wrestling the same issues the way I am wrestling today to decide whether Parkinson's is, you know, connected or isn't.

On behalf of the veteran, at least I am going to look and see whether there is a better process.

Mr. HALL. Thank you, Mr. Secretary. And your seriousness and intelligence that you bring to bear on this is certainly appreciated. And I have run out of time. I yield back. Thank you.

The CHAIRMAN. I too want to thank you for that heart-felt answer, Mr. Secretary.

Mr. Snyder.

Mr. SNYDER. Thank you, Mr. Secretary, for being here. I just make a comment. I appreciate your thoughtfulness in being here today. In your written statement, my only comment is that this whole issue is what I call the Moses gold tablets. Nobody put on gold tablets that tells us what is the right way to make these kinds of estimations.

These are human made formulas and estimates with all the frailties that we human beings have and I think that all of us need to enter into this with a certain amount of humility as, at the task of trying to estimate what is going to happen in years in the future as, you know, right now in the hallway we are just beginning a hearing for all the Members of the House on Swine Flu, with several of the Secretaries there, and you know, okay, what does that potentially do to health care estimates? Well, you can't predict

those kinds of things, but I appreciate your attending this as an issue, and appreciate your being here today. Thank you.

The CHAIRMAN. Thank you, Mr. Snyder.

Mr. Buyer.

Mr. BUYER. I think that the Secretary, the sincerity of the statement of Dr. Snyder relies upon his experience that he has done dealing with the military health delivery system, your experience as a Commander and Chief of Staff of the Army, as you work with the Secretary of the Army. Every time we do a supplemental, health care is in that supplemental, and it is where I learned about the modeling and tried doing the predictability and all the inputs.

So even if we do, let us take ourselves forward, even if we would do this advanced appropriation, as I listened to the testimony from the second panel, the testimony, the lady said the 2009 baseline would form the 2013 budget process. So, before we go and mock the 2005 budget that was passed by Congress in 2004, that utilized inputs out of 2001 and saying, oh my gosh, you used inputs that didn't include the war, that in fact was true. But no differently than if we were to do an advanced appropriation, we would go into that process, the inputs are not changing.

So what I embrace most is Dr. Snyder's comment here of, you know, we are all human, we make the errors and yet there has to be some latitude here with the Secretary in the judgments and our monies that they lay down.

Now, over the years what I have really paid attention to is the money, the bridge money that goes from 1 year to the next, how much monies have been carried over. And it is what the departments sort of prepare themselves for.

So if we are going to think outside the box, I look at this and say, if we are worried about the inputs and, in fact, we are going to use a model that provides excellent predictability for the short term, but if we are asking to go 4 years out that we are stressing the model, then perhaps let us not lock ourselves in. Perhaps maybe what we should be doing here is creating some type of a bridge fund or reserve fund and fund it with $10 billion, or pick a number and we give the discretion to the Secretary that he can move it among accounts, rather than locking us in to specific appropriation accounts whereby he then cannot have flexibility.

Take a Katrina that wipes out, you know, a medical facility, or some tornado that wipes out facilities or numbers of facilities, and yet he doesn't have the flexibility to go get extra monies.

You know, Mr. Michaud, I respect you a lot and so you have used this to your budgeting process. I am just—let me throw that out to you, Mr. Secretary. If we were to define an advanced appropriation by really giving you an X-dollar amount, say a $10 billion or a $15 billion as a bridge amount that is carried from every year so that we address the concerns that the VSOs have always brought to us, that the Veterans Integrated Services Networks (VISNs) out there, as they put those dollars out to the medical centers, it is okay to do the hires, it is okay to function.

Let me throw that out as an idea to you.

Secretary SHINSEKI. I wouldn't have any idea what a good number would be, but if that were not the issue of the discussion, I

think, you know, that would be an option that would be worth part of this deliberation.

I mean, I am not sure exactly—I think, Mr. Buyer, you know, the appropriations we get don't come to the Secretary directly. They are into three Administrations. And so, inherently there is already some constraint, and I would have to think about how this bridging mechanism might work.

Mr. BUYER. As you consider that, because I would send the bridge fund to you as discretionary authority over the three Administrations.

And if we are going to talk about the reorganizations, you know I have been asking and working with Mr. Michaud and Dr. Boozman about creating a fourth Administration, and I know you have some ideas on reorganizing. I have advocated over the years that a Secretary should have increased political appointments. And in that discussion, if you believe that we should have some increased political appointments, please let us know and I will be as helpful as I can to make sure that you have the ability to implement, and I think that is what you should need.

Especially also with regard to procurement, and I am quite certain you have some ideas and thoughts on that. With regard to advanced appropriation, are we going to see any legislative proposal now that the President has said he supports it in your 2010 budget that you are sending to us, and then comment on reorganization?

Secretary SHINSEKI. This is the piece that I would like to come and work with this Committee and the Congress and then show that implementation makes sense, that we get it right and that the veterans are well served. And so however this is done, I would like to work that with Members of this Committee.

Mr. BUYER. Can you comment on proposed reorganization, please?

Secretary SHINSEKI. One of the issues I have right now is, we do contracting in multiple locations. I don't have an acquisition oversight. An Assistant Secretary should do that exclusively and that is something I would like to have an opportunity to discuss with the Congress and whether or not that is possible and how that would be structured and what authorities that individual would have in concert with any other proposals for reorganizations.

Mr. BUYER. Very good. Thank you, Mr. Chairman.

The CHAIRMAN. Again. Thank you, Mr. Secretary. We appreciate you being here with us today. I don't know if you have a copy of the statement that was entered into the record by the VSOs by the former VA officials who have endorsed advanced funding. Do you have that document?

Secretary SHINSEKI. I don't have it here.

The CHAIRMAN. Make sure——

Secretary SHINSEKI. I have seen it. I just read it.

The CHAIRMAN. I just think it is pretty impressive when I look at former Secretaries, one in the Clinton Administration and one in the Bush Administration, the Deputy Secretaries under both, and every Under Secretary for Health since Clinton and into the Bush Administration, including many VISN directors and hospital directors. I think that is a pretty powerful endorsement that if

some of those really high officials have dealt with this year after year and they see it as a worthwhile model.

I listened to the discussion today. It comes down to a policy decision of do you go with some of the uncertainty of the model, which as you have pointed out is very high, or with the uncertainty of the delay to the whole system.

The first one is correctable, so I would live with that as opposed to living with a 4 or 5 or 6 month delay. I know both you and the President are hopeful that all of the budgets are passed on time, especially the veterans' budget, but the system does not always work the way we all want it to work. As someone pointed out today, the House can pass a bill, the Senate can pass a bill and we can all agree on it. The President can agree on it, and yet it doesn't come out of the Congress for other reasons that have nothing to do with veterans or with the budget of your Department.

Factors outside of our control affect that and lead to the uncertainty that we have heard described today. I am convinced that whatever uncertainty there is in the model, that uncertainty is present in this year's budget. The Swine Flu is not because we have an advance appropriation to the Swine Flu because we didn't know it was coming. For example, if tens of thousands of veterans end up in the hospital because of "Swine Flu" we are going to have to address it with more funding—whether this was an advanced appropriation or this year's appropriation. I think we can live with those uncertainties.

Mr. Secretary, you have been with us all day today and I appreciate it. I appreciate your listening to the other panelists and I will give you the last word for anything you would like to comment on.

Secretary SHINSEKI. Thank you, Mr. Chairman. Just to reiterate that I am here to make very clear that the President and I support the requirement for advanced appropriations and that I look forward to working with the Congress in ensuring that we implement this in a way that veterans begin to benefit from this in the short term. Thank you, Mr. Chairman.

The CHAIRMAN. Again, thank you, Mr. Secretary and we look forward to working with you on that.

This hearing is adjourned.

[Whereupon, at 12:55 p.m. the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Bob Filner, Chairman, Full Committee on Veterans' Affairs

Good morning. I would like to thank the Members of the Committee, our witnesses, and all those in the audience for being here today.

Congress' power to set the spending and taxing policies of the nation, the "power of the purse," is the most important power that Congress possesses. The budgets we pass reflect our National goals and fulfill our constitutional responsibilities.

Veterans are one of our top national priorities, as evidenced by the appropriations measures adopted last Congress and the Administration's proposed VA budget for FY 2010. These record funding increases followed on the heels of inadequate health care budgets and budget shortfalls, such as the one faced by VA in 2005.

Veterans' groups argue that even if the VA health care budget is sufficient to meet the needs of veterans, if it is not passed in a timely fashion then health care services to veterans will be jeopardized. The VA budget has been enacted before the start of the fiscal year four times over the last 20 years; 1989, 1995, 1997, and 2009.

Advanced funding is supported by President Obama, many here in Congress, and many veteran service organizations. In February, Senator Akaka, Chairman of the Senate Committee on Veterans' Affairs and I introduced the Veterans Health Care Budget Reform and Transparency Act of 2009; the House version of this bill, H.R. 1016, is supported by many on this Committee.

The law of unintended consequences reminds us to proceed with wholesale change in a systematic manner. I am reminded of a favorite saying of Augustus—"make haste slowly." I believe that it is essential that the issue of advanced funding be thoroughly discussed so that Members, veterans, and our fellow citizens understand the benefits, as well as any disadvantages, that might arise from the decision to provide VA health care funding a year removed from the annual budget debate.

Today, we will begin the discussion as to how best to fund the VA of the future and how we can meet the needs of our returning servicemembers, as well as our veterans from previous conflicts. Our goal is to make sure that the VA has sufficient budgets to meet the needs of veterans and that these budgets are provided in a timely fashion in order for the VA to make the most out of these dollars.

To this end, we will explore advance appropriations as a budgeting mechanism for the Department of Veterans Affairs. We will also examine the efficacy of the VA's budget forecasting model in making sound out-year budget projections. Finally, we will look to the VA and veterans' groups to provide recommended funding levels to assist Congress' decision-making as we move forward.

Prepared Statement of Hon. Steve Buyer, Ranking Republican Member, Full Committee on Veterans' Affairs

Thank you Mr. Chairman,

Good morning. I'd like to join in welcoming everyone to this morning's hearing on funding the VA of the future. It is my pleasure to once again have Secretary Shinseki with us as well as our other witnesses, and I look forward to your testimony.

The appropriations process for VA has been a topic of discussion for several years now. Throughout most of this time, veterans' service organizations held the view that "guaranteed" or "mandatory" funding for VA health care was the key to addressing timeliness problems.

However, after hearings on this subject brought to light a number of reasons why a switch to a mandatory appropriation would be detrimental to VA, the idea was abandoned and replaced with the current proposal for advanced funding.

As I have stated previously, I have some deep concerns with what such an overhaul may hold. Primarily among them is the fact that budgets planned so far in advance would be based on stale data by the time of implementation.

Appropriations should be formulated using the most contemporary information possible, and I can envision a number scenarios in which the advanced funding model would prove dysfunctional. I understand that problems have occurred using the current appropriations model, but I believe the answer to such problems lies largely with Congress doing its job in a proper and timely manner. This especially means that funding for our Nation's veterans should not be deliberately stalled for political reasons, as it was in 2007.

For those of you who may not recall, that year the House had passed a bipartisan appropriations bill prior to the 4th of July recess. A few weeks later, the Senate passed its version and immediately appointed conferees to negotiate differences with the House. At the same time, President Bush indicated he would sign the bill, so it seemed as if funding for troops and veterans was assured.

However, instead of appointing conferees, House Democrat leaders decided to exploit the bill's favorable standing and use it as a vehicle to move a pork-laden Labor, HHS, and Education Appropriations Conference Report. But aside from the unacceptable political maneuvering that took place, Congress clearly illustrated that it can complete appropriations work in a timely manner.

It proved so again last year, when Congress did pass a timely appropriations bill. If that were to happen every year from now on, there would be no need for advance appropriations.

Congress has also illustrated the ability to make rapid adjustments when necessary, as we did in 2005 when the funding shortfall occurred. I continue to be open to exploring proposals to improve the budget process used by VA.

Our oversight of the issues that led to the 2005 shortfall resulted in significant improvements to the process. But very little objective analysis has taken place on the advanced funding model other than the CRS report I requested. I'll have questions for the panels based on that report, and I look forward to your testimony.

Thank you Mr. Chairman, I yield back.

Prepared Statement of Hon. Harry E. Mitchell

Chairman Filner, thank you for calling this hearing to examine a proposal that is, for many VSOs, the very top priority for the 111th Congress. Thank you also to our witnesses for appearing today.

Secretary Shinseki, this third appearance before our Committee in as many months is a testament to your hard work and willingness to cooperate on the work of caring for veterans and their families. Thank you for appearing again today.

Today's question seems simple—should we budget a year ahead for veterans' health care and insulate it from the disruptions of continuing resolutions? The Chairman of this Committee has said yes. I have said yes, and at least 96 other Democrats and Republicans in the House agree.

Some things are too important for us to let them fall victim to the partisan appropriations process. Veterans' health care is a life and death issue. It is too important.

However, appropriating funds a year in advance poses real challenges that we must address. I am concerned that the VA's current actuarial model does not have the capacity to reliably forecast costs a year beyond the typical 18-month period of appropriations planning.

I look forward to hearing the challenges of health care budget forecasting from Panel 2. I am also eager to hear the VA's proposals to overcome those challenges and facilitate advance budgeting.

The veteran community has made it clear that this issue must be addressed. Scores of Members have registered their agreement. I look forward to hearing input today and working with all sides to ensure that veterans receive the health care they need and deserve.

Thank you again, Chairman Filner. I yield back.

Prepared Statement of Joseph A. Violante, National Legislative Director, Disabled American Veterans, on Behalf of the Partnership for Veterans Health Care Budget Reform

Mr. Chairman and Members of the Committee:

Thank you very much for holding today's hearing and for inviting representatives from the Partnership for Veterans Health Care Budget Reform to testify. The Partnership, which includes The American Legion, AMVETS, Blinded Veterans Association, Disabled American Veterans, Jewish War Veterans, Military Order of the Pur-

ple Heart, Paralyzed Veterans of America, Veterans of Foreign Wars and Vietnam Veterans of America, was created more than a decade ago to reform the budget and appropriations process for veterans health care, the subject of today's hearing.

Mr. Chairman, it has been over 18 months since I sat in this same chair testifying before this same Committee at a hearing on this same subject: how to provide sufficient, timely and predictable funding for veterans health care programs. Then, as had been our position for the many prior years, the Partnership's focus was on mandatory funding. However, at that hearing I told this Committee that:

> If the Committee chooses a different method for effecting this change . . ., we will examine that proposal to determine whether it meets our three essential standards for reform: *sufficiency, predictability and timelines* of funding for VA health care. If that alternative fully meets those standards, our organizations will enthusiastically support it.

Well, you did, we have, it does, and we do. That is, you did introduce new legislation, H.R. 1016, the Veterans Health Care Budget Reform and Transparency Act, that proposes advance appropriations rather than mandatory funding; the Partnership was honored to work with you and Senator Akaka in developing and examining that proposal; the new legislation does meet our goals of sufficiency, timeliness, and predictability; and the Partnership does enthusiastically support this legislation.

Briefly, H.R. 1016 would change VA's medical care appropriation to an advance appropriation, approving funding for the health care system 1 year in advance of the actual fiscal year (FY) involved. Had this proposal previously been in effect, there would be an existing FY 2010 budget in place for VA, and Congress could now be working on the FY 2011 appropriations bill for VA health care. Advance appropriations are done for a number of other Federal programs, including housing and education programs, such as Section 8 housing vouchers and Head Start, as well as for the Corporation for Public Broadcasting. We believe that veteran's health care should certainly have the same status as PBS.

Moreover, to help ensure that we have sufficient funding, H.R. 1016 adds transparency to the budget process. The bill would require the Government Accountability Office (GAO) to audit VA's internal budget model and publicly report to Congress whether the VA budget request accurately reflects the projected needs of veterans as measured by VA's model. Having GAO independently review the assumptions and data used in preparing the budget will add further integrity and accuracy to the process.

Mr. Chairman, since I testified at the hearing in October 2007, we have significantly altered our legislative focus and strategy for reforming the VA budget and appropriations process; however, one thing that has not changed is the documented need for reform. While VA health care has expanded and its quality increased, late and inadequate funding continues to threaten the long term quality of care provided to veterans.

With over 200,000 employees, a budget approaching $50 billion, more than 1,000 health care access points, including hospitals, medical centers, outpatient clinics, and other sites, the Veterans Health Administration (VHA) operates the largest integrated health system in the country, providing care to almost 6 million enrolled veterans. Thanks to visionary reforms begun over a decade ago, the quality and safety of veterans health care has improved dramatically. In fact, numerous independent health care analysts and leading journalists who have studied the VA health care system have concluded time and again that VA health care is as good, if not better, than any other public or private health care system in the U.S. VA's shift from an inpatient hospital model to an outpatient clinic model brought VA closer to where veterans live, and in the past decade there has been a tremendous influx of veterans into VA health care.

From 1998 to 2003, the number of enrolled veterans rose by more than 70 percent—from under 4 million to over 7 million enrolled veterans. However, the level of appropriations for VA health care has risen less than 50 percent, placing a tremendous strain on VA's ability to treat so many new veterans. As veterans increasingly sought out VA health care, the pressures on the system began to boil over. In 2001, VA reported that more than 250,000 veterans were waiting 6 months or longer for their first appointments with a doctor or for a follow-up visit with a specialist. As waiting lists grew, in 2002, VA placed a moratorium on marketing and outreach activities to slow down the number of new veterans coming into the system. In 2003, then-Secretary Anthony Principi announced that VA would invoke its regulatory authority to cut off enrollment of new Priority 8 veterans, those veterans without service-connected disabilities or lower incomes, effectively closing VA health care to 16 million veterans. Also in 2003, a Presidential Task Force appointed by President Bush concluded that there was a "mismatch" between demands for serv-

ices and available resources, recommending that the VA budget and appropriations process be modified to provide full funding, either through mandatory funding or another mechanism to better align demand and resources.

Although there were significant funding increases during each of these years, VA continued to fall farther and farther behind. In 2004, Secretary Principi told this Committee that VA's FY 2005 budget request was cut $1.2 billion by the Office of Management and Budget (OMB). A year later, Principi's successor, Jim Nicholson, who had just been sworn in as Secretary, testified before this Committee that the Administration's FY 2006 budget request for VA was adequate. However, within months, Secretary Nicholson reversed that testimony, admitting that VA's budget requests for both FY 2005 and FY 2006 were insufficient by $975 million and $2 billion, respectively.

A GAO review of the 2005 and 2006 VA budget turmoil found that VA had relied upon cost-saving policy proposals, such as new user fees, as well as so-called "management efficiencies," to make up differences between funding needs identified by its internal budget model and the amount of appropriations requested in the budget. When policy proposals failed to be enacted by Congress, and "management efficiencies" were not realized, VA repeatedly found itself with insufficient resources, eventually forcing them to issue a mea culpa. A lack of transparency in the budget process had left Congress without the information necessary to address these problems until it was too late. H.R. 1016 would increase transparency to help prevent such an occurrence in the future.

Mr. Chairman, we fully appreciate and applaud Congress for the significant funding increases that have occurred in recent years, and we strongly support the President's 2010 budget request and the funding levels recommended by this Committee for VA health care next year. However, for too long the VA health care system has had to struggle with budgets that were too little and too late. Insufficient funding for veterans health care leads to rationed care, waiting lists and veterans being turned away from VA hospitals and clinics. Long term underfunding can also threaten the quality of care, something that VA has worked so hard to achieve.

And just as important as how much funding VA receives is when VA receives that funding. Although we do appreciate Congress completing the VA appropriation on time last year, albeit just 1 day prior to the start of the new fiscal year, that is the exception that proves the rule. Notwithstanding the fine work done last year, the budget has been late for 19 of the last 22 years, averaging 3 months late over the past 7 years. In fact, last year's budget was the first one completed on time since September 11, 2001. This is not a problem of one party or one side of Capitol Hill; it is a systemic problem that cries out for systemic reform.

As a result of this history, VA officials have become accustomed to continuing resolutions at the beginning of fiscal years, and emergency supplemental appropriations at the end of fiscal years. This has created a constant "feast or famine" mentality, wherein VA administrators and managers will hoard money in the beginning of the year, and later spend money unnecessarily at the end of the year. When VA is forced to operate month-by-month under a continuing resolution, hospital and clinic administrators are often forced to delay hiring new doctors and nurses, purchasing new equipment, or leasing new space clinical space. The inability to properly plan leads to inefficiencies and waste. Short term management fixes become long term problems, further straining the system. No private sector business or organization, especially a health care system, could operate effectively without knowing what their budget will be until months AFTER the start of the fiscal year; and neither can VA.

For these and many other reasons, The Partnership for Veterans Health Care Budget Reform continues to call for reform of the budget and appropriations process. We believe it is time to take the politics out of VA health care and reform the system to assure sufficient, timely and predictable funding. While we have long advocated mandatory funding as one option to achieve our goal, that goal is quality health care for veterans when they need it, where they need it. Mandatory funding was a mechanism to achieve a goal, sufficient, timely and predictable funding, not the goal itself.

The Partnership today believes that the proposal most likely to achieve success is H.R. 1016, the Veterans Health Care Budget Reform and Transparency Act, which you introduced in the House and which Chairman Akaka introduced in the Senate as S. 423. We thank you, Mr. Chairman, for working with the Partnership and the Senate in developing and drafting this legislation, and we are pleased that these bills have already garnered significant bipartisan support in Congress. As of April 24th, there were 89 cosponsors in the House and 38 in the Senate, with more being added every day.

The coalition of supporters outside Congress has also grown considerably. In addition to the Partnership, this legislation is endorsed by The Independent Budget, The Military Coalition, which includes 35 veterans and military service organizations, and the American Federation for Government Employees (AFGE), which represents 600,000 government employees, many of whom work at VA.

Advance appropriations have also been fully endorsed by a coalition of former VA senior officials, including former VA Secretary Anthony Principi, two former Deputy Secretaries, four former Under Secretaries for Health, several Assistant Secretaries, and over a dozen hospital or regional VISN directors who know the firsthand, the effects of late and unpredictable funding. An Advance appropriation for VA health care is also overwhelmingly supported by the American people. In a national survey conducted last August for DAV by Beldon, Russonello & Stewart, 83 percent of the public supported providing VA health care funding 1 year in advance. The survey also showed that the public considers health care for veterans as one of the highest priorities for Congress and the President.

Mr. Chairman, since the introduction of the Veterans Health Care Budget Reform and Transparency Act in February, there has been a number of very significant developments that bode well for the legislation's ultimate success. Earlier this month, the Senate approved an amendment to the budget resolution to allow advance appropriations for VA medical care. The bipartisan Inhofe-Akaka amendment allows VA's medical care programs to be funded through advance appropriations without being subject to a point of order. This important change to the budget resolution would clear the way for enacting advance appropriations this budget cycle. We certainly hope that the conference Committee will retain the Senate provision as well as include a similar House provision, and I want to thank Congressmen Harry Teague, Michael Michaud and Jerry Moran for organizing a bipartisan letter to conferees urging them to do just that.

I also had the honor, along with other VSO representatives, of meeting directly with President Obama on April 9th to discuss advance appropriations. Most of you are aware of his campaign pledge to request advance appropriations legislation in the FY 2010 budget. While we are still waiting for the Administration's final, comprehensive budget, President Obama assured us in our private meeting, and then reiterated at a subsequent public event, that he fully intended to keep his campaign promise. President Obama said the following:

> . . . the care that our veterans receive should never be hindered by budget delays. I've shared this concern with Secretary Shinseki and we have worked together to support Advance Funding for veterans medical care. What that means is a timely and predictable flow of funding from year to year, but more importantly that means better care for our veterans. And I was pleased to see that the budget resolution, passed by the Senate, supports this concept in a bipartisan manner."

Mr. Chairman, your legislation, H.R. 1016, is a commonsense solution to a long-standing problem, which has gained broad bipartisan support in the House and Senate, from the President, from dozens of former VA leaders, from the American public, and from virtually every major veteran's organization.

Unlike mandatory funding, advance appropriations are not subject to PAYGO rules. Advance appropriations do not in any way limit Congress' ability to perform oversight, hold VA accountable, or restrict or direct funding to meet changing demands of VA health care. Advance appropriations will not add one more dollar to the Federal deficit or national debt. With an advance appropriation, if VA's budget needs significantly change before the "advance" year, Congress still has that full year in advance to correct it through amendment or a supplemental process.

And while we do appreciate both the on-time budget last year, and desire and good faith promises to get it done on time in the future, neither the President, VA Secretary, Speaker nor Senate Leader can guarantee "timely" funding: it is the very nature of the legislative process and budget system that leads to breakdowns, and which advance appropriations can fix.

Mr. Chairman, we look forward to continuing to work with you and the other cosponsors of H.R. 1016 to help move this legislation through Congress and onto the President's desk so that we can finally guarantee that veterans health care funding will be sufficient, timely and predictable.

Mr. Chairman, my colleagues will now address the details of your legislation and we all look forward to answering any questions the Committee may have for us.

Prepared Statement of Steve Robertson, Director, National Legislative Commission, American Legion, on Behalf of the Partnership for Veterans Health Care Budget Reform

Chairman Filner, Ranking Member Buyer, and Members of the Committee on behalf of the Partnership for Veterans Health Care Budget Reform (Partnership), The American Legion would like to thank you for the opportunity to testify today. The Partnership is a coalition of nine veterans' service organizations—AMVETS, Blinded Veterans Association, Disabled American Veterans, Jewish War Veterans, Military Order of the Purple Heart, PVA, Veterans of Foreign Wars, Vietnam Veterans of America, and The American Legion. Our goal is funding reform for the Department of Veterans Affairs (VA) health care system that will ensure sufficient, timely, and predictable funding.

Chairman Filner, the Partnership fully supports the Veterans Health Care Budget Reform and Transparency Act, H.R. 1016, introduced by you and cosponsored by many of your colleagues. The Partnership believes, if enacted, this bill would significantly help reform the current VA budget process by providing advance appropriations for veterans' health care. For more than a decade, the Partnership has worked to achieve a sensible and lasting reform of the funding process for veterans' health care. While the Partnership has long advocated converting VA's medical care funding from discretionary to mandatory funding, there has been virtually no movement in Congress in this direction.

The Veterans Health Care Budget Reform and Transparency Act would ensure that the goals of the Partnership—sufficient, timely, and predictable funding—are met. Historically, advance appropriations have been used to make a program function more effectively, better align with funding cycles of program recipients, or provide insulation from annual partisan political maneuvering. By moving to advance appropriations, veterans' health care programs would accrue all three of these benefits.

The Partnership fully supports the mechanism in section 3 of H.R. 1016 that would fund the Department of Veterans Affairs (VA) medical care accounts 1 year ahead of the current fiscal year. This appropriations mechanism is known as *advance appropriations*. The goals of the Partnership are to make veterans' medical care funding sufficient, timely, and predictable. Advance appropriations will particularly help to ensure that funding is both timely and predictable.

The problem the Partnership is trying to cure is that annual discretionary appropriations are not always available to VA on October 1. This delay in the timely and predictable provision of medical care funds means the VA medical care system administrators are cautious in decisions to hire medical personnel; procure new medical equipment, supplies and services; and construct and maintain VA medical care facilities until those funds are appropriated.

This failure to provide funding clearly puts at risk the quality of life, if not life itself, of veterans enrolled in VA medical care. Congress, by not adequately addressing the medical care needs of some of the nation's most vulnerable citizens, the enrolled veterans who earned this benefit due to their selfless military service, is just as clearly not fulfilling President Lincoln's promise—"To care for him who shall have borne the battle, and for his widow, and his orphan."

While Congress has taken great strides to *increase* the level of funding during the past several years, there have still been significant delays in VA receiving this funding. VA has received its annual funding late in 19 of the last 22 years. Over the past 7 years, VA has received its final budget an average of 3 months after the start of the new fiscal year. The core problem in the timely funding of veterans' medical care is the inherently volatile nature of the annual appropriations process. Unlike Medicare or Medicaid, VA must rely upon Congress and the President to pass a new appropriations law each year that provides VA the funding it needs to treat enrolled veterans. Due in large part to the current medical care funding process used to approve annual discretionary appropriations being clearly flawed, the Partnership looked for a new way of funding VA medical care.

Initially, the Partnership wanted to end the annual political fight for VA discretionary appropriations by supporting mandatory funding. Mandatory funding for VA meant that veterans' medical care funding would be on par with Social Security, Medicare or Medicaid funding, which do not have to go through the same annual appropriations process because they are mandatory appropriations. This recommendation was met with great resistance by Congress.

Congress gave the Partnership two main reasons for maintaining the current flawed system. One, mandatory funding would interfere with Congress' own self-imposed budgetary rules (known as PAYGO), and two, Congress may lose oversight capability of the VA medical care system. Although the Partnership disagrees with both reasons and still believes that mandatory funding would improve VA's funding

problems, we decided to develop an alternative approach for providing VA medical care funding; one that meets the Partnership's goals of providing *sufficient, timely and, predictable*, funding for VA medical care, but also meets the concerns expressed by Congress.

The new approach is to provide advance appropriations for VA medical care accounts. Advance appropriations will stabilize VA medical care funding and provide those funds on a timely and predictable basis.

With advance appropriations, VA will know the specific amounts to be provided to its medical care accounts 1 year *ahead* of most other government programs. Congress still maintains its discretionary authority to approve and oversee the use of these funds. Because the medical care discretionary appropriations would be decided 1 year in advance, VA's medical programs could be more closely monitored to make sure the funding levels would be sufficient. More importantly, VA medical care funds will become available on October 1 of every new fiscal year

In addition, if advance appropriations for VA medical care are adopted by Congress, VA administrators will know 1 year in advance what their fiscal year appropriations will be and can thus plan accordingly for delivering quality medical care services to all enrolled veterans who need it. Most importantly, advance appropriations allow Congress to improve its oversight responsibilities over VA medical care because VA administrators can be held more accountable due to the fact they should be able to better plan for the use of these resources.

Advance appropriations is a technique used by Congress for many years to approve funding authority 1 year in advance for certain government programs, such as the Low Income Home Energy Assistance Program (LIHEAP) and Section 8 housing. Programs funded 1 year in advance in this year's budget resolution are the Employment and Training Administration; Office of Job Corps; Education for the Disadvantage; School Improvement Programs; Special Education; Career, Technical and Adult Education; payments to the Postal Service; Tenant-based Rental Assistance and Project-based Rental Assistance. In addition, the budget resolution includes appropriations for *2* years in advance for the Corporation for Public Broadcasting.

Although Congress has provided advance appropriations for those programs for a variety of public policy reasons, it does not provide advance appropriations for the timely and predictable provision of veterans' medical care. As a nation at war, and with the economic difficulties we face today, now is the time to enact this crucial legislation. In addition, given the more complex injuries suffered by today's wounded warriors of Operations Enduring Freedom and Iraqi Freedom and the aging veterans' population from prior wars now entering their retirement years; the problem of providing sufficient, timely, and predictable VA medical care funding becomes more politically acute as the demands on the VA health care system will increase for the foreseeable future.

The implementation of advance appropriations for VA medical care accounts is a straightforward process. First, to begin the new cycle, there is a one-time 2 year appropriations for the VA medical care accounts for Fiscal Years (FY) 2010 and 2011 in the FY 2010 appropriations act. Then, in the FY 2011 appropriations cycle, VA medical care accounts for FY 2012 will be provided in the FY 2011 appropriations act and the new cycle continues into the future.

Congress passes a 5-year budget resolution annually. It will have to ensure it appropriately incorporates this funding change into the 5-year budget resolution in the manner it already does with the other programs that are currently provided advance appropriations. Again, Congress will need to review this upcoming change to the annual concurrent resolution on the budget and will have to ensure that the budget resolution sets the appropriate VA budget policies and functional spending priorities for the upcoming five fiscal years. This will also mean the proper allocations are made to the Committee, both for this budget year and the five fiscal years period covered by the budget resolution.

Congress passes three main types of VA appropriations measures. *Regular appropriations acts* provide budget authority to VA for the next fiscal year. As previously stated, however, even though advance appropriations will provide timely and predictable funding to the VA medical accounts, contingencies may arise that will impact the *sufficiency* of these funds. Consequently, Congress has a 1 year period to review those medical care accounts and provide additional funds; or it can pass one or more *supplemental appropriations acts* that will provide the additional needed funds during the current fiscal year if the regular appropriations are insufficient or to finance activities not provided for in the regular appropriations. In the case of regular appropriations not being passed and Congress passes *continuing appropriations acts* that provide stop-gap (or full-year) funding for VA, then the medical care accounts will still be provided for at the level decided in the previous fiscal year appropriations act.

Advance appropriations will increase budget flexibility for Congress to provide sufficient funding if faced with unforeseen medical care circumstances that dictate changing funding amounts. Advance appropriations removes VA medical care funding from the current political wrangling that may deadlock the Federal budget process and will provide VA officials knowledge of their budget funding in advance for VA medical care facilities around the country in order that they can responsibly manage the VA medical care system. In summary, advance appropriations fully addresses two of the three prongs for sufficient, timely, and predictable VA medical care funding, while helping to create an environment that is more likely to produce sufficient funding. Section 4 of H.R. 1016, which adds greater transparency to VA's internal budget process will also ensure sufficient funding and provide Congress additional tools to conduct its oversight responsibilities for the provision of VA medical care.

Mr. Chairman, the Partnership welcomes the opportunity to continue working with you and your colleagues toward enactment of budgetary reform which will achieve sufficient, timely and predictable annual discretionary appropriations for veterans' medical care.

Prepared Statement of Carl Blake, National Legislative Director, Paralyzed Veterans of America, on Behalf of the Partnership for Veterans Health Care Budget Reform

Chairman Filner, Ranking Member Buyer, and Members of the Committee on behalf of the Partnership for Veterans Health Care Budget Reform (Partnership), Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to testify today. The Partnership is a coalition of nine veterans' service organizations—AMVETS, Blinded Veterans Association, Disabled American Veterans, Jewish War Veterans, Military Order of the Purple Heart, PVA, The American Legion, Veterans of Foreign Wars, and Vietnam Veterans of America. Our goal is funding reform for the Department of Veterans Affairs (VA) health care system that will ensure sufficient, timely, and predictable funding.

Chairman Filner, we were pleased that you, along with a number of your colleagues on this Committee, recently re-introduced the "Veterans Health Care Budget Reform and Transparency Act"—H.R. 1016—that would reform the VA budget process by providing advance appropriations for veterans' health care. The legislation was developed in consultation with the Partnership. For more than a decade, the Partnership has worked to achieve a sensible and lasting reform of the funding process for veterans' health care. While the Partnership has long advocated converting VA's medical care funding from discretionary to mandatory funding, there has been virtually no movement in Congress in this direction.

The Veterans Health Care Budget Reform and Transparency Act would ensure that the goals of the Partnership—sufficient, timely, and predictable funding—are met. Historically, advance appropriations have been used to make a program function more effectively, better align with funding cycles of program recipients, or provide insulation from annual partisan political maneuvering. By moving to advance appropriations, veterans' health care programs would accrue all three of these benefits.

While much of the attention during the debate of this legislation has been focused on the advance appropriations aspect, we believe that the second part of the proposal is equally important. To ensure sufficiency of the VA health care budget, section 4 of H.R. 1016 would require VA's internal budget model to be shared publicly with Congress to provide accurate estimates for VA health care funding, as determined by a Government Accountability Office (GAO) audit, before political considerations take over the process. This would add transparency and integrity to the VA health care budget process.

In recent years, VA developed a new methodology to estimate its resource needs for veterans' health care called the Enrollee Health Care Projection Model (Model). Developed in collaboration with a leading private sector actuarial firm (Millman, Inc.) over the last several years, the Model has substantially improved VA's ability to estimate its budgetary needs for future years. The Model has been thoroughly reviewed by the Office of Management and Budget (OMB) and approved for use in developing VA's budget.

The Model estimates VA health care resource needs by combining estimates of enrollment levels, utilization rates and unit costs for 58 medical services and over 40,000 separate enrollee groups, or "cells." Each of the 40,000 cells represents a combination of one geographic sector, age range and priority level. The Model incorporates additional usage trends, such as reliance and intensity of services. It also

separates out special populations, such as Operations Enduring Freedom and Iraqi Freedom veterans, and services, such as mental health care, for additional adjustments. While the Model relies heavily on Millman's proprietary Health Cost Guidelines, substantial adjustments are made to account for the unique characteristics of the veteran enrollee population and the VA health care system. The final results produced by the Model provide the most comprehensive, robust and accurate estimate of what it will cost VA in future years to provide current services authorized in law to the veterans expected to seek those services.

We recognize that the Model itself directly accounts for approximately 84 percent of the real costs to the VA to provide services in a given year. The remainder of the budget needed by the VA primarily goes to long-term care (both nursing home and non-institutional care), as well as some smaller programs. As the aspects of the Model are continuously refined, we believe that these services should be included.

In fact, we would prefer to see long-term care components added to the Model, as the VA's current methodology for determining resources for long-term care is clearly flawed as evidenced by the findings of the GAO report (GAO–09–145), *VA Health Care: Long-Term Care Strategic Planning and Budgeting Need Improvement*, released in January 2009. The GAO specifically recommended:

> To strengthen the credibility of the estimates of long-term care spending in VA's budgeting proposals and increase transparency for Congress and stakeholders, we recommend that VA, in future budget justifications, use cost assumptions for estimating both nursing home and non-institutional long-term care spending that are consistent with VA's recent experience or report the rationale for using cost assumptions that are not.

This recommendation was made as a result of GAO finding that VA cost assumptions were unrealistically low, when compared to economic forecasts of increases in health care costs. Moreover, GAO stated that VA officials informed them that they (VA) made these assumptions in order to be conservative in VA's fiscal year 2009 budget estimates.

This statement alone shows that budget forecasting is not immune to political considerations when developing estimates. It is also telling that the single biggest component of the VA budget not governed by the Enrollee Health Care Projection Model is the component that seems to be manipulated the most. We believe that the Model overcomes these problems.

The Partnership also recognizes that the biggest argument against relying on the Model for budget forecasting is the impact unforeseen events (i.e. exceedingly large numbers of new enrollments, catastrophic events) might have on a tight budget. For instance the report released on April 3, 2009, by the Congressional Research Service titled *Advance Appropriations for Veterans' Health Care: Issues and Options for Congress* addresses this concern directly. The report specifically states that "it is reasonable to assume that future year budget projections could have variances that could create budget shortfalls if there are unanticipated shocks to the model." This is simply a statement of the obvious since this point is true even under the current budget process.

The Partnership does not believe that the advance appropriations proposal somehow changes the actions that Congress would take under these circumstances. There seems to be an assumption that if our entire proposal were to be enacted, that Congress would no longer have or choose not to use its authority to provide emergency supplemental appropriations when warranted. The Partnership actually sees no reason why emergency supplemental appropriations should not be considered an additional tool as part of this process.

The Partnership would also like to point to the detailed analysis of the Enrollee Health Care Projection Model conducted by the RAND Corporation. The Veterans Health Administration's Office of the Assistant Secretary for Policy and Planning commissioned the study conducted jointly by RAND Health's Center for Military Health Policy Research and the Forces and Resources Policy Center of the National Defense Research Institute (NDRI). In November 2008, RAND released the report *Review and Evaluation of the VA Enrollee Health Care Projection Model*. This study assessed four issues with the Model—Validity, Accuracy, Tractability, and Transparency.

With regards to Validity, the RAND Corporation concluded that the "EHCPM [Model] is likely to be valid for short-term budget planning but may not be valid for longer range planning and policy analysis." This obviously begs the question of what constitutes short-term planning? The Partnership believes that the advance appropriations proposal does fall within a short-term budget planning spectrum. We also believe that the RAND study's conclusion is targeted more at its limitation in providing 5 and 10-year strategic planning projections.

To be fair, the RAND study does make the point that the Accuracy of the Model is difficult to assess and uncertain. However, the study emphasizes that the "most challenging barrier to accuracy stems from the lack of unit cost measures that are independent of the VA's budget allocation. This is because the discretionary nature of the VA's budget complicates the relationship between model projections and actual expenditures." In other words, the VA is constrained by the resources it is given through the discretionary budget process, not by the demand on the system.

More importantly, the RAND study also states that "the EHCPM represents a substantial improvement over the budgeting methodologies used by the VA in the past for two reasons: (1) The model builds total expenditures from detailed service categories and enrollee types, and (2) it disaggregates enrollment, utilization, and cost components."

Ultimately, we believe that the most important point of the RAND study is that "compared to traditional methods, the current specification offers the benefit of a substantially more flexible and detailed platform from which to plan the VA's appropriation request, monitor budget execution, and assess system performance." This statement goes directly to our emphasis on transparency and truth in budgeting. If the outcomes of the Model were shared publicly, Congress would have better information in order to develop its own appropriations plan for VA.

Making VA's data and budget estimates public should also lead to greater confidence in the VA funding process since it would be hard for Congress or a future Administration to cut VA's funding below the projected need since the VA's own data would be available to show what the funding needs really are. Furthermore, GAO would have responsibility for validating the budget projections of the Model each year. This additional oversight in the process will make less likely that the VA would underestimate (or even overestimate) its resource needs. This transparency to the budget process would also prevent any future Administration or Congress from making these kinds of cuts behind closed doors, as has too often been the case over the past two decades.

The Partnership simply believes that the outcomes of the Model better reflect the needs of the VA health care system than any other method currently used. While *The Independent Budget* has gained significance in recent years due to the budget recommendations put forth, the methodology is still much simpler than that which is provided by the Model. Of course, the outcome of the Model has to be shared prior to the manipulations that we all know occur once budget details are analyzed by the Office of Management and Budget (OMB). The success of *The Independent Budget* can at least partially be attributed to the fact that there are no external forces (i.e. OMB, politics, etc.) that can influence change. And yet, *The Independent Budget* endorses the concept of advance appropriations to produce a timely and predictable budget with transparency added to the VA's budget model to ensure sufficiency.

Mr. Chairman, we look forward to working with the Committee to ensure that your legislation, H.R. 1016, is advanced and ultimately enacted. We appreciate the opportunity to lay out our proposal in detail. We would be happy to take any questions that you might have.

Prepared Statement of Katherine M. Harris,* Ph.D., Study Director Review and Evaluation of the VA Enrollee Projection Model RAND Corporation

Gauging Future Demand for Veterans' Health Care— Does the VA Have the Forecasting Tools It Needs? [1]

Mr. Chairman and distinguished Members of the Committee, thank you for inviting me to testify today. It is an honor and pleasure to be here. I will discuss the

---

*The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of RAND or any of the sponsors of its research. This product is part of the RAND Corporation testimony series. RAND testimonies record testimony presented by RAND associates to Federal, state, or local legislative Committees; government-appointed commissions and panels; and private review and oversight bodies. The RAND Corporation is a nonprofit research organization providing objective analysis and effective solutions that address the challenges facing the public and private sectors around the world. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.

[1] This testimony is available for free download at http://www.rand.org/pubs/testimonies/CT327/. This product is part of the RAND Corporation testimony series. RAND testimonies record testimony presented by RAND associates to Federal, state, or local legislative committees; government-appointed commissions and panels; and private review and oversight bodies. The RAND

Continued

findings from RAND's recent evaluation of the VA's Enrollee Health care Project Model as it relates to the topic of your hearing today. More specifically, my testimony will briefly review the findings from our evaluation, discuss the model's utility to support the proposed advance appropriation of the VA budget, and discuss recommendations for improving the model.

Background

In 1996, the mission of the Veterans Administration (VA) broadened dramatically. The Veterans' Health Care Eligibility Reform Act 1996 transformed the VA from an episodic provider of inpatient care for veterans to a comprehensive health care provider responsible for all the medical needs of veterans who enroll. To support budgeting and planning for this broader mission, the VA relies on a complex model known as the Enrollee Health Care Projection Model (EHCPM). This model predicts future demand for veterans' health care needs. The VA asked RAND (in conjunction with an independent actuary) to evaluate the model, which was developed and is operated by an actuarial consulting firm.

The RAND team reviewed how the model works and addressed three main questions in its evaluation:

- Does the modeling approach support long-term budget planning and policy analysis?
- Does it accurately project VA service demand and costs?
- Is the design and operation of the model transparent to users and outside parties?

Overall, RAND's evaluation found that the EHCPM is useful for short-term budget planning, but is less useful for longer range planning, especially in a dynamic policy environment. Fortunately, the model is structured in a way that would allow modifications to support longer term policy and planning applications without disrupting its usefulness for near-term budget planning.

How Does the Model Work?

The EHCPM estimates the use of VA services in a base year for each service category (e.g., inpatient care, office visits), using proprietary benchmarks derived from utilization in commercial health plans. The costs associated with the estimated use of each service are derived from data provided by the VA's cost accounting system. In the next step, the EHCPM estimates budget-year service use and the unit cost of services. These estimates are based on anticipated changes in demand for VA care, the efficiency and intensity of care provided by the VA system, and overall projected medical inflation in the United States. In any given year, the VA forecasts expenditures for each service by multiplying expected enrollment, forecast utilization, and forecast unit costs.

Does the Model Support Budgeting and Policy Analysis?

The RAND evaluation found that the EHCPM supports VA's short-term budget planning and monitoring in a stable policy and practice environment. The model identifies factors that drive specific types of spending or spending for specific types of enrollees and can adjust those factors as needed. Model results can also help the VA to develop more informed strategies for managing expenditures. In addition, the current model allows the VA to monitor budget execution and performance relative to pre-established benchmarks. Assuming there are no short-term "shocks" to the system, only the accuracy and timeliness of VA data systems—not the model's structure—limit the EHCPM's utility for short-term budget planning and monitoring.

However, for longer term strategic planning and policy analysis, the model could yield misleading results because the model structure does not account for two things: key drivers of future demand for VA care and the costs of delivering it. Using the model to inform scenarios beyond the current policy and budgetary environment requires information about a wide range of factors, including the VA's future cost structure, how rapidly the VA can expand its capacity to meet demand, factors driving enrollment, and the relationships among enrollee health status, VA treatment capacity, and enrollees' preferences for treatment in VA facilities versus other facilities. In many cases, required information does not exist or was not available to model developers. In the absence of such information, model forecasts rely on a number of unrealistic assumptions. Thus, substantial modifications to model

Corporation is a nonprofit research organization providing objective analysis and effective solutions that address the challenges facing the public and private sectors around the world. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors. RAND is a registered trademark.

subcomponents and enhancements of supporting data inputs would likely be required before the EHCPM could effectively support longer range planning.

Is the Model Accurate?

The model's ability to accurately predict the level of resources needed by the VA in future years to meet projected demand is uncertain. The discretionary nature of the VA's budget complicates the comparison between model projections and actual expenditures. Under a discretionary budget, the VA does not have the authority to spend more than Congress appropriates. If demand for VA services cannot be satisfied under its appropriation, then actual expenditures will reflect the constraints inherent in the appropriation and not actual demand for VA services.

Model accuracy becomes less certain as it is used to project the impact of policy and budget scenarios farther from the status quo. The main source of this uncertainty stems from the fact that the EHCPM begins its expenditure projection with the VA's congressional budget allocation, rather than with an independent measure of resource needs. Past VA budgets are imbedded in expenditure projections through the derivation of the model's unit cost measure and through the calibration of utilization benchmarks to actual VA workload data. In other words, the accuracy of the model is uncertain because there exists no expenditure information independent of the VA appropriation with which to formulate a "gold" standard against which to compare model projections.

Is the Model Transparent?

It is important that large, complex policy models like the EHCPM be transparent. A lack of transparency can undermine the credibility of the model and make the model difficult to operate and manage. The overall structure of the model is relatively easy for users and outside evaluators to understand. However, the model's subcomponents are less transparent. Transparency of the model's subcomponents is limited by several factors: complicated algorithms that are used to set parameters of model subcomponents; uneven and often incomplete model documentation; reliance on data and clinical efficiency benchmarks that are proprietary to the contractor who operates EHCPM and therefore not available for outside review; and the lack of a standing process for obtaining independent review.

Does the Model Support Advanced Appropriation?

If enacted, the Veterans Health Care Budget Reform and Transparency Act of 2009 (HR1016) would give Congress the ability to appropriate funds. Advance appropriation would, in essence, lengthen the time horizon over which the model forecasts resource requirements from 3 years in the current model baseline to 4 years. Under the current system, for example, the VA plans the FY 2012 budget request using a version of the model with an FY 2009 baseline. Under advanced appropriations, the FY 2009 baseline would inform the FY 2013 budget request. Generally the farther out the forecast, the less accurate the projections.

Advance appropriations may serve to mitigate the challenges of operating a large, complex health care system posed by delayed enactment of the VA's annual budget. At the same time, the expanded time period between budget appropriation and the time spending actually occurs makes it even more imperative that the VA have robust budget planning tools at its disposal.

Again, our findings suggest that the model is useful for short-term budget planning to the extent that the VA's treatment capacity and the policy environment surrounding the VA remain stable. This is because model projections are tied to past VA budgets and not an independent measure of resource requirements. The longer the period of time between the baseline year and the budget planning year, the higher the risk that that past budgets do not reflect the resources required by the VA to achieve its mission. Both the conflicts in Iraq and Afghanistan and the impact of the current recession on the employment and private health insurance coverage of veterans raise concerns about the impact of a changing policy environment for the robustness of short-term model forecasts. Lengthening the forecasted time period under advanced appropriation amplifies these concerns.

Recommendations for Improving the EHCPM

Based on the results of our evaluation, we recommend that VA take a number of steps to increase the model's ability to generate budget forecasts that are robust to changes in the policy environment over longer periods of time.

Develop a Methodology for Estimating Demand-Based Resource Requirements

We recommend that the VA develop and apply a method to enhance the model's capacity to estimate resource requirements that reflect any unmet demand using VA

data sources. Budget forecasts are not fully demand-based, because calibrating commercial utilization benchmarks to VA workload data imbeds constraints that arise from VA capacity constraints in the baseline utilization estimates. Forecasting of resource requirements requires measures of demand that are responsive to changes in VA treatment capacity, benefit generosity, and case-mix. Estimating demand for VA health care for these purposes requires the development and application of methodologies for (1) estimating the utilization that would have occurred in the absence of constraints on VA's capacity to deliver care, (2) estimating the relationship between VA benefit generosity relative to other payors and demand for VA care, and (3) estimating the relationship between enrollee health status and demand for VA care.

These methodologies could be developed by combining VA workload data with data describing treatment capacity and various sources of data on enrollee reliance. Exploiting variation in VA capacity across locations and over time could allow modelers to infer demand for VA care in constrained markets from administrative workload data collected from unconstrained regions and time periods, controlling for case-mix. The ability to control for and measure enrollee's partial reliance on VA care will require additional data beyond VA workload and VA treatment capacity. As reflected in the current model, such information is likely to include Medicare claims data linked to VA workload and self-reported reliance from survey data.

To assure full exploration of the capabilities and limitations of VA administrative and survey data sources in estimating unconstrained demand for VA health care, we recommend the VA consult with a wide variety of independent experts including actuaries, economists, and in particular, individuals with experience aggregating VISN-level workload data to conduct national-level analyses.

Use Survey-Based Methods to Strengthen Demand Forecasting and Policy Analysis

We recommend the VA use survey-based methods to strengthen forecasting and policy analysis capabilities. The fact that veterans do not receive medical care exclusively from the VA makes it impossible to project future demand for VA health care from administrative data alone. For example, VA eligibility data does not contain information needed to measure the effect of changes in availability and generosity of employer-sponsored health insurance benefits on demand for enrollment and use of VA health care services. Likewise, it is not possible to distinguish the effect of reliance from veteran health status when using VA workload data to predict future demand.

The current survey of enrollees provides useful information in estimating demand for VA care by asking insurance status and source, anticipated use of VA health care, health and functional status, and use of VA and non-VA health care. However, the utility of the current survey could be greatly increased if the sample (for both respondents and non respondents) were designed to be linkable to VA workload data, included non enrollees, and was stratified to ensure representation of veterans across VA markets identified as being supply constrained or having excess capacity. Likewise, the utility of the survey could be greatly increased if the questionnaire were modified to include screening questions regarding diagnosed health conditions, utilization of services in broad service categories, and more information about other health insurance coverage availability and costs.

We recommend that the VA consult a variety of sampling statisticians and survey design experts in making design changes to assure that modifications support to the greatest extent possible VA's objectives related to forecasting and policy analysis while minimizing respondent burden and cost to the VA.

Explore the Utility and Feasibility of Improving Unit Cost Measures Through Alternative Approaches

We recommend the VA consult with a variety of experts to improve its understanding of the likely biases resulting from the current costing methods, whether and how alternative approaches could improve unit cost estimates. We found that the method used to derive unit costs has the potential to produce biased expenditure projections. The potential for bias stems from the implicit assumption that per unit costs do not vary with changes over time in the number of treated patients. In essence, the model assumes that VA pays for care on a fee-for-service basis, similar to Medicare. Our analyses suggest that the potential for bias is greatest for services with large fixed cost components for both capacity constrained markets and markets with substantial excess capacity.

Alternative approaches may yield more valid and accurate expenditure projections that can be more readily related to the VA's actual expenditures. In particular, we recommend the VA explore whether it is feasible to implement a staffing model

using VA's cost accounting system. A staffing model explicitly maps resources expended in a delivery system to anticipated demand based on cost histories of service for major expenditure components, such as diagnostic equipment, office supplies, purchased services, administration, salaries and benefits and rent.

We recommend that the VA consult actuaries, economists with expertise in costing methods, and individuals familiar with VA data systems to recommend a strategy for analyzing the problems associated with the current costing method and to assess whether a staffing model (or alternative costing method) is likely to result in improved accuracy and could be supported using the VA's current cost accounting system.

The implementation of a staffing model as a basis for forecasting VA resource requirements would be time-consuming and resource intensive. However, investing in the capacity to develop, implement, and maintain a staffing model would most likely produce returns beyond the ability to improve the quality of model-based expenditure projections. In particular, the development of a staffing model would inform the development and refinement of productivity benchmarks for physicians, physician support staff, and medical equipment and the accurate measurement of performance relative to these benchmarks. A staffing model can also help the VA to evaluate potential return from investments in cost saving or quality enhancing technology.

Consider Streamlining the Current Model for Short-Term Budget Planning

If model enhancements required to improve the model's capability to support long-term planning and analysis prove impractical, we recommend that the VA streamline the current model to provide more transparent support for short-term budget planning. Streamlining would entail discontinued use of commercial utilization benchmarks, the development of VA-specific utilization benchmarks, and the simplification of trend assumptions used to project base year utilization forward 3 years. We expect a streamlined model based on VA data would be close in structure to the current methodology used to project expenditures for non modeled services (e.g., outpatient mental health services, over-the-counter drugs and supplies). We expect that commercial benchmarks will prove useful in isolated instances in which VA data systems do not adequately capture utilization of covered services.

Because VA workload drives short-term expenditure projections under the current model through the calibration of estimated utilization to actual utilization using VA workload data, discontinuing use of commercial utilization benchmarks will substantially reduce complexity and increase transparency without substantially affecting the continuity of the VA's budget planning process. The VA is substantially larger than many large health insurers who use their own experience for budgeting and strategic planning purposes. For this reason, it should be feasible to use standard statistical methods and the aggregation of data across multiple time periods to develop assumptions regarding variation in VA utilization by age, priority-level, and geographic region, even when the volume of workload is low for a given service.

Use a Wide Range of Expertise to Enhance Validity, Accuracy, and Credibility

We recommend that the VA draw on a broader range of expertise than is currently being employed for the purpose of enhancing the validity, accuracy, and external credibility of the model. Our evaluation suggested that model development activities were staffed solely by actuaries with support from programmers with limited support from outside experts. However, many modeling tasks are well within the purview of other disciplines, including economics, statistics, health services research, and epidemiology. Many individuals with backgrounds in these areas have relevant modeling experience and expertise in specialized analytic approaches needed to address model limitations identified in our evaluation. These approaches include cost measurement, estimating demand in supply constrained environments, and case-mix adjustment using administrative data.

Initiate Periodic External Review of the Model

We recommend that VA initiate periodic review of the model by independent experts recruited from outside the VA. Independent review helps to insure model credibility in the eyes of stakeholders who may not have the time or expertise to evaluate the model themselves. To our knowledge, the EHCPM model has not been subject to external review prior to our evaluation. Sponsors of other large scale forecasting models, such as the models used by the Social Security Administration and the Center for Medicare and Medicaid Services (CMS), periodically engage panels of experts to review modeling methodologies, key assumptions, and model outputs. Proceedings from these meetings could serve as models in establishing a review process.

Involve Technical Writers in Documentation Process

We recommend that the VA increase transparency and credibility through the use of technical writers to improve the quality of model documentation. As we note earlier in this report, any valid approach to projecting future VA health care expenditures under enrollment reform policies is likely to involve a very high degree of complexity. Given this complexity, it is crucial that model documentation be comprehensive, be clear, and meet the reviewers' expectations with respect to the appropriate level of detail. Technical writers have the skills and experience to assure that these goals are met through the use of unambiguous language and visual formatting.

Capture Institutional Knowledge through the Addition of Internal Analytic Staff

We recommend that the VA add internal analytic staff to participate in model development and related activities in order to accelerate institutional learning and increase the return on the VA's investment in the model. Our evaluation did not support conclusions one way or the other about the desirability of outsourcing model development and related activities. Our evaluation did, however, raise concerns about outsourcing the institutional knowledge that arises through day-to-day participation in model-related activities and interaction with other VA staff, both formal and informal. In our view, the capture of institutional knowledge is key to enhancing the VA's return on its investment in the model. Internal analytic staff would likely be familiar with the VA's strategic mission and have detailed knowledge of VA data systems. Thus, in addition to the general knowledge enhancement and related benefits achieved by the analytic staff, such individuals could also help to enhance the strategic value of the VA data systems.

[The RAND Report entitled, "Review and Evaluation of the VA Enrollee Health Care Projection Model," by Katherine M. Harris, James P. Golasso and Chrinstine Eibner, will be retained in the Committee files. The report can also be found online at http://www.rand.org/pubs/monographs/2008/RAND__MG596.pdf.]

Prepared Statement of Sidath Viranga Panangala, Analyst in Veterans Policy, Congressional Research Service, Library of Congress

Introduction

Chairman Filner, Ranking Member Buyer, and distinguished Members of the Committee, my name is Sidath Panangala, from the Congressional Research Service (CRS). I am honored to appear before the Committee today. As requested by the Committee, my testimony will highlight some of the issues that are discussed in the CRS Report entitled *Advance Appropriations for Veterans' Health Care: Issues and Options for Congress*. As a supplement to my testimony, I have included this report for the record. CRS takes no position on any of the legislative proposals to authorize advance appropriations for certain accounts that fund the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA).

Current Funding for VHA

Prior to discussing issues highlighted in our report, I will briefly provide an overview of VHA's current budget formulation process and the current appropriations process for VA health care programs. Historically, the major determinant of VHA's budget size and character was the number of staffed beds, which was controlled by Congress.[1] The preliminary budget estimate, to a large extent, was based on the funding and activity of the previous year. VHA developed system-wide workload estimates, by type of care, using forecasts submitted by field stations. Costs associated with new programs were estimated by the VA central office and added to the budget estimate.[2] Costs associated with staffing improvements, pay increases, and inflation were also added to this estimate. In 1996, Congress enacted the Department of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act 1997 (*P.L. 104–204*), requiring VHA to develop a plan for the allocation of health care resources to ensure that veterans eligible for medical care who

---

[1] U.S. Congress, House Committee on Veterans' Affairs, *Health Care for American Veterans*, prepared by National Academy of Sciences, National Research Council, 95th Cong., 1st sess., June 7, 1977, House Committee Print No. 36 (Washington: GPO, 1977), p. 37.

[2] Ibid, p. 42.

have similar economic status and eligibility priority have similar access to such care, regardless of where they reside.[3] The plan was to "account for forecasts in expected workload and to ensure fairness to facilities that provide cost-efficient health care."[4]

In response to the above-mentioned Congressional mandate, as well as the mandate in the Health Care Eligibility Reform Act 1996 (*P.L. 104–262*) that required the VHA to establish a priority-based enrollment system, VHA established the Enrollee Health Care Demand Model in 1998. The model, which has evolved over time, develops estimates of future veteran enrollment, enrollees' expected utilization of health care services, and the costs associated with that utilization. A more detailed description of the model is provided in our CRS report accompanying this testimony as well as in the RAND Corporation study titled *Review and Evaluation of the VA Enrollee Health Care Projection Model*.[5]

VHA's budget request to Congress begins with the formulations of the budget based on the Enrollee Health Care Projection Model (EHCPM) to estimate the demand for medical services among veterans in future years. Each year, through the annual appropriations process, Congress appropriates funds to the accounts that comprise VHA: (1) medical services, (2) medical support and compliance account, (3) medical facilities, and (4) medical and prosthetic research.

One proposal that has been discussed in the past few months to provide more "predictability" in funding VHA in the future is the use of advanced appropriations for certain medical care accounts of VHA.

An *advance appropriation* provides funding to an account one fiscal year or more ahead of schedule. In an annual appropriations act for FY2010, for example, an appropriation to an account for FY2011 or a later fiscal year would be an advance appropriation. Because advance appropriations are not subject to the budget enforcement procedures that normally apply to the annual appropriations acts for the upcoming fiscal year, the annual budget resolution for several years has placed a cap on advance appropriations and specified the accounts eligible to receive this type of funding. For FY2010, the conference report (H.Rept.111–89) on the budget resolution identifies certain veterans' medical care accounts as eligible to receive advance appropriations but exempts them from the cap.[6]

VHA Advance Appropriation: Implementation Issues

Let me highlight some potential implementation issues that were discussed in our report. One concern for Congress might be the effect or impact of funding some accounts under an advance appropriation based on the estimates generated by the Enrollee Health Care Projection Model. The Government Accountability Office has noted that "[VHA's] formulation of its budget is by its very nature challenging, as it is based on assumptions and imperfect information on the health care services [VHA] expects to provide."[7] The RAND Corporation has found that while the Enrollee Health Care Projection Model reasonably projects future enrollment estimates and is "likely to yield accurate projections in a stable policy environment," it has also found that "the current specification of the Enrollee Health Care Projection Model appears to lack the specificity to inform explicit scenarios regarding the relationships among VA benefit generosity, other sources of health coverage, veterans' enrollment decisions, and enrollee health status."[8] Under such findings, it is reasonable to assume that future year budget projections could have variances that could create budget shortfalls if there are unanticipated shocks to the VA health care system or to the surrounding policy environment. For instance, if under the current economic climate, large numbers of veterans were to lose their employer provided health insurance coverage, and for the first time try to seek care from the VA health care system, the Enrollee Health Care Projection Model may not be able to accurately forecast such a scenario.

---

[3] Department of Veterans Affairs, Office of Inspector General, *Report of Audit Congressional Concerns over Veterans Health Administration's Budget Execution*, Report No. 06–01414–160, Washington, DC, June 30, 2006, p. 2.

[4] Ibid.

[5] Katherine M. Harris, James P. Galasso, and Christine Eibner, *Review and Evaluation of the VA Enrollee Health Care Projection Model*, The RAND Corporation, Center for Military Health Policy Research, 2008, pp. 23–43.

[6] For a detailed description on budget procedures, see, CRS Report 98–721, *Introduction to the Federal Budget Process*, by Robert Keith.

[7] U.S. Government Accountability Office, *VA Health Care Challenges in Budget Formulation and Execution*, GAO–09–459T, March 12, 2009, p. 1.

[8] Katherine M. Harris, James P. Galasso, and Christine Eibner, *Review and Evaluation of the VA Enrollee Health Care Projection Model*, The RAND Corporation, Center for Military Health Policy Research, 2008, p. 46.

Another issue that may arise would be how funding for VHA information technology programs including its electronic medical records system relate to funding the rest of the VHA under an advance appropriation. Beginning in 2005, VA consolidated all information technology (IT) functions throughout the VA and brought them under control of the VA Chief Information Officer (CIO). As a result of this reorganization, VHA's health IT budget was brought under central control. Currently, all IT programs within the VA are funded under the Information Technology account. Therefore, providing an advance appropriation for some VHA accounts and funding IT accounts under a regular appropriation act could create a situation whereby, for example, VHA could not purchase computer software although it has procured medical equipment that needs software. Another example would be the difficulty of procuring the IT infrastructure to support the opening of a new community-based outpatient clinic (CBOC).

Option for Congress

There are some options that might help Congress in deciding on the long-term financing of VA health care.

One option might be to create an independent entity modeled along the lines of the Medicare Payment Advisory Commission (MedPAC).[9] Creation of such an entity could bring transparency to VHA's funding process and would create credibility, particularly among key constituent groups. MedPAC was established by the Balanced Budget Act 1997 (*P.L. 105–33*) to advise Congress on issues affecting the Medicare Program. The Commission's statutory mandate includes advising Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program. Furthermore, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare. The Commission meets publicly to discuss Medicare issues and policy questions and to develop and approve its reports and recommendations to the Congress. Such a program for VHA might independently analyze issues facing VHA and advise Congress on funding for both short- and long-term issues affecting health care for veterans. This could, in turn, provide an added layer of transparency and accountability to VHA's budget process.

This concludes my statement. I would be pleased to answer any questions the Committee may have.

[The CRS Report entitled, "Advance Appropriations for Veterans' Health Care: Issues and Options for Congress," CRS Report No. R40489, dated April 28, 2009, will be retained in the Committee files. The Report can also be found online at http://apps.crs.gov/products/r/pdf/R40489.pdf.]

Prepared Statement of Jessica Banthin, Ph.D., Director of Modeling and Simulation, Center for Financing, Access, and Cost Trends, Agency for Health Care Research and Quality, U.S. Department of Health and Human Services

Introduction

Good morning, Mr. Chairman and Members of the Committee. Thank you for the opportunity to testify before the Committee on the issue of modeling long term projections. Before beginning the substance of my remarks, I want to state that the Agency for Health care Research and Quality (AHRQ), an agency of the Department of Health and Human Services (HHS), has benefited from extensive collaboration with the Department of Veterans Affairs (VA) in the areas of health services research, patient safety, and clinical quality of care. We consider the VA an important partner in improving health care.

I serve as the Director of Modeling and Simulation in the Center for Financing, Access and Cost Trends at AHRQ. At AHRQ, we have extensive experience with working on sophisticated health care models. For example, we developed a simulation model that estimates the number of eligible uninsured children in the U.S. and can be used to project enrollment in Medicaid and the Children's Health Insurance Program (CHIP), and informs outreach efforts to increase enrollment of eligible children ages.[1–4] We worked closely with actuaries at HHS's Centers for Medicare and Medicaid Services (CMS) to benchmark national health expenditure estimates.[5] In

[9] [www.medpac.gov].

addition, researchers at AHRQ designed an economic microsimulation model that predicted consumer choice of health insurance in response to changes in health insurance offerings.[6] The model also projected changes in total health care spending resulting from the change in insurance offers.

I have had the opportunity to review RAND report on the VA Enrollee Health Care Projection Model (EHCPM).[7] The EHCPM includes three major components: an enrollment projection model, a utilization projection model, and a unit cost projection model.

The RAND report draws distinction between actuarial models that are based on historical trends and economic models that incorporate behavioral parameters. I have worked with both actuarial and economic models. I have also worked with models that combine elements of both approaches. There are caveats to all long-term projection models.

In my testimony, I will briefly describe an enrollment model that we have constructed at AHRQ that can be used to project children's enrollment in Medicaid and CHIP. I will also discuss the benefits, caveats and limitations that affect long-term cost and utilization projection models.

An Example of Modeling Medicaid and CHIP Eligibility and Enrollment

In AHRQ's modeling efforts, we model Medicaid and CHIP enrollment using survey data from our Medical Expenditure Panel Survey (MEPS) as well as state-specific eligibility rules. We make use of information on family structure and family income and then apply state specific eligibility rules to all sampled children in the MEPS data. We simulate the eligibility of each child for public coverage through Medicaid or CHIP. We then compare the simulated eligibility status to the child's reported insurance status. Many eligible children are enrolled in public coverage, and our model supports the calculation of take-up rates.

Next, we use output from our eligibility simulation model to develop economic models that explain why some children are more likely than others to enroll. These models, as with all actuarial and economic models, are limited by the available data. We cannot easily measure the effects of factors that are not observed or measured. Nonetheless, the enrollment (or take up) model identifies the factors that have the largest marginal effects on enrollment. We find, for example, that among children who are eligible for public coverage, age, children's health and disability status and parents' employment status are strong predictors of enrollment (4). These models can easily support longer term enrollment projections and are flexible enough to account for changes that may affect enrollment decisions.

In the aforementioned studies, MEPS data were used. Data from the American Community Survey (sponsored by the Bureau of the Census) also measure veteran status. As of 2008 the American Community Survey is also measuring health insurance status.

Cost and Utilization Projections

The long-term projection of costs and utilization is very difficult because of the number of factors that affect use of health care services. Factors include unpredictable changes in both the demand for and the supply of various services. Technological change can yield new treatments for medical conditions and improved diagnosis of ailments. Changes in the prevalence of disease can affect the demand for care. When AHRQ projects health care expenditures, we refrain from applying complex models and assumptions and instead apply publicly available projections from census data (regarding demographic changes) and from CMS (regarding expenditure growth), so we project expenditures using a more conservative approach that is more aligned to actuarial methods. AHRQ-projected expenditure data are publicly available, so modelers can then use these data to develop more complex microsimulation models that predict the cost changes resulting from various behavioral parameters and assumptions. These more complex microsimulation models with behavioral parameters are critical for policy analysis, but their long-term accuracy in projecting expenditures is very hard to gauge. The advantage of having extremely detailed information from private claims data on the use of health care services is that the data project use and costs associated with an array of specific health care services. Breaking down long-term projections in this way avoids the need for relying solely on these behavioral parameters.

Issues in Projecting Enrollment, Utilization and Costs

Programs such as the VA face several challenges in projecting utilization and costs for its patient population when there is limited information on the other non-program sources of care patients may use. This issue is more pronounced for patients under age 65 without Medicare claims data to examine. To the extent that the VA patient population is unique and differs in many ways from the commer-

cially insured population, such data limitations present additional challenges in projecting future utilization and costs.

It is important to account for illness severity or morbidity when projecting costs. Morbidity is a strong predictor of both enrollment and use of services. Morbidity can be measured with clinical measures but can also be accounted for with some survey-based measures of patient reported physical and mental health status, functional status, and work disability. These patient reported measures have strong predictive power in many economic models of demand for services.

Conclusion

In conclusion, I want to emphasize that there are caveats associated with all long-term projection models, whether they use actuarial or economic methods. In addition, the accuracy of all projection models depends critically on the available data. Without sufficient data there may be areas in the models that rely on best guesses rather than solid data. As most modelers know, long-term projection models can constantly be improved and enhanced. This is usually an ongoing process. Nevertheless, the VA Enrollee Health Care Projection Model is a very sophisticated model that benefits each year from better information on the current veteran population.

Mr. Chairman, this concludes my prepared testimony. Thank you, and I would be happy to answer any questions you may have.

References

[1] Hudson, J. and Selden, T., “Children’s Eligibility and Coverage: Recent Trends and a Look Ahead.,” *Health Affairs* 26(5). August 2007.

[2] Hudson, J., Selden, T., and Banthin, J. The impact of SCHIP on insurance coverage of children. *Inquiry* 2005 (Fall); 42(3):232–54.

[3] Selden, TM, Hudson, JL and Banthin, JS. 2004. “Tracking Changes in Eligibility and Coverage Among Children, 1996–2002.” *Health Affairs* 23(5):39–50. September/October 2004.

[4] Selden, TM, Banthin, JS, Cohen JW. March, 1999. “Projecting Eligibility and Enrollment for the State Children’s Health Insurance Program,” AHCPR Pub. No. 99–025.

[5] Sing M, Banthin JS, Selden TM, et al. Reconciling Medical Expenditure Estimates from the MEPS and NHEA, 2002. *Health Care Financing Review* 2006 Fall; 28(1):25–40.

[6] Zabinski, D, Selden, TM, Moeller, JF and Banthin, JS. 1999. “Medical Savings Accounts: Microsimulation Results from a Model with Adverse Selection,” *Journal of Health Economics* 18(2):195–218.

[7] Harris, Katherine M., James P. Galasso, Christine Eibner. Review and evaluation of the VA Enrollee Health Care Projection Model. RAND 2008.

Prepared Statement of Randall B. Williamson, Director, Health Care, and Susan J. Irving, Director, Federal Budget Analysis, Strategic Issues, U.S. Government Accountability Office

VA Health Care: Challenges in Budget Formulation and Issues Surrounding the Proposal for Advance Appropriations

GAO Highlights

Why GAO Did This Study

The Department of Veterans Affairs (VA) estimates it will provide health care to 5.8 million patients with appropriations of about $41 billion in fiscal year 2009. It provides a range of services, including primary care, outpatient and inpatient services, long-term care, and prescription drugs. VA formulates its health care budget by developing annual estimates of its likely spending for all its health care programs and services, and includes these estimates in its annual congressional budget justification.

GAO was asked to discuss budgeting for VA health care. As agreed, this statement addresses (1) challenges VA faces in formulating its health care budget and (2) issues surrounding the possibility of providing advance appropriations for VA health care.

This testimony is based on prior GAO work, including *VA Health Care: Budget Formulation and Reporting on Budget Execution Need Improvement* (GAO–06–958) (Sept. 2006); *VA Health Care: Long-Term Care Strategic Planning and Budgeting Need Improvement* (GAO–09–145) (Jan. 2009); and *VA Health Care: Challenges in Budget Formulation and Execution* (GAO–09–459T) (Mar. 2009); and on GAO re-

views of budgets, budget resolutions, and related legislative documents. We discussed the contents of this statement with VA officials.

What GAO Found

GAO's prior work highlights some of the challenges VA faces in formulating its budget: obtaining sufficient data for useful budget projections, making accurate calculations, and making realistic assumptions. For example, GAO's 2006 report on VA's overall health care budget found that VA underestimated the cost of serving veterans returning from military operations in Iraq and Afghanistan. According to VA officials, the agency did not have sufficient data from the Department of Defense, but VA subsequently began receiving the needed data monthly rather than quarterly. In addition, VA made calculation errors when estimating the effect of its proposed fiscal year 2006 nursing home policy, and this contributed to requests for supplemental funding. GAO recommended that VA strengthen its internal controls to better ensure the accuracy of calculations used to prepare budget requests. VA agreed and, for its fiscal year 2009 budget justification, had an independent actuarial firm validate savings estimates from proposals to increase fees for certain types of health care coverage. In January 2009, GAO found that VA's assumptions about the cost of providing long-term care appeared unreliable given that assumed cost increases were lower than VA's recent spending experience and guidance provided by the Office of Management and Budget. GAO recommended that VA use assumptions consistent with recent experience or report the rationale for alternative cost assumptions. In a March 23, 2009, letter to GAO, VA stated that it concurred and would implement this recommendation for future budget submissions.

The provision of advance appropriations would "use up" discretionary budget authority for the next year and so limit Congress's flexibility to respond to changing priorities and needs. While providing funds for 2 years in a single appropriations act provides certainty about some funds, the longer projection period increases the uncertainty of the data and projections used. If VA is expected to submit its budget proposal for health care for 2 years, the lead time for the second year would be 30 months. This additional lead time increases the uncertainty of the estimates and could worsen the challenges VA already faces when formulating its health care budget.

Given the challenges VA faces in formulating its health care budget and the changing nature of health care, proposals to change the availability of the appropriations it receives deserve careful scrutiny. Providing advance appropriations will not mitigate or solve the problems we have reported regarding data, calculations, or assumptions in developing VA's health care budget. Nor will it address any link between cost growth and program design. Congressional oversight will continue to be critical.

Mr. Chairman and Members of the Committee:

We are pleased to be here today as the Committee considers issues in budgeting and funding for the Department of Veterans Affairs (VA) health care programs. These programs form one of the largest health care delivery systems in the nation and provide, for eligible veterans, a range of services, including preventive and primary health care, outpatient and inpatient services, long-term care, and prescription drugs. VA estimated that in fiscal year 2009, its health care programs would serve 5.8 million patients with appropriations of about $41 billion.

VA health care programs are funded through the annual appropriations process along with other areas of critical importance and high priority to the nation, including national defense, homeland security, transportation, energy and natural resources, education, and public health. VA formulates its health care budget by developing annual estimates of its likely spending for all of its health care programs and services. This is by its very nature challenging, as it is based on assumptions and imperfect information on the health care services VA expects to provide. For example, VA is responsible for anticipating the service needs of two very different populations—an aging veteran population and a growing number of veterans returning from the military operations in Afghanistan and Iraq—calculating the future costs associated with providing VA services, and using these factors to develop the department's budget request submitted to the Office of Management and Budget (OMB).[1] VA provides its annual congressional budget justification to the appropria-

[1] VA begins to formulate its own budget request at least 18 months before the start of the fiscal year to which the request relates and about 10 months before transmission of the President's budget request, which usually occurs in early February.

tions subcommittees, providing additional explanation for the President's budget request.[2]

VA uses an actuarial model to develop its annual budget estimates for most of its health care programs, including inpatient acute surgery, outpatient care, and prescription drugs. This model estimates future VA health care costs by using projections of veterans' demand for VA's health care services as well as cost estimates associated with particular health care services.[3] In fiscal year 2006, VA used the actuarial model to estimate about 86 percent of its projected health care spending for that year. VA uses a separate approach to project long-term care demands and costs, which accounted for about 10 percent of VA's estimated health care spending for fiscal year 2006. VA used other approaches to project demand and costs for the remaining 4 percent of the medical programs budget request for fiscal year 2006.

In 2006 and 2009, we issued reports that examined some of the challenges VA faces in budget formulation; these reports pertained to VA's overall health care budget as well as portions of its budget that pertain to long-term care.[4] We also testified in March 2009 before the House Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, about challenges VA faces in formulating and executing its budget.[5] You asked us to discuss budgeting for VA health care. As agreed, today we will discuss (1) challenges VA faces in formulating its health care budget and (2) some issues surrounding the possibility of providing advance appropriations for VA health care.[6]

For our 2006 report on VA's overall health care budget for fiscal years 2005 and 2006, we analyzed and reviewed budget documents, including VA's budget justifications for health care programs for fiscal years 2005 and 2006, and interviewed VA officials responsible for VA health care budget issues and for developing budget projections. In addition, from August to September 2008, we reviewed VA documents to determine whether VA had implemented the recommendations we made in our 2006 report. For our 2009 report on VA's long-term care budget, we reviewed VA's fiscal year 2009 congressional budget justification and related documents. We also interviewed VA officials. VA did not initially comment on the recommendations in our 2009 report, but said it would provide an action plan. VA provided this action plan in a March 23, 2009, letter to GAO. For this statement we reviewed VA's letter and action plan. For the discussion of appropriations and budgeting we reviewed previous GAO work, budgets, budget resolutions, and related legislative documents.[7]

We conducted our work for these performance audits in accordance with generally accepted government auditing standards.[8] Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We discussed the contents of this statement with VA officials.

---

[2] The President's budget request for VA is developed by the Office of Management and Budget.

[3] The actuarial model reflects factors such as the age, sex, and morbidity of the veteran population as well as the extent to which veterans are expected to seek care from VA rather than health care providers reimbursed by other payers such as Medicare and Medicaid.

[4] See GAO, VA Health Care: Budget Formulation and Reporting on Budget Execution Need Improvement, *GAO–06–958* (Washington, D.C.: Sept. 20, 2006); GAO, VA Health Care: Long-Term Care Strategic Planning and Budgeting Need Improvement, *GAO–09–145* (Washington, D.C.: Jan. 23, 2009).

[5] See GAO, VA Health Care: Challenges in Budget Formulation and Execution, *GAO–09–459T* (Washington, D.C.: Mar. 12, 2009).

[6] The Veterans Health Care Budget Reform and Transparency Act of 2009 would provide for the VA Medical Services, Medical Support and Compliance, and Medical Facilities appropriations accounts to receive advance appropriations beginning with fiscal year 2011. H.R. 1016 and S. 423, 111th Cong. (2009). Advance appropriations represent budget authority that becomes available 1 or more fiscal years after the fiscal year covered by the appropriations act in which they are made.

[7] See GAO, *Budget Process: Issues in Biennial Budget Proposals*, *GAO/T–AIMD–96–136* (Washington, D.C.: July 24, 1996); GAO, *Budget Process: Comments on S. 261—Biennial Budgeting and Appropriations Act*, *GAO/T–AIMD–97–84* (Washington, D.C.: Apr. 23, 1997); GAO, *Budget Issues: Cap Structure and Guaranteed Funding*, *GAO/T–AIMD–99–210* (Washington, D.C.: July 21, 1999); GAO, *Congressional Directives: Selected Agencies' Processes for Responding to Funding Instructions*, *GAO–08–209* (Washington, D.C.: Jan. 31, 2008).

[8] We conducted our work on VA's overall health care budget from October 2005 through September 2006, our work on VA's long-term care budget from November 2007 through January 2009, and our work for this statement in April 2009. The discussion of advance appropriations draws on work and analysis conducted on an ongoing basis for over a decade.

VA Faces Challenges in Formulating Its Health Care Budget

Our prior work highlights some of the challenges VA faces in formulating its budget: obtaining sufficient data for useful budget projections, making accurate calculations, and making realistic assumptions. Our 2006 report on VA's overall health care budget found that VA underestimated the cost of serving veterans returning from military operations in Afghanistan and Iraq, in part because estimates for fiscal year 2005 were based on data that largely predated the Iraq conflict.[9] In fiscal year 2006, according to VA, the agency again underestimated the cost of serving these veterans because it did not have sufficient data due to challenges obtaining data needed to identify these veterans from the Department of Defense (DoD). According to VA officials, the agency subsequently began receiving the DoD data needed to identify these veterans on a monthly basis rather than quarterly.

We also reported challenges VA faces in making accurate calculations during budget formulation. VA made computation errors when estimating the effect of its proposed fiscal year 2006 nursing home policy, and this also contributed to requests for supplemental funding. We found that VA underestimated workload—that is, the amount of care VA provides—and the costs of providing care in all three of its nursing home settings.[10] VA officials said that the errors resulted from calculations being made in haste during the OMB appeal process,[11] and that a more standardized approach to long-term care calculations could provide stronger quality assurance to help prevent future mistakes. In 2006, we recommended that VA strengthen its internal controls to better ensure the accuracy of calculations it uses in preparing budget requests. VA agreed with and implemented this recommendation for its fiscal year 2009 budget justification by having an independent actuarial firm validate the savings estimates from proposals to increase fees for certain types of health care coverage.

Our 2006 report on VA's overall health care budget also illustrated that VA faces challenges making realistic assumptions about the budgetary impact of its proposed policies. VA made unrealistic assumptions about how quickly the department would realize savings from proposed changes in its nursing home policy. We reported the President's requests for additional funding for VA's medical programs for fiscal years 2005 and 2006 were in part due to these unrealistic assumptions.[12] We recommended that VA improve its budget formulation processes by explaining in its budget justifications the relationship between the implementation of proposed policy changes and the expected timing of cost savings to be achieved. VA agreed and acted on this recommendation in its fiscal year 2009 budget justification.

In January 2009, we found that VA's spending estimate in its fiscal year 2009 budget justification for noninstitutional long-term care services appeared unreliable, in part because this spending estimate was based on a workload projection that appeared to be unrealistically high in relation to recent VA experience.[13] VA projected that its workload for noninstitutional long-term care would increase 38 percent from fiscal year 2008 to fiscal year 2009. VA made this projection even though from fiscal year 2006 to fiscal year 2007—the most recent year for which workload data are available—actual workload for these services decreased about 5 percent. In its fiscal year 2009 budget justification, VA did not provide information regarding its plans for how it would increase noninstitutional workload 38 percent from fiscal year 2008 to fiscal year 2009. We recommended that VA use workload projections in future budget justifications that are consistent with VA's recent experience with noninstitutional long-term care spending or report the rationale for using alternative projections. In its March 23, 2009, letter to GAO, VA stated it concurs with this recommendation and will implement our recommendation in future budget submissions.

In January 2009, we also reported that VA may have underestimated its nursing home spending and noninstitutional long-term care spending for fiscal year 2009 because it used a cost assumption that appeared unrealistically low, given recent VA

---

[9] See *GAO–06–958*.

[10] VA provides nursing home care in VA-operated nursing homes, in state veterans' nursing homes, and in community nursing homes under local or national contract to VA.

[11] In late November, OMB "passes back" budget decisions to the agencies on the President's budget requests for their programs, a process known as "passback." These decisions may involve, among other things, funding levels, program policy changes, and personnel ceilings. The agencies may appeal decisions with which they disagree.

[12] In June 2005, the President requested a $975 million supplemental appropriation for fiscal year 2005, and in July 2005, the President submitted a $1.977 billion budget amendment for the fiscal year 2006 appropriation.

[13] VA provides two types of long-term care: institutional long-term care, which is provided almost exclusively in nursing homes, and noninstitutional long-term care, which is provided in veterans' own homes and in other locations in the community.

experience and economic forecasts of health care cost increases. For example, VA based its nursing home spending estimate on an assumption that the cost of providing a day of nursing home care would increase 2.5 percent from fiscal year 2008 to fiscal year 2009. However, from fiscal year 2006 to fiscal year 2007—the most recent year for which actual cost data are available—these costs increased approximately 5.5 percent. VA's 2.5 percent cost-increase estimate is also less than the 3.8 percent inflation rate for medical services that OMB provided in guidance to VA to help with its budget estimates. We recommended that in future budget justifications, VA use cost assumptions for estimating both nursing home and noninstitutional long-term care spending that are consistent with VA's recent experience or report the rationale for alternative cost assumptions. In its March 23, 2009, letter to GAO, VA stated it concurs with our recommendations and will implement these recommendations in future budget submissions.

Issues in Changing the Appropriations for VA Health Care

Consideration of any proposal to change the availability of the appropriations VA receives for health care should take into account the current structure of the Federal budget, the congressional budget process—including budget enforcement—and the nature of the nation's fiscal challenge. The impact of any change on congressional flexibility and oversight also should be considered.

In the Federal budget, spending is divided into two main categories: (1) direct spending, or spending that flows directly from authorizing legislation—this spending is often referred to as "mandatory spending"—and (2) discretionary spending, defined as spending that is provided in appropriations acts.

It is in the annual appropriations process that the Congress considers, debates, and makes decisions about the competing claims for Federal resources. Citizens look to the Federal Government for action in a wide range of areas. Congress is confronted every year with claims that have merit but which in total exceed the amount the Congress believes appropriate to spend. It is not an easy process—but it is an important exercise of its Constitutional power of the purse.

Special treatment for spending in one area—either through separate spending caps or guaranteed minimums or exemption from budget enforcement rules—may serve to protect that area from competition with other areas for finite resources. The allocation of funds across Federal activities is not the only thing Congress determines as part of the annual appropriations process. It also specifies the purposes for which funds may be used and the length of time for which funds are available. Further, annually enacted appropriations have long been a basic means of exerting and enforcing congressional policy.

The review of agency funding requests often provides the context for the conduct of oversight. For example, in the annual review of the VA health care budget, increasing costs may prompt discussion about causes and possible responses—and lead to changes in the programs or in funding levels. VA health care offers illustrations of and insights into growing health care costs. This takes on special significance since—as we and others have reported—the nation's long-term fiscal challenge is driven largely by the rapid growth in health care costs.

Both the Congress and the agencies have expressed frustration with the budget and appropriations process. Some Members of Congress have said the process is too lengthy. The public often finds the debate confusing. Agencies find it burdensome and time consuming. And the frequent need for continuing resolutions[14] (CR) has been a source of frustration both in the Congress and in agencies. Although there is frustration with the current process, changes should be considered carefully. The current process is, in part, the cumulative result of many changes made to address previous problems. This argues for spending time both defining what the problem(s) to be solved are and analyzing the impact of any proposed change(s).

In considering issues surrounding the possibility of providing advance appropriations for VA health care—or any other program—it is important to recognize that not all funds provided through the existing appropriations process expire at the end of a single fiscal year. Congress routinely provides multi-year appropriations for accounts or projects within accounts when it deems it makes sense to do so. Multi-year funds are funds provided in 1 year that are available for obligation beyond the end of that fiscal year. So, for example, multi-year funds provided in the fiscal year 2010 appropriations act would be available in fiscal year 2010 and remain available

[14] When Congress and the President do not reach final decisions about one or more regular appropriations acts by the beginning of the Federal fiscal year, October 1, they often enact a continuing resolution (CR). A CR provides agencies with funding for a period of time until final appropriations decisions are made or until enactment of another CR.

for some specified number of future years.[15] Unobligated balances from such multi-year funds may be carried over by the agency into the next fiscal year—regardless of whether the agency is operating under a continuing resolution or a new appropriations act. For example, in fiscal year 2009 about $3 billion of approximately $41 billion for VA health care programs was made available for 2 years. Congress also provides agencies—including VA—some authority to move funds between appropriations accounts. This transfer authority provides flexibility to respond to changing circumstances.

Advance appropriations are different from multi-year appropriations. Whereas multi-year appropriations are available in the year in which they are provided, advance appropriations represent budget authority that becomes available one or more fiscal years after the fiscal year covered by the appropriations act in which they are provided. So, for example, advance appropriations provided in the fiscal year 2010 appropriations act would consist of funds that would first be available for obligation in fiscal year 2011 or later.

In considering the proposal to provide advance appropriations, one issue is the impact on congressional flexibility and its ability to consider competing demands for limited Federal funds. Although appropriations are made on an annual cycle, both the President and the Congress look beyond a single year in setting spending targets. The current Administration's budget presents spending totals for 10 fiscal years.[16] The concurrent Budget Resolution—which represents Congress's overall fiscal plan—includes discretionary spending totals for the budget year and each of the four future years.[17] The provision of advance appropriations would "use up" discretionary budget authority for the next year. In doing so it limits Congress's flexibility to respond to changing priorities and needs and reduces the amount available for other purposes in the next year.

Another issue would be how and when the limits on such advance appropriations would be set. Currently the concurrent Budget Resolution both caps the total amount that can be provided through advance appropriations and identifies the agencies or programs which may be provided such funding.[18] It does not specify how the total should be allocated among those agencies.

A related question is what share of VA health care funding would be provided in advance appropriations. Is the intent to provide a full appropriation for both years in the single appropriations act? This would in effect enact the entire appropriation for both the budget year and the following fiscal year at the same time. If appropriations for VA health care were enacted in 2-year increments, under what conditions would there be changes in funding in the second year? Would the presumption be that there would be no action in that second year except under unusual circumstances? Or is the presumption that there would be additional funds provided? These questions become critical if Congress decides to provide all or most of VA health care's funding in advance. Even if only a portion of VA health care funding is to be provided in advance appropriations, Congress will need to determine what that share should be and how it should be allocated across VA's medical accounts.

While providing funds for 2 years in a single appropriations act provides certainty about some funds, the longer projection period increases the uncertainty of the data and projections used. Under the current annual appropriations cycle, agencies begin budget formulation at least 18 months before the relevant fiscal year begins. If VA is expected to submit its budget proposal for health care for both years at once, the lead time for the second year would be 30 months. This additional lead time increases the uncertainty of the estimates and could worsen the challenges VA faces when formulating its health care budget.

Concluding Observations

Given the challenges VA faces in formulating its health care budget and the changing nature of health care, proposals to change the availability of the appropriations it receives deserve careful scrutiny. Providing advance appropriations will not mitigate or solve the problems noted above regarding data, calculations, or assumptions in developing VA's health care budget. Nor will it address any link be-

---

[15] Some of these funds are available for 2 years; some are available for a longer specified time; some are available "until expended."

[16] These are usually provided by budget category, by budget function, and by agency as well as for the total budget. The President's budget for fiscal year 2010 includes summary budget totals for the 10 years spanning fiscal year 2010 through fiscal year 2019.

[17] The FY 2010 budget resolution specifies discretionary spending amounts—both budget authority and outlays—in total and for each budget function for each of fiscal years 2010–2014. (It also specifies the amount of new appropriations and outlays for FY 2009).

[18] A point of order can be raised against advance appropriations provided for those entities not identified by the Resolution.

tween cost growth and program design. Congressional oversight will continue to be critical.

No one would suggest that the current budget and appropriations process is perfect. However, it is important to recognize that no process will make the difficult choices and tradeoffs Congress faces easy. If VA is to receive advance appropriations for health care, the amount of discretionary spending available for Congress to allocate to other Federal activities in that year will be reduced. In addition, providing advance appropriations for VA health care will not resolve the problems we have identified in VA's budget formulation.

Mr. Chairman, this concludes our prepared remarks. We would be happy to answer any questions you or other Members of the Committee may have.

GAO Contacts and Staff Acknowledgments

For more information regarding this testimony, please contact Randall B. Williamson at (202) 512–7114 or williamsonr@gao.gov or Susan J. Irving at (202) 512–8288 or irvings@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. In addition to the contributors named above, Carol Henn and James C. Musselwhite, Assistant Directors; Katherine L. Amoroso, Helen Desaulniers, Felicia M. Lopez, Julie Matta, Lisa Motley, Sheila Rajabiun, Steve Robblee, and Timothy Walker made key contributions to this testimony.

Prepared Statement of Hon. Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs

Chairman Filner, Congressman Buyer, distinguished Members of the Committee: Thank you for this opportunity to discuss advance appropriations and the challenge of projecting VA's budget needs 2 years into the future.

It has been a very busy 3 months at VA, as we have begun laying the groundwork for fulfilling the President's vision of transforming VA into a 21st century organization. On April 9, the President himself announced the joint VA–DoD initiative to create one virtual lifetime electronic health record for all members of our armed forces, to stay with them from the day they put on the uniform to the day they are laid to rest.

In making that announcement, the President repeated his concern that the care our veterans receive should never be hindered by budget delays. I share the President's concern as well as his support for advance appropriations as a way to provide uninterrupted care. Having lived with continuing resolutions in another life, I know how inefficient they can be, especially to health care and other services provided to Veterans. One advance funding proposal under consideration targets three critical medical care accounts of the Veterans Health Administration: Medical Services, Medical Support and Compliance, and Medical Facilities. These are vital accounts that should never fall prey to interruptions of funding.

Implementing an advance funding mechanism is not without challenges and careful planning is needed to ensure timely funding without unintended consequences. Budget projections are rarely right on the mark, and the further out they are made, the farther off the mark they are likely to be. For an advance appropriations mechanism to function effectively, it must be linked to a forecasting model that is both reliable and accurate, to the extent possible. Today I will concentrate on VA's principal forecasting model—the Enrollee Health Care Projection Model.

The Enrollee Health Care Projection Model, or VA Model, is a comprehensive enrollment, utilization, and expenditure projection model. It was originally developed in 1998 in partnership with Milliman, Inc., the largest actuarial firm in the country. Through the past 11 years of periodic updates and continuous refinement, VA and Milliman have developed a strong partnership that has resulted in a powerful modeling tool. VA guides the overall development of the VA Model and ensures that it meets the needs of stakeholders. VA program staff provide expertise on the unique needs of Veterans, patterns of practice in the VA health care system, and how the system is expected to evolve over the next 20 years. Milliman brings specialized expertise, access to extensive amounts of health-care utilization data VA, and excellent research to the overall modeling effort.

The VA Model produces multi-year projections to inform the VHA budget process, estimate the impact of proposed policies, and support strategic and capital planning. For each year, the VA Model projects:

- the number of veterans expected to be enrolled;
- the priority level, age, gender, and geographic location of enrolled veterans;

- the total health care demand for enrolled veterans across 58 health care services;
- the portion of that care enrollees are likely to receive from VA versus other health care providers; and
- the expenditures associated with the projected utilization.

The enrollment modeling process begins with comprehensive and accurate veteran population data developed by VA's Office of the Actuary using a "VetPop" model. The Office of the Actuary projects veteran populations over 30 out-years using data from the Census Bureau, the Department of Defense, and mortality and supplemental data to develop refined estimates of the current veteran population and projected future levels. In 2005, independent verification and validation of the VetPop model by the Institute for Defense Analysis found the baseline veteran population estimate to be accurate in providing baseline estimates broken out by demographic characteristics such as age and gender. Additionally, VA completes a detailed validation annually to assure confidence in the VetPop output. This includes extensive peer review of our methodology and assumptions for parameters as well as of our programs, logs and output lists. All results are examined for consistency and compared with previous data and census estimates. It should be noted the accuracy of the total veteran population is unlikely to change significantly over the short term because the veteran population changes little over the short term. The accuracy of the long-term forecast is largely dependent on the accuracy of the projections of deaths and military separations.

Projections for health-care services VA offers that are comparable to the private sector, including inpatient, surgical, and ambulatory care, are based on private-sector benchmarks, which are adjusted for the demographics of the veteran enrollee population and the VA health-care delivery system. Private-sector benchmarks used in the VA Model come from the Milliman Health Cost Guidelines, which are updated and expanded annually. These guidelines are a combination of consultants' expertise, research, and actuarial judgment; they also represent the health care utilization of over 60 million Americans. The guidelines have been validated and used extensively by private-sector health plans. The guidelines also provide extensive information on the impact of age and gender, changes in health care benefits, and changes in copayments on health care utilization. The enormous volume of data allows VA to develop projections at a very detailed level. Projections for services that are unique to VA, such as blind rehabilitation, and services where VA has a unique practice pattern, such as prosthetics, are developed based on analyses of historical VA data.

The VA Model is supported by in-depth analyses of VA data, including enrollment rates, enrollee mortality, morbidity, and reliance on VA versus other health care providers, and VA's level of health care management. An annual VHA Survey of Enrollees provides data on enrollee insurance coverage, income, period of service, and self-reported health status. The 2008 Survey included new questions developed to identify the key drivers of Veterans' decision to enroll and use VA health care.

The VA Model uses utilization and cost trends to project modeled services forward 20 years into the future from the most recently completed fiscal year, or base year. Assumptions about future trends are developed by a workgroup of VA staff and Milliman experts on health care trends. The workgroup reviews VA historical trends and historical and estimated future trends in the broader health care industry in developing the assumptions. While there are differences between VA's closed-panel, integrated system and the fee-for-service environment in Medicare and the private sector, the broader health care industry trends serve as a frame of reference for how future changes in the provision of health care will impact VA. These trends include expected changes in medical-care practice and custom. For example, gall bladder surgery is now routinely performed on an outpatient basis, so trends and projections now include a reduction in inpatient surgery utilization rates based on this shift.

The projections are developed at a very detailed level and then aggregated to provide national projections. Projections are developed by 13 priority levels and by 5-year age bands. Projections are also developed separately for enrollees who used VA health care before eligibility reform since they have unique demographic and utilization patterns. Geographically, the projections are developed at the sector level, which is the lowest geographic area for which credible projections can be developed at the level of detail used in the model. A sector consists of one or more complete counties and is fully contained within a single submarket. Over 3,100 counties are mapped into 506 sectors. Sector-level projections are then aggregated into 103 submarkets, 80 markets, 21 Veterans Integrated Service Networks (VISNs), and the national level.

The VA Model has evolved significantly since 1998 and continues to evolve. Plans for future model enhancements are developed through an assessment of the predictive capability of various model components or the identification of new data sources. For example, we recently assessed the accuracy of the 2008 enrollment and patient projections from the 2006 Model, which supported the 2008 Budget. The 2006 Model projected Veteran enrollment to within 0.3 percent, or 26,607, of actual 2008 enrollment, while it over-projected patients by 161,166, or 3.3 percent. In the last five fiscal years, the average variance between the VA Model's projection of enrollees and the actual enrollee population was 0.54 percent under-forecast. In other words, slightly more veterans enrolled than were projected to enroll. In the same 5 years, the average variance between the VA Model's projection of veteran patients and actual patients was 1.7 percent over-forecast. In other words, slightly fewer patients were actually enrolled than projected.

Regarding the latest generation of veterans with service in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), or other theaters, VA initially had difficulty modeling this population because we did not have estimates of the total force expected to be deployed in these conflicts. However, since 2007 VA has used a future force deployment scenario developed by the Congressional Budget Office to estimate the number of future OEF/OIF Veterans. We have conducted extensive analyses of the enrollment and health care utilization of this population, and with each additional year of data, we gain more insight into their unique characteristics. The VA Model reflects the fact that OEF/OIF enrollees have exhibited significantly different VA health care utilization patterns than non-OEF/OIF enrollees. For example, OEF/OIF enrollees have an increased need for dental services, physical medicine, prosthetics, and outpatient psychiatric and substance use disorder treatment. Alternatively, OEF/OIF enrollees seek about half as much inpatient acute surgery care from VA as non-OEF/OIF enrollees.

While the VA Model addresses many areas of the health care budget, it does not account for all areas of the VA medical care funding. Approximately 16 percent of the VA's health care budget is developed through alternative models and estimations, which each present challenges in projecting future costs.

Long-Term Care (both Institutional and Non-Institutional) estimates are developed in accordance with the VA's Long-Term Care Strategic Plan and historical cost and workload trends. The VA will continue to focus its long-term care treatment in the most clinically appropriate and least restrictive setting by providing more non-institutional care than ever before and making more care available to veterans closer to their homes.

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), the Foreign Medical Program, the Spina Bifida Program, and Children of Women Vietnam Veterans estimates are based on the current benefit structure, the mix of users, and workload estimates that reflect historical trends.

Readjustment Counseling estimates reflect historical trends and the establishment of new Veterans Centers and provide for the three major functions of direct counseling for issues related to combat service, outreach, and referral.

Non-Veteran health-care cost estimates reflect collateral care, consultations and instruction for spouses, reimbursable workload from affiliates (such as sharing agreements with the Department of Defense), humanitarian care, and preventive health occupational immunizations for VA employees, and are based on historical workload and cost trends adjusted to reflect the current benefit structure.

As noted earlier, while VA's methodology for health-care budget development is sound, we recognize the realities of economic, policy and other uncontrollable factors which alter the requirements for care and the ultimate costs of it. This limitation should be recognized in any proposal to implement an advance appropriations process. Any such proposal should provide flexibility for near-term changes in workload or performance needs.

We support the intent of H.R. 1016 and are committed to working with Congress to provide our veterans with the timely, accessible, and high-quality care that they expect and deserve. Finally, in the coming months close consultation between Congress, the Administration, and other stakeholders is necessary to develop the details in overcoming the challenges for the implementation of an advance appropriations proposal. Today's hearing, I believe, recognizes that necessity.

I look forward to hearing the Committee's views on advance appropriations and to answering any questions I can about VA budget projections. Thank you.

Statement of Coalition of Former VA Officials

As physicians, network and facility health care administrators, budget formulators and managers, and agency heads with hundreds of years of combined experience in the Department of Veterans Affairs (VA) and other health care systems, we are united in urging the Committee and the Congress to approve the Veterans Health Care Budget Reform and Transparency Act to provide advance appropriations for veterans' health care.

For most of the past two decades, VA budgets have been late, which has caused serious delays and interruptions in service for veterans being treated at the system's hospitals and clinics. In response, some in Congress have promised to bring VA budgets in on time, and we welcome that promise, just as we did in the past and would in the future. But the reality is that only three times in two decades have those promises been kept. It is not the intentions of Congress that have resulted in this failure; it is the very nature of the budget and political process. We strongly urge you to set a safety mechanism—advance appropriations—to make certain good intentions are met. To those who claim this bill is not necessary, we simply would point to the 86% failure rate of delivering veterans' health care budgets on time in the last two decades.

We know well the challenge of managing the Nation's largest integrated health care delivery system when, year after year, we did not know what level of funding we would receive or when it would arrive. Having been granted the privilege of serving on the frontlines of health care for America's veterans has given us close-up perspective of the agonizing results of uncertain budgets and continuing resolutions and the anxieties they inflict upon the delivery of health care. Among the recurring problems: drug and medical equipment purchases are stalled; hiring of health care professionals and other staff are delayed or deferred; repairs and replacement work to fix and modernize facilities are put on hold; and veterans medical appointments are pushed back.

Late budgets are not just a matter of numbers and money, they lead to an inability to properly manage and, ultimately, interrupted and diminished health care quality and patient safety. The impact of deferred obligations is manifested in reduced efficiency of operations as needed resources to support programs and purchases are withheld and resources available at prior year levels are used to fund only the most critical services. In many ways these funding restraints thwart efforts by VA to fully implement or carry out the intent of Congress and the Administration with regard to VA programs, such as the mandate to expand access to care, which has been a high priority.

Restricted funding levels can prevent a VA medical center from investing in personnel, equipment, supplies, contracts and leases to support expanded operations designed to increase access, thereby precluding VA from accomplishing the very goals set for it by Congress and the Administration. A system as vast and integral to the Nation's health care, especially one serving our most venerated constituency, should never be held hostage to late and unpredictable funding. Forcing health care administrators and professionals to await months-late budgets that dictate delayed strategies, planning and action is no way to run a health care system.

President Obama made a promise on the campaign trail to ensure the VA gets its budget on time by requesting advance appropriations, something he also supported as a senator and for which he publicly reaffirmed his support earlier this month. Advance appropriations still allows Congress to decide how much money to allocate to veterans' health care, it simply would be determined 1 year before VA needs those funds. While the actual dollars would not flow until the start of each new fiscal year, it would allow VA administrators and directors sufficient time to properly plan how best to use the money. This is no different than how a family budgets and spends based on expected income. Congress already provides advance appropriations for a number of programs, including Head Start, Job Corps and the Corporation for Public Broadcasting, and we strongly believe that providing health care to our Nation's veterans should be given the same funding consideration.

We urge the Committee and Congress to use your authority to adopt this simple budgeting tool to help ensure that VA has the resources to continue meeting the health care needs of veterans. We urge you to pass, and the President to sign, legislation to provide advance appropriations for veterans' health care.

Coalition of Former VA Officials:

Hon. Anthony J. Principi, Secretary (2001–2004)
Hon. Hershel W. Gober, Deputy Secretary (1993–2001)
Hon. Gordon H. Mansfield, Deputy Secretary (2005–2008)
Hon. Kenneth Kizer, MD, MPH, Under Secretary for Health (1994–1999)

Hon. Thomas L. Garthwaite, MD, Under Secretary for Health (1999–2002)
Hon. Robert H. Roswell, MD, Under Secretary for Health (2002–2004)
Hon. Jonathan B. Perlin, MD, PHD, Under Secretary for Health (2004–2006)
Frances M. Murphy, MD, MPH, Deputy Under Secretary for Health
Laura J. Miller, MPA, MPH, Deputy Under Secretary for Health
C. Wayne Hawkins, Deputy Under Secretary for Health
J. Arthur Klein, Director of Budget and Forecasting Service, VHA
Kenneth J. Clark, VISN 22 Director (CA, NV)
Larry Deal, VISN 7 Director (AL, GA, SC)
James J. Farsetta, FACHE, VISN 3 Director (NJ, NYC)
Dennis M. Lewis, FACHE, VISN 20 Director (WA, OR, ID, AK)
Robert E. Lynch, MD, VISN 16 Director (AR, LA, MS, OK)
Fred Malphurs, VISN 2 Director (NY)
James J. Nocks, MD, MSHA, VISN 5 Director (DC, MD, WV)
Clyde Parkis, FACHE, VISN 10 Director (OH)
James W. Dudley, VA Medical Center Director, Richmond, VA
John R. Fears, VA Medical Center Director, Phoenix, AZ
Joseph M. Manley, VA Medical Center Director, Spokane, WA
Robert A. Perreault, VA Medical Center Director, Charleston, SC
Wayne C. Tippets, MHA, VA Medical Center Director, Boise, ID
Timothy B. Williams, VA Medical Center Director, Seattle, WA

POST–HEARING QUESTIONS FOR THE RECORD

Committee on Veterans' Affairs
Washington, DC.
May 13, 2009

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Full Committee hearing entitled "Funding the VA of the Future" on April 29, 2009, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 26, 2009.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full committee and subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

CW:ds

Questions for the Record
The Honorable Bob Filner, Chairman
House Committee on Veterans' Affairs
April 29, 2009
Funding the VA of the Future

Question 1: With the President's support of advance appropriations, and your stated support, please explain why the VA did not provide a 2011 budget request when the 2010 budget was released in May? When can we expect this request? What steps must the VA undertake to provide an accurate 2-year budget forecast for purposes of advance appropriations?

Response: The Department of Veterans Affairs (VA) had not completed the development of estimates for advance appropriations for fiscal year (FY) 2011 at the time the President's 2010 budget was released. Since the release of the FY 2010 budget, the estimates for FY 2011 have been completed, and are detailed in the information that follows.

VA is seeking support for $48.183 billion for the three medical care appropriations to support estimated growth to 6.1 million patients. This represents an increase of 8.3 percent over the President's FY 2010 appropriation request of $44.498 billion. The FY 2011 total is comprised of $37.136 billion for Medical Services, $5.307 billion for Medical Support and Compliance, and $5.740 billion for Medical Facilities. In addition to the appropriated resource level, we anticipate collections in the amount of $3.355 billion, for a total advance appropriations resource level of $51.538 billion.

To prepare the FY 2011 advance appropriation estimate, VA used its enrollee health care projection model. This model uses FY 2008 as the base year, which is the most recent actual data available. Our estimate also factors in required funding increases provided in FY 2009 for programs that will continue in FY 2010 and FY 2011, which are not accounted for in the model. This estimate also includes resources for programs that are not projected by the model, such as long-term care and readjustment counseling.

Question 2: What new steps must the VA undertake, or what must the VA do differently, in order to be able to provide us with an out-year request?

Response: The response to Question 1 above describes the steps VA undertakes to develop an advance appropriation estimate. The advance appropriations request for FY 2011 was completed.

Question 3: Mr. Secretary, you explained the importance of providing the VA with the flexibility for near-term changes in workload or performance needs because of the limitations of uncontrollable factors in implementing advance appropriations. Please explain what this flexibility would look like for advance appropriations for the VA?

Response: VA will monitor medical care cost and performance indicators on a monthly basis. VA must have the flexibility to make any needed adjustments to the requested FY 2011 advance appropriation level during the regular process of formulating the President's Budget later this year.

Question 4: The Agency for Healthcare Research and Quality testimony pointed out that actuarial and economic models are limited by available data. What data do you believe would be helpful to collect; that you are not collecting now, that would enable you to better forecast health care demand and costs in an advanced appropriations environment?

Response: VA receives data from the Centers for Medicare and Medicaid Services (CMS) that identifies VA enrollees who have also enrolled in the Medicare drug benefit (Part D), but this data does not include the actual prescriptions dispensed. CMS is expected to make the 2006 prescription drug data available this year and VA is pursuing a data sharing agreement with CMS to obtain this data as allowable under applicable laws. This data will greatly improve our ability to assess the impact of the Medicare drug benefit on enrollee demand for VA health care. The knowledge we gain from this analysis will assist VA in better understanding how other changes in public and/or private health care, including health care reform, may impact VA.

Question 5: Mr. Secretary, your testimony trumpets the model's ability to forecast enrollment, stating that "in the last five fiscal years, the average variance between the VA Model's projection of enrollees and the actual enrollee population was 0.54 percent under-forecast." Over that same period of time, how accurate has the VA model been in estimating utilization rates and costs?

Response: Comparing the projected utilization and unit costs that supported a VA budget request with the actual utilization and unit costs 3 years later does not necessarily provide an informative assessment of the model's accuracy. Results can be clouded by many factors, including changes in coding practices, initiatives that were not planned when the model was developed, and factors beyond VA's control, such as military conflicts, environmental disasters, or economic downturns.

As part of its model development process, VA assesses the predictive capability of the various components of the model to identify opportunities to enhance future models. VA also continually updates the data and analyses that serve as inputs to the model. This process assures that the model always represents the best projection methodology and represents the best set of assumptions about the future that can be made at the time given the data and intelligence available.

Question 6: Mr. Secretary, you state that "in the coming months close consultation between Congress, the Administration, and other stakeholders is necessary to develop the details in overcoming the challenges for the implementation of an advance appropriations proposal." Can you provide more details as to the implementation challenges that you foresee?

Response: First, in June of 2009, VA provided Congress with the estimate for FY 2011 advance appropriations of $48.183 billion for the three medical care appropriations. Since VA's estimates for FY 2011 were developed earlier than under the previous procedure, VA will continue to jointly monitor medical care cost and performance indicators on a monthly basis and will make any needed adjustments to the requested FY 2011 advance appropriation level during the regular process of formulating the President's FY 2011 Budget this fall. In addition, funding for new medical care program initiatives will be considered in the formulation of the President's Budget later this year. Second, the current advance appropriations proposal involves only the three medical care appropriations. These three medical appropriations contain requirements that have related impacts on other appropriations managed by VA. During the formulation of the President's FY 2011 Budget later this year, we will also identify the resources needed to support medical information technology and capital construction program budgets. Third, we will still need the ability to transfer funds among the three medical appropriations, and we hope that Congress will continue to provide that flexibility. Fourth, since it is not clear what form the final legislation on advance appropriations will take, unexpected and additional challenges may arise.

Question 7(a): RAND has testified that the "EHCPM begins its expenditure projection with the VA's congressional budget allocation rather than an independent measure of resource needs" and that "the accuracy of the model is uncertain because there exists no expenditure information independent of the VA appropriation with which to formulate a "gold" standard against which to compare model projections." How accurate is the resulting projection if it is based on prior appropriations levels, which may or may not have been adequate to meet costs and demand?

Response: VA health care utilization and unit costs are not independent of VA's appropriation since, by law, VA cannot spend more than is appropriated. However, VA's enrollee health care projection model projections are not based on historical utilization and unit costs, but on a set of assumptions about the future. While the assumptions are informed by historical data, we do not assume that VA of the future will look like VA of the past. Projected utilization rates and unit costs are adjusted, when necessary, to mitigate identified capacity constraints, reflect anticipated changes in practice patterns, incorporate policy initiatives, or respond to new events, such as military conflicts.

Question 7(b): Do you believe that the "accuracy of the model is uncertain" or do you believe that the accuracy of the model is sufficient to support accurate outyear budget forecasts?

Response: VA believes the model is an effective forecasting tool to inform the advance appropriations process. The RAND evaluation found that the model supports VA's short-term budget planning and that it represents a substantial improvement over the budgeting methodologies used by VA in the past. The model represents the best set of assumptions about the future that can be made at the time given the data and intelligence available. Actual events can differ from projected for many reasons. For example, the severe economic downturn in 2008 could not have been predicted by earlier models. If advance appropriations are implemented, we will need a mechanism to address the uncertainties and factors outside the model's capability to forecast.

Question 8: The Congressional Research Service report "Advance Appropriations for Veterans' Health Care: Issues and Options for Congress" raised an issue regarding the effect of advanced appropriations on other VA accounts, such as the IT account. In the CRS example, the VA may not be able to purchase computer software although it has procured medical equipment that needs such software. Could you comment on this concern?

Response: The main challenge will be properly synchronizing the requirements of the three medical appropriations covered by the advance appropriations with other accounts not covered by the advance appropriations because the requirements in the three medical accounts have related impacts on other accounts not part of the advance appropriations. However, we are committed to work with the Congress to ensure that the advance appropriations proposal is effectively implemented.

Question 9: The CRS report also outlined other options for Congress, which included the creation of an independent entity modeled along the lines of the Medicare Payment Advisory Commission (MedPAC). The thought is that the creation of something like that could bring transparency to VHA's funding process and create credibility. Could you comment on this idea?

Response: The VA's enrollee health care projection model has proved to be an excellent tool for forecasting the Veterans Health Administration's (VHA) annual budgetary requirements. These requirements are displayed in VA's annual budget request. A recent RAND study has validated the usefulness of the VA's model, and we would welcome similar reviews in the future, thus obviating the need for a standing independent body.

Question 10: If we were to implement advance appropriations for the VA, what are your recommendations on the issue of carryover funding and the provision of 2-year funding for certain VA accounts?

Response: VA anticipates requesting a similar, relative percentage of the Medical Services, Medical Support and Compliance, and Medical Facilities accounts for its second year request as the first year request. This would allow VA to account for unanticipated delays it may encounter, such as contracts that cannot be awarded before the first fiscal year's end or variations in program requirements not previously anticipated and accounted for in the original budget submission.

Question 11(a): VSOs support the ability of the VA to request supplemental funding in instances where previously provided budget levels are insufficient to meet newly estimated demand or costs. Do you foresee the VA seeking annual supplemental appropriations in an advanced funding environment or would there be greater pressure on VA managers to get through the fiscal year in order to access the next year's budget amounts?

Response: We do not foresee VA automatically seeking annual supplemental appropriations in an advanced funding environment. However, uncontrollable factors such as changes in patient demand, severe economic conditions or natural disasters may create the need for a supplemental appropriation.

Question 11(b): If VA accounts were over-funded would you support rescissions to recapture these additional dollars?

Response: In the event that funding for VA accounts is greater than anticipated need, VA would work through the normal budget process with the Office of Management and Budget to address appropriate adjustments.