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STATEMENT OF
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VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE
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Mr. Chairman and members of the Committee, good morning and thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) current funding process for its medical care program including budget formulation, Congressional appropriations, and alternatives to the existing process, such as moving such funding to the mandatory side of the Federal ledger. Joining me today are Paul Kearns, Chief Financial Officer for VHA, and Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning.

Following the enactment of the Veteran's Health Care Eligibility Reform Act of 1996, VA's health care system has undergone significant transformation from one that provided episodic, inpatient care to an integrated system of care that provides a full range of comprehensive health care services to its enrollees. The focus on health promotion, disease prevention, and chronic disease management has produced more effective and more efficient health care for our nation's veterans. As a result, the range of health care services utilized by VA patients began to mirror that of other large health care plans. Therefore, VA decided to follow private sector practice of large health care plans and use a health care actuary to help predict future demand for health care services. Mr. Chairman, transforming VA from an inpatient, hospital-based system to a fully integrated health care system has enabled VA to take a leadership position in health care quality in the United States.

Prior to eligibility reform, VA medical care budgets were based on historical expenditures that were adjusted for inflation and increases were based on new initiatives. However, this historical-based approach was not consistent with the practices of large, integrated, private-sector health plans. The private sector budget practices based on projected demand appeared better suited for our mission, so VA adopted a rational and predictive budget to meet the needs of veterans in this new transformed health care system. We appreciated the need to be able to continually adjust budgetary projections to account for shifting trends in the veteran population, increasing demand for services, and escalating costs of health care, e.g., pharmaceuticals and changing utilization of health care services.

Current Funding Process VA's Enrollee Health Care Demand Model
The VA Enrollee Health Care Demand Model (model) develops estimates of future veteran enrollment, enrollees' expected utilization for 55 health care services, and the costs associated

with that utilization. These projections are available by fiscal year, enrollment priority, age, Veterans Integrated Service Network (VISN), market, and facility and are provided for a 20-year period. This produces over 40,000 individual utilization and budget estimates per year.

The model provides risk-adjustment and reflects enrollees' morbidity, mortality, and changing health care needs as they age. Because many enrollees have other health care options, the model reflects how much care enrollees receive from the VA health care system versus other providers. This is known as VA reliance. Enrollee reliance on VA is assessed using VA and Medicare data and a survey of VA enrollees. The VA/Medicare data match provides VA with enrollees' actual use of VA and Medicare services, while the survey provides detailed responses from enrollees regarding private health insurance and use of VA and non-VA health care. The graphic on the next page provides a conceptual overview of the actuarial model and the key data and analyses supporting it.

The model projects future utilization of numerous health care services based on private sector utilization benchmarks adjusted for the unique demographic and health characteristics of the veteran population and the VA health care system. The actuarial data on which these benchmarks are based represent the health care utilization of millions of Americans and include data from both commercial plans and Medicare, and are used extensively by other health plans to project future service utilization and cost.

The model produces projections for future years using health care utilization, cost, and intensity trends. These trends reflect historical experience and expected changes in the entire health care industry and are adjusted to reflect the unique nature of the VA health care system. These trends account for changes in unit costs of supplies and services, wages, medical care practice patterns, regulatory changes, and medical technology.

Each year, the model is updated with the latest data on enrollment, health care service utilization, and service costs. The methodology and assumptions used in the model are also reviewed to ensure that the model is projecting veteran demand as accurately as possible. VHA and in partnership with Milliman, Inc., develop annual plans to improve data inputs to the model and the modeling methodology.

VA has integrated the model projections into our financial and management processes. Eighty-four percent of the VA health care budget request for FY 2008 was based on these detailed actuarial projections; the remaining sixteen percent is for health programs not yet included in the actuarial projections because of the unique characteristics of these programs. Some examples include: readjustment counseling, dental services, the foreign medical program, and non-veteran medical care (such as CHAMPVA and spina bifida). The budget estimates for these programs are developed by the respective program managers.

VA believes the use of actuarial projections to develop its budget estimates is the most rational way to project the resource needs for our veterans. As noted earlier, this approach is utilized by the private sector. Unlike the private sector, however, where projections are used to formulate

budgets for the next year or even the next "open season," the Federal budget cycle requires budget formulation using data 2 ½ to 3 years ahead of budget execution.

Congressional Appropriations

VA receives its medical care budget in three separate appropriations (Medical Services, Medical Administration, and Medical Facilities). This is a funding structure created by Congress in Fiscal Year 2004. This structure replaced the previous single appropriation structure and has significantly increased the operational complexity without improving the accuracy of financial accounting. In addition, the new structure has introduced unintended inefficiencies and increased complexities into VA's budget management processes and procedures. VA does not believe the benefits of this structure are superior to the previous one.

Alternatives to the Existing Process

The two most considered alternatives to the existing process are: 1) combining VHA's current multiple appropriations structure into a single medical care appropriation and 2) mandatory funding. VA supports a single appropriations structure for medical care but does not support a mandatory funding approach for veterans' health care.

A single appropriation for medical care would enable VA managers at every Medical Center and Network level to optimize resources flexibly and ensure timely delivery of high quality health care to veterans. It would also reduce the complexity of current financial management processes and procedures.

On the other hand, mandatory funding we believe would not be in the best interests of our veterans. A mandatory funding approach, in our view, is neither reflective of nor adaptable to changes in: enrollee priority level and age mix, enrollee morbidity and mortality, enrollee reliance, and advances in state-or-the-art technologies and medical practice. While we can only hypothesize at this time since there is not a concrete proposal to review regarding a mandatory funding model, this type of funding mechanism can be reactive in nature consequently may be out of date with rapidly changing best clinical practices and developments. Additionally, a mandatory funding approach potentially limits the ability of either the Executive or Legislative branches of government to match policy with financial circumstances or to execute their inherent oversight responsibility.

We believe the current process of budget formulation provides the best methodology for estimating the VHA budget and a single appropriation would significantly improve VHA's ability to deliver timely, high-quality health care to our nation's veterans.

Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions you may have.