

FIXING VETERANS HEALTH CARE

*A Bipartisan
Policy Taskforce*





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A Letter From The Co-Chairs

Dear Reader,

Few of us are unaware that there are imperfections in the way we provide health care to our nation's veterans. After the headlines of 2014, Americans of all stripes—veterans and civilians, Democrats and Republicans—know we can do better.

Concerned Veterans for America aims to be part of the solution. Last fall, CVA convened a Taskforce that we called "Fixing Veterans Health Care." The mission of the Taskforce was straightforward: to propose concrete reforms, that could be turned into legislation that would dramatically improve the delivery of health care to veterans.

We are veterans and health care experts with a shared charge: to do the right thing to meet the needs of veterans. In order to advance this mission, our Taskforce took an honest, inquisitive, and nonpartisan look at the veterans' health care delivery system.

Today's system for veterans health care exists for a reason. But few policymakers, afforded a clean slate, would recreate it in its current form. Modern veterans health care delivery is ripe for a full-scale reassessment, and this report aims to deliver one.

Our due diligence process was veteran-centered, expert-driven, and open-minded, with a focus on systemic reforms to the Department of Veterans Affairs—the Veterans Health Administration (VHA) specifically. The timeliness and quality of care for veterans varies throughout the country, driven by a myriad of known and unknown variables. We asked questions about eligibility, access, choice, and accountability in the VHA.

The majority of employees at VHA are dedicated and competent professionals. Standing in their way are bureaucratic constraints that make it hard to innovate and leave little incentive for excellence. Furthermore, there are storm clouds on the demographic horizon that will place additional pressure on veterans health care facilities. In order to avoid

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ineffective and reactionary policies in the future, our goal was to proactively ensure that eligible veterans of today and tomorrow receive timely and quality care.

In working to develop the best policies for fixing veterans' health care, we sought perspectives from health care scholars, experienced policymakers, veterans service organizations and—most importantly—veterans all across the country. You cannot come up with veteran-centered reforms without understanding what veterans need and want. Our questions to each participant in our process were always the same: What's working? What isn't? What must be reformed? What must be protected? How do we put the veteran at the center of veterans' health care?

Fundamental change to any system threatens the status quo, often provoking attacks on both the messenger and message. We anticipate this may happen to us and to our proposal. But because of our thorough process, we rest assured that veterans across America will eagerly welcome our proposal. We are committed to these recommendations, and to the follow-through required to advance them: continuing our commitment to Lincoln's promise "to care for him who shall have borne the battle."

We would like to thank CVA's CEO Pete Hegseth, our Taskforce Executive Director Darin Selnick, and the entire policy team at CVA for their indispensable support in this endeavor. We look forward to sharing our findings. Thank you for your interest in joining us to serve America's veterans.

Sincerely,



Dr. William Frist (R-TN)
Taskforce Co-Chair



Cong. Jim Marshall (D-GA)
Taskforce Co-Chair



Dr. Michael Kussman
Taskforce Co-Chair



Avik Roy
Taskforce Co-Chair

Taskforce Biographies



Dr. William H. Frist, M.D.
(R., Tenn., 1995-2007)
Taskforce Co-Chair

Dr. Frist is a nationally acclaimed heart and lung transplant surgeon and former U. S. Senate Majority Leader. Dr. Frist served the Tennessee Valley VA as a staff Cardiac Surgeon staff for nine years before going on to represent Tennessee in the U.S. Senate for 12 years (1995-2007). In the Senate he served on both the Committee for Health, Education, Labor and Pensions (HELP) and the finance committee, and as Senate Majority Leader from 2003 until 2007. His leadership was instrumental to the passage of the 2003 Medicare Prescription Drug, Improvement and Modernization Act and PEPFAR, the unprecedented national commitment to fight HIV/ AIDS globally. He is currently Adjunct Professor of Cardiac Surgery at Vanderbilt University and Clinical Professor of Surgery at Meharry Medical College. He is also Co-Chair of the Health Project at the Bipartisan Policy Center. His board service includes the Robert Wood Johnson Foundation the Kaiser Family Foundation, and the Center for Strategic and International Studies (CSIS).



Congressman Jim Marshall
(D., Ga., 2003-2011)
Taskforce Co-Chair

Congressman Marshall is a former Mayor of Macon, Georgia and a member of the 2014 National Defense Panel. During his four terms in Congress, Jim earned a reputation for being a principled and bipartisan legislator. During his first term, he received recognition from many veterans organizations for devising and successfully leading a campaign to eliminate the Disabled Veterans Tax (aka the prohibition on concurrent receipt), freeing tens of billions of dollars wrongfully denied to disabled military retirees. Jim is a graduate of Princeton University, where he was a University Scholar, and Boston University School of Law, where he graduated magna cum laude. He is a business and finance lawyer and a law professor who has taught at Princeton University and served as the President and CEO of the United States Institute of Peace. Jim is also an infantry combat veteran of Vietnam where he served as a reconnaissance platoon sergeant. He has received numerous military awards and recognitions, including the Purple Heart and membership in the United States Army Ranger Hall of Fame.



Dr. Michael Kussman
Taskforce Co-Chair

Dr. Kussman was Under Secretary for Health for the Department of Veterans Affairs from 2007 to 2009, capping a distinguished 37 years of government service. As Under Secretary for Health, Dr. Kussman directed a health care system with an annual budget of approximately \$40.2 billion, overseeing the delivery of care to more than 5.6 million veterans. Before joining the VA in 2000, Dr. Kussman retired from the United States Army as a Brigadier General. He is a graduate of the Army War College and an honor graduate of the Command and General Staff College. Dr. Kussman earned his undergraduate and medical degrees from Boston University, receiving his medical degree in 1968. In 1994, he earned a master's degree in management from Salve Regina University in Newport Rhode Island.



Mr. Avik Roy
Taskforce Co-Chair

Mr. Roy is a Senior Fellow at the Manhattan Institute's Center for Medical Progress. He is also the Opinion Editor at Forbes, and a former health care policy adviser to Mitt Romney's presidential campaign. He edits *The Apothecary*, a widely read Forbes blog on health care and entitlement reform. Recently, Mr. Roy authored a widely-acclaimed health care reform proposal, *Transcending Obamacare: A Patient Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*. Mr. Roy was educated at the Massachusetts Institute of Technology, where he studied molecular biology, and the Yale University School of Medicine.



Mr. Darin Selnick
Taskforce Executive Director

Mr. Selnick is the Fixing Veterans Health Care Taskforce Executive Director and the Senior Veterans Affairs Advisor for Concerned Veterans for America. An Air Force veteran, he also volunteers his time as Chairman of the West Los Angeles Veterans Home Support Foundation. From 2001-2009, Mr. Selnick was an appointee at the Department of Veterans Affairs, serving as a special assistant to three VA secretaries. His positions included the Director of the Center for Faith-Based and Community Initiatives and Special Assistant to the Secretary and Associate Dean, VA Learning University. In this role he was responsible for providing program and operational oversight of VA Learning University. Prior to joining the VA, Mr. Selnick spent eight years in private sector health care as a senior manager.



Mr. Pete Hegseth
CEO, CVA

Mr. Hegseth is the Chief Executive Officer for Concerned Veterans for America. He also volunteers his time as an adviser to the Eagle's Healing Nest, a Minnesota-based organization committed to meeting the needs of our veterans, service members and their families who suffer from the invisible wounds of war. Prior to joining CVA, Pete was Executive Director for Vets for Freedom, an Iraq and Afghanistan veterans advocacy organization. An Army infantry veteran, he served tours in Afghanistan, Iraq and Guantanamo Bay, Cuba. Pete earned two Bronze Stars and a Combat Infantryman's Badge for his time in Iraq and Afghanistan. He graduated from Princeton University in 2003 and earned a master's degree in Public Policy at Harvard University's John F. Kennedy School of Government in 2013.



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The digital version of this book is available at taskforce.cv4a.org

1.

EXECUTIVE SUMMARY



Politicians don't often agree,

BUT THEY DO AGREE ON THIS:

America has a responsibility to care for veterans disabled or injured in the line of duty while serving honorably in our military. The question is not *whether* entitled veterans should receive timely and quality health care; the question is *how* to best deliver that care. In order to keep faith with America's wounded warriors—while remaining good stewards of taxpayer dollars—it is critically important that we get the *how* right.

Since 1776, America's leaders have wrestled with the how: struggling to find the correct balance of financial resources, physical facilities, eligibility requirements, and delivery mechanisms. Over the past two centuries, a pattern of "reform and failure" has repeated itself. Problems with veterans programs emerge, and in response, the government enacts well-intentioned reforms. Sometimes the government gets it right, and sometimes it misses the mark. Sometimes the same problems re-emerge after a period of improvement. Some veterans receive quality, timely health care; others receive delayed and substandard care.

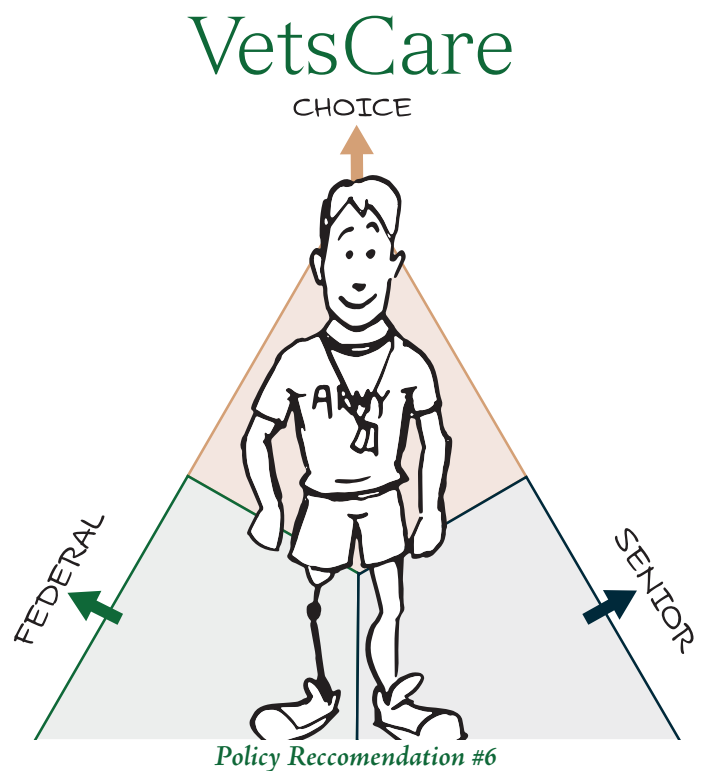
In 1921, when the Veterans Bureau was created, the nation's civilian health care infrastructure was sparse. Today we have the most developed health care infrastructure in the world. Indeed, U.S. health care spending represents more than seventeen percent of the nation's economic output, dwarfing the Veterans Health Administration's health care spending.¹ Moreover, VHA enrollees already receive on average three-quarters of their care, measured in dollars, from non-VHA health care sources. There is no reason for veterans to wait in line for health care at VA facilities.

Yet, as the recent Department of Veterans Affairs wait-time scandal revealed, today's veterans are not being adequately served by the VHA. Despite a \$91 billion cumulative increase in the VA's budget since 2006, and a 101,000-person increase in the VA's staff, the timeliness of health care delivery for a shrinking veteran population has not improved.

In addition, the quality of care appears to be mixed, and is certainly not commensurate with the VHA's massive growth in funding and personnel. Recent attempts to address perceived funding and staffing shortfalls at the VHA have failed to meet the twenty-first century needs of veterans.

If proactive and fundamental reforms are not made soon, demographic realities will force further drastic and reactionary changes. As the Vietnam generation passes on, the size of the veteran population will shrink considerably. **In 2009, there were 24 million U.S. veterans; by 2029, the VA expects that population to shrink to 16 million.**

The number of VHA enrollees, while older in age, will shrink as well. Advances in medical technology have also led to fewer hospitalizations and more care delivered in physicians' offices. Future wars could, of course, re-expand the veteran population, but this is not a possibility that the VHA can either predict or rely upon. Moreover, given the scale, flexibility, and competence of America's private health care sector, maintaining costly excess capacity in VHA can no longer be rationalized as a hedge against future contingencies. The VHA must get ahead of its demographic destiny, or be overcome by it.



We believe there are two choices in confronting these challenges. On the one hand, we could advance incremental reforms to the current system, leading to incremental improvements in the near term. But this course would not empower veterans to choose the health care best for them and would ignore looming demographic realities. On the other hand, we could advance long-term reforms of the current system, while addressing the immediate needs of veterans and in doing so, give veterans control over their own health care, improve the sustainability of VHA facilities for the long haul, and break the government cycle of reform and failure.

We enthusiastically choose the latter option. Now is the time to ensure that all eligible veterans—young and old, male and female, rich and poor, urban and rural—are the centerpiece of veterans health care. For too long, concerns unique to the VHA as a legacy institution have distorted the planning, funding and delivery of health care for veterans. While the VHA will remain an important component of veterans health care delivery, we firmly believe that veterans' interests must take precedence.

America's veterans agree. Our nationwide, nonpartisan survey found that 90 percent of veterans favor reforming veterans' health care, and that 89 percent believe it is "very important" that these reforms include "increasing health care choices for veterans." Eighty-six percent believe that eligible veterans should be able to choose a private physician, and 77 percent believe veterans should be given this choice—even if it costs them a little more out of pocket. Bottom line: veterans want choices.

The Veterans Access, Choice and Accountability Act of 2014 (VACAA), passed by Congress in 2014, expands veterans' choices somewhat. Under these reforms, the VHA serves as the gatekeeper for care and limits the number of veterans who qualify for private health care choices. Geographic restrictions are made based on VA facilities, not where veterans receive care, and wait-time restrictions are based on what the VA deems "medically necessary," not when a veteran requests an appointment.

Furthermore, the VHA's implementation of these reforms has been slow and confusing. The VACAA is a good first step, but it is a temporary one whose funding is expected to run out in a few years. In February 2015, VA Secretary Robert McDonald proposed reducing the VACAA's budget for privately-provided veterans health care, and reallocating those funds for other purposes. In the end, VACAA has kept the VA bureaucracy in control, and offers few real choices to veterans.

This Taskforce seeks to flip that equation. Our proposal puts veterans in control of their health care. This approach is not anti-VHA. It is pro-veteran. The VA should be given every opportunity to compete for veterans' health care dollars. But it can no longer take veterans for granted as customers. Some veterans get great care from the VA and will want to continue doing so. Others do not and will not. Ultimately our veterans deserve the same degree of choice that is available to other Americans.

In pursuing this goal we agreed on these 10 core reform principles:



Principles For Veterans' Health Care Reform

- 1. The veteran must come first, not the VA.** The institutional priorities of the VHA weigh too heavily in current planning, funding and care delivery decisions. We believe the interests of veterans should be paramount.
- 2. Refocus on, and prioritize, veterans with service-connected disabilities and specialized needs.** Veterans with service-connected disabilities and specialized health care needs should be heavily prioritized; any reforms should ensure that VHA health care delivery centers on service-connected veterans and leveraging the VHA's comparative advantage in specialized areas.
- 3. VHA should be improved, and thereby preserved.** Those veterans who choose to use VHA facilities should receive timely and quality care. In order to achieve this goal, the VHA should be restructured—as an independent, efficient, and modern organization—that can compete with private providers.
- 4. Grandfather current enrollees.** Veterans should have the option to seek care outside of VA system but current enrollees who wish to continue to receive care within the system should retain the option to do so. Currently enrolled veterans will also have the option to “opt-in” to the reformed system.
- 5. Veterans should be able to choose where to get their health care.** Based on eligibility, veterans should have the option to take their earned health care funds and use them to access care at the VA or in the voluntary (civilian) health care system. Because private health care is somewhat costlier than VHA-based care, most veterans who choose this option will be expected to share in some of the costs of such care, through co-pays and deductibles.
- 6. Veterans health care reform should not be driven by the budget.** More efficient health care for our veterans may reduce the cost of their care, but reform should not be viewed as an avenue to reduce federal spending. Conversely, increased funding is insufficient to address VHA's deficiencies. Thankfully, our fiscal modeling suggests reform can be achieved in a revenue-neutral manner.
- 7. Address veterans' demographic inevitabilities.** The VHA must be reformed now, or demographic changes in the veteran population will force difficult—and inevitable—changes in the future. Any reform proposal must consider substantial forthcoming demographic shifts in the veteran population, including substantial shrinkage in overall numbers—save for another protracted conflict—and disproportionate decreases in future enrollment.
- 8. Break VHA's cycle of “reform and failure.”** Minor tweaks to the current system may incrementally improve health care in the near term, but the monopolistic VHA bureaucracy is likely to return to a standard operating procedure heavily influenced by the desires and concerns of the institution and its employees. Only fundamental reform will break the cycle and empower veterans.
- 9. Implementing reform will require bipartisan vision, courage and commitment.** A well-connected VA bureaucracy, parochial congressional concerns, and powerful outside groups frequently stifle difficult reforms across the government—and the same could happen with VHA reform.
- 10. VHA needs accountability.** The VHA must be accountable to both veterans and taxpayers for its performance. An independent VHA will have more latitude to reward high performers, fire poor performers, and monitor the quality of health care delivery.

These principles provide the guiding foundation for reform, but the devil is always in the details. Turning these principles into policies was the most time-consuming aspect of our work and will involve the greatest challenge for policymakers. We were hindered in our efforts by a dearth of readily available data from the VA; such data is needed to build a model that can accurately forecast the fiscal and economic impact of different options for reform.

We aren't the only ones to point out this unacceptable information gap. In a December 2014 report, the Congressional Budget Office noted that "comparing health care costs in the VHA system and the private sector is difficult partly because the Department of Veterans Affairs...has provided limited data to Congress and the public about its costs and operational performance." CBO then suggested the VA be required to provide detailed annual reports to Congress, like those tendered by the Department of Defense concerning TRICARE.

This, at a bare minimum, should be required of the VA, the VHA, and any successor entities. They should publicly report on all aspects of their operation, including quality, safety, patient experience, timeliness, and cost-effectiveness. That way, policymakers and reformers can take into account detailed information about the veterans' population and VHA enrollees in particular, to better understand their needs, and their probable behavior when offered different alternatives.

We believe this report offers a strong start and foundation for policymakers, although we acknowledge that our recommendations will benefit from further examination, refinement and fiscal modeling. We know there remain both "known unknowns" and "unknown unknowns" in the veterans health care sphere, and present our recommendations and assumptions with the requisite humility.

The gradual expansion of the VHA's mission to provide health care to an ever-increasing pool of veterans has made it more difficult to perform its original mission of caring for veterans injured in service to our country, greatly increased the cost of VA health care, and contributed to the many access issues that are highlighted in the history portion of this report. It is worth noting that 59 percent of the current unique VHA patients do not have a service-connected disability. We feel strongly that these reforms are an opportunity for Congress to move VA health care gradually back to its service-connected care roots, using our report as a baseline for further refinement and precision. Appropriately involving the private sector can assure no bifurcation of care and can essentially eliminate the cyclical excess capacity issue that has plagued VHA.

Among our "known unknowns" are how many veterans would select our choice plans and what the consequent cost would be. We decided to base our fiscal modeling and structure of recommendations on current patient eligibility because of the dearth of detailed information on the true costs of VA health care—more "known unknowns". We cannot emphasize enough how important it is for Congress to demand that the VHA provide detailed and transparent accounting of how they spend their appropriated funds. Only then, will the true cost of caring for our nation's veterans be understood. We did not alter the current priority groups since that would have made any fiscal modeling even more difficult.

For these reasons and others, this report proposes an overall roadmap for reform, entitled The Veterans Independence Act: Transforming Veterans Health Care for the Twenty-First Century. We do so with a humble understanding that no plan is perfect. While we believe that our proposal would significantly improve veterans health care, we know the plan would benefit from continued refinement and input from interested parties. **With this caveat in place, we propose three major categories of reform:**

59% of the current unique VHA patients do not have a service-connected disability

The Veterans Independence Act:

Restructure the VHA as an independent, government-chartered non-profit corporation.

The VHA would function more effectively as an independent organization that is fully empowered to make difficult decisions on personnel, facilities, partnerships, and other priorities—all in the interest of serving eligible veterans better. Presently, VHA is charged with delivering health care outcomes, while constrained by parochial bureaucratic and political priorities. As an independent entity—answering to its customers and balance sheet—it would be liberated to make the decisions necessary to ensure veterans who continue to choose VHA receive quality and timely care. In addition, we believe that separating the VHA into two functional entities—one, the provider of health care services and the other, the payor of health insurance premiums and claims—will give veterans more options.

Give veterans the option to seek private health coverage with their VA funds.

The dollars needed for veterans' service-connected health care should follow veterans wherever they choose to seek care. Our analysis suggests a premium support model for eligible veterans would be well suited to deliver authentic choice for many, perhaps most, veterans; but other health care delivery mechanisms should also be considered. Likewise, veterans who prefer high-deductible coverage would gain the additional option of directing the remainder of their premium support benefit into an interest-bearing health savings account.

Veterans education benefits serve as an attractive model for VA health care reform. Through the GI Bill, veterans who meet eligibility requirements have the opportunity to use taxpayer dollars to pursue the accredited academic institution

of their choice. VA determines the eligibility, ensures academic institutions meet a certain standard, and monitors the process for payment. The VA does not, however, require veterans to receive their education through a "Veterans University," or tell veterans what schools they can attend. The same principle can apply to health care, with VHA giving veterans general guidance and assistance, if they seek it.

Refocus veterans health care on those with service-connected injuries.

That was the VA's original mission: to provide health care for those who bear the physical and mental scars of war. For decades, often in order to justify its existence, the VHA has expanded eligibility requirements to those without service-connected health needs. But, when it comes to health care obligations, not every veteran is created equal. Those veterans with service-connected health needs should be prioritized in the current system, and even more so for future veterans. Such an approach permits the VA to focus on providing quality and timely care to eligible veterans who most need it.

We hope that our proposal serves to kick start a long overdue national conversation. For years, veterans' advocates, health care experts, and members of Congress—on both sides of the aisle—have privately echoed the recommendations we discuss herein. But those echoes have remained behind closed doors, due to an adversarial political climate. Our goal is to bring that principled conversation into the public square for robust debate, and thereby help policymakers advance legislation that achieves lasting reform of veterans' health care.

We believe that our proposal could reshape the VHA reform debate, because it truly places veterans at the center of their own health care. Concerned Veterans for America will fight to advance these reforms, and looks forward to working with lawmakers on both sides of the aisle to turn them into reality. Together, we can improve the lives of those who fought to defend the freedom we love.

Policy Recommendations

Below is a more specific outline of our policy recommendations. Further details are available in the main body of the report.

RESTRUCTURING THE VETERANS HEALTH ADMINISTRATION

- 1. Separate the VA's payor and provider functions into separate institutions.**

In order to best offer veterans the option of receiving care from private physicians, the VA's health insurance function should be separated from its function as a provider of hospital and clinical care. The Veterans Independence Act proposes dividing the VHA's existing responsibilities into the Veterans Health Insurance Program (VHIP) and the Veterans Accountable Care Organization (VACO).
- 2. Establish the Veterans Health Insurance Program (VHIP) as a program office in the Veterans Health Administration.**

VHIP would administer the VA's health insurance and premium support programs within the Department of Veterans Affairs. Over time, the purpose of VHIP would evolve to subsidizing veterans' health coverage, from private and public institutions, while maintaining a market for private health insurance plans that offer veterans the choice of voluntary and VA health care providers.
- 3. Establish the Veterans Accountable Care Organization (VACO) as a non-profit government corporation fully separate from the Department of Veterans Affairs.**

VACO would encompass the VA's brick and mortar health care facilities. The Veterans Independence Act proposes to establish the VACO as a non-profit government corporation that is fully separate from the Department of Veterans Affairs, along the lines of the National Railroad Passenger Corporation.

The VHA would continue to administer VHIP and the other non-provider programs currently under its purview, such as the domiciliary care, programs for homeless veterans, administering education and training for health care personnel, conducting health care research and providing contingency support for DoD and HHS during times of war or national emergency.

- 4. Institute a VA medical center realignment procedure (MRAC) modeled after the Defense Base Realignment and Closure Act of 1990 BRAC.**

VA medical center capacity is not efficiently designed to serve the needs of veterans. In some areas, VA medical facilities are scarce, forcing veterans to drive long distances to receive care. In other areas, VA facilities go largely unused, due to overcapacity and demographic shifts.

The profoundly inefficient distribution and scale of VA facilities serves veterans poorly, not only because they are difficult to access but also due to cost. The high fixed costs associated with maintaining unused VA medical centers utilize funds that could be applied to improve the quality of veterans' health coverage.

We hope the independence of the Veterans Accountable Care Organization will enable it to freely rationalize and manage its facilities to more efficiently devote its resources to veterans' care. If, in practice, it does not enjoy this freedom, the Veterans Independence Act will provide ongoing authority for the president to institute a medical center realignment procedure modeled after the Defense Base Realignment and Closure Act of 1990 (BRAC).

Under MRAC, like BRAC, the president would be empowered to appoint an independent nine-member panel whose recommendations for medical center closures become law, unless Congress formally passes a resolution objecting to those recommendations within 45 days. For example, there could be an automatic trigger whereby the MRAC panel reviews VA facilities that have filled less than 30 percent of their beds on an average daily basis over a five-year period.

5. Require the VHA to report publicly on all aspects of its operation, including quality, safety, patient experience, timeliness, and cost-effectiveness.

In 2014, the Congressional Budget Office (CBO) attempted to compare health care costs in the VA system with those in other U.S. health care systems. However, CBO noted “comparing health care costs in the VHA system and the private sector is difficult partly because the Department of Veterans Affairs...has provided limited data to Congress and the public about its costs and operational performance.”

In order for the government to better monitor and exact continuous improvement on the VA system, the VHA should publicly report on all aspects of its operation, including quality, safety, patient experience, timeliness, and cost-effectiveness, using standards similar to those in the Medicare Accountable Care Organization program.

EXPANDING VETERANS' HEALTH CARE CHOICES

6. Preserve the traditional VA health benefit for current enrollees who prefer it, while offering an option to seek coverage from the private sector.

Under the Veterans Independence Act, all currently enrolled veterans from Priority Groups 1 through 8 would continue to be eligible for traditional VA health care. Those who are satisfied with their current coverage would be able to maintain it, with no additional changes or cost-sharing. In addition, currently enrolled veterans would also gain the option of choosing private health insurance, including plans customized for the veteran population.

VETSCARE FEDERAL

Veterans who are satisfied with VA health care would be able to maintain their existing coverage, with no changes to benefits or cost-sharing. This plan would be called VetsCare Federal. Veterans in this plan would have full access to the VA's integrated health care system, the Veterans Accountable Care Organization.

VETSCARE CHOICE

Like VA employees, our veterans should be free to choose their own source of health insurance. This program would be called VetsCare Choice, and offers veterans the ability to purchase heavily discounted private health coverage.

Specifically, enrolled veterans would be able to use the funds currently spent on them through the VA health care system to purchase private health coverage through a mechanism called premium support, comparable to the way VA employees obtain coverage through the Federal Employees Health Benefits Program.

Veterans in higher Priority Groups would be offered larger amounts of premium support. In addition, the VetsCare Choice program would be phased in, such that Priority Groups 1 through 3 would gain access to the program upon enactment of the Veterans Independence Act and Groups 4 through 8 would become eligible for the program within five years after enactment.

The VetsCare Choice program would fully fund premiums for a benchmarked health insurance plan according to the following schedule. Veterans who are 100 percent disabled due to a service-connected injury will receive the option of “Diamond” coverage with zero cost sharing; in health insurance parlance, the plan would retain an actuarial value of 100 percent. The remaining Priority Group 1 and 2 veterans would gain the option of “Platinum” coverage in which co-pays and deductibles would cover 10 percent of expected costs; i.e., an actuarial value of 90 percent.

Members of Priority Group 3 and 4 would gain the option of “Gold” coverage with an actuarial value of 80 percent; Priority Groups 5 and 6, “Silver” coverage with an actuarial value of 70 percent; Priority Groups 7 and 8, “Bronze” coverage with an actuarial value of 60 percent.

For all VetsCare Choice plans, services delivered in VA facilities or by VA physicians would be covered at 100 percent, with no cost-sharing. Hence, veterans who purchase private health coverage through this program would continue to be able to use VA facilities through insurance products that contract with VA providers. The Veterans Independence Act would create a mechanism to ensure that VetsCare Choice health plans contract with VA facilities for this purpose.

Additionally, veterans who prefer high-deductible coverage—i.e., insurance plans with more cost sharing and a lower actuarial value—would have the choice to do so. Because such plans are less costly than conventional insurance plans, veterans would gain the option of directing the difference in price into an interest-bearing health savings account.

VETSCARE SENIOR

Enrolled veterans over the age of 65, and those who qualify for Medicare due to disability, would gain the option of using their VA funds to defray the costs of Medicare premiums and supplemental coverage (“Medigap”). This plan would be called VetsCare Senior.

As with VetsCare Choice, all veterans who purchase private health coverage in this manner would continue to be able to use VA facilities, through insurance products that contract with VA providers. The Veterans Independence Act would create a mechanism to ensure that VetsCare Senior health plans contract with VA facilities for this purpose.

7. Reform health insurance coverage for future veterans.

For future veterans, those who are eligible, would be entirely transitioned into the premium support system, providing a clear path for integration of veterans' health care into the broader health care system. New eligibility requirements would go into effect for those veterans who applied for enrollment after a predetermined cutoff date.

Eligibility for sponsored health coverage would be based on the current Priority Group requirements. However, veterans with service-connected disabilities—i.e., those in Priority Groups 1 through 3—would be even more highly prioritized with the most robust coverage, minimal cost-sharing, and expedited access to VHA facilities. The program would also assist disadvantaged veterans, such as those in Priority Groups 4 through 6.

8. Offer veterans access to the Federal Long Term Care Insurance Program.

Unlike acute-care insurance, which pays for hospital and other medical costs due to illness or injury, long-term care insurance is designed to finance the costs of care for individuals who can no longer perform everyday tasks—such as getting in and out of bed, getting dressed, or using the bathroom—without assistance. High quality long-term care is an important part of supporting veterans with service-connected health care needs.

Under the Veterans Independence Act, eligible veterans would gain the option of enrolling in the Federal Long Term Care Insurance Program, a benefit currently available to VA employees, and also to active and retired members of the uniformed services. In addition, veterans could apply the equivalent premium support payment to the purchase of alternative long-term care insurance.

MONITORING THE PROGRESS OF VETERANS' HEALTH REFORM

9. Create a VetsCare Implementation Commission, a nonpartisan legislative branch agency, to implement the Veterans Independence Act.

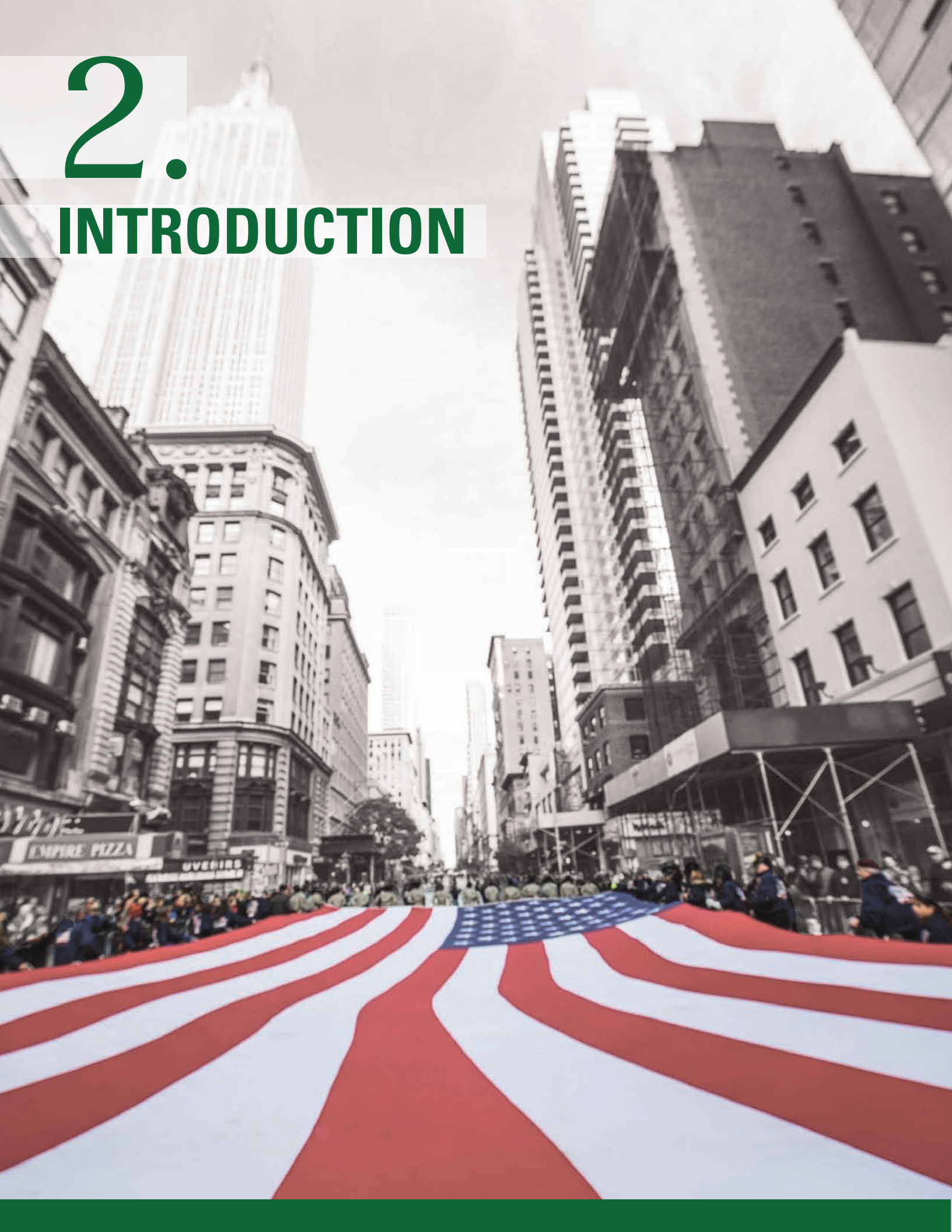
As we have seen in the past, the mission is not over once Congress has passed a bill. If the Veterans Independence Act were to be enacted, it would be incumbent upon Congress to “keep the foot on the gas” and ensure appropriate progress with the implementation of VHA reform.

With that in mind, the Veterans Independence Act would create a nonpartisan commission, modeled after the Medicare Payment Advisory Commission (MedPAC), to assist and advise congress and the Department of Veterans Affairs on veterans health reform. Membership in the VetsCare Implementation Commission would comprise solely of health care experts in academia, the private sector, and the veterans community.

The Commission's mandate would be to manage the implementation of reform, to monitor progress in delivering reform, to continuously assess the quality of VA health care delivery and coverage, and to recommend refinements to congressional statutes and federal regulations where needed to improve veterans' care.

2.

INTRODUCTION



Background

IN THE SPRING OF 2014,

whistleblowers at the Phoenix VA hospital alleged that administrators at that facility were using secret wait lists to conceal the true amount of time it took for eligible veterans to access health care in the hospital's various clinics.

In addition, those whistleblowers also alleged that dozens of veterans died waiting for medically necessary care while on manipulated wait lists. Eventually, through multiple audits, congressional inquiries, and VA Inspector General investigations, it was determined that the majority of VA hospitals were using some form of a manipulated wait list to hide the true wait times for their patients—and that hundreds of thousands of veterans are still waiting long periods of time to access needed health care.

These revelations forced the resignation of the Secretary of the VA, the Under

Secretary for Health for the VA, and other top VA officials across the country, in addition to precipitating further investigations of over one thousand VA employees for their involvement in the manipulation of wait time data within the VA – most of which are currently ongoing. Even worse, as the scandal unfolded, it became clear that there were deep systemic and cultural problems that had existed for years within the VA health care system that made it more difficult for veterans to access their health care – despite massive funding increases that have nearly tripled the VA's budget since 2001.

In response to the wait list scandal, Congress passed, and President Obama enacted, the Veterans Access, Choice and Accountability Act of 2014 (VACAA). VACAA made it easier to fire poorly-performing senior VA managers, created a temporary “Veteran Choice Card” that enabled certain eligible veterans to access private health care outside of the VA system, and provided additional funds to build more VA hospitals and hire more VA doctors.

However, almost every lawmaker involved in crafting the VACAA—including the chairmen of the House and Senate VA committees—admitted that the \$16.3 billion dollar bill was only a temporary fix that did not solve many of the systemic problems within the Veterans Health Administration. In particular, VACAA did not address the future demographic shifts in the veteran population that will make the current structure of the VHA more unsustainable than it already is.

It is in this context that Concerned Veterans for America convened the Fixing Veterans Health Care Taskforce with the mission of isolating existing challenges to veterans' health care, identifying systemic solutions, and proposing concrete reforms that would improve health care delivery for our nation's veterans. It is the hope of CVA that the recommendations made in this report will dramatically improve health care access, timeliness, and outcomes for eligible veterans.



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Scope of the Taskforce



CVA assembled a bipartisan group of health care experts, former VA leaders, and former congressional representatives to co-chair the Fixing Veterans Health Care Taskforce and to shape the Taskforce's recommendations. The co-chairs were Dr. Bill Frist (R., Tenn.), a cardiothoracic surgeon who served as Senate Majority Leader from 2003 to 2007; former Congressman Jim Marshall (D., Ga.), a Purple Heart recipient and member of the 2014 National Defense Panel; Dr. Mike Kussman, Under Secretary for Health for the Veterans Health Administration from 2006 to 2009; and Avik Roy, senior fellow at the Manhattan Institute's Center for Medical Progress. The Taskforce executive director was Darin Selnick, who worked as a special assistant to the Secretary at the VA and also has experience working in the private health care industry.

Through months of work and stakeholder consultations, the Taskforce's lodestar remained constant: the system must focus on the health care needs of veterans, especially those with service-connected injuries.

The co-chairs agreed to focus the Taskforce solely on veterans health care, in particular the VHA, instead of looking at a wider range of veterans' benefits issues. For example, the Taskforce did not examine the veterans disability system, which like the VHA faces serious systemic problems, nor other benefit programs within the VA that are not related to veterans health care.

The Taskforce emphasized the importance of seeking out the best possible set of fiscally and institutionally viable reforms: reforms that would assign highest priority to the interests of veterans. In addition,

the Taskforce sought to develop a proposal with enough specificity—and with sufficient awareness of the tradeoffs inherent in any reform—that it could be effectively translated into congressional legislation.

CVA and the Taskforce sought extensive input from other stakeholders, including veterans organizations, VA employees, and policymakers. The participation of these entities and individuals further helped shape the Taskforce's recommendations, and provided a deeper level of understanding of the systemic problems within the VHA.

We believe that we have accomplished our mission of proposing specific reforms that will substantially address the systemic problems that have plagued veterans' health care for years.

Procedures and Methodologies

SUMMARY

The Taskforce used multiple information-gathering methods. Research consisted of surveys, polling, roundtable discussions, expert briefings, interviews, and review of publications (i.e. government reports, university studies, and stakeholder reports). The information was then reviewed, synthesized, and briefed for review by the Taskforce. After reviewing all of the evidence, anecdotes, conjecture, and numbers, the Taskforce then submitted its recommendations to rigorous analysis and fiscal modeling.

PROCESS

To inform the discussions, drafting, and thinking that shaped this report, the co-chairs and researchers gathered and reviewed an exhaustive list of documents pertaining to health care and veterans health care. This included a variety of organizational management documents, health care policy reports, comparative delivery model studies, CBO reports and congressional budgeting documentation. The insight lent by this literature review led to several group meetings and conference calls conducted by the co-chairs.

At these meetings, a variety of witnesses and stakeholders offered information and advice. For example, participants included Dr. Sam Foote, the lead whistleblower at the Phoenix VA, and senior representatives of several veterans service organizations.

Stakeholders responded to questions from Taskforce members and provided commentary regarding specific topics covered in this report. The questions, responses, and comments were noted and circulated for accuracy, then distributed for internal review and reflection. Any issues raised that required more context or research were delegated to CVA researchers for further review, briefing, and circulation.

Members of the Taskforce also conducted an in-depth analysis of the strengths, weaknesses, opportunities, and threats facing the VHA, in order to better evaluate the agency's current structure and health care delivery system.

SUBMISSION PORTAL

In order to obtain a better understanding of the challenges facing those who serve veterans and those who use the services for the veteran, Concerned Veterans for America solicited anonymous feedback regarding veterans' health care appraisals and proposed improvements. CVA staff then reviewed and qualified over 1,400 responses. Data was classified into six focus areas including staff, service, access, benefits, choice, and privatization as well as the individual's attitude towards each. All of this information was then reviewed, appraised, and discussed by the co-chairs and

Procedures and Methodologies

Continued

CVA INTERNAL SURVEY

In order to give proper weight to submission portal content and the broader health reform discussion, the Taskforce sought to further learn about how veterans consume health care. CVA circulated an internal survey pertaining to the type, frequency, and specialty of health services consumed. This survey also included duration of time between care and duration of time between scheduling and receipt of services. This information was internal to CVA members and completely voluntary.

VETERANS' NATIONAL SURVEY

Another information gathering effort was done via a formal poll conducted by the Tarrance Group. The poll circulated nationally over a nine-day period during which no relevant news cycle items received media attention. One thousand and five past or current members of the military were polled online or over the phone. This population was carefully selected to be representative of the broader demographics within the veteran population. Respondents were asked their opinion on the provision of health services to veterans, the impact of cost and choice, and various other factors impacting timeliness and cost of care. The poll informed the Taskforce of the appetite for reform and provided necessary insight into the thinking of current military affiliated health service consumers.

FISCAL MODELING

We retained the services of the Health Systems Innovation Network (HSI), led by University of Minnesota economist Stephen T. Parente, to assess the fiscal impact of the proposed reforms. HSI's work began with initial research and base statistics and budgets to establish a baseline understanding of the economic environment surrounding veterans' health care. Afterwards, HSI projected the cost of continuing the status quo for ten years and crafted another concurrent model using suggestions proffered by the Taskforce. These assumptions are explained in depth within this report.

3.

THE MISSION OF
VETERANS' HEALTH
CARE: AN EVOLUTION



The History



The United States has a long history of providing financial support and health care services to our nation's veterans. It is a history intertwined with America's earliest legal traditions. But the government's precise responsibilities in this regard have evolved over time. The quality of the delivery of health care services to veterans has fluctuated. And the health care system in the broader United States has evolved significantly, especially in the last 70 years.

A review of the history of veterans' health care, therefore, helps us assess how best to improve it.

PENSIONS FOR THE DISABLED

On May 31, 1776, the Continental Congress created a committee "to consider what provision ought to be made for such as are wounded or disabled in the land or sea service, and report a plan for that purpose." John Adams declared, in a letter to a colleague, that "the equity and the policy of making provision for the unfortunate officer or soldier is extremely just." Eight weeks after the Declaration of Independence, the Congress passed the nation's first federal pension law, promising half pay for life to any officer, soldier, or sailor disabled in the service of the United States.

Despite repeated pleadings from General George Washington, the promise was not initially kept. When war ended in 1783, the fledgling federal government was drowning in debt. Instead of providing half pay for life, disabled veterans received interest-bearing "commutation certificates" whose cash value dwindled over time.

But federal finances gradually stabilized. In 1828, President John Quincy Adams signed a law granting full pay for life to surviving veterans of the Revolutionary War, whether disabled or able-bodied. It was the first of many instances of the U.S. government expanding compensation beyond those with service-connected injuries.

OLD SOLDIERS' HOMES

Congress expanded the scope of veterans benefits during the Civil War. In 1862, President Lincoln signed a law providing pensions not only to disabled veterans of past wars, but also to veterans of all future military actions undertaken by the United States, so long as the claimant could demonstrate that his disability was the direct consequence of his military duty. **Lincoln used his second inaugural address to uphold the government's role in providing care to disabled veterans:**

With malice toward none, with charity for all, with firmness in the right as God gives us to see the right, let us strive on to finish the work we are in, to bind up the nation's wounds, **to care for him who shall have borne the battle and for his widow, and his orphan**, to do all which may achieve and cherish a just and lasting peace among ourselves and with all nations.

In 1827, architect William Strickland was tasked by the U.S. Navy with making "the necessary contracts for materials, and superintend the building of a 'permanent asylum for decrepit navy officers, seamen, and marines,' at Philadelphia."² What became known as "old soldiers' homes" proliferated after the Civil War, to care for disabled and elderly veterans, and the widows and orphans of those who died in battle.

HOSPITALS FOR DISABLED VETERANS

As veterans returned home from World War I, veterans' care underwent severe strain. In 1890, the U.S. Census recorded 1 million Union veterans. But 4.7 million Americans had been mobilized for World War I, from which 116,000 died and 204,000 returned home wounded. American involvement in the war had drawn up and down so quickly that the government could not adequately prepare.

World War I made clear that veterans needed more than homes: They needed hospital care. The War Risk Insurance Act of 1917 provided federal financing for care of all service-connected injuries, whether through government-owned or private hospitals. Prior to that time, because voluntary (i.e., civilian) hospital³ beds were scarce, veterans needing hospital care received it from active duty military hospitals.

Furthermore, World War I veterans came home with two unusual health problems: tuberculosis, a malady that hadn't afflicted American troops in previous conflicts and "shell shock," a term coined because of the unprecedented use of artillery during the Great War. This latter war wound, now known as post traumatic stress syndrome (PTSD), previously had been little acknowledged or treated.

By this time, veterans' financial and health care needs were being managed by five different government agencies: the Bureau of War Risk Insurance, the Public Health Service, the Federal Board of Vocational Education, the Bureau of Pensions, and the National Homes for Disabled Volunteer Soldiers.

This set of problems—the sudden burst of wartime activity, the unique medical problems of World War I veterans, the uncoordinated and overlapping administration of veterans' benefits; outdated civil-service laws, and the inherently slow-moving nature of government agencies—combined to renew outcry about the way veterans were treated after they came home.

In response, Congress established the U.S. Veterans Bureau in 1921. The new Bureau was designed to provide a single point of responsibility for health care for wounded and disabled veterans, consolidating the government's risk insurance, public health, and vocational programs.

President Warren Harding appointed Col. Charles Forbes, a manager of a construction company in Washington state, to serve as the first director of the Veterans Bureau. The Bureau was assigned a substantial budget to build hospitals for veterans around the country, in order to ensure that soldiers and sailors would receive high quality health care.

Few of those hospitals were completed. A congressional investigation found that Forbes had massively overpaid for land to build veterans hospitals, and provisions to supply them, in exchange for kickbacks from landowners and manufacturers. The total taxpayer cost of Forbes' waste, fraud, and abuse amounted to \$200 million, or \$2.8 billion in 2015 dollars.⁴ He was sentenced to two years in Leavenworth Penitentiary.

HEALTH CARE FOR ALL VETERANS

President Herbert Hoover further consolidated veterans services in 1930, signing an executive order combining the Veterans' Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers into a new entity called the Veterans Administration.

Under a new director, Frank Hines, and amidst complaints of overcrowding at existing veterans' facilities, new hospitals were built. In 1921, there were 41 Veterans Bureau facilities; in 1925, there were 94; and by 1941, 149. The number of hospital beds rose from 10,655 in 1925 to 61,848 in 1941.⁵

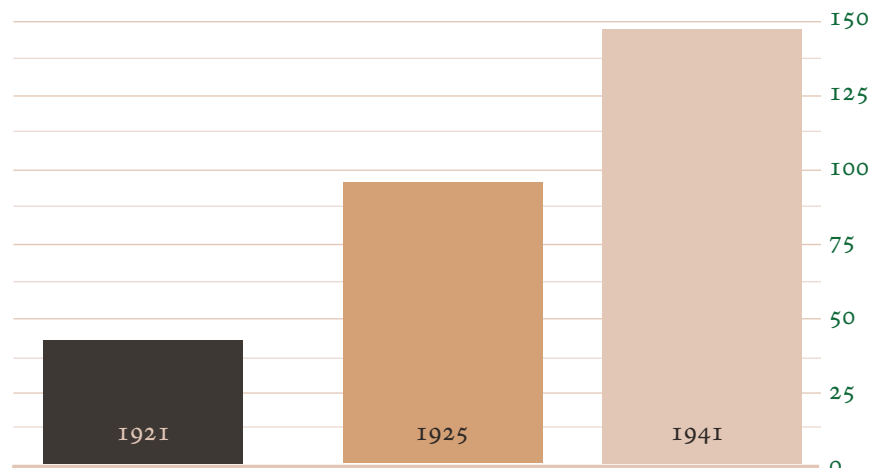
But as World War II drew to a close, it became clear that the new VA had overshot the problem of overcrowding, creating a new problem of overcapacity. Many VA hospital beds lay empty, consuming hundreds of millions of dollars in fixed operating costs. Moreover, a contemporary commission led by Herbert Hoover found that construction costs for the typical VA hospital ranged from \$20,000 to \$50,000 per bed, compared to approximately \$16,000 per bed at voluntary hospitals.⁶

In an attempt to keep these beds filled, in 1966 Congress passed the Veterans Readjustment Benefits Act, expanding VA health care benefits to veterans without service-connected injuries, so long as veterans' facilities had available space. Such a step had been taken

during the Depression, as a temporary measure. Now it was being done in a time of economic prosperity. By 2008, two-thirds of patients treated in the VA system did not have a service-connected disability.⁷

Gradually, Congress continued to expand the VA's role in sponsoring health coverage. In 1973, Congress also authorized funding for outpatient care for veterans without service-connected disabilities. In addition, Congress created the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA), a Medicare-like health insurance benefit for the spouses and children of veterans who were either disabled or dead due to a service-connected injury. In 1980, CHAMPVA was extended to spouses and children of members of the military who had died on active duty. Importantly, like Medicare, enrollees in CHAMPVA could seek care from private hospitals and physicians.

NUMBER OF VETERANS BUREAU FACILITIES



The number of hospital beds rose from 10,655 in 1925 to 61,848 in 1941.⁵

REFOCUSING THE VA ON THE DISABLED

In 1986, Congress sought to reduce the trajectory of VA health spending, and refocus existing spending on those with service-connected injuries. Over the strenuous objections of some, Congress authorized the VA to contract veterans' non-service-connected health care services to third-party insurers.⁸ Congress also required meanstesting for VA treatment of non-service-connected disabilities, and also allowed the VA to introduce cost-sharing mechanisms for veterans with annual incomes above \$20,000.⁹

For the first time, Congress established Priority Groups for the purpose of offering access to VA health care services. Category A, the highest-Priority Group, was reserved for veterans with service-connected disabilities, those eligible for a VA pension, former prisoners of war, Medicaid-eligible veterans, and other low-income veterans. Categories B and C encompassed higher income veterans without service-connected disabilities. Those in Category C were required to reimburse the VA for a portion of their health care expenses.

In 1996, Congress reorganized the Priority Groups into eight categories. Broadly speaking, Priority Groups 1, 2, and 3 are for veterans with service-connected disabilities; Priority Group 4 is for those with non-service-connected disabilities; Priority Groups 5, 7, and 8 are for low-income able-bodied veterans; and Priority Group 6 is mostly for veterans of the Vietnam and Persian Gulf wars.

Priority Groups Table

The number of Veterans who can be enrolled in the health care program is determined by the amount of money Congress gives VA each year. Since funds are limited, VA set up Priority Groups to make sure that certain groups of Veterans are able to be enrolled before others.

PRIORITY 1

- Veterans with VA-rated service-connected disabilities 50% or more disabling
- Veterans determined by VA to be unemployable due to service-connected conditions

PRIORITY 2

- Veterans with VA-rated service-connected disabilities 30% or 40% disabling

PRIORITY 3

- Veterans with VA-rated service-connected disabilities 10% or 20% disabling
- Veterans who are Former Prisoners of War
- Veterans awarded the Medal Of Honor (MOH)
- Veterans awarded a Purple Heart medal
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans awarded special eligibility classification under Title 38, U.S.C., § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

PRIORITY 4

- Veterans who are receiving aid and attendance or housebound benefits from VA
- Veterans who have been determined by VA to be catastrophically disabled

PRIORITY 5

- Nonservice-connected Veterans and non-compensable service-connected Veterans rated 0% disabled by VA with annual income below the VA's and geographically (based on your resident zip code) adjusted income limits.
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid programs

PRIORITY 6

- Compensable 0% service-connected Veterans
- Veterans exposed to Ionizing Radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki
- Project 112/SHAD participants
- Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975
- Veterans of the Persian Gulf War that served between August 2, 1990 and November 11, 1998
- Veterans who served on active duty at Camp Lejeune for not fewer than 30 days beginning August 1, 1953 and ending December 31, 1987
- Veterans who served in a theater of combat operations after November 11, 1998 as follows:
Currently enrolled Veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for 5 years post discharge

PRIORITY 7

- Veterans with gross household income below the geographically-adjusted income limits (GMT) for their resident location and who agree to pay copays

PRIORITY 8

- Veterans with gross household income above the VA and the geographically-adjusted income limits for their resident location and who agree to pay copays
- Veterans eligible for enrollment:
 - Noncompensable 0% service-connected
 - Nonservice-connected
- Veterans not eligible for enrollment:
 - Veterans not meeting the criteria above

THE ACA EXPANDS FEDERAL RESPONSIBILITIES

Today, veterans receive health care services from a variety of sources, including the VA, Medicare, Medicaid, and private insurers. These methods of delivering health care services more or less evolved independently, creating an inefficient patchwork of overlapping federal policies— a problem that the VA has been attempting to address for nearly 100 years.

77%

In 2008, veterans enrolled in the VHA, on average, received their health care services outside of the VA system¹⁰



In 2008, according to VA estimates, veterans enrolled in the VHA received an average of 77 percent of their health care services outside of the VA system.^{10 11} The combination of Medicare, Medicaid, and an expanded VA increased the expectation that the government would take a role in subsidizing health care spending for all Americans in need, an expectation that culminated in the controversial passage of the Affordable Care Act in 2010.

The ACA, often called “Obamacare,” expands the Medicaid program to all able-bodied and disabled adults with incomes below 138 percent of the Federal Poverty Level (FPL). The law also offers tax credits to those with incomes below 400 percent of FPL to defray the cost of purchasing regulated private insurance products.

COST-SHARING AND THE VHA

The near-absence of cost-sharing in the VHA has superficial appeal, because it minimizes the financial contribution required from eligible veterans. However, there is no such thing as a free lunch in health care. Health systems that offer coverage that is free at the point of service commonly ration access to care in order to contain costs. For example, in the British National Health Service—a system similar in structure to the VHA—the average wait time for a knee replacement is twelve months, compared to three to four weeks in the United States.¹² In the Medicaid program, where cost-sharing is similarly constrained, access to needed care is a serious and chronic problem.¹³ Similarly, waiting lists and delayed access are among the most common complaints of VHA enrollees.

Economists and actuaries recognize that cost-sharing is a critical tool for managing the overall cost of health care, by giving patients an incentive to avoid unnecessary services. “Cost-sharing, if done appropriately, can slow the growth of health spending,” notes health economist Alan Garber, the provost of Harvard.¹⁴ Indeed, at any given level of expenditures, the operational efficiencies resulting from cost-sharing would allow a larger population of veterans to gain faster, more affordable coverage.

Cost-sharing has been nearly universally embraced in the private insurance market, because of its utility in offering beneficiaries the broadest access to health care at the lowest price.

CONCLUSIONS

Veterans’ health coverage in the 21st century would improve substantially if veterans could obtain health care services in the most flexible manner possible.

As is evident from the above discussion, federal responsibilities for veterans health care have evolved substantially since America’s founding. Initially, veterans assistance took the form of direct financial aid for disabled veterans. Over time, Congress authorized spending on long-term care facilities, hospitals, and outpatient clinics. Congress also expanded health coverage to veterans without service-connected injuries.

The irregular expansion and evolution of the VA’s role has been due to several factors. First, the VA and its predecessor agencies were tasked with offering hospital care and other resource-intensive services at a time when the civilian hospital infrastructure was sparse. Second, the timing and the scale of war over the centuries has been sporadic and unpredictable, leading to a boom-and-bust cycle of VA utilization. Third, technological advances have altered the set of health care issues encountered by veterans of different eras.

Given the dramatic improvement in private sector health care in the United States in the last 70 years, it is clear that the delivery of veterans’ health coverage in the twenty-first century would improve substantially if veterans could obtain health care services in the most flexible manner possible.

4.

**CHALLENGES AND
OPPORTUNITIES
IN VETERANS'
HEALTH CARE**



The Challenges of Veterans Health Care

The Veterans Health Administration is the largest non-Defense employer within the federal government, with approximately 275,000 employees. These employees are dedicated public servants, many of whom are passionate in the service of the veteran population. However, throughout the history of the VA, there have been complaints about the quality of care at VA facilities. The similarity of these criticisms over time, spanning many different eras in American history, require some reflection.

As discussed above, the commitment of the federal government to hospital care for veterans emerged after World War I. Almost right away, there were complaints about the conditions at veterans' facilities.

In 1921, one witness told a Senate committee that care for veterans with tuberculosis and psychiatric conditions had become "so wholly inadequate as to amount to practically nothing." In addition, veterans faced substantial delays in receiving compensation for hospital care, with one senator charging that veterans were being cared for by "incompetent political doctors" in the Public Health Service, political appointees rather than meritocratic ones.¹⁵

Driven by these concerns, Congress folded the veterans portion of the Public Health Service into the new Veterans Bureau. But the Charles Forbes corruption scandals, driven in large part by waste, fraud, and abuse in the construction of veterans hospitals, led to a second round of consolidation in 1930, and the formation of the Veterans Administration.

Bureau officials did strive to improve the quality of veterans health care. In 1925, Frank Hines prompted collaboration with the American College of Surgeons to improve the performance of veterans hospitals.¹⁶ The Bureau established a section on medical research, and set up two residency programs for training in the neuropsychiatric disorders common among World War I veterans.

"However," notes Ronald Hamowy of the Independent Institute, "widespread criticism of the quality of medical care accorded veterans continued through the 1930s and 1940s. Complaints during this period were most often directed at the quality of medical facilities and at the poor qualifications of VA personnel."¹⁷

CONTROVERSIES AFTER 1945

World War II introduced an even larger generation of veterans—nearly 20 million—into the VA system. Once again, observers began to complain of inadequate conditions, describing veterans health care as "back waters of medicine" in "physical and scientific isolation."¹⁸ Albert Maisel, writing in *Readers' Digest*, decried the state of VA health care as "third rate treatment of first-rate men."

In every one of these hospitals that I have visited—from Minnesota to Massachusetts—I have found disgraceful and needless overcrowding. I have found doctors overloaded and hog-tied by administrative restrictions...nurses [who] did not bother to wash their hands after examining one patient with a contagious disease before turning to another.

Then I have gone to many [civilian] state and county hospitals, just as tied down by government restrictions and labor shortages... Here there are lower death rates and higher cure rates. That is why I know that there is no excuse for the Veterans' Administrations' third-rate treatment of first-rate men.¹⁹

Albert Maisel, *Readers' Digest*

The Veterans Health Administration is the largest non-Defense employer within the federal government, with approximately 275,000 employees.

In one of the first attempts at comparing VA health outcomes to those in voluntary hospitals, Maisel found that the civilian facilities were eleven times more effective than VA hospitals at treating tuberculosis. The VA categorized as “tuberculosis specialists” physicians with one year of internship and four months’ orientation, in contrast to the American Medical Association’s stricter standards for residencies in thoracic surgery or infectious diseases.

By this time—in part as a reaction to the Forbes-era scandals—the Veterans Bureau had developed a thick layer of bureaucracy designed to prevent corruption and waste. “By 1949,” notes Hamowy, “the agency was operating under the authority accorded it by more than 300 laws, providing benefits to nearly 19,000,000 living veterans and to dependents of deceased veterans,” amounting to approximately 40 percent of the adult U.S. population.

In 1945, New York Post columnist Albert Deutsch testified before Congress that Charles Forbes’ successor as VA director, Frank Hines, “placed excessive stress on paper work. Bureaucratic procedures were developed, which tied up the organization in needless red tape. Avoidance of scandal became the main guide of official action. Anything new was discouraged: ‘It might get us into trouble.’ Routineers and mediocrities rose to high office by simple process of not disturbing the status quo. Good men were frozen out or quit.”²⁰

In response to these concerns, in 1946 President Harry Truman replaced Hines with Gen. Omar Bradley. In the two years following, the VA’s headcount went from 65,000 to over 200,000. Its annual budget increased from \$744 million in 1944 to \$7.5 billion in 1946.

The sudden expansion did relieve the problem of overcrowding in

A federal commission led by former President Hoover found that the government was not planning its new hospital construction in a systemic fashion, but rather a political one.

VA hospitals. But a federal commission led by former President Hoover found that the government was not planning its new hospital construction in a systemic fashion, but rather a political one. Hence, some areas had far too many hospital beds, and other areas too few; 81 percent of VA hospitals in the San Francisco Bay area were unoccupied, and 86 percent in the New York City area. The Hoover Commission recommended that the VA close 20 veterans hospitals and construct no new ones. These recommendations were ignored.²¹

Gen. Bradley did make consequential changes at the VA. Bradley created a Department of Medicine and Surgery within the VA, and severed the VA’s medical staff from the federal Civil Service, with all its restrictions and regulations. These two reforms significantly improved the quality of care in VA facilities, as the VA began to draw from the same labor pool as voluntary hospitals.

Bradley’s Chief Medical Director, Paul Magnuson, established collaborations whereby medical schools would train their students and house officers at nearby VA hospitals. By 1959, almost half of VA hospitals were affiliated with academic institutions; nearly two-thirds of today’s U.S. doctors received some of their training in a VA facility.²²

FROM 1944 TO 1946



The VA’s headcount went from 65,000 to over 200,000.



The annual budget increased from \$744 million to \$7.5 billion

THE 1977 NATIONAL RESEARCH COUNCIL REPORT

The quality of VA-based care for Vietnam veterans also received critical treatment in the press, in Congress, and in the memoirs of Vietnam veteran Ron Kovic, *Born on the Fourth of July*, published in 1976 and eventually adapted into a movie.

Congress asked the National Research Council to form a blue-ribbon panel, organized by the National Academy of Sciences and led by Saul Farber of New York University, to study the VA's health care operations. The Academy's 313-page report, published in 1977, noted that the dramatic increase in the VA's budget had not solved the perception of poor quality at VA facilities.

The panel found that the VA's post-World War II emphasis on hospital construction had another unintended consequence: the substitution of inpatient hospital care for outpatient doctors' office visits. The VA had comparatively few outpatient facilities but an excess of inpatient hospital beds. This led VA facilities to hospitalize veterans who would normally be treated in doctors' offices, resulting in poorer outcomes and higher costs.

In addition, the VA's excess hospital capacity led the agency to seek to expand the number of veterans eligible for VA care, leading to comparatively less emphasis on those with service-connected injuries.

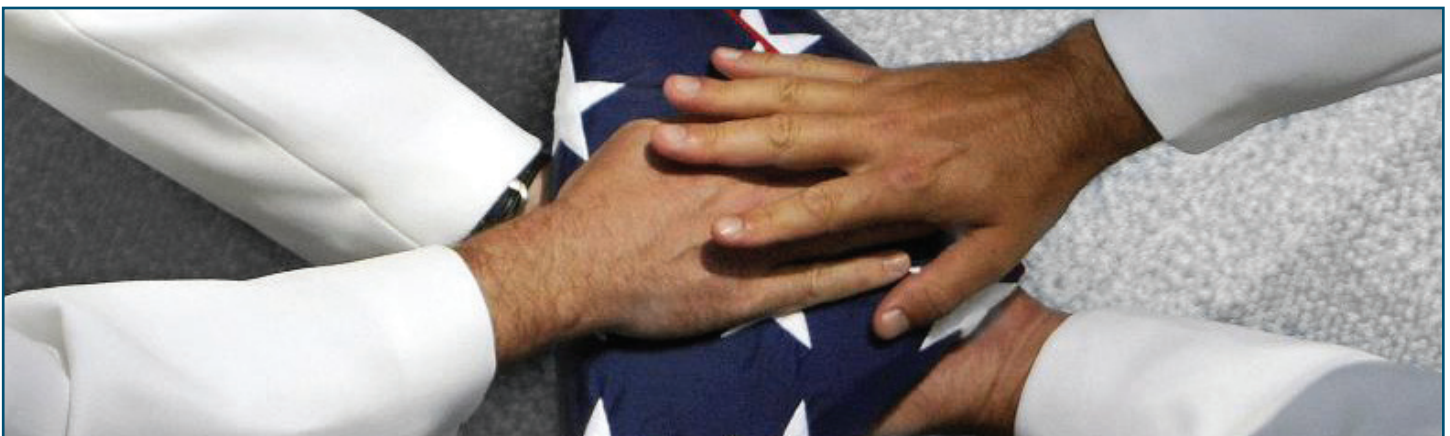
Furthermore, the panel raised concerns about the "scarcity and geographic distribution of outpatient facilities," finding that "only 36% [of veterans] lived within 30 minutes of a clinic." In addition, the panel found that "there are strong indications that

utilization of outpatient facilities is correlated with a hospital's inpatient admission and retention policies more closely than with the medical needs of the patients who apply for care."

In response to these and many other concerns, the panel recommended that veterans health care be integrated into the broader civilian health care system, one that had grown substantially since World War I. "VA policies and programs should be designed to permit the VA system ultimately to be phased in to the general delivery of health service in communities across the country," by utilizing "third-party insurers, both private and governmental, wherever such coverage is available." Veterans service organizations opposed these recommendations, and Congress did not take them up.

Without major structural changes, criticism of VA health outcomes and quality continued into the 1980s. In 1988, the Veterans Administration was elevated to a cabinet-level department called the Department of Veterans Affairs. The VA's health care programs were consolidated into the Veterans Health Administration within this new department.

However, cabinet status did not measurably improve the quality of VA health care. Meanwhile, the aging of the World War II population meant that the veteran population was declining in size; in addition, as the U.S. population moved south and west, older VA facilities in the northeast were further underutilized, while VA hospitals in the younger parts of the country faced overcrowding.²³ In the *New York Times*, fiscal scholar Richard Cogan said, "The real question is whether there should be a veterans health care system at all."²⁴



The panel recommended that veterans' health care be integrated into the broader civilian health care system, one that had grown substantially since World War I.

THE KIZER ERA, 1994-1999

An instructive bright spot for the VA emerged in 1994, when President Bill Clinton appointed Kenneth Kizer of the University of Southern California as Under Secretary for Health in the Department of Veterans Affairs. “There was universal consensus,” Kizer told Phillip Longman, “that if there was one agency that was the most politically hidebound and sclerotic, it’s the VA.” But where others saw sclerosis, Kizer saw opportunity. “The basic thesis...was that we have to be able to demonstrate that we have equal or better value than the private sector, or frankly we should not exist.”²⁵

Kizer introduced a substantial restructuring of the VA’s operations, despite considerable internal resistance.²⁶ Kizer closed more than half of the VA’s hospital beds between 1994 and 1998, emphasizing outpatient physician care over hospitalization. As a result, inpatient hospital admissions declined by 31 percent, and the number of hospitalization days decreased from 3,530 per 1,000 patients in 1995 to 1,333 in 1998: a drop of 62 percent.²⁷

In the 1970s, a group of entrepreneurial employees at the VA began secretly developing an early version of electronic patient records. Their effort was intensely resisted by the VA’s leadership in the 1970s and 1980s, but the entrepreneurs eventually prevailed, establishing a free, open-source system called Veterans Health Information Systems and Technology Architecture, or Vist A.

Kizer reorganized the VA around Veterans Integrated Service Networks, or VISNs, to improve the coordination of care that veterans received. He deployed VistA and other modern tools to ensure that veterans were receiving care based on the best available scientific evidence.

Research by Kizer and others indicated that by the late 1990s, the VA was engaging in evidence-based medicine—such as providing aspirin to heart attack victims after they left the hospital—at higher rates than the Medicare program, which worked mostly through voluntary hospitals.²⁸ One comparison of diabetic care at five VA medical centers to their commercially-insured counterparts suggested that the VA patients enjoyed better rates of blood glucose and cholesterol management.²⁹

While these studies were limited in scope, they represented the first meaningful instances of research indicating that VA health care could be the equal of private health care on some quality measures. In 2007, Philip Longman published a book entitled *Best Care Anywhere*, arguing not merely that VA health care was no longer

inferior, but that the VA was the model that the rest of American health care should follow.

THE SCANDALS OF 2014

Kenneth Kizer stepped down as director of the Veterans Health Administration in 1999. In the ensuing years, problems once again began to crop up with the delivery of VA care. “Since 2005, the VA Office of Inspector General (OIG) has issued 18 reports that identified, both at the national and local levels, deficiencies in scheduling resulting in lengthy waiting times and the negative impact on patient care,” noted the VA’s Acting Inspector General in a 2014 review.³⁰

A 2013 investigation by CNBC revealed widespread problems with unsanitary conditions in VA medical facilities. In addition, CNBC found evidence that VA officials were distorting autopsies and medical records in order to make the VA’s clinical performance look better than it actually was.³¹

In 2014, a constellation of scandals were simultaneously reported in the media. Some VA employees were misrepresenting their facilities’ performance under the metrics that Kizer had installed, in order to gain cash bonuses. Administrators at more than 26 VA facilities, including the hospitals in Phoenix, Austin, San Antonio, Durham, St. Louis, and Chicago, were found to be manipulating waiting lists so as to present the impression that veterans were receiving timely care, when they were not.³²

In retrospect, while the VA did improve the delivery of care at its facilities during Kizer’s tenure, those improvements were more temporary than many had hoped. **“VA officials have not been as closely focused on data, results, and metrics—performance measurement—as they once were,” Kizer told the New York Times in 2014. “The culture of the VA has become rather toxic, intolerant of dissenting views and contradictory opinions. They have lost their commitment to transparency.”**³³

In addition, the accuracy of VA clinical outcomes data is left in doubt by widespread evidence that VA officials manipulated patient record-keeping in order to gain performance bonuses, including “clinically significant delays in care associated with access to care.”^{34 35}



In retrospect, while the VA did improve the delivery of care at its facilities during Kizer's tenure, those improvements were more temporary than many had hoped.

THE VETERANS ACCESS, CHOICES, AND ACCOUNTABILITY ACT OF 2014

In response to deaths at the Phoenix VA due to delayed medical care, and the revelations of secret waitlists, Congress in 2014 passed the Veterans Access, Choice and Accountability Act of 2014 (VACAA). The bill rests on three major initiatives: (1) allowing veterans to seek care outside VA facilities if they can demonstrate that they have waited for a specified period or live far from a VA facility; (2) expanding the VA's internal capacity to provide care; and (3) enabling the Secretary of Veterans Affairs to fire Senior Executive Service employees for poor performance and misconduct.

However, it is not clear whether or not the VA will be able to successfully implement the changes mandated by VACAA. During a hearing on VACAA implementation, James Tuchs Schmidt, Acting Principal Deputy Under Secretary for Health for the Veterans Health Administration, expressed skepticism:

What the [VACAA] program has done—and we are having discussions right now, quite frankly, that are, for many people, very anxiety-producing, that our future is not about being a

provider organization only. We are now entering a realm where we, quite frankly, are running a health plan, where the veteran, the patient decides what happens to them, and where they go, and how they get care, and what care they get. And this is a huge cultural shakeup, quite frankly, for us as an organization.³⁶

While offering veterans the ability to decide “what happens to them, and where they go, and how they get care, and what care they get” is a desirable goal, there is limited evidence that the VA will be able to achieve that goal within its existing configuration.

Furthermore, the provisions of VACAA that assist veterans in obtaining health care outside of the VA system are of limited duration. Congress appropriated \$15 billion under VACAA for the purpose of offering veterans health care through non-VA entities; the Congressional Budget Office projects that the bulk of these funds will be used up by the end of the 2016 fiscal year. Hence, this Congress or the next one will likely be faced with the unattractive and costly option of temporarily renewing VACAA for a few more years, or enacting a permanent, long-term solution that improves access to care for veterans in a strategically sound and fiscally responsible manner.

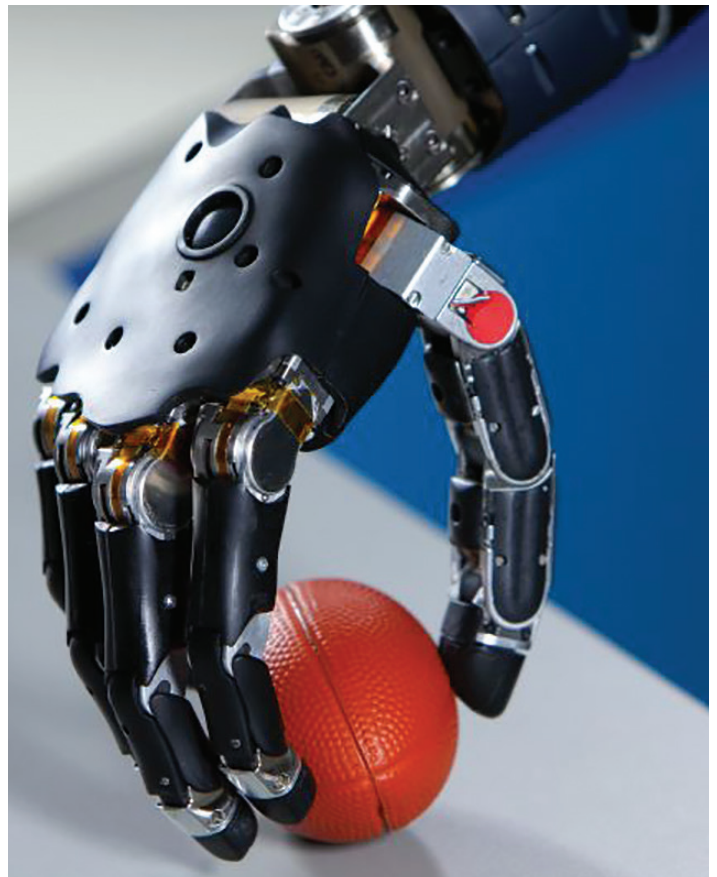
THE VA'S PAST ACCOMPLISHMENTS

In this section, we have noted many of the instances where veterans' health care has fallen short. But it is just as important to note the many scientific and medical innovations that have been pioneered by VA researchers and clinicians. "VA's accomplishments on all three pillars"—health care research, training, and delivery—are "broad [and] historically significant," wrote VA Secretary Robert McDonald in a 2014 editorial:

VA is affiliated with over 1,800 educational institutions providing powerful teaching and research opportunities. And our research initiatives, outcomes and honors are tremendous. Few understand that VA medical professionals:

- Pioneered and developed modern electronic medical records
- Developed the implantable cardiac pacemaker
- Conducted the first successful liver transplants
- Created the nicotine patch to help smokers quit
- Crafted artificial limbs that move naturally when stimulated by electrical brain impulses
- Demonstrated that patients with total paralysis could control robotic arms using only their thoughts—a evolutionary system called "Braingate"
- Identified genetic risk factors for schizophrenia, Alzheimer's and Werner's syndrome, among others
- Applied bar-code software for administering medications to patients—the initiative of a VA nurse
- Proved that one aspirin a day reduced by half the rate of death and nonfatal heart attacks in patients with unstable angina
- Received three Nobel Prizes in medicine or physiology
- Seven prestigious Lasker Awards, presented to people who make major contributions to medical science or public service on behalf of medicine
- Two of the eight 2014 Samuel J. Heyman Service to America medals³⁷

While these past accomplishments are indeed impressive, it is incumbent upon us to focus on the best way to improve the quality of health care for today's veterans, and how best to ensure that the VA is best positioned to provide high quality health coverage and care in the decades to come.



The problems identified by the Office of Inspector General in 2014—revolving around the VA's bureaucratic tendencies and the impact thereof on patient care—are not new problems; indeed, complaints of this nature run through nearly the entire history of federally-run veterans' hospitals. An undeniable thread of "reform and failure" runs through the history of veterans' health care.

The VA has served an important role in offering health care services to veterans, especially those with service-connected disabilities and those without the means to afford private health coverage. The VA's involvement in long-term care for injured veterans dates back to the nineteenth century, and it is a role that fulfills a real need, given the woefully thin private market for long-term care insurance.³⁸

However, it is unclear why veterans should be denied the opportunity to seek care outside the VA system, if that is what they wish to do. Indeed, the VHA itself estimates that veterans enrolled in the VA health care system receive three-quarters of their care outside of the VA.³⁹

VA care may remain the equal of private care, for only those who manage to get in the door. This is, of course, a subject of vigorous debate. But the comparison of VA care to private care is not meaningful if veterans have to wait for months, or even years, to see a doctor.

In 1921, when the Veterans Bureau was created, civilian health care infrastructure was sparse. Today, the U.S. has the most developed health care infrastructure in the world; U.S. health care spending represents more than 17 percent of the nation's economic output.⁴⁰ There is no legitimate reason for veterans to wait in line for access to health care, when there are so many ways for veterans to gain that access, if they are given the means to do so.

THE DEMOGRAPHIC UNSUSTAINABILITY OF TODAY'S VHA

If Congress does not soon enact proactive and fundamental reforms of the VA, demographic realities will force changes that are more drastic and reactionary than those proposed today. As the Vietnam

generation passes on, the size of the veteran population will shrink considerably. In 2009, there were 24 million U.S. veterans; by 2029, the VA expects that population to shrink to 16 million.

The number of VHA enrollees, while older in age, will shrink as well. Advances in medical technology have also led to fewer hospitalizations and more care delivered in physician offices. Future wars could, of course, re-expand the veteran population, but this is not a possibility that the VHA can either predict or rely upon. Simply put, the VHA must get ahead of its demographic destiny, or be overcome by it.

We believe there are two choices in confronting this challenge. On the one hand, we could advance incremental reforms to the current system, leading to incremental improvements in the near term. But this course would not empower veterans to choose the health care best for them, and would ignore looming demographic realities. On the other hand, we could advance long-term reforms of the current system, while addressing the immediate needs of veterans, and in doing so, give veterans control over their own health care, improve the sustainability of VHA facilities for the long haul, and break the government cycle of reform and failure.

We enthusiastically choose the latter option. Now is the time to ensure that veterans—young and old, male and female, rich and poor, urban and rural—are the centerpiece of veterans' health care. For too long, concerns unique to the VHA as a legacy institution have distorted the planning, funding and delivery of health care for veterans. While the VHA will remain an important component of veterans' health care delivery, we firmly believe that veterans' interests must take precedence.

THE IMPEDIMENTS TO VETERANS' HEALTH CARE REFORM

As discussed above, past efforts at improving veterans' health care have faced enormous resistance from a constellation of forces sometimes described as the "Iron Triangle."

"The VA and its advocates," wrote John K. Iglehart of the *New England Journal of Medicine* in 1985, "represent a classic example of an 'iron triangle' of interests that make their way through the Washington policy swirl. In this instance, the triangle consists of the agency itself, the congressional committees that oversee and often protect its interests, and veterans' service organizations, many of which operate under a federal charter... The interlocking nature of this influential triad is well reflected by the movement of numerous staff members between its organizations."⁴¹

The VA's long history of political decision-making and bureaucratic management is the direct result of the uninterrupted dominance of Iglehart's Iron Triangle. Career senior managers at the Veterans Health Administration are often hampered by VA political appointees with significant variability in tenure, background, and management skills—many of whom have little-to-no health care experience. All comparable health care systems in the private sector have professional leadership, board oversight, well-established succession plans, and the ability to make relatively rapid decisions.

For example, the politicization of VA hospital construction—a problem that goes back to Charles Forbes and the 1920s—continues to hamper the delivery of veterans health care. The most high profile current example is the construction of a VA hospital in Aurora, Colorado, which has come under scrutiny for its numerous delays tied to cost. The initial approved budget for the hospital was listed at \$604 million, but has now ballooned to over \$1 billion and is years behind its original completion date. Contract disputes between the contractor and government became so strained recently that it led to a brief work stoppage in December.⁴² The U.S. Government Accountability Office found similar problems in Las Vegas, New Orleans, and Orlando, with cost overruns of nearly \$1.5 billion.⁴³

Each corner of Iglehart's triangle has its own incentives to oppose VA reform. VA facilities employ thousands of individuals in certain congressional districts; elected officials oppose the closure of VA

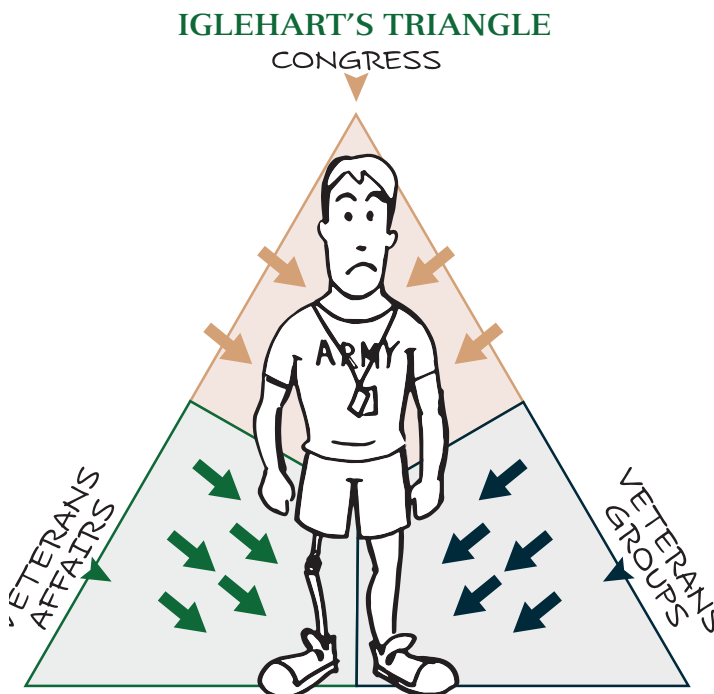
A system in which veterans can choose for themselves how to allocate their health care resources will be inherently more responsive to veterans' needs than one in which decisions are made by a confluence of Washington interests. However, some of the nation's oldest veterans organizations have been adamantly opposed to such reforms.

The prestige of certain veterans' organizations, combined with their skepticism of reform, has had a major impact on Congress. Lawmakers understandably value the policy endorsements of veterans organizations. Indeed, in the recent past, some veterans organizations have been able to review proposed budgets for the Department of Veterans Affairs, both from the White House and Congress, prior to the introduction of fiscal legislation.⁴⁴

We believe that veterans' organization are mistaken if they see for themselves a diminished role if individual veterans are empowered to access and manage their own care in the private market. Indeed, the opposite is true; if veterans have a broader range of health care choices, they will actively seek guidance from traditional veterans' organizations in navigating those choices.

Most importantly, the vast majority of rank-and-file veterans want those choices.

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...The interlocking nature of this influential triad is well reflected by the movement of numerous staff members between its organizations.”⁴¹

VETERANS' OPINIONS ON VA REFORM

The VA's flawed survey methodologies

The VA frequently reports that it delivers satisfactory care. The VA has employed the American Customer Satisfaction Index as a survey tool; the ACSI has ranked VA health care as being on par with many of the most prestigious hospital systems in the United States. However, the ACSI's survey methods are somewhat misleading. They do not attempt to measure the problems of access to care that drive many veterans away from the VA. Nor do they measure the views of those who do not utilize VA services because of their poor experiences.⁴⁵

In December 2014, the Congressional Budget Office identified federal ownership of the VHA as a likely hindrance of higher quality care, observing that "regulations that govern the hiring and firing of federal employees probably make it harder for VHA to deal with personnel who do not perform at expected levels."⁴⁶

There is considerable evidence that poor employee morale leads to declines in the quality of customer service.⁴⁷ According to the VA's 2014 Federal Employee Viewpoint Survey, high-performing VA employees have low morale, in large part because they believe that they are treated no better than poorly performing workers. Seventy percent of respondents said that they do not believe that "in my work unit, steps are taken to deal with a poor performer who cannot or will not improve." Furthermore, less than 70 percent of respondents believed that differences in performance were not recognized in a meaningful way, and that promotions were not based on merit.⁴⁸

The survey also found that over 60 percent of VA employees that responded to the survey do not believe that staff awards depend on how well employees perform at their jobs. Close to 60 percent of survey respondents also believe employees are not recognized for providing high quality products and services. Another important finding was that close to 80 percent of VA employees that responded to the survey indicated that pay raises do not depend on how well employees perform their jobs.

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CVA NATIONAL SURVEY OF VETERANS

Veterans Want Choice

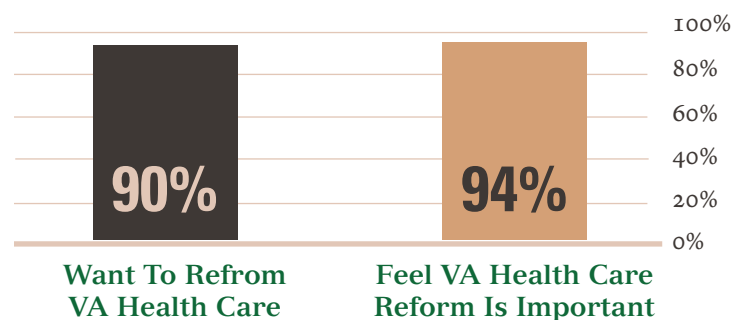
In November 2014, Concerned Veterans for America, in collaboration with The Tarrance Group, conducted a national survey of 1,005 veterans, active duty military, reservists, and members of the National Guard. Forty-eight percent of those surveyed had served in Vietnam, 21 percent in the conflicts in Kuwait, Iraq, and Afghanistan.

Ninety percent of respondents favored "efforts to reform veteran health care in this country," with 72 percent strongly in favor. Eighty percent of respondents described VA reform as "extremely important" or "very important," with an additional 14 percent describing reform as "somewhat important."

Fifty percent of respondents—including 60 percent of those who use VA facilities primarily—said that they had experienced the problem of excessive appointment wait times. More than a third complained of excessive travel times to appointments. Thirty-one percent complained of poor service. Seventy-four percent said "government bureaucracy" was the biggest source of problems at the VA.

Eighty-nine percent of veterans believed that it was "extremely important" or "very important" to increase health care choices for veterans. Eighty-eight percent agreed that eligible veterans should be given the choice to receive medical care from any source that they themselves choose.

Veterans Thoughts On Reforming Veterans Health Care



People Who Used The VA Facility Experienced



50%

Excessive Wait Time



30%

Poor Service/ Care



33%

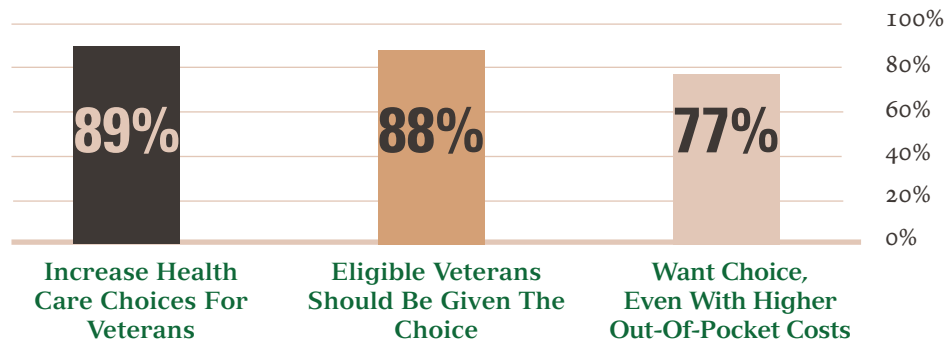
Excessive Travel Time



74% felt

Government Bureaucracy Was The Biggest Problem

Importance Of Increasing Health Care Choices For Veterans



Surveyed choices included ensuring that veterans get the best possible care, even if that means getting that care outside a VA facility (95 percent believing this option to be “extremely” or “very important”); allowing veterans to go to the doctors or hospitals closest to their homes (91 percent); and allowing veterans to use a private physician if they choose (86 percent).

Strikingly, a large majority of veterans—77 percent—thought it “extremely” or “very important” to give veterans more choices in their insurance products, even if these alternatives involved higher out-of-pocket costs. Only six percent considered this option “not at all important.”

Surveyed Veterans Felt Important Issues Are



95%

Getting Best Possible Care, Even If Care Is Outside VA Facility



91%

Going To Doctors or Hospitals Closest To Their Homes



86%

Use A Private Physician If They Choose

VETERANS' QUALITATIVE FEEDBACK

From September 29, 2014 to November 16, 2014, Concerned Veterans for America operated a portal whereby veterans could offer their feedback on the VA's performance and on opportunities for reform. CVA received 1,473 entries to the portal, of which 1,254 came from veterans. The submissions were sorted into six different issue categories that covered the spectrum of most of the suggestions received: staffing, service, access, benefits, choice, and privatization.

Ninety-seven percent of received entries expressed negative impressions of the VA status quo, though this can be substantially explained by selection bias. Qualitative submissions largely discussed possible improvements in service (28 percent of responses), followed by improvements in staff (24 percent), and benefit reform (22 percent).

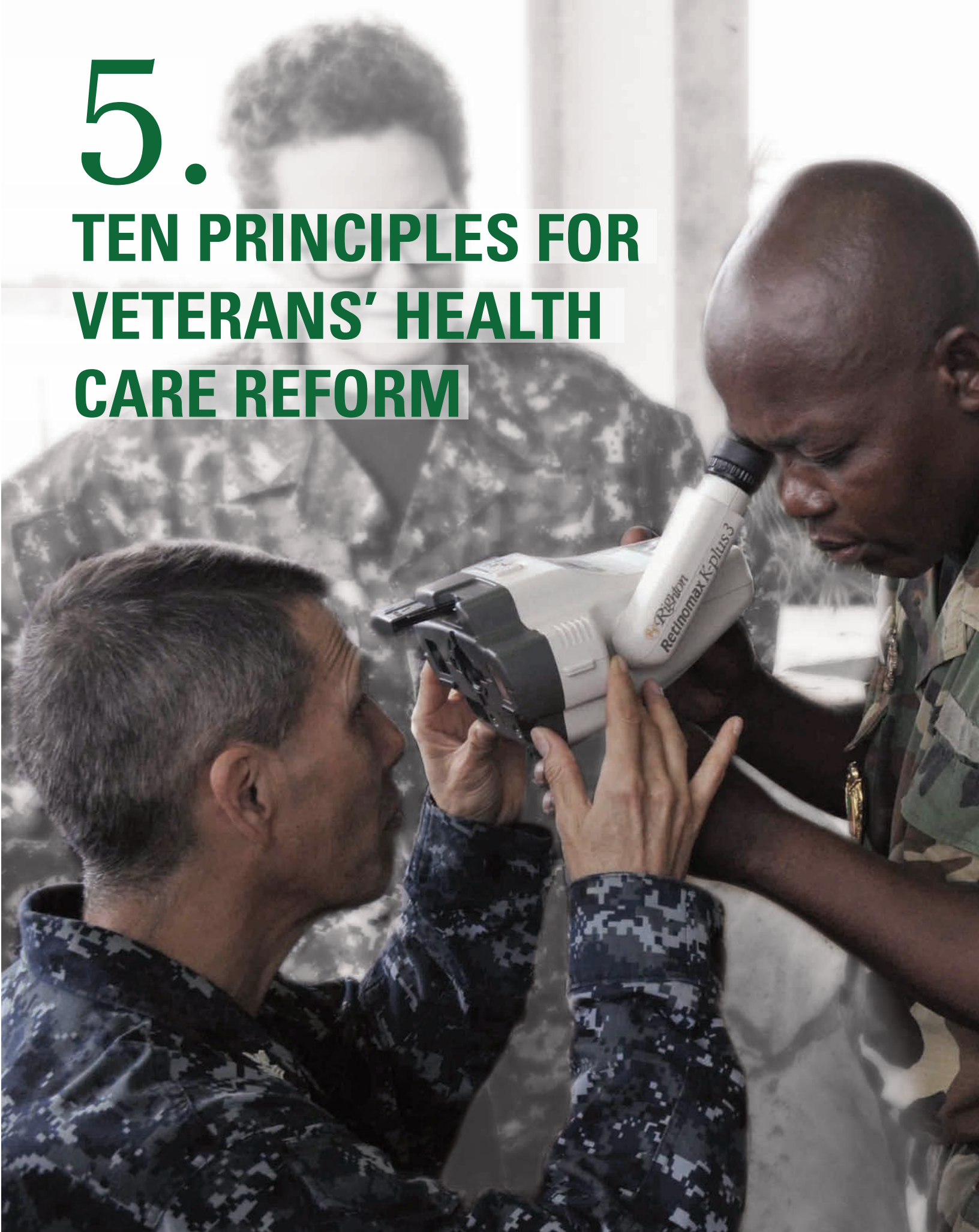


97%

of received entries expressed
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status quo

5.

TEN PRINCIPLES FOR VETERANS' HEALTH CARE REFORM



Ten Principles For Veterans' Health Care Reform

Reforming veterans health care is no easy task. Government agencies are famously resistant to reform. Even among these institutions, however, the VA is an especially challenging case, given the policy complexities of the VA's interaction with the broader health care system, and the resistance of older veterans service organizations to previous attempts at reform.

It is, therefore, of particular importance to articulate a set of principles that can guide a substantial reform effort.

1. THE VETERAN MUST COME FIRST, NOT THE VA.

The institutional priorities of the VHA weigh too heavily in current planning, funding and care delivery decisions. We believe the interests of veterans should be paramount.

2. REFOCUS ON, AND PRIORITIZE, VETERANS WITH SERVICE-CONNECTED DISABILITIES AND SPECIALIZED NEEDS.

Veterans with service-connected disabilities and specialized health care needs should be heavily prioritized; any reforms should ensure VHA health care delivery centers on service-connected veterans and leveraging the VHA's comparative advantage in specialized areas. Health care for America's veterans should be earned either through a service-connect disability or military retirement based on a certain length of honorable service—it is not, as some misrepresent it to be, an automatic entitlement for everyone who served.

3. THE VHA SHOULD BE IMPROVED, AND THEREBY PRESERVED.

Those veterans who choose to use VHA facilities should receive timely and quality care. In order to achieve this goal, the VHA should be restructured—as an independent, efficient, and modern organization—that can compete with private providers.

4. GRANDFATHER CURRENT ENROLLEES.

Veterans should have the option to seek care outside of VA system but current enrollees who wish to continue to receive care within the system should retain the option to do so. Currently enrolled veterans will also have the option to “opt-in” to the reformed system.

5. VETERANS SHOULD BE ABLE TO CHOOSE WHERE TO GET THEIR HEALTH CARE.

Based on eligibility, veterans should have the option to take their earned health care funds and use them to access care at the VA or in the voluntary (civilian) health care system. Because private health care is somewhat costlier than VHA-based care, most veterans who choose this option will be expected to share in some of the costs of such care, through co-pays and deductibles.

6. VETERANS' HEALTH CARE REFORM SHOULD NOT BE DRIVEN BY THE BUDGET.

More efficient health care for our veterans may reduce the cost of their care, but reform should not be viewed as an avenue to reduce federal spending. Conversely, increased funding is insufficient to address VHA's deficiencies. Thankfully, our fiscal modeling suggests reform can be achieved in a revenue-neutral manner.

7. ADDRESS VETERANS' DEMOGRAPHIC INEVITABILITIES.

The VHA must be reformed now, or veterans' demographics will force difficult—and inevitable—changes in the future. Any reform proposal must consider substantial forthcoming demographic shifts in the veteran population, including substantial shrinkage in overall numbers—save for another protracted conflict—and disproportionate decreases in future enrollment.

8. BREAK VHA'S CYCLE OF "REFORM AND FAILURE."

Minor tweaks to the current system may incrementally improve health care in the near term, but the monopolistic VHA bureaucracy is likely to return to a standard operating procedure heavily influenced by the desires and concerns of the institution and its employees. Only fundamental reform will break the cycle and empower veterans.

9. IMPLEMENTING REFORM WILL REQUIRE BIPARTISAN VISION, COURAGE AND COMMITMENT.

A well-connected VA bureaucracy, parochial congressional concerns, and powerful outside groups frequently stifle difficult reforms across the government—and the same could happen with VHA reform.

10. VHA NEEDS ACCOUNTABILITY.

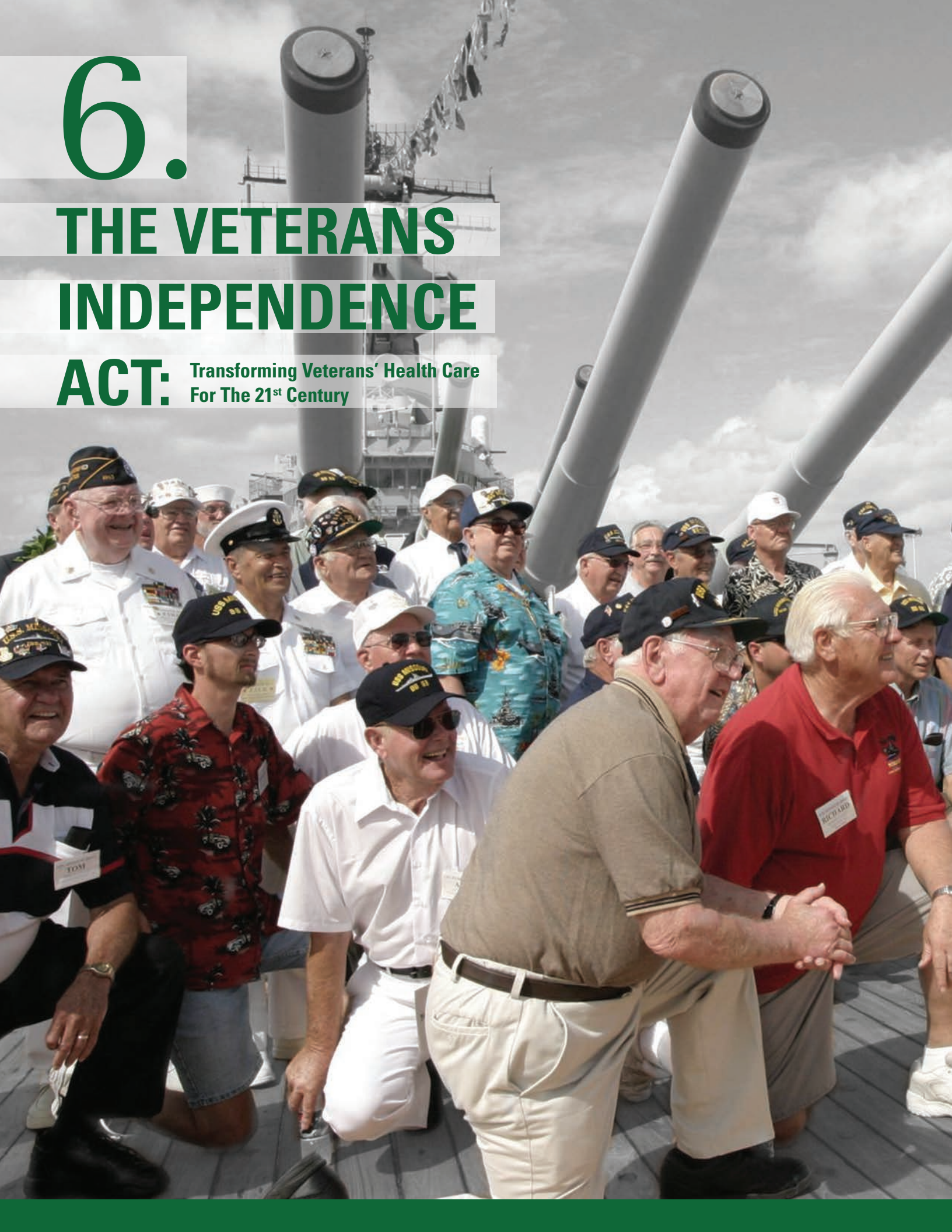
The VHA must be accountable to both veterans and taxpayers for its performance. An independent VHA will have more latitude to reward high performers, fire poor performers, and monitor the quality of health care delivery.

In order to achieve the principles discussed above, the Fixing Veterans Health Care Taskforce has developed the Veterans Independence Act (VIA). The aim of the VIA is to significantly improve the quality, convenience, and flexibility of veterans' health care.

6.

THE VETERANS INDEPENDENCE

ACT: Transforming Veterans' Health Care
For The 21st Century



The aim of the Taskforce’s reform proposal—the Veterans Independence Act—is to significantly improve the quality, convenience, and flexibility of veterans health care. It is designed to be aligned with the ten core principles described above. In this section of our report, we outline below how the VIA puts these principles into action.

I. A New Role for the Veterans Health Administration

Some advocates of VA reform argue that the Veterans Health Administration should be dismantled altogether. “The medical component of the Department of Veterans Affairs needs to be abolished,” argues Col. Jack Jacobs (Ret.), a military analyst for NBC News.

We need to shut the doors of the thousands of medical facilities that are failing to serve our veterans. . . It makes no sense to have a parallel universe to take care of our veterans, separate doctors, separate facilities, equipment and even protocols. There is no reason that veterans who would otherwise wait for months to be seen at a VA health clinic can’t be seen by private doctors, the same doctors who treat everyone else.⁴⁹

We do not agree with this sentiment. Veterans should certainly have the option to seek care outside of the VA system. But many veterans have been well cared for at VA facilities, and those who wish to continue to receive care there should retain the option to do so.

A HEALTH CARE SYSTEM WORTH PRESERVING

The Veterans Health Administration is home to the United States’ largest integrated health care system, consisting of 150 medical centers, nearly 1,400 community-based outpatient clinics, community living centers, Vet Centers, and other facilities.

As of fiscal year 2013, the number of patients served by the VHA included 5.8 million veterans and nearly 681,000 non-veterans, for a total of 6.5 million. **Included in this number are more than 616,000 of our newest veterans from Operations Enduring Freedom, Iraqi Freedom, and New Dawn.**

For fiscal year 2016, the VHA has requested congressional appropriations of \$63.2 billion for medical care, including \$3.2 billion in collections, and seeks to employ nearly 304,000 full-time workers.⁵⁰

A significant part of the VHA budget is dedicated to maintaining its medical facilities. But the high fixed costs associated with maintaining unused VA hospital beds and other brick-and-mortar resources siphon off funds that could be used to improve the quality of veterans’ health coverage.

Furthermore, the profoundly inefficient distribution and scale of VA medical facilities serves veterans poorly. In some areas, VA medical facilities are scarce, forcing veterans to drive long distances to receive care. In other areas, VA medical facilities go largely unused, due to overcapacity and demographic shifts. These problems compound those related to long wait times and other access problems at VA providers.

Under the Veterans Independence Act, all VHA enrollees will be offered the choice to seek coverage and care outside of the traditional VHA system.

As veterans from World War II, Korea, and Vietnam pass on, VHA patient volume will significantly decline. In 2009, there were 24 million American veterans; by 2029, the VA expects that population to shrink to 16 million. In part, the decline in the size of the veteran population is driven by the difference between the largely conscripted cohort from World War II, Korea, and Vietnam, relative to the all-volunteer force fielded in more recent conflicts; on average, veterans from volunteer forces are healthier, wealthier, and less likely to need VHA assistance.

Furthermore, under the Veterans Independence Act, all VHA enrollees will be offered the choice to seek coverage and care outside of the traditional VHA system. This change would further reduce VHA patient volume, depending on the proportion of veterans who elected to seek care outside of VA facilities.

Either way—with or without reform of veterans' health care—the dramatically shifting demographics of the U.S. veteran population require us to give VA hospitals and facilities the tools they need to best serve those who rely on them.

The dramatically shifting demographics of the U.S. veteran population require us to give VA hospitals and facilities the tools they need.

SEPARATING THE VA'S PROVIDER AND PAYOR FUNCTIONS

Some institutions, like California's Kaiser Permanente, have successfully integrated a health insurer with a provider of medical services. The theoretical advantage of an integrated system is that hospitals have less incentive to charge higher prices, knowing that doing so would increase the cost of their insurance product.

However, it is far from clear that such a model is workable for a government agency like the Veterans Health Administration as it does not have the political independence necessary to make economically efficient decisions. Furthermore, an integrated system heavily restricts the ability of veterans to seek care in voluntary (i.e., civilian) hospitals and from private physicians.

Veterans should have a choice as to where they receive their health care. At the same time, Congress must provide the VHA with the flexibility to make independent operating decisions, free of excessive regulatory and political interference.

In order to best offer veterans the option of receiving care from private physicians, then, it is desirable—if not necessary—to separate the VA's payor and provider functions into separate institutions. The Veterans Independence Act proposes to do so by dividing the VHA's existing responsibilities into the Veterans Health Insurance Program (VHIP) and the Veterans Accountable Care Organization (VACO).

VHIP, a program office of the Veterans Health Administration, would administer the VA's health insurance and premium support programs within the Department of Veterans Affairs. Over time, the purpose of VHIP would naturally evolve in the direction of subsidizing veterans' health coverage, whether from private or public institutions, and maintaining a market for private health insurance plans that offer veterans the choice of voluntary and VA health care providers.

The Veterans Accountable Care Organization would encompass the VA's brick-and-mortar health care facilities. The Veterans Independence Act proposes to establish the VACO as a non-profit government corporation that is fully separate from the Department of Veterans Affairs, along the lines of the National Railroad Passenger Corporation, which manages Amtrak.

The VHA would continue to administer the other programs currently under its purview, such as the domiciliary care, programs for homeless veterans, administering education and training for health care personnel, conducting health care research and providing contingency support for DoD and HHS during times of war or national emergency. The VHA could, of course, contract with VACO for execution of some or all of these programs, in whole or part. For example, at least in the short run, most domiciliary care will be provided on VACO owned and operated campuses and facilities.

INTEGRATED, ACCOUNTABLE CARE FOR VETERANS

Restructuring the VHA as a non-profit government corporation has been proposed before. In 1996, at the behest of Congress, the Department of Veterans Affairs published a report authored by the Klemm Analysis Group, the Lewin Group, and Arthur Andersen that investigated the feasibility of “transforming the Veterans Health Administration into a government corporation.” The authors concluded that either a government corporation or “performance-based organization” would enhance the ability of the VHA to carry out its core functions.⁵¹

In 2009, the Veterans Coalition formed a Commission on the Future for America’s Veterans, including Kenneth Kizer and former American Legion National Commander Ron Conley. This group proposed that Congress “establish a new entity with characteristics not unlike a federal government ‘not for profit’ corporation, called the Veterans’ Health Service” that would, among other things, “receive all assets of the VHA unencumbered with authority to use them in a manner that maximizes benefits to veterans.”⁵² The coalition’s proposal would have moved all of the VHA’s functions into the new corporation, not merely its provider facilities.

The Amtrak Model

There are several examples of corporations chartered and owned by the federal government. These corporations provide public services; however, unlike services provided directly by government agencies, chartered corporations are independent legal entities separate from the U.S. government. Government-chartered corporations often receive federal budgetary appropriations, but they can also have independent sources of revenue.

The most prominent example of a federally chartered corporation is the National Railroad Passenger Corporation (NRPC), which operates Amtrak. The construction of interstate highways and the emergence of air travel led to a steep decline in passenger rail ridership; by the late 1960s, most private intercity rail services were unprofitable. In order to avoid the possible collapse of the U.S. railroad industry, in 1970, President Nixon signed the Rail Passenger Service Act, which created the National Railroad Passenger Corporation.

While Amtrak continues to require federal subsidies—including \$1.39 billion in congressional appropriations in 2014—the NRPC has succeeded in growing the passenger rail market. In 1972, Amtrak carried 15.8 million passengers; in 2014, it carried 30.9 million, with ticket revenues of \$2.2 billion.⁵³

Because Amtrak receives congressional subsidies, it remains subject to oversight from Congress. But the NRPC has been able to invest in the heavily traversed Northeast Corridor between Washington and Boston, and to discontinue dozens of underused routes.

Accountable Care Organizations

One of the principal problems with the delivery of health care in the United States is its uncoordinated nature. In particular, patients with multiple chronic conditions may be seeing multiple physicians who do not talk to each other, leading to overlapping prescriptions and, in some cases, dangerous mistakes. “Badly coordinated care, duplicated efforts, bungled handoffs, and failures to follow up result in too much care for some patients, too little care for others, and the wrong care for many,” observed Katherine Baicker and Helen Levy in 2013.

A number of health care systems—comprised of hospitals, outpatient physician clinics, and other facilities—have attempted to rectify this problem by using information technology and aligned financial incentives to coordinate care between different physicians and different treatment modalities.

Model practitioners of this approach—called “accountable care organizations”—include the Mayo Clinic in Rochester, Minnesota; the Cleveland Clinic in Ohio; the Geisinger Health System in central Pennsylvania; and Intermountain Healthcare in Utah.⁵⁵ Central to the ACO approach is the use of primary care physicians, who serve as the primary coordinators of patient care.

The VA’s health care facilities, in many ways, already incorporate some of the concepts utilized by accountable care organizations. In 2013, the VA employed 5,100 primary care physicians.⁵⁶ The VA’s hospitals and clinics are all owned by the same entity, and the VA’s VistA electronic medical records system has helped the VA coordinate care for veterans with multiple medical conditions.

Hence, formally organizing VA provider facilities along the ACO model could help improve veteran patient care within the VA system, and give the VA a natural set of private-sector benchmarks with which to assess its progress in improving health care delivery.

OPPORTUNITIES FOR THE NEW VETERANS ACCOUNTABLE CARE ORGANIZATION

There are numerous ways in which the Veterans Accountable Care Organization could rationalize its medical center capacity and improve its overall veterans’ integrated health care system. We received numerous suggestions from veterans, veterans’ relatives, and VA employees through our Fixing Veterans Health Care submission portal.

Focus on Areas of Expertise

Veterans with service-connected injuries have distinct health care issues; for example, a higher prevalence of traumatic brain injuries, spinal cord injuries, and post-traumatic stress disorder. The Veterans Accountable Care Organization should build centers of excellence around these disciplines to serve the needs of the veteran population. VHA might contract with VACO to provide much of its veterans’ specific medical research plus health care education and training at these centers of excellence.

Accountability and Transparency

In 2014, the Congressional Budget Office attempted to compare health care costs in the VA system with those in other U.S. health care systems. However, CBO noted that “comparing health care costs in the VHA system and the private sector is difficult partly because the Department of Veterans Affairs...has provided limited data to Congress and the public about its costs and operational performance.”

The Veterans Accountable Care Organization should publicly report on all aspects of its operation, including quality, safety, patient experience, timeliness, and cost-effectiveness, using standards similar to those in the Medicare Accountable Care Organization program. In addition, the VACO must have the authority to hire and fire employees in a manner consistent with that in the private sector.

Obtain Evaluations From External Consultants

Organizations like the Advisory Board and McKinsey help private hospitals consider ways to improve the quality and cost-effectiveness of health care delivery. The Veterans Accountable Care Organization could avail itself of the same tools.

Rationalize medical center portfolio

We hope the independence of the Veterans Accountable Care Organization will enable it to freely rationalize and manage its facilities to most efficiently devote its resources to veterans’ care. If, in practice, it does not enjoy this freedom, the Veterans Independence Act will provide ongoing authority for the president to institute a medical center realignment procedure modeled after the Defense Base Realignment and Closure Act of 1990 (BRAC). Under BRAC, the president is empowered to appoint an independent nine-member panel whose recommendations for base closures become law, unless Congress formally passes a resolution objecting to those recommendations within 45 days.

Under this Medical Realignment and Closure (MRAC) process, the President would be empowered to appoint an independent nine-member panel whose recommendations for medical center closures become law, unless Congress formally passes a resolution objecting to those recommendations within 45 days.

For example, there could be an automatic trigger, whereby medical center facilities which have, on average, filled less than 30 percent of their beds on an average daily basis over a five-year period would be reviewed by the MRAC panel.

Consider Admitting Civilian Patients

In the private sector, rising hospital consolidation has led to higher U.S. health care prices without evidence of improved quality.⁵⁷ The Veterans Accountable Care Organization could consider opening up its under-utilized medical facilities to non-eligible veterans, the families of enrolled veterans, and even civilians in regions where VHIP-enrolled patient volume is low.

This could help VA hospitals weather the decline in the veteran population, and also smooth the transition to a premium support model for veterans’ health insurance. Furthermore, it could increase provider competition in areas where the hospital market is highly concentrated, reducing system-wide hospital prices.

Investment in Human Capital

The Veterans Accountable Care Organization should upgrade its employee development program so that VACO employees have the professional development, technical training, and management training they need to provide world-class health care to veterans. VACO must develop new ways to recruit and retain health care professions so as to ensure that VACO can compete with private hospitals and retain the best health care professionals. For example, VACO could consider expanding its postgraduate medical training program, and offer residents the opportunity to retire some of their educational debt in return for serving in VACO facilities.

Information Technology Upgrades

While the VistA electronic medical records system is rightly hailed as being innovative for its time, the VA is not taking advantage of common twenty-first century tools to improve veteran-centered health care. For example, veterans would be well served by the ability to book appointments online use smartphones and where clinically appropriate, access VACO physicians over the internet for consultations, i.e, utilize their services via telemedicine. Furthermore, as veterans continue to receive the majority of their care outside the VA system, it will be increasingly important for VistA to coordinate with electronic medical records systems common in the private sector.

Veterans would be well served by the ability to book appointments online use smartphones.

II. Veteran-Centered Health Coverage

PUTTING VETERANS IN CHARGE OF THEIR OWN HEALTH CARE DOLLARS

Under the VIA, veterans who are satisfied with their current VA health care would be able to maintain their use of existing benefits with no cost-sharing. Importantly, however, this would not be veterans' only option.

The Veterans Independence Act offers veterans control of their own health care dollars. Specifically, veterans will be able to take the funds spent on them through the VA system and use those funds to purchase private health coverage through a mechanism called premium support—a process similar to that used by VA employees to obtain health coverage. Medicare-eligible veterans would be able to use VA funds toward their premium costs and supplemental “Medigap” coverage. The new Veterans Health Insurance Program (VHIP) will manage the nuances of providing these subsidies, in particular, designing them to assure that the cost of all service-connected care is paid either directly or through appropriate premium supports.

All veterans who purchase private health coverage in this manner would continue to be able to use VA facilities through insurance products that contract with the Veterans Affordable Care Organization. The Veterans Independence Act would create a mechanism to ensure that private payors contract with VACO for this purpose.

VHIP would set up a new program, called “VetsCare,” that could organize three new plan choices for veterans.

- **VETSCARE FEDERAL:** VetsCare Federal: Full access to the VACO integrated health system.
- **VETSCARE CHOICE:** Private health insurance financed through premium support payments, with access to both the VACO and civilian health care providers.
- **VETSCARE SENIOR:** Supplemental “Medigap” health coverage for Medicare eligible veterans, with access to both the VACO and civilian health care providers.

The Bipartisan History of Premium Support

The term “premium support” was coined by two Democrats: Henry Aaron of the Brookings Institution, and Robert Reischauer, director of the Congressional Budget Office under President Bill Clinton. Premium support, they wrote in 1995, describes a system in which the government “would pay a defined sum toward the purchase of an insurance policy that provided a defined set of services. As with private insurance for the working population...plans could manage care in any of the ways now in use or that might arise in the future.”⁵⁸

The Federal Employee Health Benefits Program, or FEHBP, is the oldest and most successful premium support program in the world. FEHBP was founded in 1959 to offer private health insurance to federal workers, including employees of the Department of Veterans Affairs. Today, approximately eight million individuals—four million federal employees and four million of their dependents—are enrolled in the program, at a projected annual cost of \$49 billion in 2015.⁵⁹

For 20 years, premium support has been part of the most consequential health reform proposals of both Democrats and Republicans. In 1995, Aaron and Reischauer proposed reforming the Medicare program by offering premium support payments to retirees to shop for the private health insurance plans of their choice.

The concept was further elaborated in 1999 by the National Bipartisan Commission on the Future of Medicare, led by Democratic Sen. John Breaux (La.) and Republican Rep. Bill Thomas (Calif.). The Commission, whose members included Dr. Bill Frist (R., Tenn.), recommended transitioning Medicare into a premium support system and adding prescription drug coverage to the program. In 2001, Sens. Breaux and Frist introduced two bills—the Medicare Preservation and Improvement Act, and the Medicare Prescription Drug and Modernization Act—in order to advance the Commission’s ideas in Congress.⁶¹

The term “premium support” was coined by two Democrats: Henry Aaron of the Brookings Institution, and Robert Reischauer, director of the Congressional Budget Office under President Bill Clinton.

A version of the latter bill was signed into law by President George W. Bush. That law, the Medicare Modernization Act of 2003, employed premium support to offer private prescription drug coverage to the Medicare-eligible population. A 2012 poll by the Healthcare Leadership Council found that 90 percent of seniors with Medicare drug coverage were satisfied with their plans.⁶²

Furthermore, the fiscal performance of the Medicare drug benefit has been outstanding. [use Figure 9 from *Transcending Obamacare* as an illustration] In 2006, the Medicare Trustees projected that 2013 Medicare Part D prescription drug spending would reach \$127 billion. Actual 2013 Part D spending was only \$72 billion: 43 percent below the projected level.⁶³ Private coverage in the broader Medicare program—known as Part C or “Medicare Advantage”—is nearing one-third of all Medicare beneficiaries, and more than half of new enrollees.

The Affordable Care Act of 2010 also uses premium support to expand health coverage to the uninsured. “We’ll do this by creating a new insurance exchange—a marketplace where individuals and small businesses will be able to shop for health insurance at competitive prices,” said President Obama in a 2009 address to Congress. “As one big group, these customers will have greater leverage to bargain with the insurance companies for better prices and quality coverage. This is how large companies and government employees get affordable insurance. It’s how everyone in this Congress gets affordable insurance. And it’s time to give every American the same opportunity that we give ourselves.”⁶⁴

Non-Medicare-Eligible Veterans

For non-elderly veterans and those ineligible for Medicare, the Veterans Independence Act would direct VHIP to use the VHA’s Priority Group system to design the VetsCare Choice program. Under this system, higher Priority Groups would receive higher levels of premium support. The sample structure described below is one of many ways to design such a system—Congress could consider others.

In the hypothetical VetsCare Choice program that we modeled, veterans with serious service-connected disabilities—Priority Groups 1 and 2—could gain the option of receiving a subsidy equivalent to the price of purchasing “platinum” level private coverage with a 90 percent actuarial value; i.e., health insurance in which 90 percent of expected claims will be paid by the insurer. Members of Priority Group 1 who are 100 percent disabled would gain a subsidy equivalent to coverage with a 100 percent actuarial value; i.e., no cost-sharing.

Members of Priority Group 3 could gain the option of subsidy worth “gold” level private coverage; i.e., with an actuarial value of 80 percent. For these three groups, services delivered in VA facilities or by VA physicians would be covered at 100 percent, with no cost-sharing.

Those in Priority Group 4—veterans with non-service-connected disabilities—could also gain the option of a “gold” level coverage subsidy. Priority Groups 5 and 6 could gain the option of means-tested premium support for “silver” coverage with an actuarial value of 70 percent.⁶⁵ For those currently enrolled, and therefore grandfathered into

current system, Priority Groups 7 and 8 would gain the option of “Bronze” coverage with an actuarial value of 60 percent. Under the VIA, veterans who would fall under Priority Groups 7 and 8 under the current system, would no longer qualify for health care within the reformed VHA.

These premium support payments would be means-tested along the following scale: veterans with annual incomes below 133 percent of the Federal Poverty Level would gain subsidies for premium costs above 2 percent of their income; those between 133 and 150 percent of FPL would gain subsidies above 3 percent of income; 150-200 percent FPL, 4 percent of income; 200-250 percent FPL, 6.3 percent of income; 250-300 percent FPL, 8.05 percent of income; 300-400 percent FPL, 9.5 percent of income.

ANNUAL INCOME	below 133	133-150	150-200	200-250	250-300	300-400
GAINED SUBSIDIES	above 2%	above 3%	above 4%	6.3%	8.05%	9.5%

Individuals with incomes below 250 percent of FPL would gain additional cost-sharing subsidies to defray co-pays and deductibles. These cost-sharing subsidies would be deposited in a health savings account owned by the veteran, such that the effective minimum actuarial value of their coverage would be as follows: for those between 0 and 150 percent of FPL, 94 percent; 150 and 200 percent of FPL, 87 percent; 200 and 250 percent of FPL, 73 percent.

% OF FPL	0-150%	150-200%	200-250%
MIN. VALUE	94%	87%	75%

Those with service-connected cognitive disabilities; i.e., who are clinically unable to use health savings accounts and related tools, would automatically remain in the traditional VA insurance program.

VA premium support payments could be benchmarked to the second-lowest-cost plan of comparable actuarial value available in the veteran’s residential area. Veterans would be able to deploy the VA-funded premium support benefit to purchase any insurance plan legally available in their state; however, the cash value of the premium support benefit will be based on the above formula. Veterans who prefer high-deductible coverage would gain the additional option of directing the remainder of their premium support benefit into an interest-bearing health savings account.

For the purpose of fiscally scoring our proposal, we modeled VetsCare Choice in the above configuration. That configuration conceives of a holistic insurance product; i.e., a veteran who is 30 percent disabled due to a service-connected injury would receive health coverage through VHIP for both his service-connected and non-service-connected health care needs. Today, the VHA makes some distinctions between these two categories.

One limitation of the VetsCare Choice approach is that while VetsCare Federal plans require no cost-sharing, the vast majority of VetsCare Choice plans do, under the hypothetical structure we have described, if care is delivered outside of VHA facilities. (Under the VetsCare Choice structure proposed, care delivered within VHA facilities would involve no cost-sharing.) Veterans who strongly prefer plans with no cost-sharing may choose to remain in VetsCare Federal.

Congress could structure VetsCare Choice plans to require less cost-sharing; however, if they did so, more veterans would enroll in these plans, which would in turn increase VHA spending—at least in the near term.

Medicare-Eligible Veterans

In our modeled plan, veterans over the age of 65, and those who qualify for Medicare due to disability, would gain the option of deploying the funds they now receive through the Veterans Health Administration to defray the costs of Medicare premiums and supplemental coverage (“Medigap”), in a program called VetsCare Senior. For veterans born after 1960—i.e., those who will turn 65 in 2025—these benefits would be available for Priority Groups 1 through 6 only.

Future Veterans

However VHIP decides to meet America’s core obligation to finance veterans’ service-connected health care needs, the Veterans Independence Act will provide that future eligible veterans would be entirely transitioned into the premium support system, so as to provide a clear path for integration of veterans’ health care into the broader health care system. For future veterans, new eligibility requirements would go into effect for those veterans who applied for enrollment after a predetermined cutoff date.

Eligibility for sponsored health coverage would be based on the current Priority Group requirements. However, veterans with service-connected disabilities—i.e., those in Priority Groups 1 through 3—would be even more highly prioritized with the most generous coverage, minimal cost-sharing, and expedited access to VHA facilities. The program would also assist disadvantaged veterans, such as those in Priority Groups 4 through 6.

LONG-TERM CARE REFORM

Unlike acute-care insurance, which pays for hospital and other medical costs due to illness or injury, long-term care insurance is designed to finance the costs of care for individuals who can no longer perform everyday tasks—such as getting in and out of bed, getting dressed, or using the bathroom—without assistance. High quality long-term care is an important part of supporting veterans with service-connected health care needs.

For various reasons, the U.S. market for private long-term care insurance is not robust. Partially this is due to the fact that the Medicaid program funds long-term care in such a way as to crowd out private insurers; more than 800,000 Americans are enrolled in Medicaid's Managed Long-Term Services and Supports program (MLTSS).⁶⁶

The other major issue is that few younger individuals see the value in purchasing long-term care insurance that they will likely not need until they are much older. Because mostly older and sicker people buy private long-term care insurance in the United States, average per-enrollee costs are high, and therefore average insurance premiums.

In 2000, Congress passed the Long-Term Care Security Act, which created a long-term care insurance program for federal and U.S. postal employees called the Federal Long Term Care Insurance Program (FLTCIP). Active and retired members of the uniformed services are eligible for FLTCIP, which is managed by the U.S. Office of Personnel Management.

From 2002 to 2009, private insurers John Hancock and MetLife formed a consortium to offer the FLTCIP's insurance product; since 2009, John Hancock has been the sole insurer. In September 2013, more than 270,000 individuals were enrolled in the FLTCIP, making it the largest employer-sponsored long-term care insurance program in the United States.

The Veterans Independence Act would optimize long-term care for veterans by offering them the option of enrolling in the FLTCIP, or applying the equivalent premium support payment to the purchase of alternative long-term care insurance.

As with acute care, future veterans in Priority Groups 1 through 6 would gain eligibility for this program.

REFORMING THE VA IN PHASES

Since we cannot accurately predict how quickly the Veterans Independence Act's private insurance options would reduce patient volume at VHA facilities, it might be appropriate to phase those options in, so as to give the VHA time to adjust to any unexpected changes, and to allow Congress the opportunity to revisit the law if the decline in the utilization of VHA facilities is unexpectedly high or low.

We have modeled one such way to phase in the VetsCare Choice and VetsCare Senior programs. Under this approach, Priority Groups 1 through 3 would gain access to the premium support option upon enactment of the Veterans Independence Act. Priority Groups 4 through 8 would gain access to the premium support option five years after enactment. Two-thirds of the VA's patient volume comes from Priority Groups 4 through 8; hence, the phase-in of these veterans into premium support should allow the VHA time to evaluate the effects of premium support on its inpatient volume and capacity.

III. Additional Policy Considerations

Allowing veterans to control their own health care dollars may seem like a simple idea. As we have noted above, however, the implementation of that idea requires taking several policy considerations into account.

THE RELATIVE COST OF VA HEALTH CARE

First is the issue of costs per enrollee. It is widely believed that VA-based care costs less than the equivalent amount of care delivered in the private sector. However, a December 2014 report from the Congressional Budget Office found that “limited evidence and substantial uncertainty make it difficult to reach firm conclusions about those relative costs or about whether it would be cheaper to expand veterans’ access to health care in the future through VHA facilities or the private sector.”⁶⁷

The VA, according to the CBO, “has provided limited data to the Congress and the public about its costs and operational performance,” making direct comparisons to the private sector difficult. In addition, as noted above, even veterans who do use the VA system receive an average of 70 percent of their health care outside of the VA. In 2008, according to CBO, the total was 77 percent. Furthermore, lower per-enrollee costs are only meaningful if the quality of care is equivalent or better.

One study by VA researchers, cited by the CBO, suggested that VA per-enrollee costs would be 20 percent lower than costs in Medicare’s traditional fee-for-service program.⁶⁸ The study was published in 2004, using 1999 data. The largest difference between the two programs was prescription drug costs, which the researchers estimated as 70 percent higher in the Medicare and Medicaid programs. This difference accounted for nearly half of the difference in estimated VA and Medicare costs.

However, this study has several limitations. Medicare in 1999 had a much different system for paying for prescription drugs than it does today. Over the last decade, the growth rate of Medicare spending has considerably declined. Furthermore, as more health care is delivered outside of the hospital setting, while the VA has considerably expanded its outpatient services, the CBO notes that “it is unclear whether VHA has maintained a cost advantage for outpatient services.”

Many of the VHA’s administrative costs flow through other departments of the VA, or other government agencies altogether, making a true cost comparison more difficult.

Most importantly, the Medicare Advantage program—under which nearly one-third of Medicare beneficiaries gain coverage from private insurers—appears to reduce per-enrollee spending by as much as 13 percent, on an apples-to-apples basis, according to a 2012 study by three Harvard economists published in the *Journal of the American Medical Association*.⁶⁹

It is also worth noting that the Veterans Access, Choice, and Accountability Act of 2014 (VACAA) offers veterans the opportunity to seek care outside the VA system if they experience delays in receiving care in VA facilities. Funding for this program is expected to dry out some time after fiscal year 2016. However, it is realistic to assume that VACAA's funding would be renewed by Congress in the absence of more far-reaching reform like the Veterans Independence Act.

For the purposes of the Veterans Independence Act, insurers will be expected to offer plans similar in costs per enrollee to those in the Medicare Advantage program.

THE FISCAL COSTS OF A MORE ATTRACTIVE PROGRAM

Recent congressional proposals to improve veterans' health care have been stymied by another problem: that a more attractive VA health care program would, by definition, attract more veterans to enroll, increasing its overall spending.

However, a well-designed reform can offset these higher VA costs by savings from reduced enrollment in other federally subsidized health care programs, such as Medicaid, the Affordable Care Act, employer-sponsored insurance, and Medicare. Ideally, these cost savings should be credited to VHA in calculating total tail end military personnel costs.

In addition, many health care policy experts believe that widespread use of premium support will lower the growth rate of health care expenditures, reducing future costs. For evidence, they cite the performance of the Medicare Part D prescription drug program; the Medicare Part C program commonly known as "Medicare Advantage," and the fact that for 2015, premium assistance subsidies in the insurance exchanges established by the Affordable Care Act are estimated to cost 18 percent less than originally predicted by the Congressional Budget Office.⁷⁰

The VetsCare Choice and VetsCare Senior programs take into account the interactions between VA-based health insurance and various civilian programs. For example, in order to prevent double subsidization, able-bodied veterans who are offered employer-sponsored coverage should not be eligible for VetsCare Choice. In addition, veterans who enroll in Medicaid or the Affordable Care Act's exchange-based insurance plans would not be eligible for VetsCare Choice, though they may remain eligible for VetsCare Federal, if they had been eligible for traditional VA-based care prior to reform.

It will be important for the Congressional Budget Office to gain access to empirical data from the VA with which to estimate the percentage of veterans who would remain in VetsCare Federal under a reformed system, relative to those who would elect to enroll in VetsCare Choice or VetsCare Senior.

In addition, CBO can provide Congress with guidance as to how different approaches to VetsCare Choice and VetsCare Senior might increase the degree to which the VA would be expected to fund non-service-connected health care costs.

LOWER UTILIZATION OF VA FACILITIES

If more veterans have access to the private, voluntary U.S. health care system, it goes to follow that fewer veterans will use proprietary VA facilities. Already, as noted above, VHA enrollees obtain 70 percent of their health care outside the VA system, if not more. In 2011, a VHA survey found that 77 percent of VHA enrollees were enrolled in non-VA-based health insurance plans.⁷¹ And the high fixed costs of maintaining VA hospitals siphon funds away from the provision to veterans of high quality health care; this problem will grow more acute if more veterans seek care outside the VA.

For these reasons, the Veterans Independence Act contains provisions to rationalize the maintenance of VA facilities.

USAGE OF THE VA SYSTEM BY NON-VETERANS

Today, a small number of non-veterans are eligible for VA benefits, primarily through the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). In 2012, 375,000 individuals were enrolled in CHAMPVA, at an annual cost of \$1.2 billion.⁷²

CHAMPVA is intended for spouses and children of veterans who have died, or have become permanently and totally disabled due to a service-connected injury, and are otherwise ineligible for benefits through the Department of Defense's TRICARE program.

CHAMPVA is similar to Medicare in that it is a government-run insurer that contracts with voluntary health care providers. Those eligible for CHAMPVA are not eligible for health care services at VA facilities unless they themselves are also directly eligible for VA coverage. Like TRICARE, CHAMPVA reimbursement rates to health care providers are similar to those in the Medicare program.

CHAMPVA insurance includes some cost-sharing. Enrollees are responsible for approximately 25 percent of inpatient medical costs up to a deductible of \$3,000; deductibles for outpatient care are \$50 per individual or \$100 per family; above these deductibles, CHAMPVA pays for 75 percent of medical costs. The program serves as a secondary payer whereby those enrolled in private insurance or Medicare must seek reimbursement from those programs before seeking coverage from CHAMPVA. Under the Veterans Independence Act, the CHAMPVA program would remain as is, with enrollees receiving care from voluntary facilities.

MONITORING THE PROGRESS OF VETERANS HEALTH REFORM

As we have seen in the past, the mission is not over once Congress has passed a bill. If the Veterans Independence Act were to be enacted, it would be incumbent upon Congress to “keep the foot on the gas” and ensure appropriate progress with the implementation of VHA reform.

With that in mind, the Veterans Independence Act would create a nonpartisan commission, modeled after the Medicare Payment Advisory Commission (MedPAC), to assist and advise Congress and the Department of Veterans Affairs on veterans’ health reform. Membership in the VetsCare Implementation Commission would comprise solely of health care experts in academia, the private sector, and the veterans’ community.

The commission’s mandate would be to manage the implementation of reform, monitor progress in delivering reform, to continuously assess the quality of VA health care delivery and coverage, and to recommend refinements to congressional statutes and federal regulations where needed to improve veterans’ care.



7.

FISCAL CONSIDERATIONS



Fiscal Considerations

Many previous attempts at veterans' health reform have foundered due to the VAs—and the nation's—fiscal constraints.

Congressional rules, known as PAYGO, require most increases in direct federal spending to be offset by an equivalent amount of spending reductions or tax increases elsewhere. PAYGO rules exist for a reason. The Congressional Budget Office estimates that “under current law, [federal] debt would exceed 100 percent of GDP 25 years from now and would continue on an upward trajectory thereafter—a trend that could not be sustained.”⁷³ These trends are driven in large part by the aging U.S. population, and related spending on Social Security and Medicare.

Fortunately, the Veterans Health Administration does not suffer from a lack of funds. However, **too large a proportion of its funds are spent on underused facilities. This problem not only constrains the VHA's ability to devote resources to patient care; it also stymies efforts to allow veterans to seek care outside the VA.**

Imagine a situation in which you own your own car, but choose to rent another car when you want to leave town, because you believe that the rental car drives better than the one you own. In reality, few people do this; instead, they either drive the car they own, or choose not to own a car and solely use rentals.

This, in a nutshell, is the conundrum facing VA reformers. Facilitating the ability of veterans to seek care outside the VA system involves paying for both that external care (the rental car) and the upkeep of underused VHA facilities (the owned car). Furthermore, it is widely believed that private health care providers are somewhat costlier than VHA providers, though it is difficult to quantify this difference.

One of the core goals of the Taskforce was to give veterans access to civilian health care facilities in a fiscally responsible manner. The Veterans Independence Act uses two tools to achieve this goal. First, the VIA proposes to help the VHA rationalize its brick-and-mortar

footprint, thereby freeing up more resources for patient care. Second, the VIA's private coverage options—VetsCare Choice and VetsCare Senior—are carefully designed, with co-pays and deductibles, so as to ensure that these programs do not strain the VHA's appropriated budget.

In order to test the fiscal credibility of various approaches to VHA reform, including the one proposed here, Concerned Veterans for America retained the services of Health Systems Innovation Network, LLC (HSI), led by University of Minnesota economist Stephen T. Parente. Parente and his colleagues have been engaged by numerous members of Congress to model health reform proposals.⁷⁴ He has served as a Legislative Fellow in the office of Sen. John D. Rockefeller (D., W.V.) and as a health policy adviser to Sen. John McCain (R., Ariz.). Since 2002, Parente has been a principal investigator for studies on consumer directed health plans funded by the U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation.

The full text of HSI's report is subjoined to this document as Appendix 11E.

KEY ASSUMPTIONS

Due to the limited availability of detailed data from the Veterans Health Administration as to the utilization and cost-effectiveness of VHA services, it was necessary for HSI to make educated assumptions in order to model future spending by the Veterans Health Administration, and also to model the fiscal effects of the Veterans Independence Act. There are numerous limitations to HSI's analysis; we discuss these issues at the end of this section. We believe that an evaluation of this proposal by the Congressional Budget Office will offer us further opportunities to refine our recommendations.

HSI forecast both baseline VHA spending, and spending under reform, through fiscal year 2025. Under the baseline scenario, HSI assumed: (1) that there would be no changes to the VHA's eligibility criteria; (2) that VHA patients as a percentage of the living veteran population would remain at 2013 levels of 29.1 percent; (3) that utilization of health care services among

individuals of comparable health status and demographic characteristics would remain constant; (4) that use of hospital services would increase alongside an aging population with a higher prevalence of chronic conditions; (5) that costs per visit by program and health care category would remain constant at 2013 levels; (6) that future costs grow at a rate similar to those of the Medicare program.

HSI also modeled three approaches to offering VHA benefits to veterans of future wars: Reform Scenario 1, in which health coverage would be offered solely to veterans with service-connected injuries (Priority Groups 1 through 3); Reform Scenario 2, in which health coverage would be offered to a broader range of future veterans (Priority Groups 1 through 6); and “Reform All,” under which health coverage would be offered to future veterans in all Priority Groups including non-veterans. Reform Scenario 2 is the one proposed in the Veterans Independence Act. In each of the scenarios, all veterans enrolled in VA coverage prior to 2017 would remain grandfathered into the benefits to which they are already eligible.

Three VHA Reform Scenarios

REFORM SCENARIO	DESCRIPTION
1	Health coverage would be offered solely to veterans with service-connected injuries
2	Health coverage would be offered to a broader range of future veterans
3	Health coverage would be offered to future veterans in all Priority Groups including non-veterans

THE VETERANS ACCOUNTABLE CARE ORGANIZATION (VACO)

The Veterans Independence Act proposes to separate the payor and provider functions of the Veterans Health Administration. The health insurance (payor) functions would be assigned to the Veterans Health Insurance Program (VHIP), and the health care delivery (provider) functions would be assigned to an independent, government-chartered corporation, the Veterans Accountable Care Organization (VACO).

In order to estimate the fiscal effects of the Veterans Independence Act, HSI built a model that separated out the VHA’s gross spending on its provider functions, such as brick-and-mortar facilities and clinical personnel.

In addition, HSI conducted a sensitivity analysis of the impact of the VIA on retention of veterans by VHA facilities. HSI estimated revenues, expenses, and required inpatient beds in four scenarios: (1) 100 percent retention of the baseline VHA population; (2) 75 percent retention; (3) 50 percent retention; (4) 25 percent retention.

HSI estimated that, absent reform, VACO would incur expenses in the year 2025 of approximately \$73 billion. Under Reform Scenario 2, if VACO retained 75 percent of the patient volume it had under the old system, 2025 expenses would approximate \$64 billion—a significant cost-savings.

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THE VETERANS HEALTH INSURANCE PROGRAM (VHIP)

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PRIORITY GROUP	PSM CATEGORY	PREMIUM	SUBSIDY	TOTAL PAYMENT (VA OBLIGATION)	% ACTUARIAL VALUE (VA OBLIGATION)	REVISED PAYMENT
0	Diamond	\$8,130	\$6,469	\$14,599	100%	\$14,599
1	Platinum	\$8,130	\$6,469	\$14,599	90%	\$13,139
2	Platinum	\$8,130	\$6,469	\$14,599	90%	\$13,139
3	Gold	\$7,485	\$5,878	\$13,363	80%	\$10,690
4	Gold	\$7,485	\$5,878	\$13,363	80%	\$10,690
5	Silver	\$6,812	\$3,854	\$10,666	70%	\$7,466
6	Silver	\$6,812	\$3,854	\$10,666	70%	\$7,466
7	Bronze	\$4,033	\$2,423	\$6,456	60%	\$3,874
8	Bronze	\$4,033	\$2,423	\$6,456	60%	\$3,874
Non-Veterans	Bronze	\$4,033	\$2,423	\$6,456	60%	\$3,874

Furthermore, HSI estimated the number of veterans—expressed as a percentage of VHA unique patients—who would choose to seek private coverage through VetsCare Choice, instead of remaining in the traditional VetsCare Federal program, by Priority Group. HSI projected that between 25 and 45 percent of veterans with service-connected disabilities would enroll in VetsCare Choice; in most other Priority Groups, a lower proportion of veterans would enroll in the private-coverage option.

PRIORITY GROUP	LOW	HIGH
1. >50% service-connected disabilities	25%	45%
2. 30-40% service-connected disabilities	25%	45%
3. Former POWs et al, 10-20% disabled	25%	45%
4. Non-service connected disabled	5%	15%
5. Low-income able-bodied veterans	5%	15%
6. Vietnam, Persian Gulf vets et al.	25%	45%
7. Low-income veterans willing to copay	15%	30%
8. Higher-income vets (\leq 110% VA NIT)	10%	20%
9. Non-Veterans	10%	20%

The proposed system of graduated premium support through VetsCare Choice effectively prioritizes increased access to coverage and care for veterans with service-connected disabilities.

FISCAL OUTCOMES

In 2025, absent reform, HSI estimates that VA obligations for medical care—acute care and long-term care—will approximate \$73 billion. However, the unavailability of important data related to VA health spending made it difficult to produce an apples-to-apples comparison of spending under the Veterans Independence Act and the baseline figure of \$73 billion. A properly designed version of this reform is likely to be deficit neutral, especially if the newly independent VACO is successful at rationalizing the VHA's physical footprint.

Long-Term Care

HSI could not estimate long-term care spending by the VA under the baseline scenario, because the VA does not publish data on acute-care vs. long-term care spending by Priority Group. Importantly, the Veterans Independence Act proposes to subsidize enrollment by VHA unique patients in the Federal Long Term Care Insurance Program (FLTCIP). However, because of the unavailability of veterans' long-term care data, it was not possible to fiscally model this component of the reform proposal.

Retired members of the uniformed services are already eligible for FLTCIP. Hence, it is possible that the fiscal costs of enrolling non-elderly veterans in FLTCIP are relatively low. However, we will need to await more detailed data from the VA or the Congressional Budget Office in order to refine this analysis.

A properly designed version of this reform is likely to be deficit neutral, especially if the newly independent VACO is successful at rationalizing the VHA's physical footprint.

Acute care

For Reform Scenario 2—the one proposed in the Veterans Independence Act—VA acute-care spending would approximate \$69–71 billion.

In Reform Scenario 1, under which only future veterans with service-connected disabilities gained eligibility for VA health coverage, acute care spending would be almost the same as in Reform Scenario 2 (lower by approximately \$150 million). This is because the bulk of veterans' health spending over the next decade is driven by current veterans and disabled future veterans.

In “Reform All,” the scenario under which future veterans from all Priority Groups would be eligible for VA health coverage, 2025 spending would approximate \$72 billion.

8.

CONCLUSION



CONCLUSION

If reforming veterans health care were easy, it would already have been achieved. In this report, we have documented the numerous hurdles faced by reformers. Government agencies are inherently inefficient; an “iron triangle” of special interests opposes VA reform; the VHA’s fixed costs for hospitals and other facilities limit the agency’s flexibility in offering health care choices to veterans.

These hurdles must no longer hinder us. America’s veterans have sacrificed too much, and achieved too much, for us to make excuses as to the difficulty of VA reform. After months of intensive discussions, analysis, and consideration, we believe that our Taskforce has come up with the most plausible pathway to long-term reform of veterans health care.

First, it is critical to restructure the VA’s health care facilities into an independent, government-chartered corporation. Only under such a structure can the VA rationalize its fixed costs, freeing up the resources needed to offer veterans access to a broad range of VA and civilian health care options.

Second, the only way to offer veterans true choice in health care is to give them access to private insurance options that contract with voluntary hospitals and private physicians. In order to make these options fiscally responsible, they must include cost-sharing provisions, especially for veterans without service-connected injuries.

Third, reform of both the VHA’s provider and payor functions must be carefully designed so as to preserve the traditional VA system as an option for those veterans who prefer it, and so as to strengthen the posture of VA facilities with regard to long-term demographic realities.

Fourth, the VA must begin to report detailed data about the financial and clinical aspects of its operations. Without this information, the Congressional Budget Office and independent economists will risk making inaccurate projections about the fiscal impact of reform proposals, in either an optimistic or pessimistic direction. In addition, such transparency is necessary to monitor the quality of veterans’ health outcomes.

For years, lawmakers and veterans have privately asked important questions. Why can’t the VA do more to serve those with service-connected injuries? Why not let veterans take the dollars that the VA spends on their health care, and deploy them to gain care wherever they choose?

Why not, indeed. It is long past time to bring this conversation out into the open. Concerned Veterans for America is committed to overcoming any and all obstacles that stand in the way of achieving these goals. We look forward to working with anyone, and everyone, who shares them.

ACKNOWLEDGMENTS

Concerned Veterans for America and the Fixing Veterans’ Health Care Taskforce would like to thank the following individuals for their contributions to this report, without which it could not have been completed.

The support of CVA staff—top to bottom—was instrumental the successful completion of this report. **Tal Coley, Fred Ferreira, Brandon Davis, Dan Caldwell, and Caroline Phelps** all played critical roles in ensuring this report was properly resourced, written, vetted, communicated, edited—and edited again. Without their tireless input—day-by-day, draft-by-draft, and detail-by-detail—this report would not have been possible.

Shelley Oberlin, Senior Manager at HSI Network, LLC, spent countless hours working with the Taskforce to estimate the fiscal and economic impact of the Veterans Independence Act. The credibility of our fiscal proposals is due in great part to her.

We also want to recognize the team at **The Tarrance Group** for their invaluable insights into our polling results. Their dedication to the right questions, in the right manner—and to the right cross-section of veterans—ensured our polling numbers were both bulletproof and extremely insightful.

Numerous veterans leaders, congressional staffers, and outside advisors were silent partners in this project—and we are indebted for their input. While their names are not associated with our findings, their guidance throughout the process ensured our research was thorough and recommendations were grounded in reality. We specifically thank the leaders of many veterans service organizations who contributed to our roundtable session.

Finally, we recognize—and thank—the thousands of veterans, military families, and VA employees who submitted to our online portal, responded to our poll, and engaged directly with our Taskforce. This project has been of, by, and for America’s veterans—and we are indebted to your input.

9.

ANNEXES



Annex A:

TASKFORCE MEETINGS AND PARTICIPANTS

The Taskforce met 8 times at Concerned Veterans for America's Headquarters in Arlington, VA.

- September 23, 2014
- October 3, 2014
- October 16, 2014
- November 5, 2014
- November 18, 2014
- December 9, 2014
- January 21, 2015
- February 12, 2015

These meetings were used to discuss the contents of this report, the questions around the process and the future of veterans health care and its interplay with the broader health care market. For these meetings, there were present:

Taskforce Co-Chairs:

- Dr. Michael Kussman
- Rep. Jim Marshall
- Avik Roy
- Dr. Bill Frist
(and Dr. Martha Presley,
Office of Dr. Frist)

CVA Staff:

- Darin Selnick, Taskforce Executive Director
- Pete Hegseth
- Fred Ferreira
- Caroline Phelps
- Tal Coley
- Brandon Davis
- Dan Caldwell

In certain meetings, there was the participation of individuals who were not officially part of the Taskforce that presented their perspectives on veterans health care to the Taskforce. Nonetheless, to enable a most open and honest conversation and because the discussions were not for attribution, their names have been omitted from the report.

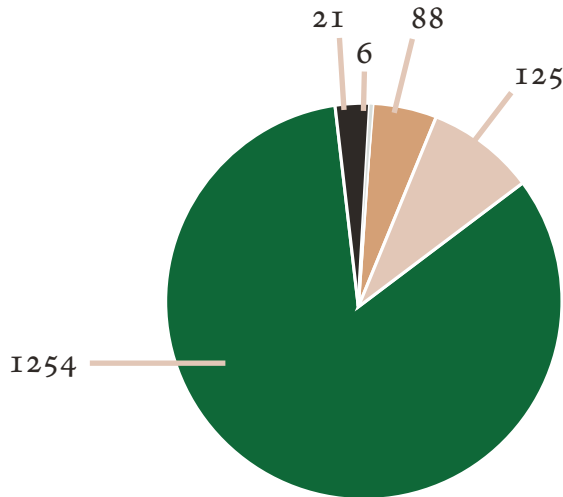
Annex B:

SUBMISSION PORTAL

Top Line Information

Coded entries: 1473

SUBMISSION SOURCES



Active Military	6
Civilian Supporter	88
Family Member	125
Veteran	1254
Total	1473
Reported VA Employees	21

- Veteran
- Reported VA Employees
- Family Member
- Active Military
- Civilian Supporter

Details on the Submissions

The submissions were divided into six major themes and each theme divided into positive or negative impressions, depending on the content of the submission. The goal is to reveal the major areas of concern for veterans on their experience with health care.

STAFF: entries that addressed staff ranged from problems related to staff behavior to commentary on the quantity and quality of the staff, or the rules that govern staff interaction with the public.

SERVICE: entries ranged from criticism of the quality of services provided to a lack of a desired service in the facility and expedience in the provision of those services.

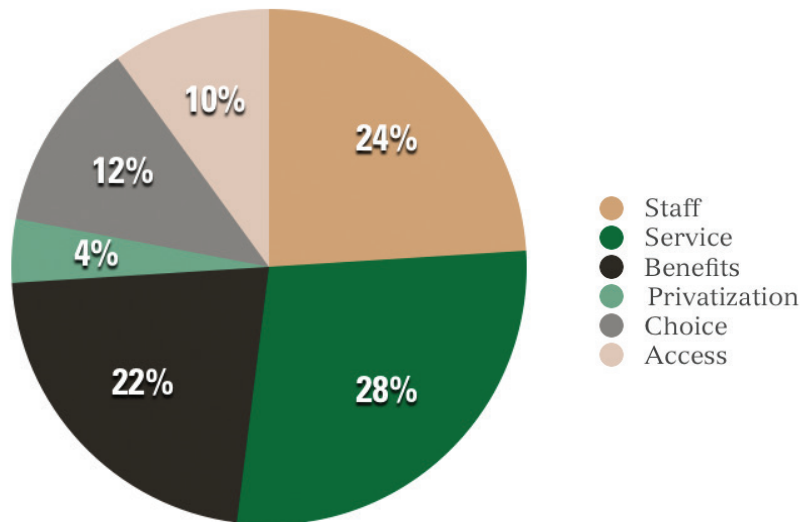
ACCESS – entries ranged from not being able to book an appointment or receive benefits payment to not being able to speak to VA employees over the phone.

BENEFITS – entries ranged from not receiving a sufficient travel reimbursement to not having Wi-Fi in the hospitals waiting rooms.

CHOICE – entries were related to having the option of consulting with a medical professional outside the VA system and having the VA cover the costs.

PRIVATIZATION – entries were related to the idea of getting VA out of the business of providing care.

SUBMISSION CONTENT THEMES

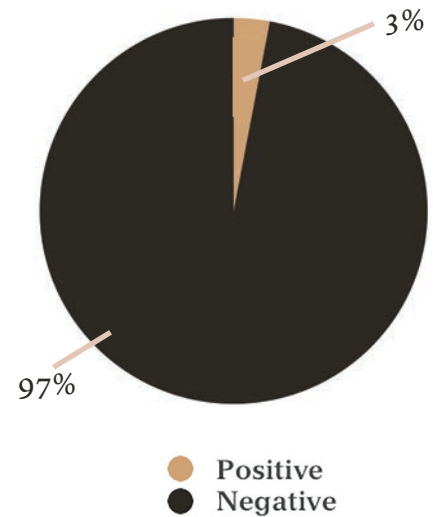


IMPRESSIONS OF THEMES

When sorted by negative and positive impressions of each theme, this is how the entries broke down:

THEME	PERCENTAGE
Positive of Staff	1
Negative Service	28
Positive Service	1
Negative Benefits	21
Positive Benefits	1
Positive Privatization	4
Negative Privatization	0
For Choice	11
Against Choice	0
Negative on Access	10
Positive on Access	0
Negative on Staff	23

IMPRESSIONS OF VA STATUS QUO



When you sort the impressions by their general feeling towards the VA status quo, meaning positive impressions on benefits, access, staff, service, and negative impressions on choice and privatization, the above pie chart illustrates how the submission breaks down.

Annex C:

NATIONAL VETERANS' SURVEY

Below is a selection of questions from a recently completed survey of veterans across the nation. The Tarrance Group was commissioned by Concerned Veterans for America (CV4A) to conduct a national survey of 1,000 veterans. Half of the respondents (n=500) completed the interview by telephone and half (n=500) completed the interview on-line. The sample was drawn to correctly represent rank, branch of service, age and gender. A random sample of this type is likely to yield a margin of error of +3.1% in 95 out of 100 cases were it possible to interview every veteran, active duty military and guard/reservist nationwide. Responses to the survey were gathered November 11-20, 2014.

4. Have you seen, read, or heard anything about problems at the Department of Veterans Affairs?

Yes, have seen, read or heard	89%
No, have not seen, read, or heard	10%
Unsure	1%

5. Even if you have not seen, read or heard anything about problems– would you strongly favor, somewhat favor, somewhat oppose, or strongly oppose efforts to reform veteran health care in this country?

Favor/strongly	72%	Favor/somewhat	18%
Oppose/somewhat	2%	Oppose/strongly	1%
UNSURE	7%		

Here is a list of ideas that some people have said should be considered as a part of any efforts to reform veteran health care. Please answer, for each one, using a scale from 0 to 10, where 0 means it is “not at all important” and 10 means it is “extremely important,” **how important each of these ideas is to you personally.** Here is the first one:

(SPLIT SAMPLE)

7A. Increasing health care choices for veterans

NOT AT ALL IMPORTANT						EXTREMELY IMPORTANT			
1%	1%	*	6%	3%	7%	15%	14%	55%	

7B. Increasing health care options for veterans

NOT AT ALL IMPORTANT						EXTREMELY IMPORTANT				
1%	*	*	*	1%	5%	2%	6%	15%	15%	55%

8. Ensuring veterans get the best possible care, even if that means getting that care outside of a VA facility

NOT AT ALL IMPORTANT						EXTREMELY IMPORTANT				
1%	*	*	*	*	2%	2%	4%	10%	11%	70%

*= less than .5%

Annex D:

VETERANS SERVICE ORGANIZATION ROUNDTABLE

Concerned Veterans for America held a Veterans Service Organization (VSO) Roundtable on November 6, 2014 at the Army and Navy Club in Washington, DC. In order to have an open and honest discussion, the names of the participants are omitted and the discussion was not for attribution.

The goals of the meeting were as follows:

- Aggregate suggestions/ideas/solutions from leading veterans service organizations
- Identify existing challenges to veterans' health care
- Identify possible solutions to veterans' health care

The roundtable was open to all Veterans Service Organizations. We had the participation of six major VSOs. Overall, the VSO roundtable served its main mission of illuminating the priorities and concerns that the VSO community share and also helped frame the discussions of the Taskforce. The roundtable was able to inform the work of the Taskforce and help compose a better image of the desires and aspirations of veterans' communities. Following the roundtable, ongoing conversations were maintained with multiple VSO representatives throughout the Taskforce process.



Annex E:

FISCAL IMPACT ANALYSIS

In the winter of 2014, Concerned Veterans for America engaged Health Systems Innovation Network, LLC to assess the fiscal impacts of proposed reforms aimed at improving the Veterans Health Care System. After reviewing the reforms, we believed there were two fundamental goals: (1) provide veterans with an option of receiving health care outside the VHA and (2) remove potential government barriers to the VHA, enabling it to focus on providing high quality, safe, and efficient care. To begin to understand the fiscal impact of these changes, we restructured the current VA health care system cost structure (appropriations to Congress) into the VA as a payor and the VHA as an independent health care delivery system. This report summarizes the outputs of our analysis, references all data sources, and where data was not available describes our assumptions and rationale supporting those assumptions.

Caveat

As mentioned in the December 2014 Congressional Budget Office Report, “Comparing the Costs of the Veterans’ Health Care System with Private-Sector Costs,” there is limited data available to the public around the VHA’s costs and operational performance. We used three primary data sources to build the foundation of our fiscal models.

I. Department of Veterans Affairs, Volume II Medical Programs and Information Technology Programs, Congressional Submissions, Funding and Appropriations from FY2010 to FY2015

A. Provided historical data from 2008 to 2013 for the following categories:

- Unique number of patients by Priority Groups 1-6 combined, 7 and 8, and non-veterans
- Workloads (visits and patients treated by health care category)
- Obligations by Activity (health care category) by health care program (Medical Services, Medical Support and Compliance, and Medical Facilities)
- Obligations by Object (typical expense categories) by health care program (Medical Services, Medical Support and Compliance, and Medical Facilities)

II. Department of Veterans Affairs, Veterans Health Administration, Office of Policy and Planning. Historical data tables prepared by the National Center for Veterans Analysis and Statistics (NCVAS)

A. Provided historical data from 2008 to 2013 for the following categories:

- Unique number patients by Priority Group (1 – 8 separately and non-veterans)
- Average expenditures per patient per Priority Group
- Selected Veterans Health Administration Characteristics

(total enrollees in millions, total outpatient visits in millions,
total inpatient admissions in thousands)

III. Table 1L: VETPOP2014 Living Veterans by Age Group, Gender, 2013-2043
retrieved from http://www.va.gov/vetdata/Veteran_Population.asp [Population
Tables > the Nation Age/Gender > Living]

A. Provided population projections and age categories for living veterans
from 2013 to 2043

The challenge with the available data is several-fold including: inconsistencies around total values/numbers, variability of the categories by which the data is presented (e.g., individual Priority Groups vs combined Priority Groups), and a lack of detail needed to model the specific reforms as outlined in the Veterans Independence Act (VIA). For example, data is not available by age or income level by priority. With regards to utilization, ambulatory care visits are provided as staff and fee visits. We were unable to find data differentiating ambulatory care visits by an office visit (primary care or specialty), surgical case, procedure, major imaging, etc. Given these data limitations as well as others, we made several assumptions to reconcile the existing data and forecast a potential future environment. Also, given the uncertainty around which veterans may choose to enroll in the premium support model and which veterans will choose to continue to use the VHA, we developed scenarios and sensitivity analyses to provide a range of potential outcomes that we believe is a reasonable starting point to discuss the fiscal impact of the proposed reforms on the VA health care system.

Methodology Overview

We developed two models to test the fiscal impact of the proposed reforms: A baseline model and a reform model. The baseline model assumes the status quo, meaning the VA health care system will continue to operate as it does today. The difference is a restructuring of the expenditures today to more directly tie to the change in patient populations. The reform model factors in the changes and assumptions as outlined in the Taskforce reform proposals. The forecasted timeframe for both models is from 2013 to 2025. Data from 2008 to 2013 were used to assess trends. We did not include 2014 to 2016 estimates from the FY2015 Funding and Appropriations Congressional Submission Report as these were estimates and we wanted to rely on actual data to the greatest extent possible.

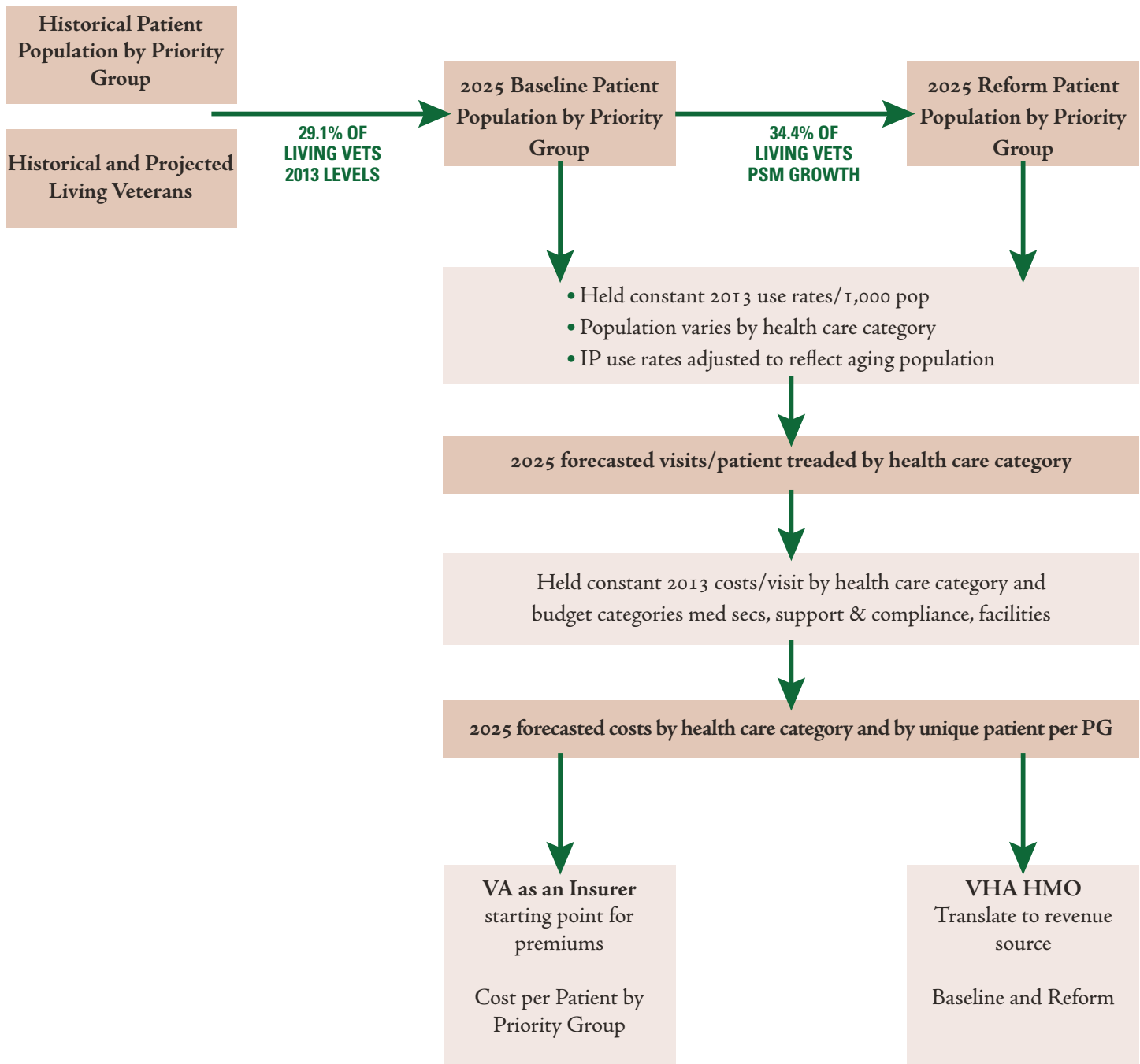
Table 1, on the following page, summarizes our key assumptions for the baseline and reform models. For the reform model, we developed two scenarios to test the impact on revised eligibility criteria for new veterans. Scenario 1 assumes newly eligible service-connected veterans (PG 1-3) will be covered by the VA through the premium support model starting in 2017. Scenario 2 assumes newly eligible veterans in Priority Groups 1 – 6 will be covered by the VA through the premium support model, also starting in 2017. Both scenarios assume veterans using VA services prior to 2017 will be grandfathered in and given the option to enroll in the premium support model.

Table 1: Summary of Assumptions for Baseline and Reform Models

MODEL	KEY ASSUMPTIONS
Baseline	<ul style="list-style-type: none"> • Forecast timeline is from 2013-2025 • No change to eligibility criteria • Holds constant percent patient population/living veteran at 2013 levels = 29.1% • Holds constant use rates per 1,000 population at 2013 levels; population varies by health care category • Inpatient use rates adjusted to reflect aging population and greater prevalence of chronic conditions relative to US population • Holds constant costs/visit by program (Medical Services, Support & Compliance, and Facilities) and by health care category • Forecasted costs factor in inflation with select categories grown at estimated Medicare rates (4.0%)
Reform All	<p>Same Assumptions as baseline model with the following changes:</p> <ul style="list-style-type: none"> • Increase percent patient population/living veterans to 34.4%; assume more enrollees may become patients with choice • Include two scenarios to test fiscal impact of changes to eligibility criteria • For both scenarios—all patients covered by the VA prior to 2017 will be grandfathered in and have the option of choosing premium support model <p>REFORM SCENARIO 1: By 2017, new patients in PGs 1-3 to be covered by the VA as a payer</p> <p>REFORM SCENARIO 2: By 2017, new patients in PGs 1-6 to be covered by VA as a payer</p>

Key drivers used to develop the forecast models for this project include patient population growth, use rates per 1,000 population by major health care category and costs per visits by medical program (medical services, support and compliance, and facilities) and health care category (ambulatory, inpatient, LTC, mental health, etc.). Obligations by medical programs (from the Congressional Submission Reports) were converted to revenues for the VHA and used as a starting point to discuss premiums and subsidies for the VA as a payor. Obligations by Object were converted to expenses for the VHA. Figure 1 provides an overview of our methodology.

Figure 1: Methodology Overview



Historical and Forecasted Veteran Patient Population

In developing a population market forecast for a delivery system in the private sector, there are a number of data sources to help inform a reasonable growth rate. Whether it is Census.gov, Claritas, or State/County Departments of Finance, most of these provide population projections by zip code (or other geographic region), by age category, and by gender. Forecasting the veterans' patient population is more challenging given limited data on population projections and uncertainty around the future environment. Will there be another war? If so, to what extent will it drive the need for future health care services? If roughly 75% to 99% (varies by age) of veterans have another source of health care coverage,⁷⁵ how many will be eligible and choose to use the VA?

Our first step to forecast the future veteran patient population, was to merge existing historical data into a format that allowed us assess patient population by Priority Group while maintaining the appropriate patient population that tied to utilization and cost data. To do this, we calculated the percentage of patient population by Priority Group from the VHA Office of Policy and Planning (which provides the number of patients by all Priority Groups) and applied these percentages to the totals from the congressional submission reports (which combines the number of patients into three categories Priority Groups 1-6, Priority Groups 7-8, and non-veterans (see Appendix for the difference in patient population between these two data sources). The blending of these data sources resulted in revised patient populations by Priority Group with totals that directly tied to utilization and cost data from 2008 to 2013.

From Table 2 below, the overall number of unique patients has grown from 5.6 million in 2008 to 6.5 million in 2013; an increase of approximately 900,000 patients. With the exception of Priority Group 6 and non-veterans, the number of service-connected veterans (PGs 1-3) have grown the fastest per year from 2008 to 2013, which is consistent with the findings from the NCVAS Trends in Utilization of VA Programs and Services: FY2009 to FY2013.⁷⁶ Over the same time period, the number of patients in Priority Groups 5 and 8 declined – a trend we carried forward in our projections.

Table 2: Revised Unique Patients per Priority Group – Blended Data Sources

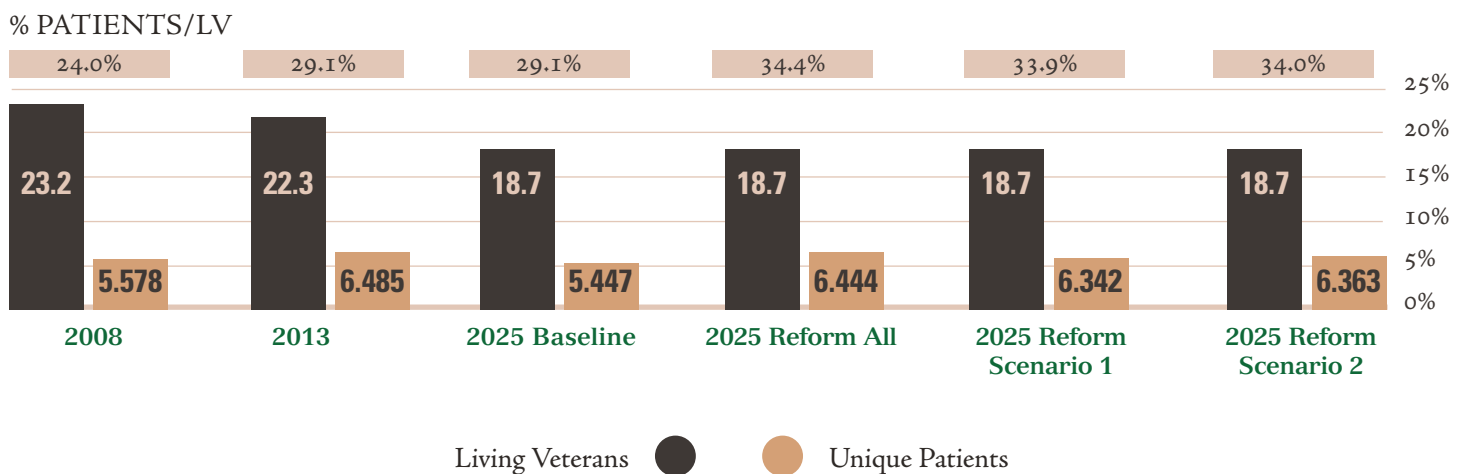
Priority Group	2008	2009	2010	2011	2012	2013	Chg 08-13	CAGR 08-13
1	899,503	990,506	1,085,318	1,192,563	1,321,903	1,467,527	568,023	10.29%
2	369,747	404,544	431,470	447,631	460,985	479,005	109,257	5.31%
3	592,297	646,589	686,451	694,994	705,097	729,439	137,142	4.25%
4	188,307	189,134	191,889	193,322	193,594	194,336	6,029	0.63%
5	1,456,841	1,422,463	1,466,519	1,456,597	1,432,544	1,375,394	(81,447)	-1.14%
6	202,364	221,720	247,680	269,362	274,987	278,805	76,440	6.62%
7	134,253	127,714	145,981	157,152	141,605	154,452	20,199	2.84%
8	1,234,956	1,218,912	1,185,752	1,170,549	1,149,659	1,124,933	(110,023)	-1.85%
Subtotal	5,078,269	5,221,583	5,441,059	5,582,171	5,680,374	5,803,890	725,621	2.71%
Non-Veterans	498,420	523,110	559,051	584,020	652,717	680,774	182,354	6.43%
Total	5,576,689	5,744,693	6,000,110	6,166,191	6,333,091	6,484,664	907,975	3.06%

Notes: CAGR = Compounded Annual Growth Rate; Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for by VA. Non-veterans include active duty military and reserve, spousal collateral, consultations and instruction, CHAMPVA workload, reimbursable workload with affiliates, humanitarian care, and employees receiving preventive occupational immunizations such as Hepatitis A&B and flu vaccinations.

After reviewing data from the VA and external reports, and testing other potential forecast methodologies, we chose to forecast the total future patient population as a percentage of living veterans – similar to a market share forecast. For the baseline model we held constant the percentage of unique patients per living veteran at 2013 levels, which

was 29.1%. For the reform models, we assumed a slight increase to 34.4% based on the idea that more enrollees may choose the VA as a payor with the premium support model. Figure 2 shows the total number of living veterans and unique patients for 2008, 2013 and our 2025 forecast models including both reform scenarios. From 2008 to 2013, the number of living veterans declined from 23.2 million to 22.3 million, and is projected to decline further to 18.7 million by 2025. The number of unique patients is forecasted to decrease to 5.4 million in the baseline model and 6.3 million to 6.4 million in the reform model – varies by scenario.

Figure 2: Historical and Forecasted Living Veterans and Unique Patients, 2008, 2013 and 2025



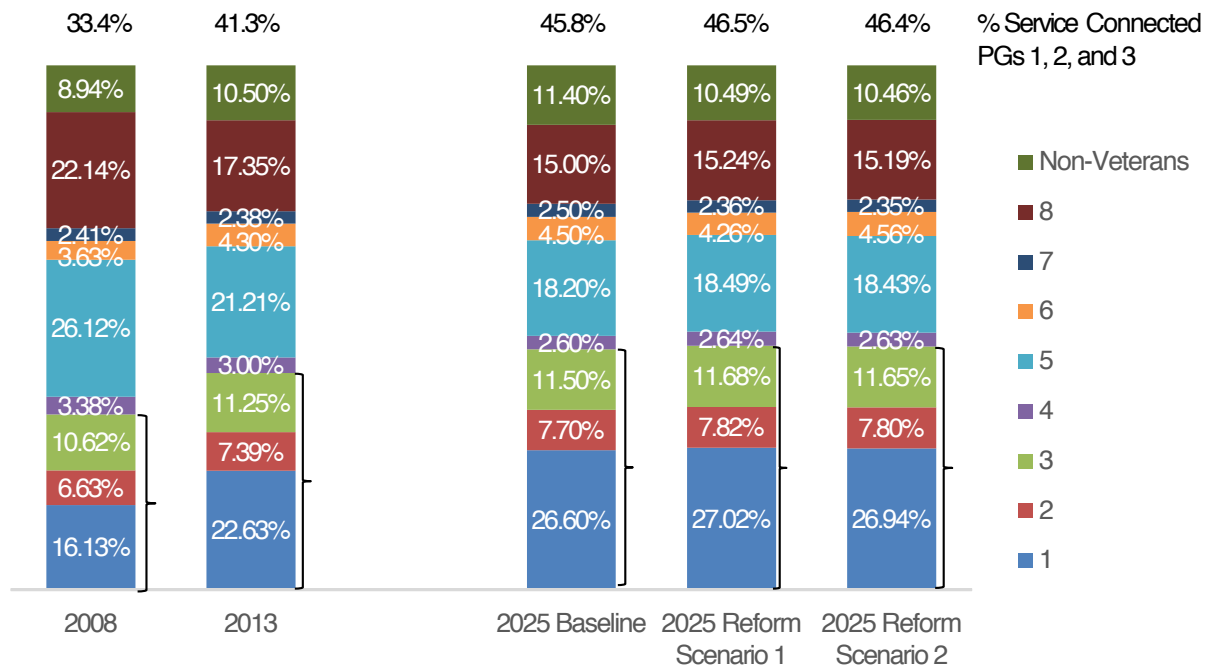
Rationale and Assumptions:

- For the purposes of this fiscal impact analysis, we did not assume there would be any major wars from now through 2025. The models are flexible to adjust this assumption over time.
- Projections of living veterans by age from 2013 to 2043 was deemed the only relevant source of data (for this scope of work) with projections through 2025. We were not able to find any patient projections by Priority Group.
- An alternative forecast methodology is to apply historical growth rates assuming the same trends will continue for the next ten years. We tested the impact of two growth rates: (1) the historical patient population growth rates by Priority Group from 2008 to 2013 (as shown in Table 2 above) and (2) a 1.8% growth rate based on the estimated patient population change from 2013 to 2016 from the FY2015 congressional submission report. The results were patient population projections ranging from 8.0 million to 9.3 million. While the percentage of patients per living veteran increased from 24% in 2008 to 29.1% in 2013, an increase to 43% or 50% of patients/living veterans by 2025 seemed unlikely considering the fact that the number of living veterans is projected to decline and more than 70% of veterans have another source of care; and, of those, most tend to receive health care outside the VHA.

- To determine the percentage of patients per living veteran for the reform model, we triangulated growth rates and projections from a few external sources, including a 2009 coalition commission report and a 2010 CBO report. The latter also describes the difficulty with projecting the number of future veterans and therefore developed two potential scenarios.⁷⁷ The two data sources varied in the population assessed (unique patients vs. enrollees) and both assumed increased eligibility criteria, particularly for Priority Group 8. Where possible, we removed the estimated population for PG8 and applied the growth rates from these projections to our 2013 baseline population. We then calculated the percentage of these population estimates per living veteran and took the average. This led to the 34.4% of patients per living veteran assumption. After reviewing this with the CVA Taskforce, there was agreement that a 5% growth in patients per living veteran was a reasonable assumption.

To forecast the number of patients by Priority Group, we calculated the annual percent change per year by Priority Group from 2008 to 2013 and created an adjustment factor to maintain a similar distribution of patients. We then applied this adjustment factor to the total 2025 population and used the CAGR from 2013 to 2025 to forecast the number of unique patients per Priority Group per year from 2013 to 2025. Figure 3 shows the percentage of patient population by Priority Group for 2008, 2013 and 2025. In line with the proposed reforms, the number of service-connected patients increases from 41.3% in 2013 to 45% - 46% by 2025. From this point forward, only scenarios 1 and 2 will be shown (unless otherwise noted) as the Reform All model was used to forecast all patients (Priority Groups 1-8 and non-veterans) prior to incorporating the revised eligibility criteria.

**Figure 3: Percentage of Unique Patients by Priority Group
2008, 2013, 2025**



Historical and Forecasted Visits/Patients Treated by Health Care Category

Historical visit data was obtained from the FY2010 to FY2015 congressional submission reports. Data varied by year so we created a mapping to match earlier year categories to 2013 actual data. See appendix for category mapping. Also, there are several terms used to describe utilization metrics including workloads, patients treated and visits. For the purposes of this report, we will use visits and patients treated interchangeably.

The veterans' health care system appears to provide comprehensive health care services along the continuum of care. From Table 3, patients treated are categorized along eight health care categories: ambulatory care; inpatient care; rehabilitative care; mental health; long-term care (LTC); dental care; CHAMPVA, Spina Bifida, FMP, CWVV; and readjustment counseling. In 2013, the number of visits (or patients treated) at the VA was more than 110 million. This was an increase of ~30 million visits over the last five years. Ambulatory visits represent more than 80% of all patient visits. Patients treated in ambulatory care and CHAMPVA, Spina Bifida, FMP, CWVV grew the fastest from 2008 to 2013 with annual growth rates of 6.27% and 11.79%, respectively. Inpatient growth has remained relatively flat, which may be due to the shift from inpatient to outpatient and/or potential capacity constraints in some locations. The bundling of data by health care category makes it difficult to draw detailed conclusions.

Table 3: 2008 to 2013 Visits by Health Care Category

Visits/Patients Treated	2008	2009	2010	2011	2012	2013	Chg 08-13	CAGR 08-13
Ambulatory Care	66,527,000	73,474,000	79,556,000	83,127,000	87,185,000	90,180,000	23,653,000	6.27%
Inpatient Care	591,825	622,146	627,648	630,242	633,148	623,839	32,014	1.06%
Rehabilitation Care	14,486	15,165	15,628	15,910	16,091	15,996	1,510	2.00%
Mental Health	138,295	141,057	160,882	157,810	155,677	152,863	14,568	2.02%
Long-term Care	96,253	98,725	100,239	97,221	101,720	108,625	12,372	2.45%
Dental Care	3,463,377	3,746,023	3,946,188	4,120,152	4,089,000	4,182,000	718,623	3.84%
CHAMPVA, Spina Bifida, FMP, CWVV	7,883,000	8,892,000	10,713,000	11,019,000	12,691,000	13,764,000	5,881,000	11.79%
Readjustment Counseling	1,113,000	1,188,000	1,283,000	1,377,000	1,505,000	1,540,000	427,000	6.71%
Total	79,827,236	88,177,116	96,402,585	100,544,33	106,376,636	110,567,323	30,740,087	6.73%

Note: Data for ambulatory visit provided in thousands so adjusted accordingly for modeling

Forecasted visits are based on patient population growth and use rates per 1,000 patients. See Table 4 for use rates by health care category.

Table 4: Use rates per 1,000 population by Health Care Category

Use Rates/1,000 population	2008	2009	2010	2011	2012	2013	Assumption
Ambulatory Care /							
Total Population	11,929.48	12,789.89	13,259.09	13,481.09	13,766.58	13,906.66	13,906.66
Inpatient Care / PG 1-8	116.54	119.15	115.35	112.90	111.46	107.49	113.82
Rehabilitation Care / PG 1-8	2.85	2.90	2.87	2.85	2.83	2.76	2.76
Mental Health / Total Population	24.80	24.55	26.81	25.59	24.58	23.57	23.57
Long-term Care / PG 1-8	18.95	18.91	18.42	17.42	17.91	18.72	18.72
Dental Care / Total Population	621.05	652.08	657.69	668.18	645.66	644.91	644.91
CHAMPVA, SB, FMP, CWVV / non-vet	15,815.98	16,998.34	19,162.83	18,867.50	19,443.34	20,218.16	20,218.16
Readjustment Counseling / Total Pop	199.58	206.80	213.83	223.31	237.64	237.48	237.48

RATIONALE AND ASSUMPTIONS

- Due to the bundling of data by health care category (e.g., limited data by surgeries, office visit, type of inpatient admission, etc.), we were hesitant to make detailed assumptions about changes to utilization of services. We also presumed many of these services (e.g., rehab, mental health) are unique to the veteran population, so without additional data – quantitative or qualitative, we held constant 2013 use rates by health care category from 2013 to 2025 for both the baseline and reform model.
- The exception is inpatient use rates. While we recognize there has been a decline in inpatient utilization, an inpatient use rate of 107.49 per 1,000 patients for this population seemed low for the following reasons: (1) it did not align with the 2013 calculated inpatient use rate from the VHA Office of Policy and Planning statistics which was ~115 admissions/1,000 patients; (2) we wanted to factor in the aging of the population (see appendix) and the higher prevalence of chronic conditions for the veteran population;⁷⁸ and (3) we assumed the shift from inpatient to outpatient has already taken place. As described by Auerbach et al., the doubling of the number of outpatients since the 1990s is partly due to the general shift to outpatient settings and a shift in VA budgeting practices (a move to a capitated budgeting system).⁷⁹
- Based on information included the narrative and footnotes of the congressional reports, we varied the population denominator by health care category (see Table 4).

Table 5 shows the forecasted number of patients treated by health care category and by forecast model. By 2025, total visits are projected to decline by ~16.6 million in the baseline model and ~ 2.0 million to 2.3 million in the reform scenarios. The decline is slightly less than the decline in overall patient population growth given the assumptions above. There is a slight increase in inpatient visits for both reform scenarios, factoring in aging and health status of the veteran population. Forecasted visits per patients treated then were used to drive future costs and capacity needs.

Table 5: Forecasted Visit/Patients Treated by Health Care Category

Visits/Patients Treated	Baseline Model				Reform Modern Scenario 1			Reform Modern Scenario 2		
	2013	2025	Chg 13-25	CAGR 13-25	2025	Chg 13-25	CAGR 13-25	2025	Chg 13-25	CAGR 13-25
Ambulatory Care	90,180,000	75,750,569	(14,429,431)	-1.44%	88,208,400	(1,971,600)	-0.18%	88,486,373	(1,693,627)	-0.16%
Inpatient Care	623,839	549,287	(74,552)	-1.05%	646,199	22,360	0.29%	648,474	24,635	0.32%
Rehabilitation Care	15,996	13,301	(2,695)	-1.53%	15,648	(348)	-0.18%	15,703	(293)	-0.15%
Mental Health	152,863	128,404	(24,459)	-1.44%	149,521	(3,342)	-0.18%	149,992	(2,871)	-0.16%
Long-term Care	108,625	90,325	(18,300)	-1.53%	106,261	(2,364)	-0.18%	106,635	(1,990)	-0.15%
Dental Care	4,182,000	3,512,851	(669,149)	-1.44%	4,090,569	(91,431)	-0.18%	4,103,460	(78,540)	-0.16%
CHAMPVA, Spina Bifida, FMP, CWVV	13,764,000	12,554,797	(1,209,203)	-0.76%	13,451,197	(312,803)	-0.19%	13,451,197	(312,803)	-0.19%
Readjustment Counseling	1,540,000	1,293,589	(246,411)	-1.44%	1,506,331	(33,669)	-0.18%	1,511,078	(28,922)	-0.16%
Total	110,567,323	93,893,124	(16,674,199)	-1.35%	108,174,127	(2,393,196)	-0.18%	108,472,912	(2,094,411)	-0.16%

VHA as an Independent Health Care System

To assess the VHA as an independent health care system and the VA as a payor, we converted the current VA obligations cost structure into revenues and expenses and constructed the models such that future expenditures would rise and fall with the patient population – a mix of variable and fixed costs.

In the congressional submission reports, there are two main data tables: obligations by program and obligations by object. The expenditures in the obligations by program are aligned with visits by health category and were, therefore, deemed to be a logical starting point to develop “revenues” for the VHA. Obligations by object are typical expense categories and were relabeled as “expenses” for the VHA. Both of these tables are provided for Medical Services, Medical Support & Compliance and Medical Facilities. Today, and historically, the totals for the two tables are equal (see Table 6 and Figure 1). Of note, the totals below may not match exactly due to rounding errors based on our assumptions for fixed and variable costs (see appendix for details).

Table 6: Medical Services Revenues and Expenses for the VHA as an Independent Health Care System

VHA REVENUES AND EXPENSES (DOLLARS IN 000)

Revenue	2008	2009	2010	2011	2012	2013	Chg 08-13	CAGR 08-13
Medical Services	\$30,752,206	\$33,810,785	\$37,390,193	\$40,203,561	\$43,031,633	\$44,251,486	13,499,280	7.55%
Medical Support & Compliance	\$3,953,539	\$4,383,081	\$5,022,103	\$5,351,468	\$5,427,405	\$5,738,337	1,784,798	7.74%
Facilities	\$4,682,250	\$5,076,201	\$5,803,674	\$5,801,870	\$5,409,370	\$5,463,388	781,138	3.13%
Medical Programs Total	\$39,387,995	\$43,270,067	\$48,215,970	\$51,356,899	\$53,868,408	\$55,453,211	\$16,065,216	7.08%
Medical Collections Fund	\$2,477,880	\$2,798,195	\$2,837,904	\$2,772,546	\$2,814,888	\$2,931,284	453,404	3.42%
Total Revenue	\$41,865,875	\$46,068,262	\$51,053,874	\$54,129,445	\$56,683,296	\$58,384,495	\$16,518,620	6.88%

Expenses	2008	2009	2010	2011	2012	2013	Chg 08-13	CAGR 08-13
Personal Services & Benefits	\$19,688,531	\$22,189,733	\$24,044,986	\$25,513,783	\$26,092,864	\$27,373,624	\$7,685,093	6.81%
Travel & Transport of Persons	\$531,839	\$807,096	\$950,642	\$1,052,867	\$1,037,993	\$989,412	\$457,573	13.22%
Transportation of Things	\$36,275	\$32,381	\$46,542	\$40,143	\$37,119	\$41,289	\$5,014	2.62%
Comm., Utilites & Oth. Rent	\$1,059,908	\$1,103,446	\$1,215,620	\$1,289,809	\$1,404,117	\$1,486,830	\$426,922	7.00%
Printing & Reproduction	\$17,122	\$21,577	\$31,344	\$82,360	\$32,259	\$33,390	\$16,268	14.29%
Other Services	\$7,614,638	\$8,650,273	\$9,845,179	\$10,547,995	\$10,985,940	\$12,075,366	\$4,460,728	9.66%
Supplies & Materials	\$6,670,044	\$7,127,218	\$7,865,114	\$8,304,589	\$8,789,755	\$8,424,262	\$1,754,218	4.78%
Equipment	\$1,479,978	\$784,464	\$1,083,275	\$1,411,118	\$2,619,533	\$2,005,927	\$525,949	6.27%
Lands & Structures	\$1,626,562	\$1,775,511	\$2,296,504	\$2,088,025	\$1,706,628	\$1,565,541	\$(61,021)	-0.76%
Grants, Subsidies & Contributions	\$662,323	\$778,368	\$836,156	\$1,025,888	\$1,161,923	\$1,457,316	\$794,993	17.08%
Imputed Interest	\$775	\$-00	\$608	\$322	\$279	\$253	\$(522)	-20.06%
Total Expenses	\$39,387,995	\$43,270,067	\$48,215,970	\$51,356,899	\$53,868,410	\$55,453,210	\$16,065,215	7.08%
Net Income (incl. Med Collect Fund)	\$2,477,880	\$2,798,195	\$2,837,904	\$2,772,546	\$2,814,886	\$2,931,285		

Notes: Totals for medical cost total and expense totals may vary slightly due to rounding error
2013 revenues modified to more closely match average expenditures/pt/pg from VHA office of policy and planning (see final report for details)

Disclaimer – We recognize the revenues and expenses (historical appropriations to congress) presented above may not include all expenses for VHA. These were used to assess the fiscal impact of the reforms as they relate to “direct” Medical Care for the Department of Veteran’s Affairs.

To project future revenues, we held constant costs per visit by health care category and program (medical service, support & compliance, and facilities). We also included dollars from the Medical Care Collections funds (parking, 3rd party collections, co-pays, etc.) and assumed revenues would grow 4% per year based on estimated growth rates for Medicare expenditures.⁸⁰ We then used the forecasted revenues to calculate average expenditures per patient per Priority Group. Table 7 shows the average expenditures per patient per Priority Group obtained from VHA office of policy and planning statistics and our 2013 calculations using cost data from the congressional submission reports.

Table 7: Data Reconciliation for 2013 Average Expenditures per Patient per Priority Group

2013 AVERAGE EXPENDITURES/PATIENT/PRIORITY GROUP

Priority Group	2013 VHA Planning Statistics (va.gov)	2013 (Congressional Report Totals)	2013 Modified
1	\$11,598	\$14,019	\$11,840
2	\$5,734	\$6,931	\$5,854
3	\$5,546	\$6,704	\$5,662
4	\$21,597	\$26,105	\$22,048
5	\$8,386	\$10,136	\$8,561
6	\$2,983	\$3,606	\$3,045
7	\$5,431	\$6,564	\$5,544
8	\$3,373	\$4,077	\$3,443
Non-Veterans	\$1,276	\$1,542	\$1,303

The average expenditures per patient per Priority Group based on the congressional submission reports are significantly higher than the VHA statistics. We originally included support and compliance and facilities as revenue given the footnotes that they include a portion of direct care obligations. After reviewing the obligations by object (expenses), we identified five categories that could be considered indirect costs of care: Travel & Transport of Persons, Communications/Utilities and Other/Rent, Printing and Reproduction, Lands and Structures, and Equipment. We then removed the equivalent dollar amount for each of these categories from our revenue totals. We did not remove equipment from Medical Services as we presumed this is directly related to patient care. The total decrease in obligations by programs was 12.0% of the total appropriations requested. The result is a modified 2013 average expenditures per patient per Priority Group. From Table 7, “2013 Modified” more closely aligns with the statistics from the VHA Office of Policy and Planning.

By 2025 the baseline model revenues and expenses are forecasted to reach \$68.4 billion and \$73.1 billion, respectively. While the model shows a negative net income of \$4.7 billion, this should be viewed as one data point to start the discussion around how the VHA should strategically plan for growing revenues and controlling expenses.

**Table 8: Baseline Forecasted Revenues and Expenses
for the New Independent VHA**

VHA REVENUES AND EXPENSES (DOLLARS IN 000)			2025 BASELINE MODEL	
Revenue	2013 Modified	2025	Chg 13-25	CAGR 13-25
Medical Services	\$40,100,661	\$54,548,245	\$14,447,584	2.60%
Medical Support & Compliance	\$4,397,797	\$5,970,802	\$1,573,005	2.58%
Facilities	\$2,335,520	\$3,168,458	\$832,938	2.57%
Medical Programs Total	\$46,833,978	\$63,687,505	\$16,853,527	2.59%
Medical Collections Fund	\$2,931,284	\$4,693,080	\$1,761,796	4.00%
Total Revenue	\$49,765,262	\$68,380,585	\$18,615,323	2.68%

Expenses	2013	2025	Chg 13-25	CAGR 13-25
Personal Services & Benefits	\$27,373,624	\$36,813,579	\$9,439,955	2.50%
Travel & Transport of Persons	\$989,412	\$1,255,848	\$266,436	2.01%
Transportation of Things	\$41,289	\$52,408	\$11,119	2.01%
Comm., Utilities & Oth. Rent	\$1,486,830	\$1,887,214	\$400,384	2.01%
Printing & Reproduction	\$33,390	\$42,381	\$8,991	2.01%
Other Services	\$12,075,366	\$15,327,106	\$3,251,740	2.01%
Supplies & Materials	\$8,424,262	\$11,329,418	\$2,905,156	2.50%
Equipment	\$2,005,927	\$2,546,097	\$540,170	2.01%
Lands & Structures	\$1,565,541	\$1,987,121	\$421,580	2.01%
Grants, Subsidies & Contributions	\$1,457,316	\$1,849,752	\$392,436	2.01%
Imputed Interest	\$253	\$321	\$68	2.01%
Total Expenses	\$55,453,210	\$73,091,246	\$17,638,036	2.33%
Net Income (incl. Med Collect Fund)	\$(5,687,948)	\$(4,710,661)		

Notes: Totals for medical cost total and expense totals may vary slightly due to rounding errors

2013 revenues modified to more closely match average expenditures/pt/pg from VHA office of policy and planning (see final report for details)

Removed travel related expenses in 2017; assumes no incremental growth in homeless for the VHA

For the reform scenarios, it is very difficult to predict who may choose to remain grandfathered in and who may choose to receive care outside the VHA. Rather than trying to pinpoint a specific dollar amount, we developed a sensitivity analysis to show the potential fiscal impact on revenues, expenses, net income and capacity based on the VHA's ability to attract VA patients (see Table 9). For example, if the VHA was only able to capture 50% of the patient population by 2025, expenses (which not follow the patients) would decrease to ~\$42.5 billion from \$55.5 billion in 2013 and bed need decreases from ~86,000 to ~38,000 over the same time period. While we did find a 2005 data source on existing number of beds, this appeared to be outdated and did not align with the Average Daily Census (ADC) data in the congressional reports. As such, we choose not to use these values for comparative purposes. A more comprehensive capacity is needed – by geography – to better understand VHA bed need.

Similar to the baseline model, the reform scenario projections should be viewed as a guide to inform strategic planning efforts at the VHA. Potential strategic topics include: (1) determining how to grow volumes by competing for market share by payor by geography (2) ensuring the right resources and capabilities to negotiate favorable rates with insurers and (3) identifying expense control/efficiency strategies (e.g., consolidating or repurposing low use facilities, reassessing FTEs – both administration and providers by specialty).

Table 9: Reform Scenarios Sensitivity Analysis

New VHA	2013	2025 Reform Scenario 1 - Sensitivity Analysis			
Patient Share	100%	100%	75%	50%	25%
Total Patients	6,484,664	6,342,890	4,757,168	3,171,445	1,585,723
Total Revenue*	\$49,765,262	\$75,417,369	\$57,736,297	\$40,055,225	\$22,374,152
Total Expense*	\$55,453,210	\$85,050,702	\$63,788,027	\$42,525,351	\$21,262,676
Net Income*	\$(5,687,948)	\$(9,633,333)	\$(6,051,730)	\$(2,470,126)	\$1,111,477
Total Beds Needed	86,043	76,310	57,232	38,155	19,077

*in thousands

New VHA	2013	2025 Reform Scenario 2 - Sensitivity Analysis			
Patient Share	100%	100%	75%	50%	25%
Total Patients	6,484,664	6,362,879	4,772,159	3,181,439	1,590,720
Total Revenue*	\$49,765,262	\$75,511,092	\$57,806,589	\$40,102,086	\$22,397,583
Total Expense*	\$55,453,210	\$85,318,724	\$63,989,043	\$42,659,362	\$21,329,681
Net Income*	\$(5,687,948)	\$(9,807,632)	\$(6,182,454)	\$(2,557,276)	\$1,067,902
Total Beds Needed	86,043	76,578	57,434	38,289	19,145

*in thousands

Note: For the reform scenarios we removed travel related expenses starting in 2017 (assuming the independent VHA would no longer be obligated to pay for these expenditures). We also assumed no incremental growth in the homeless program as provided by the VHA. The VA may choose to continue these programs through a different funding stream.

VA as a Payor

Transitioning the VA into a payor is a fundamental change in how the VA currently pays for veterans' health care services. The VA is proactive in creating eligibility criteria for enrollment, yet could be described as reactive in paying for health care services (e.g., expenditures are tied to actual utilization of services or presumed utilization of services based on the allocation of dollars in congressional submission reports and VHA office of policy and planning statistics).

Given limited publicly available data by Priority Group by age by income level, we were not able to assess the fiscal impact of the reforms as specifically outlined in the Veterans Independence Act (e.g., Medicare vs. Non-Medicare-eligible veterans or income levels). We assumed all new patients starting in 2017 would be enrolled in the premium support model (PSM). Also, as it is nearly impossible to predict patient behavior, we made the following assumptions around the potential uptake of the PSM for those patients grandfathered in (see Table 10).

Table 10: Range of Potential Patient Update of the PSM by Priority Group

SENSITIVITY ANALYSIS FOR GRANDFATHERED IN VS. PSM

Priority Group	Low	High
1. >50% service-connected disabilities	25%	45%
2. 30-40% service-connected disabilities	25%	45%
3. Former POWs et al., 10-20% disabled	25%	45%
4. Non-service-connected disabled	5%	15%
5. Low-income able-bodied veterans	5%	15%
6. Vietnam, Persian Gulf vets et al.	25%	45%
7. Low-income veterans willing to copay	15%	30%
8. Higher-income vets ($\leq 110\%$ VA NIT)	10%	20%
Non-Veterans	10%	20%

Rather than pinpointing a specific number of patients enrolling in the PSM, we developed a sensitivity analysis assuming a range of potential uptake. These percentages were based on a review of external reports and surveys including data such as the percentage of enrollees reliant on the VA for health care,⁸¹ a survey with questions around a veteran's desire for health care choice even if they had to pay more out-of-pocket,⁸² and a survey assessing provider loyalty vs. lower cost insurance plans. We also engaged in qualitative discussions with CVA Taskforce members to assess the likelihood of patients transitioning to a PSM based on percentage of disability and income levels.

From a payor perspective, it is typical to have a range of actuarial premiums and subsidies that vary across a population. Table 11 below illustrates the premiums, subsidies and actuarial obligations used to assess the fiscal impact of the PSM. The actuarial value (VA obligations) modeled is based on veterans having the option of receiving care outside the VHA. For patients choosing the VHA (similar to choosing an in-network provider), cost-sharing may change.

Table 11: Premiums, Subsidies and Actuarial Values for the PSM

Priority Group	PSM Category	Premium	Subsidy	Total Payment	% Actuarial Value (VA obligation)	2025 Revised Payment (VA obligation)
0	Diamond	\$8,130	\$6,469	\$14,599	100%	\$14,599
1	Platinum	\$8,130	\$6,469	\$14,599	90%	\$13,139
2	Platinum	\$8,130	\$6,469	\$14,599	90%	\$13,139
3	Gold	\$7,485	\$5,878	\$13,363	80%	\$10,690
4	Gold	\$7,485	\$5,878	\$13,363	80%	\$10,690
5	Silver	\$6,812	\$3,854	\$10,666	70%	\$7,466
6	Silver	\$6,812	\$3,854	\$10,666	70%	\$7,466
7	Bronze	\$4,033	\$2,423	\$6,456	60%	\$3,874
8	Bronze	\$4,033	\$2,423	\$6,456	60%	\$3,874
Non-Veterans	Bronze	\$4,033	\$2,423	\$6,456	60%	\$3,874

Notes: (1) Priority Group 0 with diamond status was added to denote that service-connected veterans with 90% disability or more will be covered 100% independent of health care setting or location. Due to data limitations (see below) we were not able to model this out. (2) The premiums, subsidies and total payments are based on the ACA metallic categories and do not include LTC.

The 2013 premiums and subsidies proposed for the PSM are from the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation <http://aspe.hhs.gov> Health Plan Choice and Premiums in the 2015 Health Insurance Market updated January 8, 2015. The premiums for 2015 were used as a proxy for 2013. To determine the premiums and subsidies for 2025 we applied growth rate projections from the Center of Health and Economy.⁸⁴

Table 12 shows the forecasted fiscal impact to the VA based on our models and scenarios. The total combined costs for the VA and veteran patients in Reform Scenario 1 and 2 is roughly budget neutral at ~\$73 billion compared to the baseline model – the latter of which assumes the VA would cover all VHA expenses as it does today. As the VA transitions to a payor, allowing for choice of services among eligible veterans, the obligation for medical care to the VA ranges from approximately \$69B to \$70B.

Table 12: Fiscal Impact of PSM using Metallic Premiums and Subsidies

VA as a Payer	2013 Actual ¹	2025 Baseline ²	2025 Reform All ³	Reform Scenario 1		Reform Scenario 2	
Total patient population	6,484,664	5,447,072	6,443,566	6,342,890		6,362,879	
New patient population ⁴				322,746		342,735	
Metallic Premiums and Subsidies							
PSM VA obligation (new patients)				\$4,145,420		\$4,294,662	
Grandfathered In Choice Scenario (Range) ^{5,6}				Low	High	Low	High
VA obligation (GF'd In Chooses PSM)				\$18,693,849	\$9,954,004	\$18,693,849	\$9,954,004
VA obligation (GF'd in no change)				\$46,433,824	\$56,346,358	\$46,433,824	\$56,346,358
Total Grandfathered In				\$65,127,674	\$66,300,363	\$65,127,674	\$66,300,363
VA Obligations for							
Medical Care	\$55,453,211	\$73,091,246	\$72,029,688	\$69,273,094	\$70,445,783	\$69,422,336	\$70,595,025
Patient obligation (new patients)				\$518,235		\$582,196	
Patient obligation (GF'd In choosing PSM)				\$4,087,480	\$2,077,544	\$4,087,480	\$2,077,544
Total patient obligations				\$4,605,715	\$2,595,779	\$4,669,676	\$2,659,740
Total Costs (VA and Patient) ⁷	\$55,453,211	\$73,091,246	\$72,029,688	\$73,878,808	\$73,041,562	\$74,092,011	\$73,254,765

1. 2013 VA obligation for medical care are equal all medical care appropriations

2. 2025 Baseline assumes VA will operate as it does today, total VA obligations for care equal total expense for VHA

3. 2025 Reform assumes all patients (PG 1-8 and non-veterans) get PSM with no cost sharing; if PG4 and 5 excess costs were factored in, obligations would increase to \$82.8B

4. New population starts in 2017; Reform Scenario 1 newly eligible is focused on service connected veterans (PG 1-3); Scenario 2 includes newly eligible in PGs 1-6

5. Choice range - Low = lower obligations for VA/higher uptake of PSM; High = higher obligations for VA/lower update of PSM

6. Grandfathered in based on assumptions of update by priority group (see appendix or table X)

7 No patient obligations except for reform scenarios 1 and 2

As mentioned above, this fiscal impact analysis is one example of how a VA-adapted premium support system could work.

As an alternative, and based on the VA pays for health care services today, we also assessed the potential fiscal impact of the PSM using forecasted average expenditures per patient per Priority Group. To calculate forecasted average expenditures per patient per Priority Group we used the total 2025 revenue for the VHA and applied an adjustment factor to maintain the same distribution and growth rates as the 2008 to 2013 average expenditures per patient per Priority Group. The 2025 average expenditure per patient per Priority Group are shown in column A in the table below.

Table 13: Cost Differential between Expenditures/PT/PG and PSM Premiums and Subsidies

		A	B	C	D	E	F	G
Priority Group	PSM Category	2025 Average Expenditures/ Patient/PG	2025 Premium	2025 Subsidy	2025 Total Payment	% Actuarial Value (VA obligation)	2025 Revised Payment (VA obligation)	Cost Differential (A - D)
0	Diamond	\$14,097	\$8,130	\$6,469	\$14,599	100%	\$14,599	\$(501)
1	Platinum	\$14,097	\$8,130	\$6,469	\$14,599	90%	\$13,139	\$(501)
2	Platinum	\$8,191	\$8,130	\$6,469	\$14,599	90%	\$13,139	\$(6,407)
3	Gold	\$8,802	\$7,485	\$5,878	\$13,363	80%	\$10,690	\$(4,561)
4	Gold	\$35,729	\$7,485	\$5,878	\$13,363	80%	\$10,690	\$22,366
5	Silver	\$16,697	\$6,812	\$3,854	\$10,666	70%	\$7,466	\$6,031
6	Silver	\$4,689	\$6,812	\$3,854	\$10,666	70%	\$7,466	\$(5,977)
7	Bronze	\$9,189	\$4,033	\$2,423	\$6,456	60%	\$3,874	\$2,733
8	Bronze	\$6,225	\$4,033	\$2,423	\$6,456	60%	\$3,874	\$(231)
Non-Veterans	Bronze	\$2,631	\$4,033	\$2,423	\$6,456	60%	\$3,874	\$(3,825)

Dollars in thousands

From Column G, there is a significant cost difference for some Priority Groups between the forecasted average expenditures per patient per Priority Group (column A) and the total premiums and subsidies (column D and F with cost-sharing). Publicly available data for VA health care expenditures are bundled by Priority Group or by health care category making it difficult to compare or reconcile the cost differential between expenditures and potential future payments. Also, the premiums and subsidies in Columns B, C and D, as laid out for the ACA do not include LTC. Since we are not able to assess LTC by Priority Group, we were not able to assess these costs in detail. For the purposes of this fiscal model, we assumed retired members of the uniformed services are already eligible for the FLTCIP, the fiscal costs of enrolling non-elderly vets into FLTCIP may be low. As more detailed data becomes available, it will be important to reassess all services including LTC.

The table on the following page illustrates the fiscal impact using premiums as average expenditures per patient per Priority Group compared to the metallic premiums. Both assume costs sharing for those opting to enroll in the premiums support model.

VA as a Payer	2013 Actual ¹	2025 Baseline ²	2025 Reform All ³	Reform Scenario 1		Reform Scenario 2	
Total patient population	6,484,664	5,447,072	6,443,566	6,342,890		6,362,879	
New patient population ⁴				322,746		342,735	
Premiums = Avg. Expend./Patient/PG							
PSM VA obligation (new patients)				\$3,701,342		\$3,766,948	
Grandfathered In Choice Scenario (Range) ^{5,6}				Low	High	Low	High
VA obligation (GF'd In Chooses PSM)				\$16,466,813	\$8,466,172	\$16,466,813	\$8,466,172
VA obligation (GF'd in no change)				\$46,433,824	\$56,346,358	\$46,433,824	\$56,346,358
Total Grandfathered In				\$62,900,637	\$64,812,530	\$62,900,637	\$64,812,530
VA Obligations for Medical Care	\$55,453,211	\$73,091,246	\$71,105,226	\$66,601,979	\$68,513,872	\$66,667,585	\$68,579,478
Patient obligation (new patients)				\$449,223		\$477,339	
Patient obligation (GF'd In choosing PSM)				\$1,761,194	\$3,673,088	\$1,761,194	\$3,673,088
Total patient obligations				\$2,210,417	\$4,122,310	\$2,238,534	\$4,150,427
Total Costs (VA and Patient) ⁷	\$55,453,211	\$73,091,246	\$71,105,226	\$68,812,396	\$72,636,182	\$68,906,119	\$72,729,905
Metallic Premiums and Subsidies							
PSM VA obligation (new patients)				\$4,145,420		\$4,294,662	
Grandfathered In Choice Scenario (Range) ^{5,6}				Low	High	Low	High
VA obligation (GF'd In Chooses PSM)				\$18,693,849	\$9,954,004	\$18,693,849	\$9,954,004
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Total Grandfathered In				\$65,127,674	\$66,300,363	\$65,127,674	\$66,300,363
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As an alternative, and based on the VA pays for health care services today, we also assessed the potential fiscal impact of the PSM using forecasted average expenditures per patient per Priority Group. To calculate forecasted average expenditures per patient per Priority Group we used the total 2025 revenue for the VHA and applied an adjustment factor to maintain the same distribution and growth rates as the 2008 to 2013 average expenditures per patient per Priority Group. The 2025 average expenditure per patient per Priority Group are shown in column A in the table below.

Conclusions

It was extremely difficult to develop a comprehensive fiscal impact analysis for the proposed reforms given data limitations. In this report, we provide one way to merge and covert multiple data sources into a format where the VA dollars follow the patient. In doing this we were able to test the potential impact of what the VHA could look like financially as an independent health care system and the financial impacts to the VA as a payor. This report does not attempt to project future appropriations to congress for the VA as a payor or delivery system. The outcomes of our analyses should be viewed as directional and help guide decision-making until more detailed data becomes available.

APPENDIX TABLES

Patient Population Data Reconciliation

The table below shows the differences in patient populations between the FY2015 Funding and Appropriations Congressional Submission Reports and the VHA Office of Policy and Planning. The largest difference is for non-veterans. As noted below, the VHA Office of Policy and Planning does not include veterans who have visits with the readjustment counseling service only, state nursing home patients, or CHAMPVA (non-veteran) patients.

Priority Groups	2013 ACTUALS		
	VHA Office of Policy and Planning	FY15 Congressional Report	Difference (CR - VHA)
PG 1-6	4,475,731	4,524,505	48,774
PG 7-8	1,244,883	1,279,385	34,502
Subtotal	5,720,614	5,803,890	83,276
Non-Veterans	296,487	680,774	384,287
Total	6,017,101	6,484,664	467,563

Living Veteran Projections by Age

Age Cohort	2013	2025	#Chg 13-25	CAGR
<20	10,384	5,926	(4,458)	-4.6%
25-39	3,200,125	2,700,762	(499,363)	-1.4%
40-64	9,222,026	7,100,185	(2,121,841)	-2.2%
65-84	8,388,153	7,467,603	(920,550)	-1.0%
85+	1,478,662	1,456,822	(21,840)	-0.1%
Total	22,299,350	18,731,298	(3,568,052)	-1.4%

% LIVING VETERANS BY AGE COHORT		
Age Chort	2013	2025
<20	0.0%	0.0%
25-39	14.4%	14.4%
40-64	41.4%	37.9%
65-84	37.6%	39.9%
85+	6.6%	7.8%

Forecasted Patient Population by Priority Group

Unique Patients Priority Group	Baseline Model			Reform Model All Population			Reform Model Scenario 1			Reform Model Scenario 2		
	2025	Chg 13-25	CAGR 13-25	2025	Chg 13-25	CAGR 13-25	2025	Chg 13-25	CAGR 13-25	2025	Chg 13-25	CAGR 13-25
1	1,448,921	(18,606)	-0.11%	1,713,989	246,462	1.30%	1,713,989	246,462	1.30%	1,713,989	246,462	1.30%
2	419,425	(59,580)	-1.10%	496,155	17,150	0.29%	496,155	17,150	0.29%	496,155	17,150	0.29%
3	626,413	(103,026)	-1.26%	741,010	11,571	0.13%	741,010	11,571	0.13%	741,010	11,571	0.13%
4	141,624	(52,712)	-2.60%	167,533	(26,803)	-1.23%	167,533	(26,803)	-1.23%	167,533	(26,803)	-1.23%
5	991,367	(384,027)	-2.69%	1,172,729	(202,665)	-1.32%	1,172,729	(202,665)	-1.32%	1,172,729	(202,665)	-1.32%
6	245,118	(33,686)	-1.07%	289,960	11,156	0.33%	269,972	(8,832)	-0.27%	289,960	11,156	0.33%
7	136,177	(18,275)	-1.04%	161,089	6,637	0.35%	149,665	(4,787)	-0.26%	149,665	(4,787)	-0.26%
8	817,061	(307,872)	-2.63%	966,535	(158,398)	-1.26%	966,535	(158,398)	-1.26%	966,535	(158,398)	-1.26%
Subtotal	4,826,106	(977,784)	-1.53%	5,709,000	(94,890)	-0.14%	5,677,588	(126,302)	-0.18%	5,697,576	(106,314)	-0.15%
Non-Veterans	620,966	(59,808)	-0.76%	734,567	53,793	0.64%	665,303	(15,471)	-0.19%	665,303	(15,471)	-0.19%
Total	5,447,072	(1,037,592)	-1.44%	6,443,566	(41,098)	-0.05%	6,342,890	(141,774)	-0.18%	6,362,879	(121,785)	-0.16%

Mapping of Health Care Categories

FY2015 Categories	2008 - 2011
Ambulatory Care	Staff
	Fee
Inpatient Care	Acute Hospital Care
	Subacute Care
Rehabilitation Care	Rehabilitative Care
Mental Health	Psychiatric Care*
	State Home Domiciliary
Long-term Care	Nursing Home Care
Dental Care	Dental Procedures
CHAMPVA, Spina Bifida, FMP, CWVV	IP and OP combined until 2011
Readjustment Counseling	Readjustment Counseling
Prosthetics Care	Assume equip cost only

Expense Assumptions

Expenses	Baseline Assumptions
Personal Services & Benefits:	30% fixed, 70% variable, grow by (4% Medicare Rates)
Travel & Transport of Persons:	includes patients and staff (grow by 1+ inflation)
Transportation of Things:	grow by 1+ inflation
Comm., Utilites & Oth. Rent:	70% fixed; 30% variable - grow by 1+ inflation
Printing & Reproduction:	grow by 1+ inflation
Other Services:	grow by 1+ inflation
Supplies & Materials:	30% fixed, 70% variable, grow by (4% Medicare Rates)
Equipment:	grow by 1+ inflation
Lands & Structures:	grow by 1+ inflation
Grants, Subsidies & Contributions:	grow by 1+ inflation
Imputed Interest:	grow by 1+ inflation

Endnotes

1. In 2013, according to the Centers for Medicare and Medicaid Services, national health expenditures rose to \$2.9 trillion, or 17.4 percent of gross domestic product.
2. Samuel Southard et al., Report to the U.S. House of Representatives. Navy Department, January 15, 1827.
3. William Pencak, Ed., Encyclopedia of the Veteran in America. ABC-CLIO, 2009.
4. Phillip Longman, Best Care Anywhere: Why VA Health Care Would Work Better for Everyone. Berrett-Koehler Publishers, 2002.
5. William Pencak, Ed., Encyclopedia of the Veteran in America. ABC-CLIO, 2009.
6. Herbert Hoover et al., The Hoover Commission Report on Organization of the Executive Branch of the Government. Greenwood Press, 1949.
7. Congressional Research Service, Health Care for Dependents and Survivors of Veterans. April 4, 2013.
8. Ronald Hamowy, Failure to Provide: Healthcare at the Veterans Administration. Independent Institute, March 2010.
9. Consolidated Omnibus Budget Reconciliation Act of 1985, §19011(c)(2).
10. Douglas Elmendorf et al., Potential Costs of Veterans' Health Care. Congressional Budget Office, October 2010.
11. Veterans in Priority Groups 7 and 8, on average, relied least on VA facilities—comprising only ten percent of their health care—and had the highest prevalence of non-VA health insurance, especially Medicare. Priority Groups 1 and 4 received on average 35 percent of their health care from VA facilities; Priority Group 2 received on average 28 percent of their care at the VA.
12. Avik Roy, “Why Americans Dislike Britain’s NHS,” National Review, July 14, 2010.
13. Avik Roy, How Medicaid Fails the Poor. Encounter Books, 2013.
14. Robert Pear, “Health Care Fixes Backed By Harvard’s Experts Now Roil Its Faculty,” New York Times, January 5, 2015.
15. “Sweet Bill To Help Veterans Up Tomorrow,” Chicago Tribune, July 6, 1921.
16. House Committee on Veterans Affairs, Medical Care of Veterans. Government Printing Office, 1967.

17. Ronald Hamowy, *Failure to Provide: Healthcare at the Veterans Administration*. Independent Institute, March 2010.
18. “Veterans Hospitals Called Back Waters of Medicine,” *PM* [New York], January 9, 1945.
19. Albert Maisel, “The Veteran Betrayed,” *Readers’ Digest*, April 1945.
20. Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone*. Berrett-Koehler Publishers, 2002.
21. Ronald Hamowy, *Failure to Provide: Healthcare at the Veterans Administration*. Independent Institute, March 2010.
22. Kenneth Kizer, “The ‘New VA’: A National Laboratory for Health Care Quality Management.” *American Journal of Medical Quality*, January-February 1999.
23. Jay Teachman, “A Note on Disappearing Veterans: 1980-2010.” *Armed Forces & Society*, October 2013.
24. Peter Kilborn, “Veterans Expand Hospital System in Face of Cuts,” *New York Times*, January 14, 1996.
25. Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone*. Berrett-Koehler Publishers, 2002.
26. Kenneth Kizer, *Vision for Change*. Department of Veterans Affairs, 1995.
27. Ronald Hamowy, *Failure to Provide: Healthcare at the Veterans Administration*. Independent Institute, March 2010.
28. Ashish Jha et al., “Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care,” *New England Journal of Medicine*, May 29, 2003.
29. Eve Kerr et al., “Diabetes Care Quality in the Veterans Affairs Health Care System and Commercial Managed Care: The TRIAD Study,” *Annals of Internal Medicine*, August 17, 2004.
30. Richard Griffin et al., “Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System (Interim Report).” VA Office of Inspector General, May 28, 2014.
31. CNBC, “Death and Dishonor: Crisis at the VA.” November 11, 2013.
32. “Epidemic of VA Mismanagement,” *Washington Post*, May 15, 2014.

- 33.** Robert Pear, "History and Context of an Embattled Department of Veterans Affairs," *New York Times*, May 21, 2014.
- 34.** Richard Griffin et al., *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*. VA Office of Inspector General, August 26, 2014.
- 35.** Tom Coburn, *Friendly Fire: Death, Delay, & Dismay at the VA*. U.S. Senate, June 24, 2014.
- 36.** James Tuchschnidt, *Assessing the Implementation of the Veterans Access, Choice, and Accountability Act of 2014*. House Committee on Veterans' Affairs, November 13, 2014.
- 37.** Robert A. McDonald, "VA is critical to medicine and vets," *Baltimore Sun*, October 23, 2014.
- 38.** Avik Roy, "CLASS Aside, Long Term Care Reform Is a Key to Entitlement Reform," *Forbes*, October 31, 2011.
- 39.** Douglas Elmendorf et al., *Comparing the Costs of the Veterans' Health Care System With Private Sector Costs*. Congressional Budget Office, December 10, 2014.
- 40.** In 2013, according to the Centers for Medicare and Medicaid Services, national health expenditures rose to \$2.9 trillion, or 17.4 percent of gross domestic product.
- 41.** John Iglehart, "The Veterans Administration Medical Care System Faces an 41 Uncertain Future," *New England Journal of Medicine*, October 31, 1985.
- 42.** Electa Draper, "VA, Coffman Clash in Denver Hearing Over Troubled Hospital Project," *The Denver Post*, April 22, 2014.
- 43.** Lorelei St. James et al., *VA Construction: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects*. U.S. Government Accountability Office, April 2013.
- 44.** Robert Gibbs, "Statement from Press Secretary Robert Gibbs on the President's Strong Commitment to America's Veterans." White House, March 18, 2009.
- 45.** Department of Veterans Affairs, *American Consumer Satisfaction Index 2013 Customer Satisfaction Inpatient Survey*. 2013.
- 46.** Douglas Elmendorf et al., *Comparing the Costs of the Veterans' Health Care System With Private Sector Costs*. Congressional Budget Office, December 10, 2014.
- 47.** Jim Clifton et al., *State of the American Workplace: Employee Engagement Insights for U.S. Business Leaders*. Gallup, 2013.

48. Department of Veterans Affairs, 2014 Federal Employee Viewpoint Survey Results. 2014.
49. Jack Jacobs, “Want to Fix VA Health Care? Get Rid of It,” NBCNews.com, May 15, 2014.
50. Department of Veterans Affairs: Budget in Brief. Department of Veterans Affairs, February 2015.
51. Klemm Analysis Group et al., Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation. Department of Veterans Affairs, 1996.
52. Harry Walters et al., Commission on the Future for America’s Veterans: Preparing for the Next Generation. Veterans Coalition, December 2009.
53. Steve Kulm, “Amtrak Ridership and Revenues Continue Strong Growth in FY 2014,” Amtrak news release, October 27, 2014.
54. Katherine Baicker and Helene Levy, Coordination versus Competition in Health Care Reform. *New England Journal of Medicine*, August 29, 2013.
55. Jenny Gold, “Poster Boys’ Take A Pass On Pioneer ACO Program,” *Kaiser Health News*, September 14, 2011.
56. Richard Oppel Jr. and Abby Goodnough, “Doctor Shortage Is Cited in Delays At V.A. Hospitals,” *The New York Times*, May 29, 2014.
57. James Robinson, Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology. *American Journal of Managed Care*, June 2011.
58. Henry Aaron and Robert Resichauer, *The Medicare Reform Debate: What Is The Next Step?* *Health Affairs*, Winter 1995.
59. Avik Roy, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*. Manhattan Institute: August 2014.
60. John Breaux and Bill Thomas, *Building A Better 60 Medicare For Today And Tomorrow*. National Bipartisan Commission on the Future of Medicare, 1999.
61. Robert Moffitt, *Using the Breaux-Frist Medicare Proposals to Craft Solid Medicare Reform*. Heritage Foundation, March 27, 2001.
62. David Jackson, “Poll: Medicare Prescription Drug Program Popular,” *USA Today*, October 3, 2012.

- 63.** Mark McClellan et al., 2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Medicare Trustees, May 1, 2006.
- 64.** Barack Obama, Remarks by the President to a Joint Session of Congress on Health Care. September 9, 2009.
- 65.** Under the Veterans Independence Act, future veterans—those who gain veteran status after 2015—will be eligible for VA-subsidized coverage if they fall within Priority Groups 1 through 6.
- 66.** Truven Health Analytics, The Growth of managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update. Centers for Medicare and Medicaid Services, July 2012.
- 67.** Douglas Elmendorf et al., Comparing the Costs of the Veterans' Health Care System With Private-Sector Costs. Congressional Budget Office, December 2014.
- 68.** Gary Nugent et al., Value for Taxpayer Dollars: What VA Care Would Cost at Medicare Prices. Medical Care Research and Review, December 2004.
- 69.** Zirui Song et al., Potential Consequences of Reforming Medicare Into a Competitive Bidding System. Journal of the American Medical Association, August 1, 2012.
- 70.** Douglas Elmendorf et al., The Budget and Economic Outlook: 2015 to 2025. Congressional Budget Office, January 26, 2015.
- 71.** William Weeks and David Auerbach, "A VA Exit Strategy," New England Journal of Medicine, August 28, 2014.
- 72.** Sidath Panangala, Health Care for Dependents and Survivors of Veterans. Congressional Research Service, April 4, 2013.
- 73.** Douglas Elmendorf et al., The Budget and Economic Outlook: 2015 to 2025. Congressional Budget Office, January 26, 2015.
- 74.** See, for example, "The Patient Choice, Affordability, Responsibility, and Empowerment Act." Center for Health and Economy, January 30, 2014.
- 75.** Auerbach et al., Health Care Spending and Efficiency in the US Department of Veterans Affairs, RAND, 2013
- 76.** Department of Veterans Affairs, Veterans Benefits Administration Annual Benefits Reports, 2009 to 2013; Veterans Health Administration Office of the Assistant Deputy Under the Secretary of for Health for Policy and Planning; Office of Policy and Planning Office of the Actuary. National Center for Veterans Analysis and Statistics, Prepared August 2014.

- 77.** .2010 CBO Report: Potential Costs of Veterans' Health Care; Commission on the Future For America's Veterans: Preparing for the next generation Dec. 2009
- 78.** Table 1L: VETPOP2014 Living Veterans by Age Group, Gender, 2013-2043 re 78 trieveld from http://www.va.gov/vetdata/Veteran_Population.asp; Congressional Budget Office Report, "Comparing the Costs of the Veterans' Health Care System with Private-Sector Costs" December 2014
- 79.** Auerbach et al., Health Care Spending and Efficiency in the US Department of Veterans Affairs, RAND, 2013
- 80.** Kaiser Family Foundation, Historical and Projected Average Annual Growth Rate in Medicare Per Capita Spending and Other Measures retrieved from <http://kff.org/medicare/fact-sheet/medicare-spending-and-financingfact-sheet/>
- 81.** A CBO Report: Potential Costs of Veterans' Health Care, October 2010
- 82.** A National Survey of Veterans and Active Duty Military, A Survey conducted by The Tarrance Group and prepared for the Concerned Veterans For America, November 11 – 20, 2014
- 83.** Lubell, J. ACA expected to test patient loyalty to physicians, Retrieved from <http://www.amednews.com/article/20130513/government/130519977/4/>
- 84.** ASPE Research Brief
<http://aspe.hhs.gov/health/reports/2015/premiumReport/healthPremium2015.pdf>;
<http://healthandeconomy.org/health-and-economy-baseline-estimates/>



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