S. HRG. 110–215

HEARING ON VA HEALTH CARE FUNDING ISSUES

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

JULY 25, 2007

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C O N T E N T S

JULY 25, 2007

SENATORS

WITNESS

APPENDIX

HEARING ON VA HEALTH CARE FUNDING ISSUES

WEDNESDAY, JULY 25, 2007

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m., in room 562, Dirksen Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Rockefeller, Murray, Tester, Sanders, and Craig.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. Aloha and welcome to everyone. This hearing is in order.

I welcome everyone to this morning's hearing. I will be brief. I know that Members have some time constraints this morning. And several of our witnesses do, as well.

We are here today to discuss ways to improve how the VA health care system is funded every year. As we all know, budget shortfalls, continuing resolutions, and other funding constraints have taken their toll on VA in recent years.

Make no mistake, this is not simply about numbers, budget models, and inflation. What we are talking about is ensuring that VA can provide the highest quality patient care and services for our Nation's veterans.

Appropriations battles, political maneuvering, and planning errors have stalled the flow of needed monies for the past 7 years in a row. We all remember the crisis VA faced in 2005 when it was revealed that the Department was short by $1 billion.

There is no other health care system in the country that enters each fiscal year unsure of its budget. No other beneficiaries must come to Congress, hat in hand, to ask for billions of dollars to keep their health care system afloat. No other hospital managers must plan in an atmosphere of complete uncertainty and raid maintenance funds so as to furnish care. Innovative solutions must be examined so that veterans are no longer subject to such whims.

Today, we will hear from incredibly well-qualified witnesses. I know we can conduct a fruitful dialogue about what can be done now, as well as what we can do in the future. Thank you very much.

Chairman AKAKA. And now, Senator Craig for your statement.

STATEMENT OF HON. LARRY E. CRAIG, RANKING MEMBER U.S. SENATOR FROM IDAHO

Senator CRAIG. Mr. Chairman, thank you very much, and for all who have assembled, we want to thank you for being here this morning for this important hearing.

Mr. Chairman, while you and I have always done our best to maintain a strong bipartisan approach to this Committee's issues, I think this issue in particular has lent itself to some serious partisan maneuvering. For example, I can't help but recall that over the past several years, there have been Senate bills introduced each year to address mandatory funding and there have been a number of attempts to add some form of mandatory funding to the Defense Authorization Act. I recall an effort a few years ago by Senator Daschle to do so, and last year and the year prior, I believe it was left to Senator Stabenow. There were full-page ads urging Congress to act on mandatory funding, yet with the new majority taking over control of Congress this year, oddly, there were no amendments from the majority to the Defense Authorization Act to provide mandatory funding. I have not seen a bill introduced, and now full-page ads are bought to urge the President, not the Congress, to act on mandatory funding.

I also can't help but notice that we are holding this hearing almost exactly 1 month after the Committee marked up its health care legislative package for this session. I have often wondered in debating the amendments on the floor over the past few years how much politics was behind them, and I think I have learned a little about the answer that I have questioned myself on as we speak.

Having said that, Mr. Chairman, I want to assure you and other Members of this Committee that I take this issue very seriously and my comments today reflect concerns with the issues as they pertain to health care policy and fiscal prudence. It is no secret that I don't support mandatory funding legislation, and that has been introduced in all of the Congresses. I simply think it is bad policy. In fact, I articulated many of my views and thoughts on this matter in a letter I sent to Senators Johnson and Thune last year. That letter became fairly widely circulated among veterans' advocates, so I know many have read it. But for the record of this hearing, I would like to once again articulate some of my concerns with the legislation that was previously put forth to the Senate.

First and foremost, of course, is the question of whether it would improve the health care delivery by VA to provide funding on the basis of a formula laid out in the legislation. I realize there hasn't been any bill introduced in the Senate this year, but the bill before the House is identical to those introduced in previous Congresses here in the Senate, so I am working from that premise.

Mr. Chairman, I am not sure I see how the bill will improve health outcomes for veterans. In fact, I think it could have some adverse effects on the health care system.

First, as I have noted many times before, the formula is based on the number of enrollees in the health care system, yet according to VA's budget, there are 7.9 million enrollees and only 5.7 million users of the system. We would be basing a budget on 2.2 million veterans who don't use VA's health care system at all. Of course, if, for example, 300,000 of the 2.2 million began using VA in the

middle of the fiscal year, we would be in real trouble. We would be increasing the patient population by about 5 percent but not increasing the budget available to the system.

Another large problem would be what happens when the number of enrollees begin to shrink but the overall user population does not? I certainly have suggested that we control VA's spending increases over the past few years, but I can't imagine that I have ever advocated that we reduce the budget from one year to the next simply because the number of people who don't use the VA system is shrinking. It makes, in my opinion, no sense, and I certainly do not see how it would improve care.

And finally, Mr. Chairman, in my view, the formula is rather arbitrary. It just takes the previous year's budget and adds 30 percent to it, then divides it by the enrollees to get a per enrollee cost. Then I suggest that amount is deemed to be adequate. So the bill adds a medical care inflator to the per enrollee amount every year. Of course, the formula has changed with successive introductions of the bills over the years and I think that fact only supports my view that it is arbitrary and, therefore, more political than substantive.

Mr. Chairman, if you will allow me, I have brought a chart along, and I know I am already giving you more than you had hoped for in this opening statement. But the chart shows the amount of money that would be available to VA if we had enacted mandatory funding when Senator Johnson first introduced the idea in the 107th Congress. Next, we see the amount of funding if we had passed last year's version of the bill.

I also compared those two numbers, which you will see as fairly different, to the amounts provided in appropriations for each year and the amounts requested by the Independent Budget. As I hope is clear, there are four different numbers for each fiscal year. Interestingly, by 2008, you will see that the amount of appropriations recently provided in the Senate, which was called manna from heaven by one VSO, is actually more than the Independent Budget. But it is anywhere from $5 to $6 billion less than what would have been available under different mandatory funding bills.

Mandatory Funding for VA Medical Care—Hit and Miss Budgeting?

(All in billions; actual approps include supplemental funding)

	FY04	FY05	FY06	FY07	FY08[1]
Actual Discretionary Approps + Collections	$28.1	$31.5	$31.4	$36.8	$39.6
Independent Budget + Collections	29.5	32.2	33.7	35.2	39.2
Mandatory Funding (S. 2903 107th) + Collections	30.8	37.0	39.8	42.7	44.5
Mandatory Funding (S. 331 109th) + Collections	NA	NA	NA	42.1	45.1

[1]Estimates.
Sources: VA Budget Submissions; Independent Budget Recommendations; and Bureau of Labor Statistics.

Senator CRAIG. So my question is, are we short this year? Was the Independent Budget too low? Or is it possible that mandatory funding would have over-funded VA, and if it did by as much as $6 billion, how should the overage be handled? Those are legitimate and responsible questions to be asked when we begin to talk about the scheme of mandatory funding.

Mr. Chairman, I hope my colleagues do not mistake my views for suggestions that money doesn't matter. I concede that money has

some bearing on the overall quality of care provided to our veterans. We need quality staff, quality facilities to provide quality care and money can help us get there. But there have been incredible improvements over the past 10 years in VA's health care delivery system. It is ranked amongst the best in the Nation. It did so not by mandatory funding, but by discretionary funding. It was a model that worked. It is a model that is working. And it is a model that will continue to work if Congress keeps its focus.

I think much of those improvements are related to systematic changes in health care models delivered by Dr. Kizer or implemented by VERA to a more exacting model as envisioned by Dr. Roswell. I also believe the integration of the electronic health records and the clinical outcome studies and so on are significant. There is much more to be said.

But to suggest that the system is broken and, therefore, we need to change the funding model is simply, in my opinion, an exaggeration of the reality at hand. Congress has been faithful to increased funding and we have seen it going 11 and 12 percent annually, this year, a phenomenal boost in the reality. I have gone on long enough. I think my opinion and my observations are clear and I think they are valid and I will be more than happy to question and hear from those who have come.

I will ask unanimous consent that the balance of my statement be a part of the record.

[The prepared statement of Senator Craig follows:]

PREPARED STATEMENT OF HON. LARRY E. CRAIG,
U.S. SENATOR FROM IDAHO

Mr. Chairman, thank you very much. And, of course, thank you for scheduling this important hearing.

Mr. Chairman, while you and I have always done our best to maintain a strong level of bipartisanship on this Committee, I think this issue in particular has lent itself to some serious partisan maneuvering.

For example, I cannot help but recall that over the past several years there have been Senate bills introduced in each Congress to address mandatory funding. And there have even been a number of attempts to add some form of mandatory funding to the Defense Authorization Act. I recall an effort a few years ago by Senator Daschle to do so, and last year and the year prior, I believe it was left to Senator Stabenow.

There were full page ads urging "Congress" to act on Mandatory funding. Yet, with the new Majority taking over control of Congress this year, oddly there were no amendments from the Majority to the Defense Authorization Act to provide mandatory funding. I have not seen a bill introduced and now full page ads are bought to urge "The President" not Congress to act on mandatory funding.

I also can't help but notice that we are holding this hearing almost exactly one month after the Committee marked-up its health care legislative package for the first session. I've often wondered in debating the amendments on the floor over the past few years, how much politics was behind them. I think I've learned a little about the answer to that question this year.

Having said that, Mr. Chairman, I want to assure you and other Members of this Committee that I take this issue very seriously. And my comments today reflect concerns with the issues as they pertain to health care policy and fiscal prudence.

It is no secret that I do not support the mandatory funding legislation that has been introduced in previous Congresses. I simply think it's bad public policy. In fact, I articulated many of my views and thoughts on the matter in a letter I sent to Senators Johnson and Thune last year. That letter became fairly widely circulated among veterans' advocates so I know many have read it. But, for the record of this hearing, I'd like to once again articulate some of my concerns with the legislation that was previously been put forth to the Senate.

First and foremost—of course—is the question of whether it would improve the health care delivered by VA to provide funding on the basis of the formula laid out

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Of course, if for example 300,000 of the 2.2 million began using VA in the middle of a fiscal year, we'd be in real trouble. We would be increasing the patient population by about 5 percent, but not increasing the budget available to the system at all.

Another large problem would be what happens when the number of enrollees begins to shrink, but the overall user population does not. I certainly have suggested that we control VA's spending increases over the past few years. But, I can't imagine that I'd ever advocate that we reduce the budget from one year to the next simply because the number of people who don't use the VA system is shrinking. It makes no sense. And I certainly do not see how it would improve care.

Finally, Mr. Chairman, in my view, the formula is rather arbitrary. It just takes the previous fiscal year's budget, adds 30 percent to it, then divides it by enrollees to get a per enrollee cost. Then, I guess that amount is deemed to be adequate. So, the bill adds a medical care inflator to the per enrollee amount every year.

Of course, that formula has changed with successive introductions of the bills over the years. I think that fact only supports my view that it is somewhat arbitrary.

Mr. Chairman, if you'll allow me, the chart behind me shows the amount of money that would be available to VA if we had enacted mandatory funding when Senator Johnson first introduced this idea in the 107th Congress. Next, we see the amount of funding if we passed last year's version of the bill. I have also compared those two numbers, which you'll see are fairly different, to the amounts provided in appropriations for each year and the amounts requested by the Independent Budget.

As I hope is clear, there are four different numbers for each fiscal year. Interestingly, for 2008, you'll see that the amount of appropriations recently provided in the Senate—which was called "manna from Heaven" by one VSO is actually more than the IB. But, it is anywhere from $5 to $6 billion less than what would have been available under different mandatory funding bills.

So, my question is: are we short this year? Was the IB too low? Or is it possible that mandatory funding would have "over funded" VA? And, if it did by as much as $6 billion, how should the overage be handled?

Mr. Chairman, I hope my colleagues do not mistake my views for a suggestion that money doesn't matter. I concede that money has some bearing on the overall quality of care provided to our veterans. We need quality staff and quality facilities to provide quality care. And money can help us get that.

But, there have been incredible improvements over the past 10 years in VA's health care system—all under the discretionary funding model. I think much of those improvements are related to systemic changes in the care delivery model designed by Dr. Kizer, or the implementation of VERA to a more exacting model as envisioned by Dr. Roswell. I also believe the integration of the electronic record with clinical outcomes studies implemented by Dr. Perlin has had a significant effect. In other words, it was as much leadership and vision as it was money to hire the right staff that has led to VA's wonderful improvements. I don't see how a mandatory budget improves that leadership.

I said earlier that the most important question was whether mandatory funding would improve the health care provided to our veterans. But, the second question is whether it makes sound fiscal policy for our Nation. On this question, I truly believe that it does not.

We already have three very large programs that are considered to be funded by "mandatory spending." Namely: Social Security, Medicare, and Medicaid. So, it is appropriate for us to consider the fiscal implications of these programs in assessing the likely fiscal effects of adding another mandatory program. I think we all know the national fiscal picture of the three programs I've just mentioned.

But, allow me to highlight just a few thoughts. For example, this past January when discussing entitlement programs in testimony before the Senate Budget Committee, Federal Reserve Chairman, Bernanke stated "If early and meaningful action is not taken, the U.S. economy could be seriously weakened, with future generations bearing much of the cost." And in response to a question from Senator Conrad of

"how urgent is it we address the imbalance [between income and spending], Chairman Bernanke went on to say "the time to start is 10 years ago".

Senator Conrad, himself, has called the current health care entitlement programs "the 800 pound gorilla of federal spending." And David Walker, our Comptroller General has said "we have a fiscal cancer" growing in the United States.

Yet, we as a Congress have been completely unwilling to address those fiscal calamities. Amazingly, in spite of that, here we are contemplating adding another tumor to the problem! It's baffling!

Please keep in mind that this move would provide a mandatory budget to a federal agency. And the money would be "no year money." Meaning, if the formula "over budgets" as I noted above it just might, then VA just keeps the extra and we send them a bigger check the next year. I can think of no precedent for that. Even agencies like the Social Security Administration are funded with discretionary appropriations. A mandatory agency budget would, in my judgment, be horrible national fiscal policy.

So, Mr. Chairman, I've taken up enough time this morning with my statement. But, I've read the testimony of our witnesses and I look forward to hearing from them and to asking some questions as well.

Thank you Mr. Chairman.

Chairman AKAKA. It will be included in the record.

Senator Craig, as you know, we have worked very well together over the years and we will continue to do that. I want you to know it is clear to me, Senator Craig, that we have lots to do to bring VA and all its services about to help our veterans throughout the country, and funding is one of them. Today, we expect to hear from witnesses about how to best fund VA health care and I hope we will hear some answers from you out there and look upon this as not being a political hearing but a hearing to try to find the best methods of dealing with the responsibilities of VA.

Now, I would like to call on Senator Sanders for your statement.

STATEMENT OF HON. BERNARD SANDERS, U.S. SENATOR FROM VERMONT

Senator SANDERS. Thank you very much, Mr. Chairman. I am going to have to apologize to you and our guests because I am going to have to be running off soon for an important markup.

In a certain sense, while I disagree with much of what my friend, Senator Craig, said, he is right about politics and he is right about priorities, and the essence of the issue to my mind is that when somebody joins the Armed Forces of this country and puts his or her life on the line, do we make a commitment to that person and say that the U.S. Government and the VA will always be there for them, or do we not?

As the Chairman mentioned, several years ago, we had an absolute crisis where the VA virtually ran out of money. Four or five years ago, the President of the United States in his wisdom said, yes, we have hundreds of billions of dollars in tax breaks for the wealthiest 1 percent, but if you have a non-service-connected disability, if you don't have a service-connected disability and you make more than $27,000 a year, we are shutting the doors of the VA to you. That is politics. I happen to disagree with those priorities.

The truth of the matter is, that in my State of Vermont and all over this country today, there are waiting lines for veterans to get the health care that they need. Very often, people have to wait long periods of time to get the care that they are entitled to.

To my mind, I would very strongly agree with the Chairman and say that when you are running what I believe is the largest health care organization in the world, it is pretty hard to hire the staff and buy the equipment and do all of the things that you need when you do not know what your budget will be. How do you plan for the future?

The reality is also that when you are talking about veterans, you are talking about a special population. What we are learning from the War in Iraq and certainly what we have learned from Vietnam is that many of the problems that arise, when medical problems arise, take place years after somebody served in the military.

In May of this year, media reports, for example, told us, and I quote, that "from 125,000 to 150,000 U.S. troops may have suffered mild, moderate, or severe brain injuries in Iraq and Afghanistan." The Defense Department's Task Force on Mental Health states that it found, "38 percent of soldiers and 31 percent of the Marines report psychological concerns, such as Traumatic Brain Injury and Post Traumatic Stress Disorder after returning from deployment. Among members of the National Guard, the figure is 49 percent." Does anyone seriously believe that today we have anywhere near the capability of addressing that very serious problem? I would argue we certainly do not.

I would also argue that because of lack of money, what we have seen over the last many decades are shameful acts on the part of the U.S. Government. Who in this room can be proud that the Department of Veterans Affairs and the Government of the United States of America fought as hard as they could against those Vietnam veterans who said, Hey, we came back from Vietnam. We were exposed to Agent Orange. Our people are dying. Our people are getting sick. And what the U.S. Government has said, sorry, that is not the case. You have got to go to court to win your rights. And a lot of that has to do with funding.

Now, I think I speak for many Members of Congress who say that perhaps the most difficult vote that any Member has to make is whether or not we send our young men and women into war, and what I would simply say, if we are not—when we make that vote, if we are not prepared to understand that the cost of war is a lot more than planes and tanks and guns but is to understand what happens to that soldier when he or she comes back from war, 20 years later or 50 years later, that is the cost of war and we have got to own up to it.

I think that the Chairman is right, Larry Craig is right in saying that, in many ways, we have a good system. When people get into the VA, they generally feel that the service they get is good. The problem is the waiting lines. The problem is that we have thrown over a million veterans off of VA. So if we are serious about, in fact, keeping the promises made to our veterans, taking care of them, I think we have to move toward mandatory coverage. I strongly support it and will do my best to see that that happens.

Thank you very much, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Sanders.

Senator Tester?

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman. On Saturday, I chaired a VA Committee field hearing in Great Falls addressing the needs of rural veterans. I just want to thank you, Mr. Chairman, and the Ranking Member for sending two outstanding staff members to that hearing, Kim Lipsky and Jeff Gall. I appreciate you sending those staff members there. They did a very, very nice job and I am much appreciative of it and I want the record to show that.

Once again, we had the opportunity to hear from a number of Montana veterans who said that once they get into VA, the care they get is very good. The problem is getting in the door. We heard concerns about distance for veterans, in between veterans and veterans' facilities. We heard about inadequate staffing levels at the VA facilities as well as inadequacy in addressing the mental health issues that revolve around the returning veterans from Iraq and Afghanistan.

One thing that struck me in particular is learning that when the VA adds outpatient clinics to a region, the region doesn't always get more money. They have to figure out how to do it with what they have been getting, and that makes adding these facilities to a State or to a region to address some of the problems that I spoke of earlier an extremely difficult proposition.

The President's budget, remember, for Fiscal Year 2008 assumed a 2 percent decrease in Fiscal Year 2009. They would essentially remain frozen for 3 years in a row after that. This proposal was rejected by the Congressional Budget Resolution, but it should be a serious concern that the White House is not providing a clear picture of the likely future of VA funding needs.

So to me, it is clear that we find a way to increase lead time for capital projects. We have got to get some more assurances in the system that the dollars will be there so that the regional and State-level administrators can make decisions about how best to serve the unique needs of veterans and their area, and to me, that means guaranteed funding for VA.

I look forward to hearing the views of the witnesses and I hope that we can have a good discussion on mandatory funding. I understand it is going to be much harder to address this issue at this point in time with pay-go, but I think it is due time to restart this dialogue.

Once again, thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Tester.

Senator Murray?

STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Mr. Chairman, thank you very much. I will submit my opening statement for the record, and let me just say, as Senator Tester said, I think the one point we all agree on is once you get in the door of the VA, you do get excellent health care and that is exactly what our veterans should be getting. Their focus on patients, the integrated delivery model the VA has, the first-rate

IT system that manages the patients is something that is a model for everyone and we want to make sure veterans get that.

But as Senator Tester said, it is getting in the door that is a challenge and that really goes to the budget and how we budget and how we look at the long-term costs that we need to be able to meet for our veterans, both ones from previous wars to the coming generations that will be impacted, that we need to be looking at how we do that.

I look forward to today's testimony from all of our witnesses and hope we can have a good discussion. Clearly, on the table, looking at the proposals, we have to make sure that each one of them that we look at is done responsibly and in a way that allows both the flexibility for the future but also requires that we have that funding there and it isn't continuing resolutions that we have to go to or supplemental funding because we haven't planned correctly. That doesn't serve our veterans well.

So I really appreciate the hearing today and look forward to the testimony from our witnesses.

[The prepared statement of Senator Murray follows:]

PREPARED STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Chairman Akaka, thank you very much for holding today's hearing on funding for veteran's health care. I applaud you and Ranking Member Craig for holding this important hearing and I look forward to the testimony from our distinguished witnesses.

Mr. Chairman, I often say that the VA provides excellent care to veterans, once they get in the door. The VA's long term focus on patients, its integrated delivery model, and its first-rate health IT system provide distinct advantages over private sector care, and we need to keep it that way. But too often, getting in the door is a problem. All of us have heard from constituents who have waited months to see a primary care doctor. Some veterans have even had to wait years to get surgery. And all of us have surely heard from veterans who were denied enrollment because of the Bush Administration's decision in 2003 to deny VA healthcare access to new Priority 8 veterans.

Mr. Chairman, this country has a moral obligation to care for those who have served this country in uniform. That means providing access to the VA health care system for *all* veterans. The men and women who have served in our military have born significant burdens of war. They have assumed great risk for our country, and they have sacrificed life and limb to protect our freedoms. They kept their promise to serve our Nation. It is only right that we keep our promise to serve them.

For too many years under this Administration, veterans have been "last in line," and we in Congress have had to fight the Administration tooth and nail to meet their needs. That has to change. I am tired of having to fight and fight and fight—to just barely meet the needs of veterans. I want to get to a point in this country where we don't have to fight to provide the resources that meet our veterans' needs, but where it is just plain understood and done.

DEMOCRATIC CONGRESS MEETING THE NEEDS OF OUR VETERANS

It is clear that this new Congress and the American people want to do what's right by our veterans. In the most recent Iraq war supplemental funding bill, we included $1.8 billion in emergency funding for veterans programs—the first time veterans funding has ever been included as a cost of this war. And the FY 2008 VA funding bill that has passed the Senate Appropriations Committee provides a $3.6 billion increase over the President's request. It meets nearly all of the funding recommended by the Independent Budget.

Despite this good news, we can't stop there. We have to take a long term view of how to best meet the needs of veterans. And that starts at today's hearing. As the massive shortfall in 2005 and 2006 demonstrated, the VA's budget model is not flexible enough to meet changing realities and take into account new costs. And we simply cannot continue the pattern of falling back on Continuing Resolutions, which hamstring the VA and force them to scrape by on inadequate resources. Some of our witnesses today have proposed that we make VA health care funding manda-

tory. This is an idea that merits strong consideration. But as we consider this option, we need to make sure that any formula created gives the VA enough flexibility to meet the needs of veterans and respond to any unforeseen consequences.

I appreciate the participation of all of today's witnesses and I look forward to hearing their testimony.

Chairman AKAKA. Thank you, Senator Murray.

Senator Rockefeller?

STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. I will submit my opening statement for the record. I just want to praise two people, and I don't mean to leave you out, Congressman. I would be happy to praise you, too, but it will be based upon a little bit less knowledge.

Number one, Ken Kizer, I have been wanting to say this for years. I have been on this Committee for 23 years and I remember when you came and mostly we met in the regular meeting room. I looked upon you as another one of those people who were coming through and who were going to serve, in your case, a substantial amount of time. Something I have rarely seen in government before, and it is suddenly clear to the American people are two things. One is that the VA health care system is the best in the country, the most efficient. I read at length only your testimony.

But you did it. You did it, and that has now become clear to people. While you didn't do it all by yourself, you were the person in charge of the health services and you took a hold of things which the rest of us simply didn't understand and which the rest of the VA bureaucracy was not willing to deal with or wasn't fully aware of. You exercised, I think, supreme leadership. I think you should have gotten one of those Medals of Freedom. I could have named two or three that probably shouldn't have, but you are somebody who should have gotten one. I mean that and I wanted to say that to you. You did a spectacular job—and your face is showing no emotion whatsoever as I pour my heart out to you.

[Laughter.]

Senator ROCKEFELLER. But at least I want that to sink in.

And then I want to say to Dr. Reinhardt, who has always understood things about 40 years in advance of the rest of America, and you have laid out questions here, including sustainability and all kinds of things. Senator Murray raised this huge question of budgeting, which I want to ask you about in your role as an economist. But I think that you are also one of those, in a different way from Ken but on a very, very broad range, one of those people who has led our Nation for years in thinking controversially, out of the box, and I think almost always completely correctly. So you are both national assets. Congressman, you would be, too, if I knew you better.

[Laughter.]

Senator ROCKEFELLER. You understand that I mean that, and I want you to give my regards to May and I am very much aware of where your son is.

[The prepared statement of Senator Rockefeller follows:]

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV,
U.S. SENATOR FROM WEST VIRGINIA

Chairman Akaka and Senator Craig, as always I want to thank you for your leadership and commitment to oversight. This is an important hearing on VA health care funding and you have a series of thoughtful and impressive witness—their views will help us more than my opening statement so I will be brief.

Dr. Kizer, you should be proud of the changes at VA. Dr. Reinhardt, welcome my friend and I value your insights on American health policy for VA and our system at large. Each part of our health care system interacts with other aspects so your testimony provides important context.

Unfortunately, I cannot stay for the full hearing, but I will have written questions and I will carefully review the testimony of each witness. And to Joe Violante, the DAV and all members of the Partnership, thank you for your leadership and your commitment—it matters.

Mr. Reinhardt. Thank you.

Chairman AKAKA. Thank you very much.

Senator MURRAY. Mr. Chairman?

Chairman AKAKA. Senator Murray?

Senator MURRAY. Mr. Chairman, if I could just inform the Committee, I just came from the floor of the Senate where we passed by unanimous consent the Dignified Troop Wounded Warriors Act out of the Senate. I think that is a major step forward. Many of us on this Committee worked on it. Mr. Chairman, you did along with the Armed Services Committee in order to address that gap between the Department of Defense and the VA and the different rating systems and the lack of services for our wounded warriors. It is a great step forward and I think that we all should really be proud of the work that is done in a bipartisan manner to move that forward efficiently after we heard about the Walter Reed scandals, and we will keep working until we get it signed by the President.

Chairman AKAKA. Thank you so much, Senator Murray.

In addition to the witnesses that we have listed, we are joined today by Representative Chris Smith of New Jersey. The Committee looks forward to your statement on health care funding.

I also want to say that the full statements of Senator Murray and Senator Rockefeller will be included in the record.

Senator ROCKEFELLER. Amended statements.

Chairman AKAKA. Amended statements. Thank you.

Congressman Smith, please proceed.

STATEMENT OF HON. CHRISTOPHER SMITH, HOUSE REPRESENTATIVE FROM NEW JERSEY

Congressman SMITH. Thank you very much, Mr. Chairman, and to Senator Craig and all the Members, and to Senator Rockefeller, it is nice to be a potential national asset, so I think I thank you. It is a very, very rare privilege to be here and I thank you for this opportunity to testify on the compelling need to reform VA health care funding.

As former House Chairman, I deeply appreciate and respect all the work that this Committee has done and is doing to ensure that our men and women who have served in uniform have all the benefits and services they need and have earned. No one on earth, Mr. Chairman, as you know and as Members of the Committee know, has done more to protect and preserve freedom, democracy, and fundamental human rights than our veterans. When the dust settles, it is the veteran and his or her family who bear the physical

and emotional scars of war, and for some, it is paying the ultimate price. A grateful Nation, therefore, must at all times and in every circumstance put veterans first.

As we may hear this morning, the President's Commission on Care for Returning Wounded Veterans and Warriors is meeting with President Bush to provide its recommendations on how to improve the transition, health care and benefits for injured servicemembers and veterans. I commend Senator Dole and Secretary Shalala and all the members of that Commission for their service and look forward to reading their recommendations.

However, unless we resolve the underlying funding problems that have plagued VA health care since at least 1990, I am not optimistic about the prospects of seeing any meaningful reforms implemented. Notwithstanding a potentially huge plus-up in Fiscal Year 2008 medical appropriations, the funding mechanism remains broken.

As I am sure most of you know, this is not the first commission or task force created to address problems in the delivery of care to injured and disabled servicemembers and veterans. In fact, it is not even the first convened by President Bush. Four years ago, the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans presented two dozen solid recommendations on how to resolve the decades-old problems of cooperation and collaboration between the VA and DOD in order to improve health care. That Task Force, chaired by Dr. Gail Wolensky, who is also a member of the President's new commission, spent almost two years studying both the VA and DOD health care systems.

Among the Commission's key findings, even though it was not part of their original mandate, but they had to deal with it because it was staring them right in the face, was the conclusion that, "The mismatch between funding for the VA health care system and the demand for services from enrolled veterans affects the delivery of timely health care."

Mr. Chairman, even a cursory look at recent shortfalls in veterans' health care funding shows that the mismatch remains a serious and vexing problem. Remember the summer of 2005. First, $975 million had to be added to the 2005 budget, only to be followed just one month later by an over $1.9 billion increase for Fiscal Year 2006 appropriation. Unless we fix the funding process for VA health care, all efforts to improve its delivery will continue to be impeded, and worse, we risk new Walter Reed-like problems at VA facilities in the future.

From 2001 to 2004, Mr. Chairman, I had the honor of chairing the House Veterans' Affairs Committee during a time when usage of the VA health care system rose dramatically. The consequence of expanding coverage and eligibility, the VA's low copayment for prescription drugs, and the huge growth in the Community Based Outpatient Clinics made utilization skyrocket. If you build access points, men and women will use the system. It was and is a great news story and Dr. Kizer deserves a lot of credit for having created this modern system.

Thus, no single issue garnered more of our Committee's attention than ensuring that VA received the funds it required to provide the services veterans needed. Both my good friend and colleague and

Ranking Member Lane Evans and I spent hundreds of hours examining the Administration's budget request and made bipartisan recommendations to the Budget Committee, Appropriations, and all of our colleagues on the proper level of funding.

We began not with the Administration's budget request, however, but rather with the VA's full demand model, which is its, as you know, internal projection of the level of funding needed each year based upon their latest actuarial and cost data. Our analysis showed that VA's full demand model was extraordinarily accurate. However, the process that occurred along the way from VA's internal estimate to the President's budget submission to final Congressional appropriations is one that is often replaced by—that often replaces sound data with other agendas.

As a result, the VA budget requests under both Presidents Clinton and Bush have often been lackluster, deficient, and infirm. Virtually every year, Congress has had to add millions, sometimes billions, to the Administration's request. Compounding the problem, Congress's budget and appropriations process has been consistently late and totally unacceptable.

It is astonishing to me that since 1990, 16 of the 18 VA appropriations were late. On two occasions, 5 months late. Once, it was 7 months late. How can the Secretary, the VISN Directors, and medical directors plan and execute delivery of medical services under those adverse circumstances? No one can honestly look at that and dispute the evidence that VA's health care funding has been woefully inadequate. Persistent shortfalls have resulted in long waiting lines, a cutoff of Priority 8 veterans, and very public and very embarrassing admissions by the last two Secretaries that budget requests were sometimes a billion dollars less than needed.

There are also an array of budget gimmicks routinely employed to cover the shortfalls, such as billions of dollars of so-called savings through what is euphemistically called management efficiencies and overly rosy expectations of third-party collections that never materialized, as well as repetitive and unrealistic annual policy proposals to shift the cost of care to veterans with new user fees and copayment increases.

The effect on the VA has been extremely harmful, leading to huge management and staffing problems as well as construction funding shortfalls that threaten VA's physical infrastructure. The VA health care system, the system that Senator Rockefeller and others have pointed out is the best health care system in America and has been shown that by a number of authoritative studies and leading publications, could very well be threatened if we do not correct the underlying funding problem.

That is the very same conclusion that the President's task force came to back in 2003 when they recommended a full funding system and offered two alternatives, a mandatory funding system or the establishment of an independent panel of experts charged with submitting the Administration's request absent OMB vetting and veto.

In the summer of 2002, Mr. Chairman, I introduced legislation, H.R. 5250, to move VA's health care funding from discretionary, which is subject to political forces in both Congress and the Administration, to one that is mandatory and driven by formula, meas-

uring demand for care and the cost of care. Opposition to new entitlement spending in the House, however, was strong, and there were admittedly some potential weaknesses in this approach. But our goal was to jump-start the debate to ensure full funding that is predictable and delivered on time.

In 2005 and again this year, I have introduced another bill, H.R. 1041, based on this second model offered by the President's Task Force. My current bill would create an independent expert panel called the Veterans Health Care Funding Review Board, to determine the level of funding required to meet projected demand with accepted access standards. The Board's estimate would bypass OMB and be submitted to Congress as the Administration's budget request. Although Congress would still have the discretion to adjust that amount either up or down, the imprimatur, it seems to me, of an impartial and ex parte body would make it very hard from a political standpoint to go below the Board's spending floor, although further increases would certainly be possible.

Despite some drawbacks, and Senator Craig did mention a few, I believe that either of these bills, or perhaps a hybrid of both, would be a dramatic improvement over the status quo.

Finally, while the aggregate number of veterans is likely to decline, the number of veterans who rely on VA continue to rise, and this trend is likely to continue over the next decade and beyond. Furthermore, with the devastating types of injuries being suffered in war today and the long-term care needs of so many veterans on the rise, we must ensure that the VA continues to provide world class medicine far into the future. It must be sufficient, it has to be timely, and we need predictability. I thank the Chairman.

[The prepared statement of Mr. Smith follows:]

PREPARED STATEMENT OF HON. CHRISTOPHER H. SMITH,
HOUSE REPRESENTATIVE FROM NEW JERSEY

Chairman Akaka, Senator Craig, Members of the Committee, It is a rare privilege to testify before the Committee today on the compelling need to reform VA health care funding.

As former House Chairman, I deeply appreciate and respect all the work that this Committee has done and is doing to ensure that our men and women who have served in uniform have all of the benefits and services they need and have earned.

No one, on earth, has done more to protect and preserve freedom and democracy than our veterans. And no one, has had to bear the physical and emotion scars—for some even death—to protect our liberties, as have our veterans. A grateful Nation must put veterans first.

As we meet here this morning, the President's Commission on Care for Returning Wounded Warriors is meeting with President Bush to provide its recommendations on how to improve the transition, health care, and benefits for injured servicemembers and veterans. I commend Senator Dole and Secretary Shalala and all the members of that Commission for their service and I look forward to reading their recommendations.

However, unless we resolve the underlying funding problems that have plagued VA health care since at least 1990, I am not optimistic about the prospects of seeing any meaningful reforms implemented. Notwithstanding a potentially huge plus-up in FY 2008 VA Medical Appropriations—the funding mechanism remains broken.

As I am sure most of you know, this is not the first commission or task force created to address problems in the delivery of care to injured and disabled servicemembers and veterans. In fact, it is not even the first one convened by President Bush.

Four years ago, the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans presented two dozen solid recommendations on how to resolve decades old problems of cooperation and collaboration between VA and DOD in order to improve health care. That Task Force, chaired by Dr. Gail Wilensky, who

is also a member of the President's new Commission, spent almost two years studying both the VA and DOD health care systems. Among that Commission's key findings—even though it was not part of their original mandate—was the conclusion that, "the mismatch between funding for the VA health care system and the demand for services from enrolled veterans affects the delivery of timely health care. . . "

Even a cursory look at the recent shortfalls in veterans health care funding acknowledged by VA and Congress shows that the "mismatch" remains a serious problem. Remember the summer of 2005? First $975 million had to be added for FY 2005 only to be followed just one a month later by over a $1.9 billion increase for Fiscal Year 2006. Unless we fix the funding process for VA health care, all efforts to improve its delivery will continue to be impeded, and worse, we risk new Walter Reed-like problems at VA facilities in the future.

From 2001 through 2004, I had the honor of chairing the House Veterans' Affairs Committee during a time when usage of the VA health care system rose dramatically. The consequence of expanding coverage and eligibility, the VA's low copayment for prescription drugs, and the huge growth in Community Based Outpatient Clinics made utilization skyrocket. It was—and is—a great news story.

Thus, no single issue garnered more of the Committee's attention than ensuring that VA received the funds it required to provide the services veterans needed. Both my good friend and Ranking Member, Lane Evans, and I spent hundreds of hours examining the Administration's budget requests and made bipartisan recommendations to the Budget Committee, Appropriations Committee and all our colleagues at large, on the proper level of funding required to allow VA to faithfully discharge its functions. We began not with the Administration's budget submission, but rather with VA's "full demand model", which is its internal projection of the level of funding needed each year, based upon their latest actuarial and cost data.

Our analysis showed that VA's full demand model was extraordinarily accurate. However, the process that occurs along the way from VA's internal estimate to the President's budget submission to final Congressional appropriations is one that often replaces sound data and prudent policy with other agendas.

As a result, VA's budget requests—under both Presidents Clinton and Bush—have often been lackluster and infirm. Virtually every year Congress has had to add millions, sometimes billions, of dollars to the Administration's request. Compounding the problem, Congress' budget and appropriations process has been consistently late and totally unpredictable.

Since 1990, sixteen of the eighteen VA appropriations were late—on two occasions 5 months late, once 7 months late. How can the Secretary, VISN directors and medical directors plan and execute delivery of medical services under those adverse circumstances?

No one can honestly look at and dispute the evidence that VA's health care funding has been woefully inadequate. It has resulted in long waiting times, a cutoff for Priority 8 veterans, and very public and embarrassing admissions by the last two Secretaries that budget requests were sometimes a billion dollars less than needed.

There has also been an array of budget gimmicks routinely employed to cover these shortfalls—such as billions of dollars of so-called "savings" through "management efficiencies" and overly rosy expectations of third party collections that never materialized, as well as repetitive and unrealistic annual policy proposals to shift the cost of care to veterans with new user fees and copayment increases.

A GAO analysis done last year of the VA health care budget process concluded that:

> Unrealistic assumptions, errors in estimate, and insufficient data were key factors in VA's budget formulation process that contributed to the requests for additional funding for Fiscal Years 2005 and 2006.

Moreover, GAO concluded that:

> VA's total projected management efficiency savings in the President's budget request for fiscal years 2003 through 2006 were used to fill the gap between the costs associate[d] with VA's projected demand for health care services and anticipated resources.

In plain English, when VA's internal estimates of what it would cost to provide health care services to veterans was greater than the amount of budget authority that OMB designated for VA health care, they plugged it with unspecified "management efficiencies." And during the four years I was Chairman, despite repeated requests, VA failed to document any significant savings through these so-called efficiencies, much less the billions of dollars they had plugged into their budget requests.

The effect on VA has been extremely harmful, leading to huge management and staffing problems, as well as construction funding shortfalls that threaten VA's physical infrastructure. The VA health care system—system that has been hailed as the best health care in America by authoritative studies and leading publications—could be threatened if we do not correct the underlying funding problems.

That's the very same conclusion that the President's Task Force came to back in 2003 when they recommended a "full funding" system, and offered two alternatives: a mandatory funding system; or the establishment of an independent panel of experts charged with submitting the Administration's request absent OMB vetting and veto.

In the summer of 2002, I introduced legislation H.R. 5250 to move VA's health care funding from a discretionary system—which is subject to political forces in both Congress and the Administration—to one that is mandatory and driven by formula measuring demand for care and the cost of care. Opposition to new entitlement spending in the House however was strong and there were admittedly potential weaknesses in this approach. But our goal was to jumpstart the debate, to ensure full funding that is predictable and delivered on time.

In 2005, and again this year, I have introduced another bill, H.R. 1041, based upon the second model offered by the President's Task Force. My current bill would create an independent, expert panel—the Veterans Health Care Funding Review Board—to determine the level of funding required to meet projected demand with accepted access standards. The Board's estimate would bypass OMB and be submitted to Congress as the Administration's budget request. Although Congress would still have discretion to adjust that amount either up or down, the imprimatur of an impartial and expert body would make it very hard from a political standpoint to go below the Board's spending floor, although further increases would certainly be possible.

Despite some drawbacks in both approaches, I believe that either of these bills—or perhaps a hybrid of both or perhaps some other alternative—would be a dramatic improvement over the status quo.

Mr. Chairman, while the aggregate number of veterans is likely to decline, the number of veterans who rely on VA continues to rise, and this trend is likely to continue over the next decade. Furthermore, with the devastating types of injuries being suffered in war today, and the long term care needs of so many veterans on the rise, we must ensure that the VA continues to provide world class medicine far into the future.

I want to commend this Committee for holding this hearing on this most important issue and I urge you to move forward with recommendations for a systemic reform of VA's health care funding system that provides sufficient, timely, and predicable funding.

I'd be happy to address any questions you may have.

Chairman AKAKA. Thank you very much, Congressman Smith, for your statement.

I am pleased to welcome our first panel. It would be very hard to overstate the credentials and accomplishments of its members.

Dr. Kenneth Kizer, as most of you know, was VA's Under Secretary for Health from 1994 to 1999. Dr. Kizer is credited with turning around the Veterans Health Administration, which in the early 1990s was seen as overly centralized and inefficient. We are very fortunate to have access to his perspective at this hearing.

I also welcome Dr. Uwe Reinhardt, who teaches at Princeton University's Woodrow Wilson School of Public and International Affairs. He is a renowned expert on health care, economics, and a true leader in his field, and I thank you both for being here.

Your full statements will appear in the record of the hearing, and I would like to call first on Dr. Reinhardt for your statement and then we will hear from Dr. Kizer. Dr. Reinhardt?

STATEMENT OF UWE E. REINHARDT, PH.D., PROFESSOR OF POLITICAL ECONOMY, ECONOMICS, AND PUBLIC AFFAIRS, WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS, PRINCETON UNIVERSITY

DR. REINHARDT. Thank you, Mr. Chairman and distinguished Members of this Committee. My name is Uwe Reinhardt. I am the James Madison Professor of Economics and Public Affairs at the Woodrow Wilson School of Public and International Affairs and the Department of Economics at Princeton University. My research over the years has been on health economics and policy, and I had the privilege of serving in the early 1980s on the Special Medical Advisory Group of the Veterans' Administration. Hence my longstanding interest in this system.

In my written statement, I have focused mainly on the part of the VA budget that deals with health care, because that is my expertise. The other part is disability payments and cemeteries, which I think are separate issues.

It is true, as I show in Figure 1 of my statement, that in the last 10 years, the VA budget has doubled. When you plot that on a graph and if you scale the axis over a narrow range of numbers you can always draw a really scary picture, because you can make that line pretty steep.

Of the VA budget, only less than half is actually going to health care proper. But, as I said, we see in Figure 2 that this VA health care budget did rise 100 percent in the last decade, which means it doubled. But national health spending under private health insurance rose by 124 percent, faster than the VA budget, and Medicare by 110 percent. Overall national health spending in that period rose by 105 percent.

So of those bars in Figure 2, the VA budget was actually not the fastest-rising, in spite of the fact that in that last decade, the VA had to cope with the wars in Iraq and Afghanistan, that is, with veterans who bring trauma of a sort that earlier wars had not produced in these numbers, also psychological trauma. This trauma is deepened because we are recycling the same troops time and time again as not enough of other Americans volunteer to stand tall for America. The Congress just voted against giving soldiers a longer break between combat missions, which I find quite astounding, and that wears on the troops' minds, too. So even if their body comes home in good shape who knows what happens to the mind.

On top of it, during the last decade, my colleague Ken Kizer reformed the VA health system and made it worldwide. I just came from the International Health Economic Association, where everyone talks about the VA as a model of how to run health care, and Ken deserves so much of the credit, but also all the men and women who are so motivated that worked with him in modernizing the VA.

Although the VA is expensive, it is expensive because it is imbedded in the most expensive health system in the world. As shown in Figure 3 of my written statement, we spend per capita (in purchasing power parity) roughly twice as much as Canadians do, more than twice what Germans do, although Germany is a much older country, and even the Swiss, who have a system, they have more of everything, spend much less than we do. The reason

is that we pay higher prices for the same goods and services partly because we have a higher GDP and can afford to spend so much on health care. And secondly, in our wisdom, we have created a health system where the market power all lies on the supply side of the market. That supply side can dictate volume and prices to the demand side, which is splintered, fragmented, and weak. We chose this as a people, and the VA has to buy inputs in that system and be part of it.

The next point I address in my testimony is whether it is sustainable in the future. The VA health care budget is now only one-fifth of one percentage point of GDP. That is a round-off error, I think. The VA health budget is 1.15 percent of the Federal budget. So in a way, that budget really doesn't scare me ever. If one had to err on the side of generosity, it would not be a big deal and it might actually be appropriate to err a bit on the generous side for our veterans.

In Figure 4 of my testimony, I extrapolate current trends in VA health spending to 2055. Even under worst-case scenario, VA health spending will not exceed one percent of GDP. It will also remain less than 4.5 percent of the Federal budget.

So the bottom line here is this is not a budget that is going to overwhelm either the Federal Government or the people of the United States, especially when we consider what we get for it in return. How many Americans actually still serve and fight for our country? These veterans have or were willing to do so. When they come back, if they do, should they not have an entitlement to good health care? I really use that word judiciously. If any time, anyone ever deserved an *entitlement,* it would surely be the people who put their lives at risk out there on behalf of the rest of us.

To highlight how often we get hung up on this word "sustainable," I used the Medicare program just by way of illustration. It is often said the Medicare program is not sustainable, but I have a chart in my testimony—I think it is Figure 7—that says even if we ran Medicare as inefficiently as we now do, and I am not recommending that, even if we did, the Gross Domestic Product per capita of Americans 50 years from now will be almost double what it is now. One way to put it, if you took 9 percent of that budget from Medicare, the amount of money left over for all other stuff that our descendants in 2050 will have is still 80 percent more than what we now have after the current Medicare haircut of about 3 percent of GDP.

The way I put it to my students, I will be doggone if I now lose sleep over people who will have 80 percent more than I do have when we have waitresses in America with kids who are uninsured. So that is my view on this. I agree that this is a subjective personal statement—that is, a purely political statement—but so is the argument that Medicare is not financially sustainable. The program is eminently sustainable in our country if the young are willing to share their good fortune with the old.

I do, however, point out in Figure 8, Section 5 of my testimony, that the Medicare program and all other health care in America is not cost effectively delivered now. We all know this. All health services researchers know that we could probably shave 20 percent off national health spending and do no harm to patients, if we

knew how to get at the current waste. In fact, I think we will do this. But even if we didn't, we will be all right. I hope the young people in this room, once they run the country, will do better than my generation on the issue of sharing good fortune.

In concluding, I have said if there is pressure on the Federal budget, yet we are the least-taxed nation in the world, as is shown in Figure 8 of my testimony. Japan and the U.S. have the lowest tax rate as a percent of GDP in the world. So I don't think there has to be this pressure on the Federal budget, we certainly could raise taxes, but if there is, there are many other trade-offs we could make.

One of these, I mentioned in my statement, agricultural subsidies. I don't think you can find an economist in this country who would defend the agricultural subsidies we now pay on either the basis of equity or efficiency. So, if you had to cut the Federal budget you may consider cutting there and not the VA health care budget.

Thank you very much.

[The prepared statement of Mr. Reinhardt follows:]

PREPARED STATEMENT OF UWE E. REINHARDT, PH.D., PROFESSOR OF POLITICAL ECONOMY, ECONOMICS, AND PUBLIC AFFAIRS, WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS, PRINCETON UNIVERSITY

Chairman Akaka and Distinguished Members of This Committee:

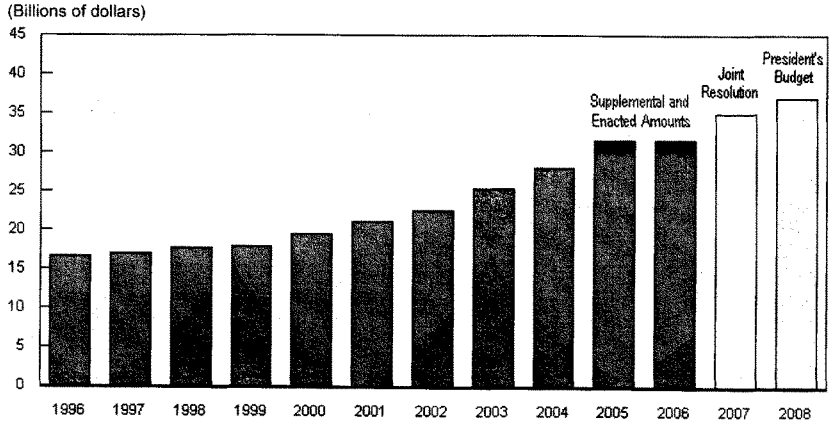
My name is Uwe E. Reinhardt. I am the James Madison Professor of Economics and Public Affairs at the Woodrow Wilson School of Public and International Affairs and the Department of Economics at Princeton University, Princeton, New Jersey. My research over the last several decades has focused primarily on health economics and policy, although I also teach or have taught at Princeton University general economics, financial accounting and financial management. In the early 1980s, I had the privilege of serving on the Special Medical Advisory Group (SMAG) of the Department of Veterans Affairs (VA)—hence my long-standing interest in the VA health system. Over the years, I have also served on several other government commissions, including for some nine years on the Physician Payment Review Commission (PPRC) which advised Congress on payments of physicians by Medicare.

I would like to thank you, Mr. Chairman, and your colleagues for inviting me to testify before this Committee on a matter I personally deem of the utmost importance to the well being of our nation's most deserving citizens: our veterans.

I. VA HEALTH SPENDING

As is shown in Figure 1 below, in the decade from 1997 to 2007, the Department of Veterans Affairs' annual funding for medical care rose by 100%, that is, it doubled. During the same period, the total federal outlays increased by only 74%, and gross domestic product per capita (GDP) by roughly only 69%.[1]

FIGURE 1 -- THE DEPARTMENT OF VETERANS AFFAIRS' FUNDING FOR MEDICAL CARE, 1996 TO 2008



SOURCE: Allison Percy, "Future Medical Spending by the Department of Veterans Affairs," CBO Testimony Before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies,

These differential growth rates naturally lead to the question whether the annual spending on health care by the Department of Veterans Affairs is "sustainable." It is a

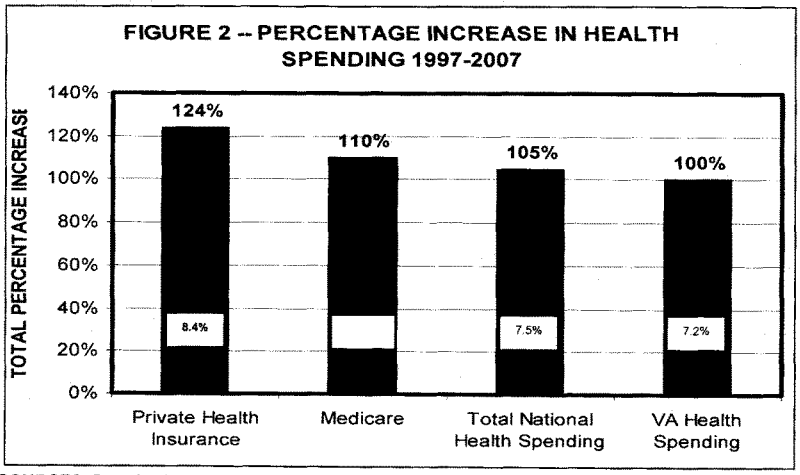
[1] Calculated from tables B-1 and B-78 of the Economic Report of the President, February, 2007.

fair question calling for a thoughtful answer. That answer, however, should be developed against the broader context of health spending in the U.S., lest Congress inadvertently make the VA health system the fall guy for a much wider problem with America's health system and, in the process, impair what one distinguished member of this Committee has called "the VA's world-class health system."[2] It is a judgment, by the way, with which the health services research community in this country and abroad wholeheartedly agrees.

This testimony is intended to provide that broader perspective. Section II presents comparisons of VA health-spending trends with overall health spending trends in the United States. It will be seen that, if anything, health spending by the VA has risen slightly less rapidly than it has in other segments of the health sector. Section III extrapolates the burden that VA health spending is likely to impose on total federal health spending and on gross domestic product (GDP) in the decades ahead, to make a judgment on whether the system is sustainable. I conclude that it is. Section IV explores the fiscal sustainability of the entire U.S. health system and Section V the potential savings in health-care spending that appear available to the United States. Curiously, the Congress has never shown any interest in harvesting these savings. Section VI offers some concluding observations, including the suggestion that, if federal budget increases must be cut, agricultural subsidies are a much more logical target for cuts than the budget of the VA.

II. VA HEALTH SPENDING AND OVERALL HEALTH SPENDING IN THE U.S.

Figure 2 presents percentage increases in health spending over the decade 1997-2007 under (1) private insurance, (2) Medicare and (3) the VA health system, along with the increase in (4) total national health spending. The numbers at the top of the vertical bars represent *total* percentage increases over the period. The numbers in the middle of the bars are the equivalent *annual* compound growth rates.



SOURCES: Data for the VA from CBO op. cit.; data for the other segments from CMS data base on "National health Spending 1965-2015.".

[2] Senator Larry Craig, "Veterans Update, Summer 2006," http://craig.senate.gov/i_vetlink.cfm

A. VA Health Spending in Perspective

Figure 2 shows that, as far as spending growth goes, the VA health system is in good company. In fact, its spending over the past decade grew less rapidly than did spending in the rest of the U.S. health system. Although the data in Figure 2 are not adjusted for differences in case mix, benefit packages and growth in the number of insured, it is safe to say that, even after such adjustments, any particular segment embedded is bound to share in the overall cost-growth experience of the U.S. health system, which has long ranked as the most expensive health system in the world (see Figure 3 below).

In this connection, it must be kept in mind that during this period the VA had to absorb increasing numbers of young veterans who were physically and mentally traumatized by the wars in Iraq and Afghanistan. Furthermore, during the last decade the VA health system has transformed itself from a system with highly varied quality to what is now generally acknowledged to be a system with the smartest use of electronic information in U.S. health care.[3] In a recent, rigorous exploration of the quality of U.S. health care researchers at the Rand Corporation concluded that the probability that a patient receives the recommended medical treatment is significantly higher in the VA health system than in the rest of the U.S. health system.[4]

Cost growth in the VA system in the decades ahead may well begin to outrank that in other segments of the U.S. health system, for at least two reasons.

First, the rapid cost growth in the entire health systems has begun seriously to erode traditional, employment-based private insurance coverage, particularly among low-wage workers in smaller business firms. Veterans hitherto covered by employment-based private insurance are bound to look to the VA health system for insurance coverage of last resort. That shift will reduce spending growth under private health insurance, but increase VA spending.

Second, the wars in Iraq and Afghanistan, and possibly yet other sites abroad, will continue to confront the VA health system with new challenges. In fact, counting in the future cost of health care for veterans and of yet other deferred expenses associated with the Iraq war, Nobel Laureate economist Joseph Stiglitz and his co-author Linda Bilmes of Harvard University have estimated that the properly counted cost of that war may already have reached $2 trillion.[5] Although, like all estimates about future spending, these authors' estimate depends on a number of assumptions, including the duration of hostilities, it is safe to say that the properly calculated, true cost of the wars in Iraq and Afghanistan far exceed the $500 billion or so frequently cited in the halls of Congress and the press. The VA's future budgets represent a good fraction of these larger costs.

It is appropriate to apprise U.S. taxpayers now of this debt owed their patriotic fellow citizens and of the added future tax burden it will impose on the rest of society.

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[3] See, for example, Adam Oliver, "The Veterans Health Administration: An American Success Story?" The Milbank Quarterly 85(1), 2007.

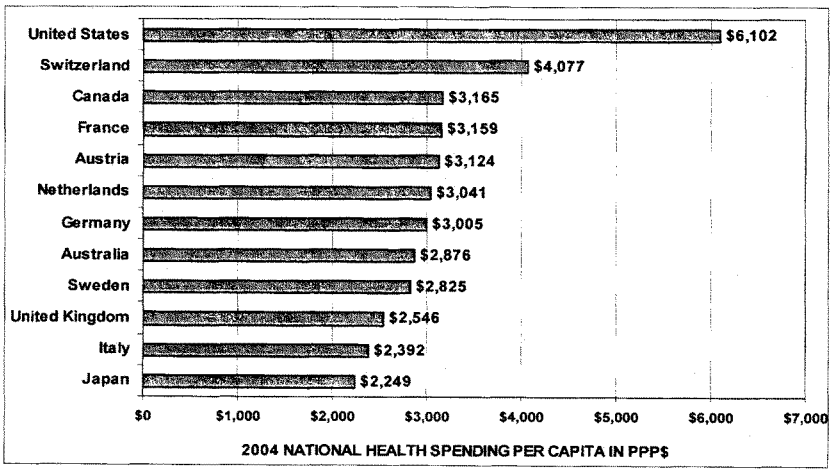
[4] Steven M. Asch et. al., "Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a national Sample, Annals of Internal medicine 141(12 (December 21, 2004): 938-45.

[5] Joseph E. Stiglitz and Linda Bilmes, "The Economic Costs of the Iraq War: An Appraisal three years after the beginning of the conflict," National Bureau of Economics Working Paper 12054 (February, 2006).

B. Why is U.S. Health Care so Costly?

Figure 3 presents the most recent available data on national health spending per capita in the OECD nations. All dollar figures are expressed in international purchasing power parity (PPP) dollars.

FIGURE 3 --2004 NATIONAL HEALTH SPENDING PER CAPITA IN OECD COUNTRIES In Purchasing Power Parity Dollars (PPP$)



It is seen that in 2004, the U.S. spent close to twice as much per capita on health care as did neighboring Canada and more than twice per capita than most other nations in the OECD. It can fairly be asked whether Americans receive commensurately higher benefits from their health system, given that the U.S. is known to rank rather low on common health-status indicators, such as longevity, infant mortality and general health status.

Switzerland, for example, spends only two-thirds as much per capita on health care as does the U.S., although the Swiss health system has more physicians, hospital beds and MRI machines per capita than does the U.S. and has a flourishing pharmaceutical industry. Swiss patients spend more days in the hospital than do American patients, have a higher number of physician visits per capita, consume more prescription drugs per capita and face no queues to health care. Switzerland does not have a significant number of uninsured citizens and has generally superior health-status indicators (such as longevity and infant mortality) than does the U.S.[6]

What, then, can account for the higher U.S. health spending? Cross national health services research has shown that Americans pay much higher prices for particular health care goods and services than do citizens of other countries. It was first

[6] See Uwe E. Reinhardt, "The Swiss Health System: Regulated Competition without Managed Care," Journal of the American Medical association 292(10) (September 8, 2004): 1227-31.

noted in a paper by Mark Pauly.[7] Subsequent research based on OECD data has corroborated the finding.[8, 9]

These higher prices paid by Americans for health care are the result of two main factors.

First, U.S. GDP per capita is higher than that in most other countries. Through its effect on prices, on the technical sophistication of health care and on the degree of the luxury of health care facilities, GDP per capita is the most powerful predictor of cross national differences in health spending per capita.

Second, the demand side of U.S. health system – that is, its health insurance system -- is highly fragmented. This structure is not only very costly to administer. It also accords relatively more market power to the supply side of the health-care market than to the demand side. It allows the supply side considerable discretion in dictating to society the terms on which health care is delivered, including volume and prices.

The point here is not to criticize the current configuration of the U.S. health system. Presumably it is what the American people prefer or are willingly accept. Rather, the point here is to apprise members of this Committee (and of the Congress) that a health system configured in this way will be extraordinarily expensive and will inevitably burden the budgets of government programs intended to provide health care to citizens. The VA system can never fully escape the effects of these market forces.

The only consolation in this regard is that government budgets are not the only ones struggling under the ever increasing burden of growing health-care costs. These costs now threaten to push some large American employers to the brink of bankruptcy, make other employers simply shift costs to their employees or drop health insurance coverage for their employees altogether, and drive many American families first into the ranks of the uninsured and perhaps increasingly into bankruptcy.

III. THE FISCAL SUSTAINABILITY OF THE VA HEALTH SYSTEM

On his previously cited website, Senator Larry Craig, Ranking Member of this Committee, presents the following chart on the VA budget with the remark:

> "All of us are committed to making life and services better for veterans, but can double-digit, annual increases in VA's budget be sustained over the long haul?"[10]

It is a fair question deserving a thoughtful answer.

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[7] M. V. Pauly, "U.S. health care costs: the untold true story," *Health Affairs*, Fall 1993; 12(3): 152-159.

[8] Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's The Prices, Stupid: Why The United States Is So Different From Other Countries," *Health Affairs*, May/June 2003; 22(3): 89-105.

[9] Uwe E. Reinhardt, Peter S. Hussey, and Gerard F. Anderson, "U.S. Health Care Spending In An International Context," *Health Affairs*, May/June 2004; 23(3): 10-25.

[10] http://craig.senate.gov/i_vetlink.cfm

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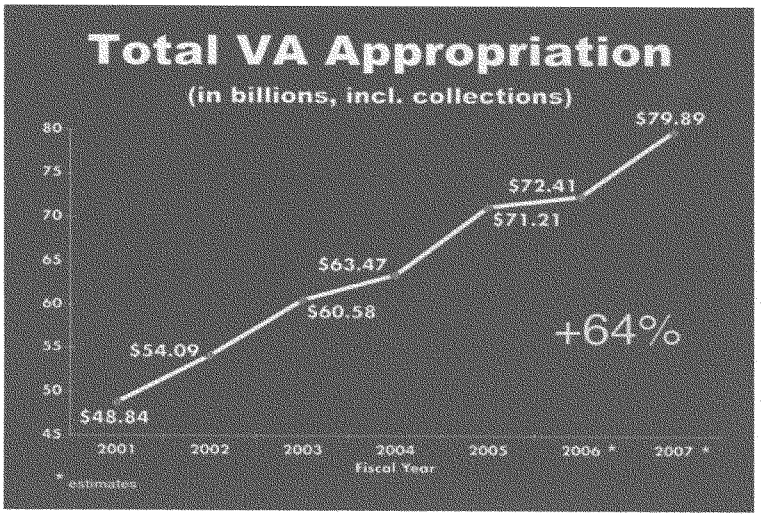


For starters, it must be noted that the figures in this graph represent the Department of Veterans Affairs' *total* budget, which includes many items other than outlays for health care proper. A larger portion of the budget was allocated to non-medical care, "mandatory" spending – for the most part, disability pension payments and other pension benefits. In 2007, for example, the VA's "discretionary"[11] budget for "medical care" proper amounted to only $31.511 billion. It was close to $32 billion if one includes funding of the research for which the VA is so well known.

How heavy a burden is a sum of $32 billion on the federal budget and on GDP?

In 2007, it represented only about 1.15% of that year's total federal outlays of about $2.8 trillion. Seen in that light, the VA budget is not a large burden on the federal budget.

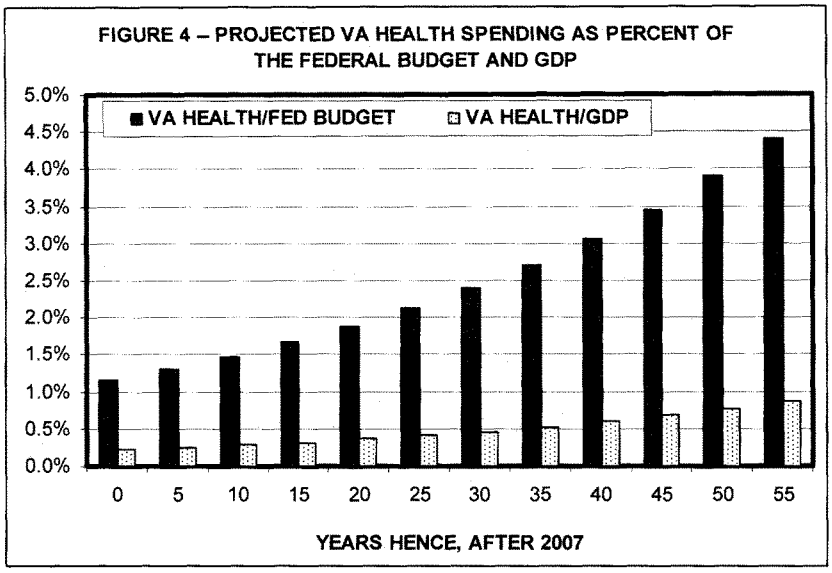
The VA budgets represents an even smaller burden if one relates it to this nation's ability to pay for its veterans, best measured by the nation's GDP of about $14 trillion in 2007. VA health spending accounted for only 0.22% -- that is, about one fifth of a percentage point – of the nation's GDP.

But what about future VA spending? Are current spending trends "sustainable"?

Suppose we assumed that nominal (not inflation-adjusted) VA health spending were to grow by 7.5% per year annually (faster than the 7.2% over the last decade). Next, suppose we assume somewhat pessimistically that nominal GDP grew by only 5% per year (slower than the rate of 5.5% to 6.8% in recent years). Finally, suppose quite optimistically that Congress somehow managed to keep the growth of total federal outlays in step with GDP, that is, at 5% per year only. On this rather conservative set of

[11] An interesting question is why VA health care should be a "discretionary" rather than a "mandatory" budget item, like the pensions of civil servants and Members of Congress. Should veterans not be entitled to good health care in return for the services they rendered the nation?

assumptions, what would be the time paths of the future VA health spending as a percentage of the total federal budget and of GDP? The projection in Figure 4 sheds light on this question.



In light of these data, what, then, might be meant by "sustainability"? Clearly, the answer here is highly subjective, reflecting mainly the respondent's personal moral values. In my own view, the burden our veterans will impose on the rest of us – as a percentage of the federal budget or of our GDP – is now and will remain rather small for the foreseeable future. In my own subjective view, that burden is a small price to pay for the valuable service our soldiers, Marines and sailors render the nation, for the risk they voluntarily assume, for the anxiety they impose on their loved ones, and for the tragic personal sacrifices in life and limb that service all too frequently entails.

I would hope that all members of this Committee and, indeed, all Americans, would see it that way, too.

IV. IS AMERICA'S HEALTH SYSTEM SUSTAINABLE?

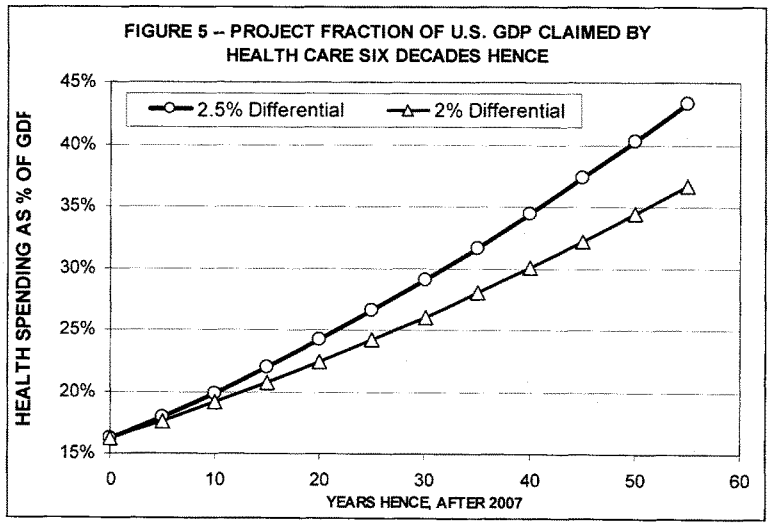
The previous section suggested that the sustainability of the VA health system certainly is not the major issue confronting American society in health care. Large as it is, with its budget of about $32 billion in 2007, that system represents only about 1.4% of the currently estimated total U.S. national health spending of $2.262 trillion. The truly important question confronting American society is whether the entire health care system is sustainable.

A. Total National Health Spending

During the past four decades, the growth of total *real* (inflation adjusted) national health spending in the United States has grown, on average, by about 4.5% per year. During the same period, *real* GDP per capita has grown at a long-run average annual growth rate of only 2%. From these numbers follows what one might call the *"2½% Rule of U.S. health spending,"* meaning that, on average, the annual growth in real health spending in the U.S. has tended to outpace the annual growth in real GDP by about 2½ percentage points.

The gap of 2.5 percentage points is, of course, a long-run average. In some years – e.g., 1993-1997 the growth gap was smaller, in others – e.g., 2001-2004 it was larger. Indeed, during the period 2001 to 2004, the growth in U.S. health spending was the chief economic locomotive pulling the economy along and crating most of the new jobs. During 2001-2002 alone the growth in health spending represented over half of the entire growth in GDP that year.

How long is the growth in overall U.S. health spending sustainable? Figure 5 sheds light on that question.



The actuaries of the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (DHHS) estimate that in 2007 the U.S. health system will claim 16.2% of GDP. They estimate that by 2016 that percentage will have risen to 19.6%. In their projections, the CMS actuaries assume a growth differential between health spending and GDP of only about 2.2%, which is a bit lower than the traditional 2.5%. Therefore, Figure 5 presents projection for two assumed growth differentials: the traditional 2.5% and only 2%, a range that brackets the CMS assumption. It is seen in Figure 5 that, at the growth-trend assumptions in the graph, five

decades hence the U.S. health system will claim somewhere between 35% to 40% of GDP.

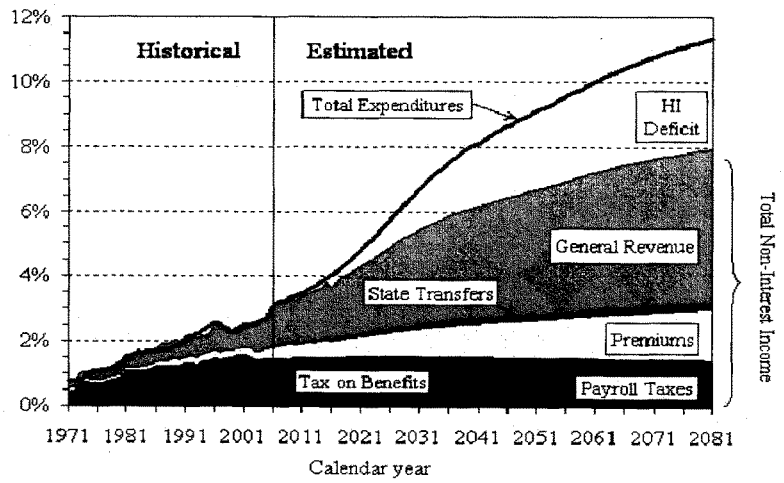
Most economists would be reluctant to offer a judgment on whether so large a claim on GDP is "sustainable" or will be "affordable" 50 years hence, because these are entirely subjective terms. Economists would ask what the health system would offer society in return for such an enormous claim on the then much larger GDP. A priori, one cannot rule out the possibility that those benefits might be so enormous – e.g., the conquest of cancer, Alzheimer's disease and similar dread diseases – that society might want to accept the bargain.

In fact, however, there is a substantial body of research suggesting that a considerable fraction of past and current U.S. health spending cannot be justified on the basis or clinical outcomes and patient satisfaction. I return to that point further on, in Section IV.

B. Medicare

Shown below is a chart from the most recent report of the Medicare Board of Trustees.

Figure 6 -Medicare Expenditures and Non-Interest Income by Source as a Percent of GDP



SOURCE: Summary of the 2007 Annual report of the Social Security and Medicare Boards of Trustees, Chart D. http://www.ssa.gov/OACT/TRSUM/trsummary.html

It is seen from the chart that, currently, the Medicare program claims about 3% or so of GDP. Under Medicare's current structure, that claim is projected to triple to about 9% by 2050. The chart also shows that, under the current tax structure, the program would have a huge annual deficit. These numbers lead many commentators to argue

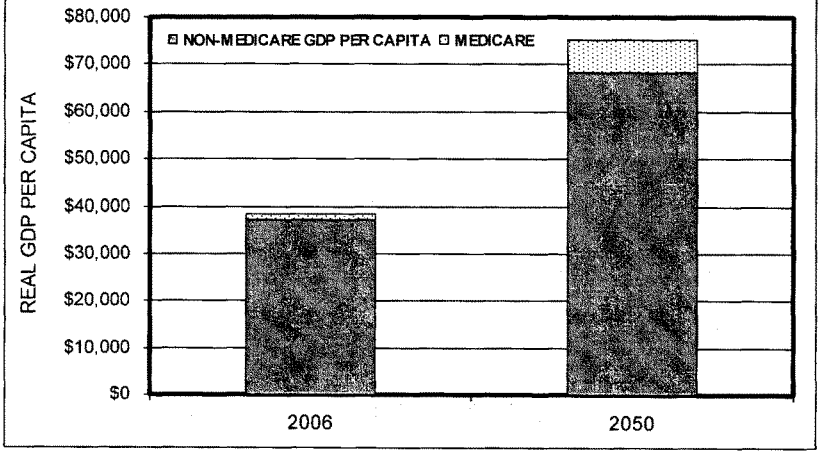
that the Medicare program is "unsustainable" in the future. Once again, however, one needs to explore what could be meant by the word "sustainable" in this context. In that exploration, it will be helpful for starters to project *real* (inflation-adjusted) GDP per capita under plausible assumptions. That figure is an indication of the nation's ability to pay for the health care of its elderly population in the future.

During the period 1980 to 2006, real, inflation-adjusted GDP per capita grew from $22,700 to $38,400. Although there were year-to-year fluctuations in that growth, its represents a long-run average growth rate in real GDP per capita of about 2%. Suppose we assume somewhat pessimistically that the future long-run average growth in real GDP per capita will be only about 1.5% per year until 2050. Even at that assumed lower growth rate, real (inflation adjusted) GDP per capita would grow from $38,400 in 2006 to $75,124 by 2050. In other words, it would roughly double.

Even if 9% of the real GDP per capita of $75,124 in 2050 were then taken away for Medicare at that time, the remaining real GDP per capita of $68,274 would still be 83% larger than the $37,248 of non-Medicare GDP available to Americans in 2006. To this observer, it is not clear why anyone would argue that Americans living in 2050 could not afford to take care of their elderly.

Figure 7 illustrates these numbers graphically. The solid parts of the bars represent non-Medicare real GDP per capita; the dotted parts represent Medicare spending per capita.

FIGURE 7 -- MEDICARE AND GDP PER CAPITA, 2006 AND 2050
Assuming real GDP per capita grows at 1.5% per year



To be sure, as Figure 6 illustrates, the 9% that might be claimed by Medicare in 2050 could not be paid for under the current tax structure. Taxes would have to be raised to effect that transfer. Here one may note, however, that the U.S. remains, with Japan, the least taxed nation in the OECD.[12] Although raising taxes is never much

[12] OECD website http://www.oecd.org/dataoecd/18/23/35471773.pdf

appreciated by citizens, it cannot be argued that a higher tax burden for Americans would put them quickly at a competitive disadvantage relative to other nations whose tax burden now is already significantly higher than ours.

C. Styles of Rationing Health Care

The upshot of this discussion is that "affordability" and "sustainability" in the context of the macro-economy of the U.S. are not purely economic terms on which all sensible citizens can agree. Both terms are, in essence, value-laden political terms. "Sustainability" in the context of health care really means "political feasibility." It has to do with the question whether or not well-to-do taxpayers are willing to pay added taxes to afford their low-income fellow citizens access to the kind of health care the well-to-do would prefer to have for themselves.

If commentators argue that current health-care programs for veterans, for the poor or for the aged are not "sustainable," they implicitly allude to the need for rationing health care to these groups. It is a topic worth discussing openly in the health policy debate. There are basically two approaches to rationing: (1) rationing by administrative mechanisms, hopefully on the basis of clinical need, and (2) rationing through market-forces through price and ability to pay. (As textbooks in economics teach their student readers, prices are the mechanism by which markets ration scarce resources among unlimited ends.) The distribution of economic privilege under these two distinct forms of rationing is, of course, quite different.

V. IS U.S. HEALTH CARE COST-EFFECTIVE?

The preceding sections implicitly assumed that the current *modus operandi* of the U.S. health system will remain in place for the indefinite future, including the overuse, underuse and misuse known to characterize that system. There is no reason, however, why that *modus operandi* should be preserved.

Figure 8 presents data on total Medicare spending per beneficiary in 1996 in diverse market areas (counties or groups or counties) of the United States, after adjustment for inter-area differences in the age and gender composition of the elderly population, case mix and prices. In other words, the data in effect reflect different utilization patterns of health care which, in turn, reflects differences in the medical practice style preferred by physicians.

It is seen in Figure 8 that the adjusted Medicare spending per beneficiary varied by a factor of close to 3 across the United States. As a general rule of thumb, Medicare spending per beneficiary in the Sun belt states tends to exceed comparable spending in the Wheat belt states (all the way west to Oregon) by a factor of 2 or more. Research funded mainly by the Robert Wood Johnson Foundation suggests that these spending variations appear to make no discernible difference to the quality of health care processes, to medical outcomes or even to patient satisfaction.[13]

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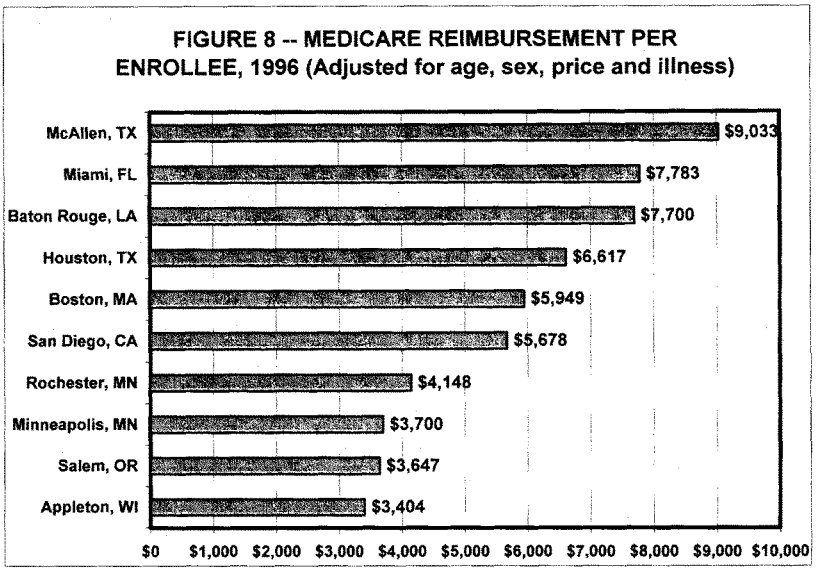
[13] Elliott S. Fisher et al., "The Implication of regional Variations in Medicare Spending," Annals of *Internal Medicine* 138(4) (February 18, 2003): 273-898.



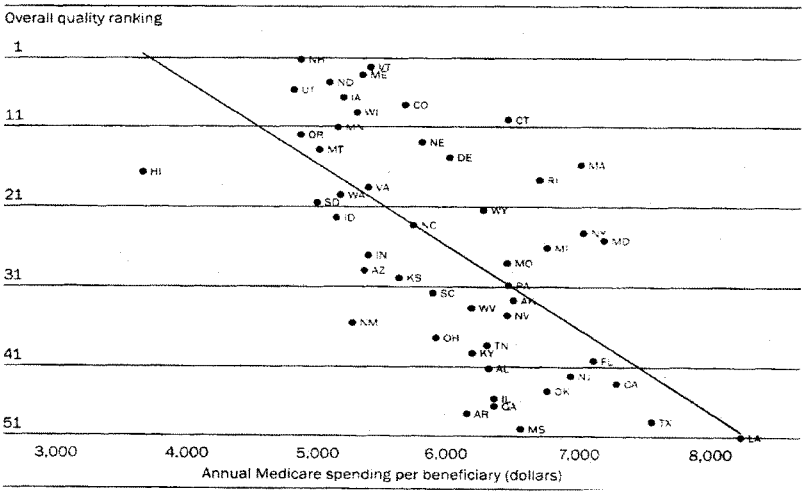
SOURCE: John E. Wennberg et al., *Dartmouth Atlas of Health Care 1999*, AHA Press, 1999: Chapter 1,Table, pp. 33-40.

Furthermore, a paper published in *Health Affairs* in 2004 by Katherine Baicker (now on President Bush's Council of Economic Advisors) and Amithab Chandra suggests a *negative* correlation between spending per Medicare beneficiary and the quality of health care processes. These authors' explanation for this perplexing result is that high-spending states tend to neglect the role of primary care in favor of specialty care, which generally leads to more expensive treatment patterns but less cost-effective, timely or appropriate care. Exhibit 1 from their paper is reproduced on the next page.

More recent work by Wennberg and associates at Dartmouth University has concentrated on Medicare spending per beneficiary during the last two years and the last six months of these beneficiaries' lives. The authors find vast variations in Medicare spending per beneficiary in their last two years of life not only across the United States, but even within states. Table 1 below illustrates such data for the State of New Jersey alone. Figure 9 exhibits similar data for patients in hospital market areas within Los Angeles.

Using the U.S. average as a benchmark and setting it equal to 1, Table 1 shows that Medicare beneficiaries in their last two years of life residing in hospital market area A in New Jersey cost tax payers 3.21 times the national average for inpatient care, while in New Jersey's hospital market area J similar patients cost taxpayers only 1.11 times the national average. Although the data in Table 1 may not be fully adjusted for differences in the morbidity of patients, it is hard to believe that morbidity alone can explain this vast difference in hospital utilization. A more plausible explanation is that these differences reflect differences in the practice style preferred by physicians in the various hospital market areas – differences that may reflect either differences in professional opinion or differences in professional profit-seeking.

EXHIBIT 1
Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001



SOURCE: Katherine Baicker and Amitabh Chandra, *Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care, Health Affairs* Web Exclusive, April 7, 2004

Table 1 -- Medicare Payments for Inpatient Care During the Last Two Years of Life of Medicare Beneficiaries
(Ratio of New Jersey Hospital's Data to Comparable U.S. Average, 1999-2003)

	Inpatient reimbursements	Hospital Days	Reimbursement per Day	CMS Technical Quality Score
HOSPITAL A	**3.21**	**2.34**	**1.37**	**0.91**
HOSPITAL B	**2.32**	**1.26**	**1.83**	**0.95**
HOSPITAL C	**1.86**	**1.85**	**1.01**	**0.81**
HOSPITAL D	**1.83**	**1.83**	**1**	**0.59**
HOSPITAL E	**1.75**	**1.72**	**1.02**	**0.74**
HOSPITAL F	**1.58**	**1.86**	**0.85**	**0.83**
HOSPITAL G	**1.27**	**1.36**	**0.94**	**0.90**
HOSPITAL H	**1.17**	**1.26**	**0.93**	**0.94**
HOSPITAL J	**1.11**	**1.12**	**0.97**	**0.89**

Source: Data supplied to the Commission by John H. Wennberg, M.D., Director of the Dartmouth Atlas Project, December 2006.

Wennberg and other health services researchers have for over a decade and a half apprized members of Congress and their staff to these variations in health care utilization and spending under the Medicare program. Remarkably, Congress has never shown any interest in enquiring what difference these enormous variations in health-care utilization and health spending make to the quality of care or life of patients. Alternatively put, Congress has never justified to taxpayers why they must spend twice as much or more per Medicare beneficiary in some states than for similar beneficiaries in other states.

In fact, the total amount of funding Congress allocates to the operations research (health services research) has always been paltry – much less than ½% of total Medicare health spending. Few enterprises could function efficiently with so paltry an allocation of operations research. The neglect of operations research for health care can fairly be called penny wise and pound foolish.

The upshot of this discussion for a hearing on the VA health system is that there is much evidence of inefficiency in the U.S. health system in general and that the VA health system may not be free of sin in this regard either. In this regard, however, it is reassuring that the VA now is endowed with a world-class electronic information infrastructure (IT), and that it in recent years has been found to attain significantly higher quality standards than have been attained in the rest of the U.S. health system.

Congress should encourage the VA in its campaign to root out whatever waste remains in its system and to strive for the highest quality attainable in the care it renders. Congress can do its part by making sure the VA's health services research and IT operation, and its management in general, are adequately funded for the remaining task at hand.

VI. CONCLUDING OBSERVATIONS

The central focus of my testimony has been the future "sustainability" of current spending trends in the VA health system. My overarching conclusion is that "sustainability" really is not the issue. Rather, it is cost-effectiveness, and in that regard the VA health system is likely to be the leader among the various segments of the U.S. health system.

It was shown above that the VA health system, large as it is, nevertheless imposes only a modest burden on the federal budget and an even more modest one on the nation's GDP. Most Americans -- and especially members of the nation's moneyed elite – view America mainly as a great source of wealth and income, rather than as something worth personal sacrifice. They rely on the few patriots and warriors among us to stand tall for this country in dangerous fields abroad. It was not always so – certainly not in WWII -- but it is so now.

Speaking now as a citizen, rather than an economist, it seems to me that the very least the rest of us who are unwilling or unable to sacrifice physically for America can do for our soldiers, Marines and sailors is to grant them an entitlement to the best health care this nation knows how to give its people. This country's highly paid corporate executives take it largely for granted that shareholders owe them fully comprehensive health care for the rest of their lives after retirement. Why ought not someone ready to die for this country be entitled to the same privilege?

To be sure, an economist always is the first to point out that resources are finite and that trade-offs must be made within our GDP and within the federal budget. If budget cuts must be made, however, targets other than the VA easily suggest themselves.

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Foremost among these targets, for example, would seem to be this nation's vast system of agricultural subsidies, which can range as high as $30 billion a year. Rare would be the economist ready to defend these subsidies, either on the ground of economic efficiency or on the basis of horizontal equity. To this economist's mind, these subsidies would be an inviting source for funding future health spending by the VA within the government's budget constraint. Yet other inviting targets come to mind.

Chairman AKAKA. Thank you very much, Dr. Reinhardt.

Dr. Kizer?

Senator ROCKEFELLER. Mr. Chairman, if Dr. Reinhardt has to leave at 10:30 to catch a 11:45 plane—how he is going to manage that, I have no idea—would it be possible to ask him a question or two, because he does have to leave.

DR. REINHARDT. Well, actually, I booked a back-up plane, so——

[Laughter.]

Senator ROCKEFELLER. OK.

DR. REINHARDT. This, to me, is more important, so I booked a back-up plane.

Senator ROCKEFELLER. Thank you.

Chairman AKAKA. Dr. Kizer?

STATEMENT OF KENNETH W. KIZER, M.D., M.P.H., CHIEF EXECUTIVE OFFICER AND CHAIRMAN OF THE BOARD, MEDSPHERE SYSTEMS CORPORATION

DR. KIZER. Chairman Akaka, Members of the Committee, good morning. Thank you for inviting me to testify before you today on the health care funding for the Department of Veterans Affairs.

Senator Rockefeller, thank you for your very kind comments. I deeply appreciate those. Any lack of expression should not be cause for concern.

At the outset of these comments, I think I should echo what others have said in different ways. In considering funding for VA health care, I think that it is worth reminding ourselves that the benefits and services provided for veterans are inherently an extended cost of maintaining the Armed Forces and one of the long-term costs of national security. Likewise, since establishing and maintaining the Armed Forces are the responsibility of the Federal Government, the Federal Government has an enduring obligation to pay for the costs of veterans. The Federal Government creates veterans and the Federal Government must pay for veterans.

In considering funding for VA health care in the near-term, I believe we should also keep in mind that based on the nature of the injuries and illnesses seen so far from veterans of Operation Enduring Freedom and Operation Iraqi Freedom—with their high incidence of Traumatic Brain Injury, multiple amputations and mental health problems—the relative costs of caring for these veterans will almost certainly exceed anything that we have ever seen before. From a veterans' health care perspective, the per capita or relative costs of caring for veterans of the War in Iraq is likely to be the most expensive of any war in history.

There are many aspects of health care funding for VA that we could discuss this morning. I would like to associate myself with many of the comments that have been made by Professor Reinhardt, both in his oral and written testimony. I think he has

done an excellent job of putting recent increased VA health care spending in context with increased spending for Medicare and health care overall. He has done an excellent job of summarizing information about the disproportionately greater spending for health care in the U.S. compared to other developed countries and the inverse relationship between Medicare per capita expenditures and the quality of care.

He has also commented, I think quite correctly, on the sustainability of both VA health care, and perhaps the more important question of whether the costs of U.S. health care overall is sustainable. I would also reaffirm his comments that substantial evidence shows that a considerable fraction of U.S. health care spending cannot be justified on the basis of either clinical outcomes or service satisfaction. Indeed, probably 25 to 30 percent of all of the health care spending in the United States is simply wasted. If even a relatively small portion of these wasted funds could be recovered, I believe there would be more than enough money to ensure that all Americans had guaranteed access to health care.

And if we might digress for one moment and talk about the VA health care experience in this regard, during the 5 years that I was Under Secretary for Health, the VA medical care budget increased a total of 6 percent. We went from $16.3 billion to $17.3 billion in a 5-year interval. During that same period of time, the number of veterans who received hands-on care increased by 24 percent. We were able to demonstrate dramatic improvements in quality as well as service satisfaction. I am *not* recommending that we continue that trend of increase, but the point there is simply that during that time, we were able to recover inefficiencies and waste, redirected those funds to taking care of more veterans and doing a better job of doing so at the same time.

I am mindful of the clock, and I would like to use my remaining time to comment on a couple of issues not addressed by Professor Reinhardt. The first of these is whether VA could achieve greater cost effectiveness with its funds without compromising quality or service satisfaction. I believe that it could. Notwithstanding the huge savings that were wrung out of the system in the latter 1990s and VA's admirable cost effectiveness today compared to Medicare and private health insurance, I think the VA should assiduously seek to achieve cost savings wherever it is reasonable to do so, and especially in those non-patient-facing areas such as the procurement of supplies and services. The VA spends many billions of dollars each year on goods and services.

The VA could achieve substantial savings almost immediately by doing two things in particular.

The first would be to do as most of the top hospitals in the Nation have been increasingly doing in recent years, and that is to start reprocessing selected medical devices that are approved for marketing in the United States as single-use medical devices. Although this might appear at first impression to be unwise, the reuse of medical devises that are labeled "for single use only" is a well-established and safe practice regulated by the FDA and utilized by most of the hospitals that are rated in America as the "best hospitals." The two major benefits of using reprocessed single-

use devices are the lower cost of the devices and the decreased amount of biomedical waste that has to be disposed of.

Currently, as a matter of policy, VA does not use reprocessed single-use devices, although the management of a number of VA hospitals would like to do so. I estimate that the VA could easily achieve savings of $25 to $30 million in Fiscal Year 2008 if it started to reprocess these single-use devices, with potentially substantially larger savings in the out years, depending on the number and types of reprocessed devices it utilized.

The second cost savings step that VA could take would be to utilize state-of-the-art technology to optimize sourcing in the procurement process in what is now generally known as expressive commerce or expressive bidding. This technology is difficult to explain in limited time, but expressive commerce and sourcing optimization, as it is known, are based on a set of highly sophisticated algorithms that allow buyers to present more of their demand at one time and that allow sellers to be more creative in their responses. This has been made possible by software that allows literally thousands of options for combinations of goods and services at different pricings and other specifications to be processed in a single bidding run.

Expressive commerce and sourcing optimization is now an established best practice in private companies such as 3M, Proctor and Gamble, Johnson and Johnson, Unilever and many other companies. It has recently been adopted by the U.S. Postal Service, where they are achieving savings of about 10 or 11 percent on their procurement. It is just starting to be used by hospitals and health care providers, including the U.K.'s National Health Service and the University of Pittsburgh Medical Center.

In private hospitals where it has been utilized to date, expressive bidding is typically achieving savings in the range of 12 to 18 percent. Based on VA's budget for medical and surgical supplies, pharmaceuticals, and other things, and factoring in their already preferred government pricing, I would anticipate the VA could achieve savings in the range of several hundred million dollars a year in the first year after starting to utilize expressive bidding, i.e., somewhere in the range of $500 million to $700 million in areas that would be not noticed by patients at all, and possibly much larger savings as experience was gained with the technology.

The last issue I would like to raise in these comments has to do with the challenges imposed upon VA health care managers by the unpredictability of the Federal budget and the increasing rigidity of the VA health care budget. A number of Members have commented on this, as well as Congressman Smith in his comments. It seems that more often than not, the Federal budget is not passed in time, forcing the government to operate under continuing resolutions, sometimes for several months into the fiscal year.

While this may be a mild inconvenience for some agencies or departments, it has definite untoward consequences for agencies like the VA that must provide life support and mission critical services 24 hours a day, 7 days a week, 365 days a year. Typically, when VA is forced to operate under a continuing resolution, it must impose hiring freezes and take other personnel options that will likely

impede the delivery of services or planned improvements in services.

I don't propose to have a solution to this at the moment, but this is something that unquestionably has deleterious effects on the delivery of services. This matter should be further investigated by this Committee.

Likewise, the increased compartmentalization of the VA health care budget in recent years into medical services, medical administration, medical facilities, and information technology, combined with the earmarking of funds in VA's central office, reduces field management's flexibility to spend on what may be the most needed priorities locally. While I think I understand the intent of the compartmentalization of VA health care funds, and I am very sympathetic to the needs and desires of VA program leadership to ensure adequate and appropriate spending for high-priority programs like prosthetics, geriatrics and mental health, the increased rigidity of the budget produced by these practices has the effect of imposing unintended artificial spending limits.

Again, I urge the Committee to look into finding mechanisms that can both ensure accountability and appropriate spending for priority VA healthcare programs but which also give local field management the flexibility to spend their limited budget on the most important needs of the veterans that they serve.

With that, let me stop, and I will be pleased to address any questions that there might be.

[The prepared statement of Dr. Kizer follows:]

PREPARED STATEMENT OF KENNETH W. KIZER, M.D., M.P.H., CHIEF EXECUTIVE OFFICER AND CHAIRMAN OF THE BOARD, MEDSPHERE SYSTEMS CORPORATION

Good morning, Mr. Chairman and Members of the Committee. Thank you for inviting me to testify before you today about healthcare funding for the Department of Veterans Affairs.

FUNDING FOR VETERANS HEALTHCARE—A LONG TERM COST OF NATIONAL SECURITY

In considering the funding of VA healthcare we should always remind ourselves that the benefits and services provided for veterans are inherently an extended cost of maintaining the Armed Forces and one of the long term costs of national security. The cost of VA healthcare is part of the price of our foreign policy.

Since establishing and maintaining the Armed Forces are the responsibility of the Federal Government, the Federal Government has an irrevocable obligation to pay for the costs of veterans. The Federal Government creates veterans, and the Federal Government must pay for the cost of veterans.

THE HIGH COST OF OEF/OIF VETERANS

In considering funding for VA healthcare in the near term I believe that we should also keep in mind that based on the nature of the injuries and illnesses seen so far among veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF)—i.e., with their high incidence of Traumatic Brain Injury, multiple amputations and mental health problems, in particular—the relative cost of caring for these veterans will almost certainly exceed anything that we have ever seen before. That is, I believe the per capita or relative cost of healthcare for OEF/OIF veterans will exceed the cost of healthcare for veterans of any prior conflict. From a veteran's healthcare perspective, the war in Iraq is likely to be the most expensive of any war to date.

Because the nature of the morbidity being experience by OEF/OIF veterans is significantly different than what has been seen in prior wars it should also be understood that projecting the costs of services for these veterans will be more difficult than projecting the costs for veterans of prior conflicts. There is much to learn about how best to care for these veterans.

During the next several years, until the VA gains more experience in caring for the types of polytrauma and mental health problems seen among OEF/OIF veterans, it should be expected that budget predictions for the cost of caring for these veterans are probably not going to be as precise as desired, and there is likely to be greater need for supplemental funding or reprogramming of funds than in prior years.

THE MANY FACETS OF VA HEALTHCARE FUNDING

In considering funding for VA healthcare, there are multiple policy and pragmatic aspects of the topic to which we could direct our attention this morning, including the adequacy of current funding; the reasons for increased spending for OEF/OIF veterans; the sustainability of recent spending trends; the ability to reliably project future spending needs; the seeming paradox of rising costs in the face of a declining veteran population; the value and cost-effectiveness of VA healthcare; and the effect of the budget appropriations process on the delivery of VA healthcare services, to name some of the issues.

Since Professor Reinhardt has done such an excellent job of putting recent increased VA healthcare spending in context with increased spending for Medicare and healthcare overall I will not further comment on that in these prepared remarks. Likewise, he has done an excellent job of summarizing information about the disproportionately greater spending for healthcare in the U.S. compared to other developed countries and the inverse relationship between Medicare per capita expenditures and quality of care.

I observed a similar inverse relationship between expenditures and quality in VA healthcare in the 1990s, and I am pleased to say that some of the changes implemented as part of the transformation of VA healthcare in the latter 1990s have resulted in VA's demonstratively greater cost-effectiveness today compared to Medicare or private indemnity insurance.

I will also defer to Professor Reinhardt's comments on the sustainability of VA healthcare funding, and the more important question of whether the cost of U.S. healthcare overall is sustainable.

I would echo Dr. Reinhardt's comments that substantial evidence shows that a considerable fraction of U.S. healthcare spending cannot be justified on the basis of clinical outcomes or service satisfaction. Indeed, probably 25 percent to 30 percent of all healthcare spending in the U.S. is wasted.

If even a relatively small portion of these wasted funds could be recovered there would be more than enough money to ensure that all Americans had guaranteed access to healthcare.

In this regard, I think it is unfortunate that Medicare and private insurers have not expended more effort to understand and learn from the changes that occurred in VA healthcare in the latter 1990s. The evidence of VA's improved performance as a result of those changes is incontrovertible.

And while I do not want to overstress the point, it may be worth pointing out that during the 5 years that I served as Under Secretary for Health in the Department of Veterans Affairs, the VA healthcare budget increased a total of 6 percent, rising from $16.3 billion in FY 1995 to $17.3 billion in FY 1999. During this time there was a 24 percent increase in the number of patients who received hands-on care, as well as dramatic improvements in the quality of care and service satisfaction. (In the preceding 5 years, VA's healthcare budget increased 41 percent, rising from $11.6 billion in FY 1990 to $16.3 billion in FY 1995, although the number of veterans served in FY 1990 was not much different than in FY 1995.)

During the same 5-year time period, non-VA healthcare spending increased well over 30 percent—an increase of more than 5 times greater than VA healthcare.

Since FY 1999, the VA healthcare budget has increased 131 percent, rising from $17.3 billion in FY 1999 to a projected $40.0 billion in FY 2008. Of course, the number of veterans using the system has essentially doubled during this time.

POTENTIAL INCREASED VA HEALTHCARE COST-EFFECTIVENESS

I would like to address a couple areas not commented upon by Professor Reinhardt.

The first of these is whether VA could achieve greater cost-effectiveness without compromising quality or service satisfaction. I believe that it could.

Notwithstanding the huge savings that were rung out of the system in the latter 1990s and VA's admirable cost-effectiveness today compared to Medicare and private health insurance, as noted by Professor Reinhardt in his testimony, I believe VA should assiduously seek to achieve cost savings wherever it is reasonable to do so, and especially in non-patient-facing ways such as in the procurement of supplies

and services. In this regard, I believe VA could achieve substantial savings almost immediately by doing two things.

The first would be to do as most of the top hospitals in the Nation have been increasingly doing and that is to start reprocessing selected medical devices that are approved for marketing in the United States as Single-use Medical Devices (SUDs). Although this might appear on first impression to be unwise, the reuse of medical devices that are labeled for "single-use only" is a well established and safe practice regulated by the FDA and utilized by many of the nation's premier medical centers. Indeed, for many years, most of the hospitals rated as America's best hospitals have been reprocessing SUDs.

Reprocessing involves taking a medical device that has been used (or sometimes only the package has been opened and the device not used), cleaning and disinfecting it, verifying that it functions properly, repackaging it, sterilizing it and returning it for use. The more commonly processed SUDs are sequential compression device (SCD) sleeves used to prevent blood clots from forming in the legs of immobile patients; orthopedic drill bits, burrs and saw blades; biopsy forceps and snares; and endoscopic or laparoscopic scissors, graspers, dissectors and clamps.

According to the FDA, about one-fourth of all hospitals and nearly half of large hospitals use reprocessed SUDs today. When these reprocessed devices are re-sold they are significantly cheaper than the original new device.

The two major benefits of using reprocessed SUDs are the lower cost of the devices and the decreased biomedical waste that must be disposed of. The latter both reduces hospital operationing costs and helps preserve landfill capacity.

Currently, as a matter of policy, VA does not use reprocessed SUDs, although the management of a number of VA hospitals would like to do so. I estimate that VA could achieve savings of $25 to $30 million in FY 2008 if it started to reprocess SUDs, with potentially significantly larger savings depending on the number and volume of reprocessed devices it ultimately utilized.

In considering reprocessing, it is important to understand that "single use" is a designation chosen by the manufacturer typically for economic reasons without consideration for the suitability of the device for reuse or reprocessing. As the GAO has noted, approval of a device as single-use simply means that the device can be safely and reliably used at least once, not that it cannot be used safely and reliably more than once. When you consider the nature of many of the items targeted for reprocessing (e.g., orthopedic drill bits and stainless steel external fixation rods) it is obvious that they should be reusable.

The second cost-savings step that VA could take would be to utilize state-of-the-art technology to optimize sourcing in the procurement process in what is generally known as expressive commerce or expressive bidding.

Expressive commerce and sourcing optimization are somewhat difficult to explain. They are sometimes confused with what is known as a reverse auction; however, sourcing optimization is not a reverse auction.

Expressive commerce and sourcing optimization are based on a set of highly sophisticated algorithms that allow buyers to present more of their demand at one time and allow sellers to be more creative in their responses. This has been made possible by software that allows literally thousands of options for combinations of goods and/or services at different pricings and other specifications to be processed in a bidding run.

While expressive bidding and sourcing optimization is an established best practice in private companies such as 3M, Proctor & Gamble and Johnson & Johnson, and it recently has been adopted by the U.S. Postal Service, it is just now starting to be used by selected hospitals and healthcare providers, including UK's National Health Service and the University of Pittsburgh Medical Center.

The potential savings associated with expressive commerce are huge because of the vast arrays of options made possible by the technology.

Private hospitals that have used expressive bidding are typically seeing savings in the range of 12 percent to 18 percent. Based on VA's budget for medical and surgical supplies, pharmaceuticals and facilities maintenance, and factoring their already preferred government pricing, I would anticipate VA could achieve savings in the range of several hundred million dollars in the first year after starting to utilize expressive bidding (i.e., $500 million to $700 million), with probably much larger savings as experience was gained with the technology.

I believe that VA should vigorously pursue the above types of cost savings strategies as rapidly as possible, and they should rigorously look for other such opportunities. Just as we should expect VA healthcare to be a leader in quality and service satisfaction, it should also be a leader in cost-effectiveness and efficiency. We should expect VA to be a leader in providing best healthcare value.

THE NEED TO MAKE THE VA HEALTHCARE BUDGET
MORE PREDICTABLE AND MORE FLEXIBLE

The last issue I would like to raise in these comments has to do with the challenges imposed upon VA healthcare managers by the unpredictability of the Federal budget and the increasing rigidity of the VA healthcare budget.

More often than not, it seems, the Federal budget is not passed on time, forcing the government to operate under a continuing resolution (CR)—sometimes for several months into the budget year. While this may be a mild inconvenience for some agencies or departments, it has definite untoward consequences for agencies like the VA that must provide critical services 24 hours a day, 7 days a week, 365 days a year.

Typically, when VA is forced to operate under a CR it must impose hiring freezes and take other personnel actions that will likely impede the delivery of services, or planned improvements in services, because it does not have its planned budget. Such forced practices often degrade services at the point of care.

While I do not have a suggested solution to this problem at the moment, I believe the unpredictability of the Federal budget process does have significant deleterious effects on the delivery of VA healthcare on the front lines and this should be further investigated by this Committee.

Likewise, the increased compartmentalization of the VA healthcare budget in recent years (i.e., into medical services, medical administration, medical facilities, and information technology accounts) and the earmarking of funds in VA's Central Office (i.e., for prosthetics, mental health, geriatrics, etc.) combine to reduces field management's flexibility to spend on what may be most needed locally.

While I think I understand the intent of the compartmentalization of VA healthcare funds, and while I am sympathetic to the needs and desires of VA program leadership to ensure adequate and appropriate spending for their high priority program areas, the increased rigidity of the budget produced by these practices has the effect of imposing unintended artificial spending limits. I would urge the Committee to look into finding mechanisms that can ensure accountability and appropriate spending for priority programs but which also give field management the flexibility to spend their limited budget on the most important needs of the veterans they serve.

That concludes my prepared testimony. I would be pleased to answer any questions that the Committee might have.

Chairman AKAKA. Thank you very much, Dr. Kizer.

As you know, Dr. Reinhardt has a time problem here, and we are trying to move it along so that we can ask Dr. Reinhardt questions, so I am going to veer from our normal procedure here and I am going to ask a question of Dr. Reinhardt and ask other Members here who have questions for him to ask that so we can let him go. We had made a deal with him that we would let him go at 10:30. I am glad to hear that he has a back-up plan.

Dr. Reinhardt, last August, you wrote a column for the *Washington Post* that was widely read entitled, "Who Is Paying For Our Patriotism?" in which you argue that the Iraq War imposes no sacrifice of any sort on well over 95 percent of the American people. Do you believe we would be here talking about finding adequate resources for VA if that figure was, let us say, 50 percent?

DR. REINHARDT. No, I don't. In fact, the article that you refer to uses a concept that is now used in health insurance, namely, "moral hazard." We have people saying, we have too much health insurance coverage. Therefore, we have to have high-deductible policies, supplemented with HSAs to make patients feel the cost their health care imposes on others. Well, if that is all true, that people who don't bear the cost of health care are reckless in their use of health care, then I would say that a political elite that can start wars but doesn't have to pay either taxes for it or bear the blood cost of it might be much too reckless into rushing into war. So that was the first point in my editorial. I sincerely believe this

moral hazard led Congress to rush us into this war without adequate preparation.

If more children of our political and moneyed elite had been in uniform, our soldiers wouldn't have been sent there without flak jackets, as ours were, without adequate equipment, without armored Humvees. People would have risen up and protested. You marginalize the problem when you make it your neighbor's problem, and then you can go happily on your way.

So I am convinced and I am on record as saying that this entire decade, the Iraq war will go down as one of the more shameful episodes of American history on account of the sacrifice it imposed on only a few Americans, while the rest of us got tax cut and went shopping. I read in the *Trenton Times* that they had a pancake bake in order to raise money for food pantries for military families. Those were National Guardsmen. And I asked my students, what nation would possibly send the wives and the husbands of people who are serving in Iraq to a food pantry essentially begging for food? That is not true in Germany. I asked German military people. When a Reservist gets called there, the employer keeps paying his or her salary and the government reimburses the employer.

Not here. These Guardsmen's and Reservists' families take huge hits on their income when the family's breadwinner is called up for combat duty. We did a survey with the Kaiser Foundation. Quite a few Guard families and Reservists are struggling financially. Is it uncouth to wonder what kind of nation have we become, that we would allow military families to struggle financially as their loved ones face bombs and bullets. That is what that editorial was about, although not, of course, my testimony this morning.

Chairman AKAKA. I may have some other questions that I will put in the record for you.

Senator Craig?

Senator CRAIG. Thank you very much, Mr. Chairman.

Dr. Reinhardt, a couple of questions. First of all, I guess when I said earlier, and I know it is frustrating for my Chairman to suggest that when we work so bipartisanly together that I felt this hearing was political. Certainly, your last statement might confirm my beliefs. That was a very political statement that I take a certain amount of disagreement with, when you make those kinds of observations, and if that is true, then it is possible that your observations from an economic and political standpoint might be prejudiced a bit by that.

But having said that, I am going to take you at face value and at the word you have said and let me ask you the following questions. I have put up a chart that I think demonstrates the reality of where we are with Federal revenues and Federal spending. It is arguable by some and a fairly broad range of economists that if you hold a historic tax rate of about 18.2, 18.5 percent GDP, that is where our economy performs at its best. And certainly I would hope you would not disagree that this economy, like almost no other, provides the greatest work opportunity, the greatest economic opportunity for individuals in the world. It is well proven. It is why we are 25 percent of the world GDP today and I am not very embarrassed by that. In fact, I am very proud of that.

But having said that, if we accept as a norm somewhere around 18 percent, 18.5 percent GDP taxed out of the economy into government and then government begins to allocate that resource back out, and that is what we do here. That is part of the job of the authorizing cmmittee. I am an appropriator. It is part of my job as an appropriator.

Then we do have to make some determination as to where we spend the money.

In your chart on page eight in your testimony, you project the spending of VA health care out for many years.

Then you show it as a percentage both of total Federal budget and the total GDP of the U.S. VA health grows from just over 1 percent of total Federal budget to about 3.5 percent 45 years from now. And then you suggest that a moral Congress can easily sustain that.

My first question is, am I correct in assuming that under the scenario you present, Congress would need to take money from other Federal programs in order to meet that increased share of the Federal budget going to VA health care if you don't assume a higher percentage of GDP coming into government for the purpose of that funding?

DR. REINHARDT. I have——

Senator CRAIG. You mentioned agriculture.

DR. REINHARDT. Permit me, Senator Craig, to respond first to your statement that my testimony might be political before coming to the economic issue you raise. Senator Akaka had asked me a specific question about an op-ed piece I had written in August of 2005, and I responded to the Senator's question about the issues raised there. I would agree that the op-ed piece and my responses on it reflect my subject, moral values, which do make such statements political. But if showing chagrin over military families under financial distress or combat soldiers and marines without adequate armor is political, then I am not ashamed for having been political on behalf of fighting men and women in that op-ed piece.

On the other hand, the economic and budgetary data I include in the statement submitted to you today are factual. The numbers come from reputable sources, and I have followed the scholar's habit of fully describing the sources of the data I present, so that anyone can audit what I present for accuracy. You need not worry about bias here.

Senator CRAIG. Well—go ahead.

DR. REINHARDT. In this particular case, there is no question that if taxes stay at the same ratio of GDP in the United States, if one takes that as a given, you are totally correct. Then there have to be very painfull trade-offs.

You raise the question, Senator, on what is the optimal tax rate for our Nation. You mentioned that 18 percent is optimal.

Senator CRAIG. No, I am not. I am suggesting that that has been the average and it has been suggested by many economists as a tax rate that keeps the economy optimized.

DR. REINHARDT. OK. Fair enough. I recently asked my Princeton colleague, Harvey Rosen, who is a tax expert, on this very issue, because I am not a tax expert, and he sent me some literature. I was astounded that actually the issue of what taxation does to eco-

nomic growth is a lot more controversial among economic experts than I would have thought. I would have actually thought higher taxes arrest growth, but it is not necessarily the case. It depends how you raise the taxes. If you have high marginal tax rates, that is known to blunt incentives. But depending on how you raise the taxes, average tax levels and economic growth may be inversely related.

Unfortunately, when a society becomes older, and particularly where so many Americans go into old age without much or any savings, you will have these old people and you must feed and care for them somehow. If you have endless wars with very seriously injured veterans on top of it, you face this problem. You either have to cut something else, and I suggest agricultural subsidies, or you must raise taxes.

Senator CRAIG. And you, like I, would agree, you make political statements and so does Congress.

DR. REINHARDT. Saying you must either cut the budget or raise taxes is not political. Saying that you might consider cutting welfare to agriculture is political, I agree with you there.

Senator CRAIG. All right.

DR. REINHARDT. I am saying, these agricultural subsidies cannot be justified on economic grounds. That is what I am saying. On grounds of horizontal equity, economists find it difficult to defend these subsidies as well. But, no, it is a purely political decision to grant these subsidies. And, of course, yes, I don't think politics is a dirty word. I think politicians are there, they were put there by God precisely to make the moral trade-offs that the rest of us are not entitled to make or don't have the power to make or don't want to have to make.

Senator CRAIG. Well, let me make one comment and move on, because time is limited, over to Dr. Kizer. Thank you for that observation.

I would make this observation, and this is part of our difficulty. If you choose agriculture, of the $47 billion spent in agriculture last year, only $8.6 billion of it went to commodities. The rest of it went to food stamps. That is a caring Nation paying for its poor to eat. So the biggest part of agriculture today are food stamps. So the $8.6 billion that went into commodities, we just increased this budget by $6 billion. So within one year's time, you eat up the commodity portion of agriculture. Then what do you do in the outyears? That becomes the obvious of the trade-offs.

So, really, politically, you have got a problem. And then you have an economic and a budget problem that is a reality that you start—you go to agriculture first. You take those away. Then where do you go the next year and the next year and the next year as you have all of these other programs, based on your observation, and I don't disagree. A caring nation is going to fund Social Security and Medicare and Medicaid. Where do we go next? We obviously go to the revenue flow. We have to go to the revenue flow to begin to justify and fund the model that you present to us or you can't get there, is my observation.

DR. REINHARDT. I think it is correct. I would predict that taxes in the United States as a percent of GDP will rise over the next 30 years. I can't see how we can avoid it. If you try to avoid it,

some very tough trade-offs will have to be made. I doubt the voters will accept such tough trade-offs.

Senator CRAIG. Well, you have been very kind with your time. Let me ask one question, if I can, Mr. Chairman, of Dr. Kizer.

Chairman AKAKA. Can you hold with that——

Senator CRAIG. I will. My time is up. Let me move back to you.

Chairman AKAKA. Senator Rockefeller?

Senator CRAIG. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Let me make one observation in defense of the good James Madison Professor. One of our problems in making policy in this country is that we have—anytime somebody disagrees with a point of view which is earnestly felt, we call it political. And as soon as we call it political, it is discarded as such. Senator Craig used that technique, I thought unkindly and inappropriately with you. If he had read the piece which you wrote, the advice which you gave to your son (who is in Iraq) do what you must, but be advised that this Nation will never truly honor your service and it will condemn you to the bottom of the economic scrap heap should you ever get seriously wounded. The intervening years have not changed my views, they have reaffirmed them.

I find myself in total agreement with that.

Senator CRAIG. Mr. Chairman, Senator Rockefeller, I did read his comments.

Senator ROCKEFELLER. Well, I am proud of you. Thank you. But you didn't take them in. In other words, it is a fact. You have made a fact. It took Dana Priest and the *Washington Post* to make this Committee and this Nation, and for the first time this Congress aware of the fact that we have been acting outrageously, in spite of what Dr. Kizer did, in terms of our veterans. That is not my question.

You quote Stiglitz and then Linda Bilmes at Harvard. They estimate that just Iraq and Afghanistan are going to end up being $2 trillion. That is what they are going to cost. What we all do around here is we talk about $500 billion, and that sets up the question that I want to ask you, because that seems like an almost unpayable amount.

We in the Finance Committee have just been through an arduous three months of almost non-stop work, to the exclusion of virtually everything else, to try and add, and now we have done it successfully in that Committee, four million more uninsured children onto the six million which had been previously uninsured but which under the Children's Health Insurance Program started in 1997 got health insurance. So we now have, in fact, about somewhere—I don't know what the percentage would be, but 22 percent of all of the people who are uninsured in this country if this bill passes who will have health insurance.

What is extraordinary about that is that it is an amazing achievement, and second, the biggest problem we had was trying to pay for it. There is even argument as yet whether we have. Why? Because just at the time that the Democrats take over the Congress, we go to a pay-go system, which condemns us to doing nothing, because we went from a $5.6 trillion surplus under President Clinton, who failed to fence in the surplus. I wanted three-quarters of this surplus spent for national reconstruction, including

universal health care system, kids zero through five and on up in education, and everything else you can think of, including homeland security and many other aspects.

I am really wondering, where do we go? Isn't this all talk? If we had to spend all that time trying to find money for four million children, totaling $35 billion, then how can we possibly be talking about making substantial improvements in health care and other subjects?

I strongly agree with you. I mean, I can remember, and this is sort of embarrassing for me to say, not to myself but perhaps to my integrity, but my father was paying 91 percent of his personal income taxes, to the Federal Government and thought that it was the right thing to do. I admire him for that and I think he was right then and I think he would feel the same way now.

Now, we have just been through an orgy because President Clinton didn't fence in that surplus, an orgy of tax cuts, the vulgarity of which I have never seen in my entire public life. It was as if the Nation was suddenly put to sleep and everybody said it was a good thing to do. One group had control of the Congress. There is not a single Democrat who ever for a period of 6 years went to a single conference Committee on any subject at any point, not one, not even in intelligence. So it was a one-party control. They ran the tax cuts through. The tax cuts are simply the most obscene thing I have ever seen. My guess is that my colleague from Montana would agree with me.

I don't know where we go on pay-go. I rail against this in caucuses and get shouted down unanimously because we have become fiscally responsible. Well, we may be fiscally responsible, but we are making it impossible to give anybody a fair shot at life or to do anything of any significance in this country. We have condemned ourself to irrelevance. I don't know where one goes other than what you talked about, the agricultural subsidies, which are, of course, sacred and which could never pass, but that is never an excuse, is it? That is just a mantra which sort of builds up on its own and becomes theological because it affects people who don't want to go home and face other folks.

I have watched our steel industry and our coal industry disappear in West Virginia and I have complained about it, but that is sort of the way life works and I regret that. But I think that you are quite right. I think we are going to have to go back to that tax system and take the vulgarity of what was done over the past 6 years and do it wisely, which I think we would be able to do, to get some revenues from that as well as some of the suggestions that you have made.

You cut down, Dr. Kizer, you said, enormous amounts of money, 30 percent or something like that of waste and inefficiency that you just mentioned. Now it is not just a question of cutting out waste or inefficiency or programs that are politically difficult to cutoff, but to go back and undo tax cuts. I will just say this because I am mad. I walk into the office of somebody on the 86th floor of some huge building in New York, who is obviously very senior, at his invitation and he gives me a very cold look, and so I decide it is not going to be a very warm meeting.

So I start off by asking him, how much money are you going to make this year? That is not usually the way I start a conversation, but that is the way I started that one. And he said, "$183 million, he said, "but I could make more if you would defer my compensation through a variety of means." And then I explained to him I represented a State where the average working family of four, their income was $26,600 and they worked and they paid taxes and they did everything that this fellow did. And I said, how do I take your situation over here and the West Virginian situation over there and then somehow stitch that together and call it either just or America? You can't do it. You simply can't do it. There is greed in this country. There is an unwillingness to face problems. There is a lack of leadership. I guess that wasn't much of a question.

[Laughter.]

Senator ROCKEFELLER. I would sort of like you to comment on it, and I apologize to Senator Tester.

DR. REINHARDT. Well, first, this famous quote, it did happen. Before our son graduated from Princeton, he announced that he was going to join the Marines. He then was 21 years old. I said to him, "Look, you are 21. It is your decision, but be advised that my experience has been—actually, Rudyard Kipling wrote about it eons ago—that soldiers are usually not well treated by their society, and don't forget, I grew up here in this country or came to this country during the Vietnam period. I was appalled by what I saw, son." That is indeed what I told him. I have always been very pro-military, ever since I was a kid in Germany learning country music from American Forces Network. My wife from Taiwan is the same. We were appalled by how Vietnam veterans were treated when they came back. And our daughter, who is now a physician, tells me many, many of the homeless, helpless old men she treats are Vietnam veterans that were neglected. So there was that memory and I warned my son about not expecting much gratitude for his service. He went into the Marines just the same.

Now, James Taranto of the *Wall Street Journal,* who has a blog there, accused me of being disrespectful to my son for making that statement. I thought it was a ridiculous statement for him to make, but I guess that hell hath no fury like a chicken hawk scorned. I suspect that Mr. Taranto is a member of that class of Americans. I had written about chicken hawks in some op-ed pieces and said I think more young people who are for this war should step up to the breach and fight and give the guys who already did three tours a break. That is what I was writing about and that, I guess, what provoked Mr. Taranto and led him to make the ridiculous statement that I do not respect my son's service.

I did not show any disrespect for my son. On the contrary, I thought my statement to him showed respect. It merely showed a certain disrespect to the people of the United States who would allow veterans going without the right care, who would allow military families to lapse into financial distress.

On these larger trade-offs that you talk about, those, I guess, will be debated in the forthcoming Presidential election, and I have very little to say about it other than the observation that the ratio of GDP going to taxes is not God-given. It is something that a body

politic chooses, and one has to respect whatever choice is made by the body politic as long as a democracy works all right.

And in that regard, Senator Craig is right. Given the reluctance to pay more taxes by the American people, you, the politicians, have a tough job to make these trade-offs, given you can't just raise the taxes. And I often sympathize very much with that. There is a fair amount of waste in health care which we know about—I alluded to it in my testimony—that maybe we should address more seriously than we have.

There may be other areas where we could be more efficient, including possibly military procurement of the weapons systems that don't work. I recall a gun being made that was so heavy that it couldn't cross a bridge in Europe.

But my testimony here basically said if you have to make trade-offs, the VA health budget ought to be last the budget you would look to cut, and if you over-budgeted it a bit in a given year, that is not what I would lose sleep over because the VA would use it smartly. The VA is one of the great trainers of young doctors. They do wonderful medical research. It is hard to think that the VA would actually waste a lot of money and you could even make sure that they don't by the management systems Ken talks about.

That was really the thrust of my remarks. If you must cut, be careful when it comes to veterans. Some of us, and I hope all Americans, have a very soft spot for them.

Chairman AKAKA. Thank you, Dr. Reinhardt.

Senator Tester for your questions for Dr. Reinhardt?

Senator TESTER. Thank you, Mr. Chairman.

When is your next plane, Dr. Reinhardt?

[Laughter.]

Senator TESTER. I appreciate your testimony, and quite honestly, I have sat on a lot of committees. This has been an interesting one today. Perspective versus political statement is interesting to me. But I appreciate your honesty and I appreciate your forthrightness in your testimony and calling it as you see it. I, too, have a problem with our kids and grandkids and great-grandkids paying for a war that we are fighting today. I particularly agree with what you mentioned in your testimony about the benefits that we give our veterans being a relatively small measure of gratitude. It, indeed, is right on the mark. And, by the way, I don't necessarily agree with everything you say. I happen to be a farmer in my real life——

[Laughter.]

Senator TESTER [continuing].—so agriculture subsidies are something that we maybe have a debate for another time.

Maybe we can get you in front of the Agriculture Committee, but I am not on that, so another issue.

But I do have a couple of questions. Twenty-seven percent of the deaths or casualties in Iraq and Afghanistan are from rural America. That is compared to only 19 percent of the United States population comes from rural America. So we are over-represented in the war, and when kids are critically injured, they go back to rural America, farms, small towns. I was wondering if there has ever been any work done, and Dr. Kizer, you might address this, too, when we get to you, to see if this really is a problem in the VA system, if it really is a problem that we have a smaller percentage

of resources than what is actually in the service as far as rural America goes and the kind of access to health care that they get and if there has ever been any work done to point this out as being a problem, or is this just something that is a statistic for statistic's sake?

DR. REINHARDT. Well, I think it has been known. There have been sundry studies of the origin, the socio-economic origin of the Armed Forces and that rural America is very heavily represented in those ranks. Part of that is tradition, that they have this very patriotic tradition. Part of it may be that the Army is a good opportunity for them. The economic opportunities in rural America are not as great as elsewhere in the economy.

As far as health care is concerned, sometimes it may cause problems if there are no VA facilities nearby, and then one has to really worry either about transportation or one has to worry about having other health care facilities who could substitute for the VA nearby.

But the other thing that is sometimes overlooked is how easy it is for families to visit wounded veterans. When our son was wounded in the Landstuhl hospital in Germany, my wife and I jumped on a plane and flew there and stayed in a nearby hotel. How easy would that be for people with lower incomes?

Senator TESTER. Right.

DR. REINHARDT. How easy is that when sometimes even with a veteran, when he is in a VA that is very, very good, how far is that for relatives to visit, and yet those visits are crucial to the healing. So it is a real problem.

We even have a problem with the active military service. The program for the TRICARE pays rates that are roughly equivalent to Medicare. Now, anywhere near a base, that doesn't cause a problem because the military has made sure that there are health care providers who serve the military. But for families of Reservists who are not near a military base, I have read and I have heard that doctors—it was in the *Wall Street Journal*, no less—that doctors sometimes refuse to take care of these families because the TRICARE fees are so low.

See, that again, whether you call it political or whatever, this would outrage a pro-military man like me. As I said before, I have been pro-military ever since I was a kid. We Germans loved those GIs. My wife and I took our own kids to American military cemeteries abroad, we stood there with them to pay our respects for these fallen ones. So when I see a military person not properly cared for in this country, I do get angry and possibly political and I don't apologize for it.

Senator TESTER. One last one, and I am about out of time, but you had mentioned in your comments to begin with that you said, and correct me if I am wrong, because I could be, in the VA budget, half goes to VA health care proper. I looked through your written and I could not find that again. Is that what you did say? And my question is, where does the other half go?

DR. REINHARDT. There are disability pensions and regular pensions, and cemetery services and there is a whole lot——

Senator TESTER. Oh, OK. I have got you. I understand.

DR. REINHARDT. I probably have it somewhere here.

Senator TESTER. That is not important. You clarified it. The part that goes to the VA health care portion of the budget, I would assume that we are getting 90 percent or higher that gets to the veterans that need the health care. In other words, the documents I have seen is that the Administration—VA is very, very good in their administrative costs. They keep it very, very low. And I just want to make sure that is still the way it is. Dr. Kizer can answer that later. Thank you very much.

Chairman AKAKA. Thank you very much.

We have used this method, Professor Reinhardt, so that you can leave to get your plane. I know that you have been planning to do that, and we will continue, then, with the questions to Dr. Kizer. I am going to limit my questions to you, Dr. Kizer, and place others in the record for you.

Thank you very much, Dr. Reinhardt.

DR. REINHARDT. And I would like to thank you for putting up with a guy like me. Free speech, I probably take it too far.

[Laughter.]

DR. REINHARDT. But I enjoy it and I——

Senator CRAIG. Dr. Reinhardt, we may disagree, but free speech is never taken too far.

DR. REINHARDT. And I want to thank you, in particular, for being very gracious with my remarks, and Senator Rockefeller for his kind remarks, my rambunctiousness over the years, I guess. And thank you, Mr. Chairman, for having me.

Chairman AKAKA. Dr. Kizer, CBO estimates that the cost of moving VA health care funding from discretionary to mandatory is roughly the amount currently being spent. What effect would this have on the overall Federal budget?

DR. KIZER. I am not sure I can answer the question that you pose. I think the real question in my mind as far as VA health care funding is three-part: Is funding adequate? Is it on time? And does it come with enough flexibility that field management can do what they need to do to serve the veterans in their communities?

Chairman AKAKA. Thank you. Dr. Kizer, when you were Under Secretary for Health, you developed many relationships. In this particular case, let me ask this.

How was your relationship with OMB? How strong was the pressure to limit annual budget requests?

DR. KIZER. How does one answer that? OMB has a perspective and important role. I was fortunate, I think, in that our program budget person was understanding of our needs and actually we cut a deal that historically had not been possible. I am referring to Nancy Ann Min, who very much understood what we were trying to do in VA and allowed us to retain the savings that we were able to achieve. Historically, OMB had not agreed to this. Nancy did some other things that made the job a little bit easier.

Now, obviously, not everyone in OMB agreed with her perspective, and we had some spirited discussions—and we didn't always come out on the top side of those discussions. But this is a government of checks and balances, and the Congress has its role in the appropriations process as does OMB and in the end, you hope that the—in this case, the Department of Veterans Affairs gets what is needed to serve the needs of the veterans.

Chairman AKAKA. Dr. Kizer, recent VA budgets have proposed substantial savings from what VA refers to as management efficiencies. GAO has found that there is no methodological justification for the figures put forward under this term. As one who is credited with making VA more efficient, what is your view of these efficiencies and of using them to justify a lower budget request?

DR. KIZER. Well, "management efficiencies" is one of those terms that means a lot of things to different people. Most often, I think, it means that you don't know where the hell you are going to get the money from but you need to reduce your appropriation request that is going to the Congress.

And in other cases, it means there are actually known savings that can be achieved. In my comments, I highlighted two areas where I think the VA could achieve real savings in things that they are not doing now, and some of that is simply because of new technology that has only recently become available. I don't know about all of the management efficiencies that they are referring to, but I think we are all aware of the budget process and the give and take that is involved in that process between the respective parts of government.

Chairman AKAKA. I have other questions I will place in the record for you. Senator Craig?

Senator CRAIG. Well, thank you very much, Mr. Chairman, and I will be brief. I have many one question, one follow-up, and I, too, want to recognize the phenomenal work that Dr. Kizer has done in VA over the years and what he produced as a result of it. And I think your testimony in general has been imminently fair to the reality of where we are and what we try to do for our veterans.

Let me ask you this question. You talk about efficiencies in health care based on technological changes, and that is valid and it often times comes to pass. And then you can go to Dr. Reinhardt's chart that shows, if you will, probably the greatest efficiencies may be occurring as a result of your leadership in VA compared to the private sector, where I won't argue that there is unlimited funding, but there is certainly no pressure in part against cost increases, or less pressure.

When you talk about how the VA budget for health care rose only 6 percent total during your time and the fiscal pressures you had to deal with to produce what you did, could you have produced the efficiencies you did and the quality of health care you produced had you not had the fiscal pressures on you?

DR. KIZER. I think that is an interesting academic question. The reality is that I did have those pressures and that is what we had to deal with and the outcome is as it is. And frankly, I think the fiscal pressure certainly helped adjust attitudes and sometimes get people to the same page or the same place in their thinking so that we could advance some of the new ideas and newer concepts that were introduced at that time that previously were impossible, and I think that that is not unlike in many other situations where new fiscal realities or other new realities force one to change their thinking.

Certainly, and I am changing gears a little bit, technology should be looked to for where it can save funds, but on the other hand, we should be mindful that technology is also going to drive costs

up dramatically. Just to give you a couple of examples, during my tenure at VA, the protease inhibitors came out and suddenly our pharmacy budget increased by hundreds of millions of dollars overnight. Likewise with Hepatitis C and interferon and treatment for that. Again, hundreds of millions of dollars suddenly was added to the pharmacy budget, and this is going to continue the trend.

If you look at the technology coming down the pipeline in health care overall, there are just dramatic things that are going to be possible to do to improve people's lives and improve their functioning. All of those things are going to come with a cost. So I think that recognizing that we continuously have to be mindful of the need to be looking for opportunities to save dollars and to make the system more cost effective wherever possible, and particularly in areas that don't or are non-patient-facing, those areas that the patient doesn't necessarily see and doesn't affect service satisfaction or the quality of care.

Senator CRAIG. Well, I appreciate that comment because I think that is a fair judgment.

Last question, we are falling into the habit, whether it is for political purposes or for high-profile issues, beginning to earmark certain health care funds flowing through to the VA. Is that good business? It may be politically good for us here. Will it result in good administrative work or the ability to spread money and get where you need to get with health care delivery at the VA?

DR. KIZER. Well, I think that is a really important question that you ask and I have to put on my epidemiology hat, I guess, for you, on the one hand and on the other hand, because certainly from a VA headquarters perspective, I think earmarking funds makes a lot of sense, and certainly as one sits down the street on Vermont Avenue and you are looking at your needs, whether they be mental health, historically a very underserved area and where we haven't given appropriate resources, it might make sense to earmark that and make sure that those monies are going for behavioral or mental health problems, or whether it is geriatrics or whether it is prosthetics. There are multiple areas where you might want to do that.

However, if you happen to be in Twin Falls or someplace where the needs of the veterans in that community are different and you don't have the ability or the flexibility to go back and forth, then it becomes very difficult for management in the real world and on the front lines of health care to do what they need to do to provide service to the veterans in that community.

So I think this is a real challenge for the VA in assuring both the appropriateness and the accountability of dollars go to those high-priority areas, but at the same time you don't want to hamstring your management so that they then can't pay for the services that may be needed on Maui or some other local community that just has a different patient mix that has different priority needs.

Senator CRAIG. Thank you. Thank you for that observation, Doctor. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Craig.

I want to thank you so much for your statement today and also for your responses, Dr. Kizer. Your responses have been valuable to us. Thank you very much.

DR. KIZER. Thank you for the opportunity to be here today. Good luck.

Chairman AKAKA. Thank you.

At this time, I would like to welcome our second panel. Joe Violante is the National Legislative Director for the Disabled American Veterans, and Joe, you have been here many times before. Again, I want to welcome you back.

And also, J. David Cox is the National Secretary and Treasurer of the American Federation of Government Employees and has 18 years of experience representing VA staff in the field. I look forward to hearing his perspective on the effects of Washington budget struggles and VA at the ground level.

Thank you again, both of you, for being here and for being patient. Your full statements will appear in the record of the hearing.

Mr. Violante, will you please begin with your statement.

STATEMENT OF JOE VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS, ON BEHALF OF THE PARTNERSHIP FOR VETERANS HEALTH CARE BUDGET REFORM

Mr. VIOLANTE. Mr. Chairman and Members of the Committee, thank you for this opportunity to testify on the funding system for the Department of Veterans Affairs health care system. I am testifying on behalf of the Partnership for Veterans Health Care Budget Reform, made up of nine national veterans service organizations.

First, I want to thank you, Chairman Akaka and Ranking Member Craig, for holding this critical and historical hearing. Fourteen years ago, the original Partnership for Veterans Health Reform was established. In the early 1990s, as eligibility reform was being discussed, we urged Congress to also reform VA's discretionary budgeting system. Today, we remain unified in this position. We are equally unified that the VA health care system needs to be protected and sustained for the millions of veterans who depend on it as their only health care provider and will do so for many decades to come.

The Partnership acknowledges and applauds the support of this Committee and your Appropriations Committee colleagues for funding increases in recent years, including this year's likely increase of $6 billion. However, with the August recess looming and the new fiscal year starting October 1, we see a strong possibility that VA's regular appropriations for 2008 will be late again, as it has been for 12 of the past 13 years.

To resolve our concern, Congress must not only provide yearly appropriations that are sufficient to meet known needs, but those funds must arrive on time and be provided in a predictable manner. These are our three principles for funding reform: Sufficiency, timeliness, and predictability, and I believe those are the same elements that Dr. Kizer mentioned.

Without reform, we see no prospect for improvement in the current budget structure. Inadequate submissions from Presidents of both parties, proposals for new fees, copayments, and management

efficiencies, annual continuing resolutions, offsets and across-the-board cuts, supplementals, and even dire emergency appropriations provided late in the year, all of these anomalies have become so regular that they are now normal and expected activities each year. Aside from an insufficient level of funding, today's budget process itself has basically paralyzed VA officials from more properly managing, planning, and operating the VA system.

Not knowing when or what level of funding they will receive from year to year or how Congress would deal with policy proposals directly affecting the budget severely impairs their ability to recruit and retain staff and conduct planning and administrative matters across a wide path of necessary and even routine matters. We ask, is there an American business today that could operate and remain viable if it had to operate under these same conditions year after year?

Mr. Chairman, there is much at stake. A young American wounded today, particularly one with severe injuries such as limb loss, blindness, or Traumatic Brain Injury, must be able to rely on the VA health care system for decades. The goal of the Partnership is for Congress to enact a long-term funding solution that guarantees all enrolled veterans will have a dependable VA health care system, and not just today while the war is in the news, but far in the future when the headlines of these wars have faded from our national memory.

Opponents of this reform have made a number of charges. Specifically, that it would create a new entitlement, that too many new veterans would rush in to enroll, that Congress would lose its oversight power, that it would cost too much. The Partnership rejects these skeptics. Shifting VA health care to a mandatory status would not create an individual entitlement for veterans, nor would it change the current health benefit package. Most veterans today have private health insurance and would not seek VA care merely because of a change in the funding mechanism. Congress would retain all oversight authority. What the shift would do is remove politics from determining the budget for VA health care.

Most importantly, the Partnership rejects the argument that it would cost too much. Our proposal is designed to ensure that sufficient funding is made available to provide health care services to veterans whom VA enrolls, no more, no less. Funding VA health care is a continuing cost of national defense.

Mr. Chairman and Members of the Committee, the Partnership looks to this Committee for leadership. In your forthcoming Fiscal Year 2009 Views amd Estimates to the Budget Committee, we ask that you inform them of this Committee's intention to report legislation creating a mandatory and guaranteed funding system for VA health care to become effective in 2009. We ask that you recommend that the Budget Committee reserve sufficient funds to make that change.

If the Committee chooses a different method than offered in H.R. 2514 or a future Senate companion bill, the Partnership will study that proposal to determine whether it meets our three key standards for reform: Sufficiency, timeliness, and predictability. If that alternative measure meets our standards, the Partnership will sup-

port it with a great deal of enthusiasm and appreciation. If it does not, we will tell you why not.

The time for change is now. Please stand up for veterans, and thank you for holding this critical and long-awaited hearing. I will be pleased to answer your questions.

[The prepared statement of Mr. Violante follows:]

Chairman AKAKA. Thank you very much, Mr. Violante.

PREPARED STATEMENT OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS, ON BEHALF OF THE PARTNERSHIP FOR VETERANS HEALTH CARE BUDGET REFORM

Mr. Chairman and Members of the Committee:

We appreciate the opportunity to testify today about the funding process for the Department of Veterans Affairs (VA) health care system. I am testifying not only on behalf of Disabled American Veterans (DAV), but also the eight other national veterans service organizations along with DAV that make up the Partnership for Veterans Health Care Budget Reform (hereinafter, the Partnership): The American Legion; AMVETS; Blinded Veterans Association; Jewish War Veterans of the USA; Military Order of Purple Heart of the U.S.A.; Paralyzed Veterans of America; Veterans of Foreign Wars of the United States; and, Vietnam Veterans of America.

I would like to begin by thanking Chairman Akaka and Ranking Member Craig for holding this critical, and even historic, hearing. For more than a decade the Partnership has urged Congress to address and reform the basic discretionary appropriations system of funding VA health care. The VA health care system must be protected for millions of veterans who depend on it now as their only health care resource and will do so for many decades. This hearing is a key moment for Congress. There is an opportunity to create an enduring legacy of commitment to the long-term viability of the health care system dedicated to meeting the unique needs of our Nation's veterans.

While we have waited a long time for today's hearing, the Partnership acknowledges and applauds the support of this Committee and your Appropriations Committee colleagues who have elevated VA discretionary health care funding over the past several budget cycles and in particular this year's prospective increase of $6 billion in additional health care funding. Nevertheless, I hope to make clear to the Committee why funding problems persist and how Congress can solve this issue by enacting a reform that results in sufficiency, predictability and timeliness of VA health care funding.

Each year the President proposes a prospective budget and accompanying policies for the Federal Government. Based on the Views and Estimates reports from authorizing committees, including this Committee in the case of Budget Function 700, Veterans Benefits and Services, the Budget Committees create a Concurrent Resolution as a blueprint to execute that budget. The Appropriations Committees allocate funds to carry out the purposes of that budget, guided by the Concurrent Resolution. The whole Congress and the President underwrite this system. Executive Branch agencies carry out policies approved by Congress by spending the funds Congress appropriates for those purposes, approved through that process. It is intended to be a balanced system, but for a variety of reasons that we will discuss in our testimony today, it does not work in the case of veterans health care.

No matter how accurate and precise the formulation methodology for the budget may be, the budget process itself impacts the appropriateness of the final resource outcome. For example, although the budget process is designed to accommodate multiple reviews and approvals it is often too cumbersome and long requiring seven review levels (the Veterans Health Administration; VA; the Office of Management and Budget; Congressional Authorizing Committees (House and Senate) and Congressional Appropriations Committees (House and Senate); and 21 months (at a minimum) from initial formulation to the beginning of the budgeted fiscal year. The resultant budget, after multiple tactical adjustments, often lacks a clear strategic direction. Updates in estimates (during the 21-month span) are not encouraged after review officials lock-in to their approved levels. Review adjustments often lack precise calculations. Finally, the resultant budget is subject to delays in appropriations enactment often unrelated to veteran policy issues.

All veterans' programs, including its health care system, are dependent upon sufficient funding for the benefits and services provided by Congressional authorization. If Congress awards a benefit to veterans, that benefit or service should be appropriately funded by Congress. Finally, a level of funding should be provided to

guarantee that benefits or services are actually available to a veteran in need. Unfortunately, the VA discretionary appropriations process often fails against that standard.

VA has been unable to manage or plan the delivery of care as effectively as it could have, as a result of perennially inadequate budget submissions from Presidents of both political parties; annual Continuing Resolutions in lieu of approved appropriations; late arriving final appropriations; offsets and across-the-board reductions; plus the injection of supplemental and even "emergency supplemental" appropriations to fill gaps. We challenge this Comm ittee to identify an American business that could operate successfully and remain viable if, in 12 of 13 consecutive years, it had no advance confidence about the level of its projected revenues or the resources it needed to bring a product or service to market, no ability to plan beyond the immediate needs of the institution day-to-day, and no freedom to operate on the basis of known or expected need in the future. In fact, this has been the situation in VA, with 12 out of 13 fiscal years beginning with Continuing Resolutions, creating a number of challenging conditions that are preventable and avoidable with basic reforms in funding. We believe that no commercial business in America could have withstood the degree of financial insecurity and instability VA has endured over a decade. The Partnership believes this situation needn't exist, and that Congress can make vast improvements with funding reform legislation.

The Partnership is especially concerned about maintaining a stable and viable health care system to meet the unique medical needs of our Nation's veterans now and in the future. The wars in Iraq and Afghanistan are producing a new generation of wounded, sick and disabled veterans, and some severe types at a poly trauma level never seen before in warfare. A young American wounded in Central Asia today with brain injury, limb loss, or blindness will need the VA health care system for the remainder of their lives. The goal of the Partnership is to see a long-term solution formed for funding VA health care to guarantee these veterans will have a dependable system for the foreseeable future, not simply next year. Reformation of the whole funding system is essential so Federal funds can be secured on a timely basis, allowing VA to manage the delivery of care, and to plan effectively to meet known and predictable needs. In our judgment a change is warranted and long overdue. To establish a stable and viable health care system, any reform must include suficiency, predictability, and timeliness of VA health care funding.

In past Congresses we have worked with both Veterans' Affairs Committees to craft legislation that we believe would solve this problem if enacted. The current version of that bill is a House measure, the Assured Funding for Veterans Health Care Act, H.R. 2514, introduced on May 24, 2007, by Representative Phil Hare of Illinois with 77 original cosponsors and the Partnership's full endorsement. We note for the record that no Senate companion measure has been introduced in this Congress due to the illness of the expected chief sponsor, Senator Tim Johnson of South Dakota, a Member of this Committee. A number of public criticisms have been made of this bill and its predecessors, and I will address those concerns later in this statement. Suffice it to say that the Partnership believes even if each of those assertions about the bill were literally true, veterans still would have an improved funding system were that bill enacted than the one they have today under the current discretionary appropriations system.

We ask the Committee to consider all the actions Congress has had to take over only the past three years to find and appropriate "extra" funding to fill gaps left from the normal appropriations system. Please also consider the Administration's efforts to explain to Congress why VA was shortchanged by billions of dollars each year. These admissions were often very reluctantly made. In one case, the President was reduced to formally requesting two budget amendments from Congress within only a few days of each other.

Some Members have opposed mandatory funding because it would cost too much; however, the recent Congressional Research Service report to Congress detailing the running expenditures for the Global War on Terror since September 11, 2001, revealed that veterans affairs-related spending constitutes 1 percent of the government's total expenditure. Without question, there is a high cost for war and caring for our Nation's sick and disabled veterans is part of that continued cost. A report by a researcher at Harvard's Kennedy School predicted that Federal outlays for veterans of the wars in Afghanistan and Iraq will arc between $350 billion and $700 billion over their life expectancies following military service an amount in addition to what the Nation already spends for previous generations of veterans. Thus, it is clear the government will be spending vast sums in the future to care for veterans, to compensate them for their service and sacrifice, but these funds will still only constitute a minute fraction of total homeland security and war spending. We believe funding VA health care is a cost of defense and war no less important than

the weapons systems Congress authorizes in direct prosecution of the Nation's defense.

From this hearing, after considering the testimony of witnesses and based thereon, we ask the Committee, in your FY 2009 Views and Estimates to the Budget Committee that you inform them of your intention to report legislation creating a mandatory and guaranteed funding system for VA health care in 2009, and that you recommend that they reserve sufficient funds to make that seminal change. If the Committee chooses a different method than offered in H.R. 2514 or a future Senate companion bill that is similar, we will examine that proposal to determine whether it meets our three essential standards for reform: suficiency, predictability, and timeliness of funding for VA health care. If that alternative fully meets those standards, our organizations will enthusiastically support it.

HISTORICAL PERSPECTIVE AND FURTHER JUSTIFICATION FOR REFORM

In 1996, Congress passed the Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104–262, which changed eligibility requirements and the way health care was provided to veterans. Greater numbers of veterans became eligible for health care benefits as a result of this Act. As P.L. 104–262 was moving through Congress, Dr. Kenneth W. Kizer, the then-Under Secretary of Health of the Veterans Heath Administration (VHA), submitted a major administrative reorganization plan to Congress under Title 38 United States Code, Chapter 5, Section 510(b). Since Congress expressed no disapproval of this proposal, this plan created 22 Veterans Integrated Service Networks (VISNs)[1] to replace the VA's four regional management divisions.

The decentralization of operations was seen as essential to prepare VA to function more effectively in manageable and integrated delivery networks networks that would be more patient-centric and would rely on primary and preventive care rather than more intensive modes. Accentuated by authorities provided by P.L. 104–262, the VA health care system thereabout underwent significant reforms from an episodic and bed-reliant system of care to one in which veterans were enrolled and could expect continuity of care and health maintenance, including preventive services. The shift in focus from medical intervention in diseases afflicting veterans, to primary care to maintain their health, reflected a broader trend co-occurring in America's private health care sector. The shift allowed VA to close thousands of unnecessary hospital beds while establishing new facilities called Community Based Outpatient Clinics (CBOCs) to provide more veterans more convenient access to care.

With encouragement from many Members of Congress as well as your Committee and national veterans service organizations, the VISNs outreached to veterans to enroll in a reformed VA health care system. As a result millions of veterans enrolled in VA health care for the first time in their lives. A decade later, VA health care is a remarkable success story of how to transform a troubled and overburdened system into a state-of-the-art provider. Harvard University's School of Public Health and the National Quality Research Center at the University of Michigan have both scored VA at the very top of American health care systems in terms of patient safety and medical outcomes. Mainstream publications, including *Time, Newsweek, US News and World Report, Business Week, The Wall Street Journal, New York Times, Washington Post, Fortune*, and the *Washington Monthly*, have all written major stories detailing VA's transformation over the past decade. Their investigations have confirmed that VA today is the highest quality, lowest cost health care system in the Nation.

While Congress intended veterans to be able to secure an improved continuum of care, P.L. 104–262 underscored that VA health care operations would still be dependent upon appropriated resources.[2] As early as 1993, the Partnership urged Congress to "guarantee" funding for VA health care if Congress decided to reform eligibility for that care. Unlike other health care benefits available to non-VA beneficiaries, this VA benefit is not "guaranteed." This has probably been the single most significant problem for VA during the past decade and the reason we appear here today. In sum, as a result of eligibility reform veterans have been rewarded with a more integrated VA health care system, a more comprehensive health care benefit and high quality, safe health care services. However, gaining and keeping access to that system is a continuing dilemma due to the uncertainty of duration of an indi-

[1] The creation of the new VISNs began in 1995 in anticipation of the passage of the Act.

[2] "the extent and in the amount provided in advance in appropriations Acts for these purposes. Such language is intended to clarify that these services would continue to depend upon discretionary appropriations." Taken from the Committee Report (H. Report 104–690) of the P.L. 104–262.)

vidual's enrollment, VA's hobbled planning from lack of secured and predictable funding; budgetary gimmicks employed by VA and Office of Management and Budget (OMB) officials. Additionally, because of the Administration's policies, VA is constrained from publicly stating their true funding requirements.

Most importantly, eligibility reform eliminated fragmented care provisions in the statute and enabled VA to appropriately streamline care for its veteran patients. It eliminated a tangled web of rules and internal VA policies that made individual health care eligibility decisions bureaucratic, complicated, confusing, and harmful to the health of veterans who depended on VA to meet their needs. Reforming eligibility corrected the artificial inefficiencies of the system, allowed it to treat more veterans, and enabled it to preserve the system, primarily for service-connected veterans, low income veterans and veterans with special needs. We believe that goal was, and still is, a sound one. Without question VA's success has led to unprecedented growth in the system but we disagree with some who allege that eligibility reform created "the current funding problem" by enticing too many veterans to enroll. In our judgment the problem is not eligibility reform, but inadequate funding through the discretionary appropriations process.

PRESSURE BUILDS ON THE SYSTEM

In 2002, VA placed a moratorium on its facilities' marketing and outreach activities to veterans and determined there was a need to give the most severely service-connected disabled veterans a priority for care. This was necessitated by VA's realization that demand was seriously outpacing available funding and other resources, and service-connected veterans were being pushed aside as VA's highest priority. On January 17, 2003, the Secretary announced a "temporary" exclusion from enrollment of veterans whose income exceeds geographically determined thresholds and who were not enrolled before that date. This directive denied health care access to 164,000 so-called "Priority Group 8" (PG8) veterans in the first year alone following that decision. To date, over one million veterans have been denied access to VA health care under that policy. The then-Ranking Member of the House Veterans' Affairs Committee was correct when, in response to the Secretary's decision to restrict enrollments of these veterans he stated, "The problem isn't that veterans are seeking health care from their health care system it's that the Federal Government is not making the resources available to address their needs." We agree.

Mr. Chairman, the decision to exclude PG8 veterans from VA health care enrollment at the beginning of 2003 also must be taken into historical context. While VA was in the midst of unprecedented systemic—even revolutionary—change, Congress passed the Balanced Budget Act (BBA) of 1997, Public Law 105–33. That Act was intended to flatline domestic discretionary Federal spending, across the board, including funding for VA health care. As the effects of the BBA took hold during the 3-year life of that law, VA's financial situation shifted from challenging to that of crisis. In 2000, at the urgings of both this Committee and your House counterpart, Congress relented and provided VA health care a supplemental appropriation of $1.7 billion. Nevertheless, a 3-year funding drought built up conditions that could not easily be surmounted by one infusion of new funding. VA began queuing new veteran enrollees, the waiting list lengthened and rationing of care was commonly reported. Eventually, by 2002, the list of veterans waiting more than 6 months for their first primary care appointment inched toward 300,000 nationwide. Given an Administration that would not permit additional funding to stem the waiting list buildup, then-VA Secretary Principi, using the policy available to him, closed new enrollments of PG8 veterans and set about a plan to get the waiting list under control.

Another consideration important to this discussion is that the BBA also authorized a ten-site "Medicare subvention" demonstration project within the Department of Defense (DOD) health care system as a precursor to the advent of Medicare subvention in VA. This program eventually failed in DOD and, later known as "VA+Choice Medicare" and later still, "VAAdvantage," never got off the ground due to opposition from the Office of Management and Budget (OMB) and the Department of Health and Human Services. This failure meant that no Medicare funds would ever be received by VA for the care it had been providing (and is still providing) to fully Medicare-eligible veterans receiving care as enrolled VA patients, at a huge cost avoidance savings to the Medicare trust fund. At least 55 percent of VA's enrolled population is concurrently eligible for Medicare coverage. Many PG8 veterans, in and out of VA, would be Medicare eligible as well.

PRESIDENT'S TASK FORCE

An additional perspective to consider with respect to addressing funding reform is that of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). Dr. Gail Wilensky, Co-Chair of that task force, testified before the House Committee on Veterans' Affairs on March 26, 2003, two months following the exclusion of PG8 veterans from VA enrollment. She stated:

> As I noted earlier, as the Task Force addressed issues set out directly in our charge, we invariably kept coming up against concerns relating to the current situation in VA in which there is such a mismatch between the demand for VA services and the funding available to meet that demand. It was clear to us that, although there has been a historical gap between demand for VA care and the funding available in any given year to meet that demand, the current mismatch is far greater, for a variety of reasons, and its impact potentially far more detrimental, both to VA's ability to furnish high quality care and to the support that the system needs from those it serves and their elected representatives.
>
> The PTF members were very concerned about this situation, both because of its direct impact on VA care as well on how it impacted overall collaboration [with DOD]. Our discussion on the mismatch issue stretched over many months and, as anyone following the work of the Task Forces already knows, it was the area of the greatest diference of opinion among the members.
>
> Although we did not reach agreement on one issue in the mismatch area—that is, the status of veterans in Category 8, those veterans with no service-connected conditions with incomes above the geographically adjusted means test threshold—we were unanimous as to what should be the situation for veterans in Categories 1 through 7, those veterans with service-connected conditions or with incomes below the income threshold.

While the Partnership supports opening the system to new PG8 veterans who need care, we must surmise based on the above historical recounting and our analysis that the readmission of PG8 veterans to VA, absent a major reformation of VA's funding system, could stimulate and trigger a new funding crisis in VA health care. While Congress is poised to add a significant new discretionary funding increase to VA medical accounts for FY 2008—one that we deeply appreciate—we are uncertain that even that generous increase will be sufficient to offset all of VA's financial shortfalls. Also, it should be pointed out that the needs of re-admitted veterans would be challenging for VA's human resources and capital programs. We are concerned whether sufficient health professional manpower could be recruited to enable VA to put them into place in an orderly fashion to meet this new demand. Also, VA's physical space may be insufficient to accommodate the new outpatient visits that PG8 patients would likely generate. These practical problems are but additional proof that funding reform should accompany readmission of PG8 veterans into the system.

The question about PG8 veterans reenrolling in VA health care is not a question only about them and their needs for health care. It is also a larger question about the sufficiency, reliability and dependability of the current system of funding VA health care through the domestic discretionary appropriations process. Until those reforms are enacted to guarantee that on October 1 of each year, VA will have a known budget in hand, will have the means and methods to spend those funds in accordance with need, and that VA's budget will be based on a stable, predictable and sufficient methodology, we are concerned about immediate readmission of PG8 veterans.

FACTS ON ASSURED FUNDING FOR VA HEALTH CARE

Mr. Chairman, in recent years we have heard a number of reasons put forward as to why converting VA health care to mandatory funding would fail, whether from the bill we recommend or through other models to achieve that purpose. We summarize those concerns here and ask the Committee to consider them and our responses.

Myths and Reality

Myth: Congress would lose oversight over the VA health care system if VA shifted from discretionary to mandatory funding.

Reality: While funding would be removed from the direct politics, uncertainties, and capriciousness of the annual budget-appropriations process, Congress would retain oversight of VA programs and health care services—as it does with other Federal mandatory programs. Guaranteed funding for VA health care would free Mem-

bers of Congress from their annual budgetary battles to provide more time for them to concentrate on oversight of VA programs and services.

Myth: Mandatory funding creates an individual entitlement to health care.

Reality: The Assured Funding for Veterans Health Care Act would shift the current funding for VA health care from discretionary appropriations to mandatory budget status. The Act makes no other changes. It does not expand eligibility for an individual veteran, make changes to the benefits package, or alter VA's mission.

Myth: Guaranteed funding would open the VA health care system to all veterans.

Reality: The Health Care Eligibility Reform Act of 1996 theoretically opened the VA health care system to all 27 million veterans; however, it was never anticipated that all veterans would seek or need VA health care. Most veterans have private health insurance and will likely never elect to use the system. The Secretary is required by law to make an annual enrollment decision based on available resources. This bill would not affect the Secretary's authority to manage enrollment, but would only ensure the Secretary has sufficient funds to treat those veterans enrolled for VA health care.

Myth: Guaranteed funding for VA health care would cost too much.

Reality: Guaranteed funding under the Act would utilize a formula based on the number of enrolled veterans multiplied by the cost per patient, with an annual adjustment for medical inflation to keep pace with costs for medical equipment, supplies, pharmaceuticals and uncontrollable costs such as energy. The Act would ensure that VA receives suficient resources to treat veterans actually using the system.

Myth: Veterans in Priority Group 7 and 8 are using up all of VA's health care resources; and it therefore costs too much to continue to treat these veterans.

Reality: Among the 7.9 million enrollees in the VA health care system, 2.4 million veterans from Priority Groups 7 and 8 account for only 30 percent of the total enrolled population but use only 11 percent of VA's expenditure for all priority groups.

Myth: The viability of the VA health care system can be maintained even if VA only treats service-connected veterans or the so- called "core group," Priority Groups 1–6.

Reality: VA health care should be maintained and priority given to treat these veterans, since many of the specialized services they need are not available in the private sector. However, to maintain VA, a proper patient case mix and a sufficient number of veterans are needed to ensure the viability of the system for its so-called core users and to preserve specialized programs, while remaining cost effective.

Myth: Providing guaranteed funding for VA health care will not solve VA's problems.

Reality: With guaranteed funding, VA can strategically plan for the short-, medium- and long-term, optimize its assets, achieve greater efficiency and realize savings. VA continues to struggle to provide timely health care services to all veterans seeking care due to insufficient funding, and always uncertain funding beyond the operational year. The guaranteed funding formula in the bill provides a standardized approach in solving the access issue and permitting more rational planning.

Myth: Veterans health care should be privatized because the system is too big, inefficient, and unresponsive to veterans.

Reality: VA patients are often elderly, have multiple disabilities, and are chronically ill. They are generally unattractive to the private sector. Also, such patients pose too great an underwriting risk for private insurers and health maintenance or preferred provider organizations. While private sector hospitals have lower administrative costs and operate with profit motives, a number of studies have shown that VA provides high quality care and is more cost-effective care than comparable private sector health care. VA provides a wide range of specialized services, including spinal cord injury and dysfunction care, blind rehabilitation, prosthetics, advanced rehabilitation, Post Traumatic Stress Disorder, mental health, and long-term care. These are at the very heart of VA's mission. Additionally, VA supplies one-third of all care provided for the chronically mentally ill, and is the largest single source of care for patients with AIDS. Without VA, millions of veterans would be forced to rely on Medicare and Medicaid at substantially greater Federal and state expense.

Myth: Under a mandatory funding program, VA would no longer have an incentive to find efficiencies and to supplement its appropriation with third-party collections.

Reality: Mandatory funding will provide sufficient resources to ensure high quality health care services when veterans need it. It is not intended to provide excess funding for veterans health care. VA Central Office (VACO) would still be responsible for ensuring local managers are using funds appropriately and efficiently. Net-

work and medical center directors and others would still be required to meet performance standards and third-party collections goals. These checks and balances will help ensure accountability.

DECISION POINT: A CALL FOR ACTION

In closing, Mr. Chairman and Members of the Committee, we ask for your leadership, support and commitment to resolve this keystone issue in veterans' affairs. Only strong leadership from the Committee can address the current workload and resource imbalance reported to the Administration and Congress in 2003 by the President's Task Force, a mismatch confirmed nearly every day since in media accounts, learned reviews and research studies that are readily available to the Committee. We urge you to guide the Department out of this unnecessary but real and continuing dilemma. We hope, as leaders on veterans' issues, the Members of this Committee will remember the needs of America's veterans and take action to remedy this serious problem.

This Committee knows best the enormous fiscal distress that VA has faced and still faces. We hope that Congress in a bipartisan manner will be willing to break the vicious cycle that has undermined the veterans' health care system. Your action on this issue will determine what level of health care is available to meet the needs of current and future generations of American veterans. We believe guaranteed funding through a mandatory formula would provide the most comprehensive solution to VA's chronic health-care funding problem. It would ensure the viability of the system. The hopes of the entire veterans' community for a more stable future were rekindled when you, Mr. Chairman, scheduled this important Committee hearing. We trust it represents the beginning of the end of these annual budget battles we all have to fight.

Mr. Chairman, attached to this statement are legislative statements or resolutions adopted by member organizations of the Partnership urging funding reform in VA health care. We hope as you debate this crucial matter the Committee will recognize that our organizations are unified in our interests in calling for budget reform.

This concludes my testimony. Again, I appreciate the opportunity to present testimony on behalf of the Partnership, and I thank the Committee for its continuing support for veterans, especially those who are sick and disabled as a result of serving the Nation.

[Attachments to Mr. Violante's prepared statement follow:]

EIGHTY-EIGHTH NATIONAL CONVENTION OF THE AMERICAN LEGION,
SALT LAKE CITY, UTAH, AUGUST 29, 30, 31, 2006

RESOLUTION NO. 254

Subject: The American Legion Policy on Assured Funding for VA Medical Care

Origin: California

Submitted by: Veterans Affairs and Rehabilitation

WHEREAS, the Department of Veterans Affairs (VA) annual budget consists of both mandatory and discretionary funding; and

WHEREAS, mandatory funding refers to a process where the level of funding is governed by formulas or criteria set forth in authorizing legislation rather than by appropriations; and

WHEREAS, under budget law, a mandatory program is one that requires provision of benefits to all who meet the eligibility requirements of the law; and

WHEREAS, mandatory funding is provided for programs such as Social Security, Medicare, and VA compensation and pension; and

WHEREAS, in contrast, discretionary funding is "all other" funding subject to the annual appropriations process; and

WHEREAS, discretionary funding in VA's current annual budget provides for programs such as medical care, major and minor construction, National Cemetery Administration, State Extended Care Facility Grants, and State Cemetery Grants; and

WHEREAS, there have been annual struggles to obtain sufficient funding to provide access to quality care for eligible veterans seeking care in VA facilities; and

WHEREAS, a method to provide dependable, stable and sustained funding for veterans health care is needed; and

WHEREAS, assured (mandated) funding is one component of a combination of funding mechanisms to ensure adequate Veterans Health Administration (VHA) funding: Now, therefore, be it

RESOLVED, By The American Legion in National Convention assembled in Salt Lake City, Utah, August 29, 30, 31, 2006, That Congress designate assured funding for VA medical care; and, be it further

RESOLVED, That Congress continue to provide discretionary funding required to fully operate other programs within the Veterans Health Administration's budgetary jurisdiction; and, be it finally

RESOLVED, That Congress provide, if necessary, supplemental appropriations for budgetary shortfalls in VHA's mandated and discretionary appropriations to meet the health care needs of America's veterans.

RESOLUTION NO. 08–01

Subject: Assured Funding for VA Health Care

Source: National Headquarters

WHEREAS, each year, veterans service organizations fight for sufficient funding for VA health care and a budget that is reflective of the rising cost of health care and increasing need for medical services; and

WHEREAS, our nation's veterans are continuing to suffer because the system they depend on has been routinely under funded; and

WHEREAS, the FY 2006 funding shortfall of more than $1 billion in health care services for sick and disabled veterans requires a long term fix; and

WHEREAS, the current discretionary funding method for veterans' heath care is broken and the needs of our nation's sick and disabled veterans are not being met; and

WHEREAS, without assured funding, VA will continue to remain under funded and unable to provide timely access to quality health care to many of our Nation's veterans; and

WHEREAS, taking VA's budget out of the discretionary budget would eliminate the year-to-year uncertainty about funding levels that have prevented VA from being able to adequately plan for and meet the constantly growing number of veterans seeking treatment: Now, therefore, be it

RESOLVED, That Congress enact legislation to make VA health care funding mandatory, thereby guaranteeing sufficient resources to cover expenses of the veterans health care system.

LEGISLATIVE DIRECTOR
AMVETS National Headquarters.

BLINDED VETERANS ASSOCIATION RESOLUTION ON MANDATORY FUNDING FOR VHA APPROVED AT OUR CONVENTION 2006

RESOLUTION NO. 60–02

WHEREAS, veterans health care is funded annually by discretionary appropriations decided by the House and Senate Appropriations Committees, AND

WHEREAS, each year the Department of Veterans Affairs fails to receive adequate funding for Veterans Medical Care from Congressional appropriations, AND

WHEREAS, this lack of adequate funding causes veterans of all categories, delays and denials of critical medical care services: Therefore be it

RESOLVED, That the Blinded Veterans Association, in convention assembled in Buffalo, NY on this 19th day of August, 2006, hereby support H.R. 515, Assured Funding for Veterans Health Care Act of 2005.

SUPPORT LEGISLATION TO MAKE DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE FUNDING MANDATORY

RESOLUTION NO. 074

WHEREAS, the funding for Department of Veterans Affairs (VA) health care under the Federal budget is a discretionary program, meaning that it is within the discretion of Congress to determine how much money it will allocate each year for veterans' medical care; and

WHEREAS, title 38, United States Code, section 1710(a), provides that the Secretary of Veterans Affairs "shall" furnish hospital care and medical services, but only to the extent Congress has provided money to cover the costs of the care; and

WHEREAS, the Disabled American Veterans firmly believes that service-connected disabled veterans have earned the right to VA medical care through their extraordinary sacrifices and service to this Nation; and

WHEREAS, the Disabled American Veterans, along with the other Independent Budget service organizations, has fought for sufficient funding for VA health care and a budget that is reflective of the rising cost of health care and increasing need for medical services; and

WHEREAS, despite our continued efforts, the cumulative effects of insufficient health care funding have now resulted in the rationing of health care; and

WHEREAS, VA reports that it has now reached capacity at many of its health care facilities; and

WHEREAS, VA is unable to provide timely access to quality health care to many of our Nation's most severely disabled service-connected veterans; and

WHEREAS, it is disingenuous for our government to promise health care to veterans but then make it unattainable because of inadequate funding; and

WHEREAS, making veterans' health care funding mandatory would ensure the government meets its obligation to provide health care to service-connected disabled veterans and ensure all veterans eligible for care in the VA health care system have access to timely quality health care; and

WHEREAS, making veterans' health care funding mandatory would eliminate the year-to-year uncertainties about funding levels that have prevented VA from being able to adequately plan for and meet the constantly growing number of veterans seeking treatment; and

WHEREAS, by including all veterans currently eligible and enrolled for care in the mandatory health care funding proposal, we protect the overall viability of the system and the specialized programs VA has developed to improve the health and well-being of our nation's service-connected disabled veterans: Now, therefore, be it

RESOLVED, That the Disabled American Veterans in National Convention assembled in Chicago, Illinois, August 12–15, 2006, supports legislation to make VA health care funding mandatory thereby guaranteeing Congress provide sufficient resources to cover the expenses of the veterans' health care program.

JEWISH WAR VETERANS RESOLUTION ON MANDATORY FUNDING

MANDATORY FUNDING

The Jewish War Veterans of the USA strongly endorses and supports the efforts of several Members of Congress to provide required funding for veterans' health needs through the introduction of H.R. 515, the Assured Funding for Veterans Health Care Act of 2005.

The Jewish War Veterans of the USA agrees in the strongest possible terms with these friends of the veterans' contention that "We can no longer allow the VA to be hostage to the administration's misplaced priorities and the follies of the Congressional budget process. This bill would place veterans' health care on par with all major Federal health care programs by determining resources bases on programmatic need rather than politics and budgetary gimmicks."

Under the current system, funding for veterans' health care is subject to reduction at any time due to political and programmatic pressures to take money earmarked for the care of those who have served the country, many on the field of battle, and divert those funds to other programs. In this way, the most deserving among us, those who have fought to defend our basic freedoms, are often denied the care which they have earned, which they have been promised, and which they deserve.

The lack of prompt access to the care they deserve and have earned is not acceptable. As the wounded come home in ever-increasing numbers from the battlefields of Iraq and Afghanistan, the problem will only worsen in the years to come. Therefore, it is imperative that all those who honor our brave fighting men and women come together to support Representative Lane Evans' bill.

It is not enough to mouth support for our current troops and those who fought the brave fight before them. We must all support mandatory funding to ensure their future needs as set out in the legislation proposed by our friends. The Jewish War Veterans of the USA urges everyone to contact his/her senators and representatives to urge their support for this bill and corresponding legislation in the Senate. Our country owes health care to our veterans who must not be dependent on the whims

of the political process to get the benefits they have earned. We must remove funding for veterans' health care from the vagaries of political maneuvering.

MILITARY ORDER OF THE PURPLE HEART

Tom Poulter, National Commander, March 29, 2007, Testimony Before the Joint Senate and House Committees on Veterans Affairs

Chairman Akaka, Chairman Filner, Members of the Committee, ladies and gentlemen.

ADEQUATE FUNDING FOR THE VA HEALTH ADMINISTRATION

The Military Order of the Purple Heart (MOPH) is on record as supporting the Independent Budget, which is developed and submitted to Congress by the Veterans of Foreign Wars (VFW), Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA) and American Veterans (AMVETS).

I am the fourth MOPH National Commander in a row to present as our number one priority Adequate/Assured funding for the VA Health Administration. MOPH joins our fellow VSOs in urging Congress to find a long-term solution to the annual funding crisis at the VA. The VA deserves a system that delivers funds on time to allow for long-term planning. With the ongoing War on Terror and our servicemembers returning home from war with medical conditions requiring treatment at VA hospitals, the VA needs the capability to meet their needs.

Demand for VA healthcare still outpaces the capacity to deliver care in a timely manner. Within the priority system established by law, Congress should appropriate sufficient funds for all veterans the VA has agreed to treat through the enrollment process. This is not happening today as more and more veterans are triaged for care on waiting lists. A Presidential Task Force (May 2003) strongly recommended full funding for all veterans enrolled in the VA health care system. Thus far, the Administration and Congress have ignored this recommendation.

Each year the VA is to receive funding for the next fiscal year by October 1 so that they may plan for personnel and programs. Over the last several years this has not occurred and the Appropriations Act has not passed until well into the fiscal year. The 2007 Appropriations Act has not passed and the VA is currently operating on a Continuing Resolution. While MOPH appreciates the fact that Congress mandated that the VA received a $3.6 billion increase in the Continuing Resolution, for which we commend Congress, this is a perfect example of why the funding of the VA health system needs to be changed.

MOPH urges Congress to pass legislation which will fully fund the VA health care system through modifications to the current budget and appropriations process, either by using a mandatory funding mechanism, or by some other changes in the process in order to achieve the desired goal of providing care to those veterans who are enrolled in the VA health care system.

On another health care note, MOPH, like the majority of Americans is appalled by the conditions that those heroes returning from the ongoing conflicts had to endure at Walter Reed Army Hospital. There is no excuse for this episode. When our country commits its military to a mission then it must be ready to see to the needs of those warriors when they return home. We must never accept less than the best health care and treatment for these men and women. MOPH will not "pile on" this issue as it seems that Congress and the Administration are trying to correct the problems. We will closely monitor the process.

ASSURED FUNDING FOR VETERANS HEALTH CARE

RESOLUTION NO. 610

WHEREAS, there must be continued and sustained investment by Congress and the Administration in the national resource of the VA health care system, including improving veterans access to timely care, protecting and strengthening specialized services, and ensuring that the infrastructure is functional; and

WHEREAS, while the Secretary of Veterans Affairs sets standards for quality, access to health care is often constrained by the level of appropriated funding; and

WHEREAS, the amount of annual funding, and not the demand for services, defines overall access to VA health care; and

WHEREAS, without a statutory veterans' entitlement to VA health care, the Secretary of Veterans Affairs has no clear obligation to deliver a defined amount of health care nor estimate the physical capacity in response to the demand; and

WHEREAS, the lack of adequate and inconsistent appropriated funding has now resulted in the actual denial of mandated VA health care to veterans, leaving the VA also unable to justify reciprocal capital investments sorely needed to support the efficient access to health care; and

WHEREAS, the Secretary of Veterans Affairs is accordingly limited to enhancing quality of health care for some veterans by reducing access for other veterans; and

WHEREAS, as long as the annual appropriation is the statutory determinant of access to quality health care, inconvenience, delay and denial remain the de facto cost control mechanisms restricting any initiative to improve performance; and

WHEREAS, it is now obvious that veterans need a dependable entitlement to high quality health care not only for a basis of proper fiscal and economical planning but also to fulfill the moral mandate to "care for those who have borne the battle": Now, therefore, be it

RESOLVED, by the Veterans of Foreign Wars of the United States, That we urge Congress to establish a statutory entitlement for veterans health care as a means to assure veterans receive the care they justly deserve, obviate diminished access as the current primary method of cost control, and provide a basis for justification of those capital investments needed to streamline processes for efficiency improvements.

Submitted by Commander-in-Chief to Committee on Veterans Service Resolutions

The intent of this resolution is:

To have Congress establish the funding for entitlement to veterans health care as insured rather than discretionary appropriations.

APPROVED by the 107th National Convention of the Veterans of Foreign Wars of the United States.

VIETNAM VETERANS OF AMERICA

VETERANS HEALTH CARE (V–1–05)

Issue

The Department of Veterans Affairs (DVA) Veterans Health Care Administration, Veterans Integrated System Network/VISN is responsible for providing health care to veterans with service-connected disabilities and others as determined by eligibility rules established by Congress. Concerns continue regarding quality of health care, access, and eligibility for services.

Background

Many veterans have been adversely affected by what has been described as a health-care system "in crisis." This, in part, is due to budget and resource limitations. Other significant factors are directly related to the massive size of the centralized DVA health-care system, its bureaucratic inertia, and its inability to organize itself into an effective instrument to meet the changing health-care needs of all veterans under its care. Both service-connected and non-service-connected veterans have experienced a consistent unavailability of access to DVA health care, including mental health, outpatient contract, and inpatient cares.

Issues of access involve the need for many veterans to travel long distances to obtain care, as occurs with veterans living in rural communities or on island communities in Puerto Rico, the U.S. Virgin Islands, and Hawaii. Non-U.S. citizen veterans of the U.S. Armed Forces may receive DVA treatment for service-connected disabilities only if residing in the U.S. the statute allows payment for the treatment of service-connected disabilities outside the U.S. for veterans of the U.S. Armed Forces, only if such veterans are U.S. citizens, reside in the Republic of the Philippines, or are Canadian nationals.

The quality of health care in DVA remains suspect as revelations of questionable practices and adverse outcomes continue to emerge. DVA has lost sight of its obligation to provide quality health care as defined by veterans and there families, opting instead for quality as defined by health administrators and medical school affiliations.

This resolution amends V–1–95

Resolved, That:

Vietnam Veterans of America maintains that:

1. Veterans who have sustained injuries or illnesses during and/or as a result of their military service have the right to the highest quality medical and psychological services for treatment of those injuries and illnesses.

2. The first priority of the DVA must be to provide the highest quality medical and psychological treatment at no cost to veterans for illnesses and injuries incurred during and/or as a result of military service.

3. DVA must insure the highest quality of care provided in DVA health-care facilities. Monitoring activities conducted by Quality Assurance Programs must be scientifically based and include regular and consistent review by the director and chief of staff of the institution.

4. When DVA cannot provide the highest quality care within a reasonable distance or travel time from the veterans home (fifty miles) and in a timely manner (thirty days). DVA must provide care via fee-basis provider of choice for service-disabled veterans. Additionally, DVA must provide beneficiary travel reimbursement at the government rate.

5. Restrictions against providing DVA medical care to non-citizen, service-connected disabled veterans of the U.S. Armed Forces must be removed in order to treat equitably all those who served in the U.S. Armed Forces regardless of their country of origin, citizenship, or current country of residence.

6. DVA health-care policies must allow the veteran client to have input in DVA Medical Center/Outpatient Clinic operations. This should include establishment of veteran's advisory boards at the local level.

7. DVA health-care policies must be based on veteran patient needs. Health-care implementation should be decentralized to the local level, and budgeting should allow local facilities to plan for their own needs with significant consultation by the local veterans advisory board.

8. The Congress must enact and the President must sign into law legislation that creates an assured reliable funding stream for the DVA health are programs, indexed to medical inflation and the per capita use of the VA Health Care System.

9. VVA questions the philosophy and the language that limits the delivery of the VA healthcare treatment and services to a "core constituency". VVA is committed to protecting the rights of veterans and access to VA programs and services as defined in Title 38 U.S. code.

Financial Impact Statement: In accordance with motion 8 passed at VVA January 2002 National Board of Directors meeting which charges this committee with the reviewing its relevant Resolutions and determining an expenditure estimate required to implement the Resolution, presented for consideration at the 2003 National Convention; this committee submits that implementation of the foregoing Resolution be at no additional cost to the organization.This Resolution states in effect what has been a long standing part of VVA's advocacy and legislative programs.

Adopted at Vietnam Veterans of America 12th National Convention in Reno, Nevada August 9–14, 2005.

Mr. Cox, your statement.

STATEMENT OF J. DAVID COX, NATIONAL SECRETARY-TREASURER, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

Mr. COX. Chairman Akaka, Ranking Member Craig, and distinguished Members of the Committee, thank you for the opportunity to present AFGE's views on the VA health care funding process. I ask that my written statement be submitted for the record.

I would also like the privilege of thanking Representative Chris Smith for his fine leadership in the House and Dr. Kizer, that I had the privilege of working with many years in the VA, for his insight to always involve the union and the employees in his programs and the development of those programs that has made the VA what it is today.

AFGE unequivocally supports the Partnership for Veterans Health Care Budget Reform in calling for an assured funding approach that uses mandatory dollars to guarantee sufficient funds for all veterans who need medical care. The discretionary funding process is broken, so broken that it no longer supports the demands that are being placed on it. I worked for this amazing health care system as a registered nurse for 25 years before becoming an

AFGE officer a year ago. I am so proud of what the VA health care system has accomplished in recent years.

It breaks my heart to see what this funding roller coaster called discretionary funding is doing to the VA. Our members working at VA medical centers and clinics see firsthand the cumulative, corrosive effect of discretionary funding. Opponents contend that the costs of assured funding will be unmanageable, but they fail to point out the enormous cost of the stop-gap solutions that managers turn to when discretionary funds are scarce, including fee-based care, agency nurses, and diversion to non-VA medical centers.

Over the long haul, these policies will undermine the gains of the past and hurt VA's ability to provide quality care to veterans or contribute as a national leader in best practices, research, and medical training.

What I am hearing from the front lines is very disturbing. Primary care physicians were chastised for making referrals for screening colonoscopies, even though a new VA directive says that all veterans age 50 and over should be screened. Management wanted them to use stool cards that are less effective at detecting colon cancer when it is still treatable.

Nurses working in new spinal cord injury units were told there were no funds to send them to training or to observe best practices at other facilities. When new PTSD and suicide prevention programs drew staff away from other mental health units, the vacant positions were not back-filled.

The VA is a world leader in safe patient handling, but fails to provide patient lifting equipment to most of its own medical centers and nursing homes, leading to workplace injuries, patient skin tears, and lost work time.

The VA is in desperate need of workforce succession planning, but I fear that it will never be undertaken in a serious manner so long as the discretionary funding process continues to focus on the short-term and generates great financial uncertainty. The average age of the VA health care workforce is 48.3 years and it is going up every year. In 5 years, 44 percent of the entire VA health care workforce will be eligible to retire.

The statistics on VA registered nurses are frightening, especially in light of the national nursing crisis.

According to an American Hospital Association report just cited in *USA Today,* this country had 118,000 nurse vacancies last year. Can the VA health care system, which has to fight for funding every year, compete for nurses in the face of this national crisis? I am doubtful. Yet the VA isn't doing what it can to hold on to its current nurses. Almost 22,000 of the 36,000 registered nurses who work at the VA will be eligible to retire by 2010. That is 3 years away. And newer nurses are leaving in droves. In Fiscal Year 2005, nearly 78 percent of all R.N. resignations at the VA occurred within the first 5 years of employment.

A systematic funding methodology goes hand-in-hand with systematic staffing methodology that counts what needs to be counted, like patient acuity, staffing needs for new health directives, and costs of staying competitive with the private sector. Unfortunately,

VA's track record for implementing a nurse staffing methodology in a discretionary funding environment has been dismal.

In 1991, VHA collaborated with experts to develop a new staffing methodology, but it was implemented in a very few facilities. A decade later, the National Commission on VA Nursing, on which I served, called for a national staffing methodology, but like almost every other Commission recommendation, it went nowhere.

The one Commission recommendation that was enacted into law, nurse locality pay legislation, has not significantly boosted VA nurse recruitment or retention because of cash-strapped managers who are either reluctant to conduct pay surveys or increase pay for front-line nurses, even when surveys prove they are needed. By contrast, they are quite willing to conduct pay surveys and top-load the pay of nurse executives and managers.

Nurse scheduling met a similar fate. In 2004, a law to allow nurses to have compressed work schedules and limit overtime has been circumvented by politics and chronic staffing shortages.

Funding problems also took precedence over Congressional intent when it came to addressing physician shortages. Under legislation that took effect last year, local pay panels were supposed to set competitive market pay for different specialties. But many managers told their physicians they had no money for pay raises, even before the pay panel started deliberating. The law also set fixed maximums for performance pay awards, but most physicians got minimal awards, at best, regardless of their performance, again, justified by management claims that the well had run dry.

Chairman Akaka, we thank you for pursuing a GAO study on the use of agency nurses at the VA. Besides being costly, agency nurses are not familiar with VA patient care directives or its health care IT system, such as electronic health records, computerized bar code medication coding, clinical reminders, which compromise patient care and further burden staff nurses.

In closing, we urge you to reform the current funding process so that the VA is funded with mandatory dollars just like almost every other Federal health care system. Only a systematic approach to funding based on actual need and cost will be effective in alleviating the VA health care workforce crisis that is looming on the horizon.

Thank you very much, sir, and I would be glad to answer any questions.

[The prepared statement of Mr. Cox follows:]

PREPARED STATEMENT OF J. DAVID COX, R.N., NATIONAL SECRETARY-TREASURER, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

Dear Chairman and Members of the Committee:

The American Federation of Government Employees, AFL–CIO (AFGE), which represents more than 600,000 Federal employees who serve the American people across the Nation and around the world, including roughly 150,000 employees in the Department of Veterans Affairs (VA), is honored to testify today regarding the current process for funding veterans' health care and alternative funding approaches.

It is also an honor to participate in this important discussion along with the Partnership for Veterans Health Care Budget Reform (Partnership). AFGE is a long time supporter of the principles endorsed by the veterans' organizations that comprise the Partnership and the Independent Budget, including the need for an assured funding approach that uses a systematic methodology for funding veterans' health care.

The Partnership has presented a very compelling case for assured funding. The Nation's largest integrated health care system must receive its funding through a predictable, needs-based funding formula if it is to remain a leader in health care quality and respond to growing demand. Assured funding is the only approach that can utilize a systematic methodology; a systematic *discretionary* funding methodology is practically an oxymoron.

What I would like to address through my testimony today is the perspective of AFGE nurses, physicians, and other Title 38 professionals who see first hand the harm caused by the discretionary funding process. As a registered nurse at the Salisbury, North Carolina VA Medical Center for almost 25 years and a long time union president and officer of the National VA Council, I have received a great many reports from VHA employees struggling to care for veterans under a constant cloud of continuing resolutions and unpredictable funding.

The wear and tear of a broken funding process on the VA health care system is cumulative, steadily depleting its infrastructure and workforce at a time of burgeoning demand from veterans of the Global War on Terror and an aging population. Facilities remain in disrepair, hospital beds stay closed, and staffing shortages and workforce morale worsen. The occasional emergency supplemental infusion of cash leads to a rush to spend, without adequately addressing long term needs.

Opponents of assured funding contend that the VA budget will reach unmanageable levels, but they fail to point out that a discretionary funding process results in great misallocation of health care dollars, and threatens the VA's exemplary quality record. Facilities with hiring freezes and noncompetitive physician and nurse pay rates, and delayed purchases of medical equipment must contract with the private sector at much higher costs. Facilities with unstaffed hospital beds and too few specialists spend huge sums of money diverting patients to non-VA hospitals.

The following troubling reports were recently provided by members working in VHA facilities:

• Delays and cutbacks in diagnostic testing: VA pay scales for scarce medical specialists are far below the private sector. Facilities address unfilled positions by turning to high priced fee basis care. Shortages in gastroenterologists are impacting the VA's ability to implement a new policy to offer screening colonoscopies to all veterans age 50 or older, regardless of prior risk factors. Primary care physicians attempting to make colonoscopy referrals according to the new guidelines are being pressured to cut back, and offer stool cards—a far less effective tool for detecting cancer at early stages—instead.

• Reduced access to state-of-the-art treatment: A primary care physician reports that her patients who are in extreme pain are not able to receive the most effective injection-based pain treatment because her facility is unable to hire an anesthesiologist at current VA pay levels and management has capped spending on fee basis care.

• Budget driven equipment purchases: During months of the fiscal year when dollars are short, money needed to update or repair medical equipment is used for payroll. Then, at the end of the fiscal year, the rush to spend and justify next year's budget results in hasty, lower priority purchases such as furniture.

• Inadequate training in specialty care: Nurses working in new spinal cord units were told that there was no money to send them to conferences or other facilities where they could observe best practices. Similarly, ICU nurses were not permitted to attend cardiology training due to a shortage of funds and staff.

• Inadequate time with patients: Many VA providers are working with patient panel sizes (some as high as 1,400 patients or more) that exceed VA's own recommended ceiling. Nurses are discouraged from setting multiple follow up appointments even when the veteran's health problems warrant close monitoring. In addition, facilities set fixed time limits for examining each patient regardless of the individual's needs.

• Psychiatric care: Staffing shortages result in delays in treatment of PTSD and other mental health conditions, and constrain the amount of time staff can spend with each patient or visit veterans in other locations such as homeless shelters. New PTSD and suicide prevention programs have drawn staff away from patients in other mental health units; the positions they vacate are not filled, leaving remaining staff with larger patient loads.

• Safe patient handling. Although VA is a world leader in state-of-the-art patient lifting equipment, sufficient funds to equip all VA hospitals and nursing homes have not been provided. The costs: more nurse back injuries, lost work time, patient skin tears, and workers compensation claims.

• Nonmedical tasks divert time away from patients: Budget problems have resulted in widespread hiring freezes and lags for support positions, for example, clerks who check in patients, schedule reminders for future appointments and an-

swer phones. Team leaders of new health care initiatives lack staff support for added duties.

• Understating access problems: The current funding process encourages management to hide the true gap between patient need and available resources through patient appointment processes that "shape demand", manipulation of wait list data and empty "ghost beds" that lack staff.

• Discretionary style diversion policies: Patient care is compromised when decisions whether to divert to non-VA facilities are based on budget problems rather than good medicine. When VA beds are unavailable, and dollars are tight, patients who need to be admitted wait in ERs and hallways instead.

THE IMPACT OF THE CURRENT FUNDING PROCESS ON STAFFING

VHA's aging workforce should provide a wake up call to management to take succession planning more seriously than it has. Unfortunately, yearly funding fluctuations and shortfalls have undermined succession planning efforts in the past. The average age of VHA employees has risen from 45.4 years to 48.3 years over the past decade, and 44 percent will be eligible to retire at the end of 2012.

Adequate nurse staffing is a critical component of improved patient outcomes, e.g., decreases in urinary tract infections, pneumonia and shock or cardiac arrest, avoided hospital stays and fewer in-hospital deaths. [1] The impending RN workforce shortage at the VA is startling: almost 22,000 of the RNs caring for our veterans will be eligible to retire by 2010 while 77 percent of all RN resignations occur within the first 5 years.

In 1991, in response to a growing nurse shortage, VHA collaborated with a panel of staffing experts to recommend a complete overhaul of VHA's staffing methods. Unfortunately the new methodology was sparsely implemented, due in part to a lack of resources.

In 2002, Congress sought to address the growing nurse staffing crisis by establishing the National Commission on VA Nursing. As a member of that Commission, I participated in extensive discussions about the need for a systematic staffing methodology. Our final recommendations included a call for VHA to "develop, test and adopt nationwide staffing standards that assure adequate nursing resources and support services to achieve excellence inpatient care and desired outcomes." Unfortunately, the Commission's recommendation met the same fate as the previous attempt: a national staffing methodology was never implemented.

Ironically, the one Commission recommendation that was enacted into law—2001 nurse locality pay legislation—has not achieved its potential due to the reluctance of cash-strapped managers to conduct pay surveys or provide increases commiserate with private sector pay surveys. The significant inequity between locality pay increases for the rank and file and supervisory nursing staff hurts morale and worsens VA's nurse shortage.

The greater problem is that any staffing methodology operating in a system with unpredictable funding is bound to fail. Without a sound funding methodology for the larger health care system, it is our firm belief that VHA will not have the resources to adopt the Commission's important staffing recommendations. In contrast, an assured funding approach would enable the VA to base staffing on all relevant criteria, including patient acuity, the impact of alternative work schedules, the staffing needs generated by new health care directives and the impact of nursing shortages nationwide on nurse pay and other incentives.

The discretionary funding process took its toll again when Congress tried to address the VA nursing shortage through 2004 legislation that increased the availability of RN alternative work schedules and restricted mandatory overtime, in order to become more competitive with private sector nurses. Management operating under hiring freezes and uncertain funding streams continue to require or pressure RNs to work overtime and are reluctant to offer alternative work schedules, further contributing to recruitment and retention problems.

We thank Chairman Akaka for requesting a GAO study of the cost and quality impact of agency nurses in the VA. Facilities continue to over utilize costly agency nurses rather than adopt policies to improve recruitment and retention of staff nurses. Agency nurses are unfamiliar with VA's specialized care, new directives on Traumatic Brain Injury, mental health and hospital infections, and the VA's bar code medication administration system, electronic health records or clinical reminder systems. They lack security clearances to access certain computer files. As

[1] J. Needleman, et al., "Nurse Staffing in Hospitals: Is there a Business Case for Quality?" Health Affairs No. 1(2006): 204–211.

a result, they cannot work as independently as staff nurses and must be given more desirable day shifts sought by senior in-house nurses.

Provisions in 2004 legislation that addressed pay for physicians and dentists have met a similar fate. The law established new systems for setting competitive salaries ("market pay") and for performance pay awards. The chaos of the current budget process struck again. Even before the compensation panels to set new market pay rates were in place, management in many locations told physicians not to expect much of any pay increase because of budget problems, and that is just what happened on a widespread basis.

When we asked about the pay surveys that facilities used to set physician market pay, we were told it was too confidential to reveal. What we do know, however, is that the process was anything but systematic. Each facility chose its own pay surveys and had complete discretion to select compensation panel members, the resultant variations in pay decisions were often suspect. More generally, the current process is flawed in that raises for VHA employees are not addressed until after the projected budgets are submitted, leaving the facility director to absorb proposed salary increases.

The impact of a flawed budget process was even more obvious in the implementation of the physician performance pay provisions in the 2004 law. Congress set a yearly award of up to $15,000 or 7.5 percent of salary to reward quality performance. However, in the first year, the VA revised the national cap downward to $5,000 and local management has continued to play the budget card by setting even lower caps (in many cases, under $1000 or no awards at all).

Needless to say, these pay policies have failed to improve the VA's ability to recruit and retain health care professionals or reduce spending on fee basis physicians and other contract care.

In the words of one of our primary care physicians, "physicians would flood the VA" if pay rates were competitive because they are attracted to this patient population, the computerized medical record, single drug formulary and the ability to provide high quality care without worrying whether the patient will be able to pay his out-of-pocket share of services and medications.

In closing, AFGE has sadly concluded that the VA will not be able to undertake meaningful succession planning, effectively address recruitment and retention problems, or engage in strategic, long range planning for other aspects of health care delivery so long as discretionary funding is creating a constant state of financial uncertainly and the demand for and cost of delivering health care to our veterans is based on a yearly political fight rather than a systematic funding methodology.

CONCLUSION

AFGE greatly appreciates the opportunity to submit our views and recommendations to the Senate Committee on Veterans' Affairs. We look forward to working with Chairman Akaka and the Committee on short term and long term solutions to the VA's health care funding problems.

Chairman AKAKA. Thank you very much, Mr. Cox.

Mr. Cox, you have spent a considerable part of your career representing VA employees in the field. You have seen many things happen there. You have just mentioned in your statement about what you expect to happen with retirements and the huge percentage of retirements that will be occurring. Could you speak a little bit more on the effects of continuing resolutions and hiring freezes on employee morale and motivation?

Mr. COX. Every year when we had the continuing resolutions, there was the inability to replace staff that had left, retired, or quit, moved to other jobs, or moved from one section of the medical center. Medical center directors were told to hold the line. They did not have the budgets to act on. We had to reach out to use agency employees, fee basis, which cost a whole lot more. And then again, many of the schools of nursing, many of the physicians, many of the health care professionals that were available that were graduating and eligible and available to be hired, the VA was not able to reach out to them and to offer them employment because of con-

tinuing resolutions and the lack of funds. And therefore, it has greatly hampered the ability to recruit and retain.

And obviously, nothing is any more upsetting to a nurse or any health care provider, to be there on the front line providing care to veterans and have insufficient staff to meet those needs.

Chairman AKAKA. We are very concerned about morale and motivation, as well.

Mr. COX. Thank you, sir. Morale is a very serious problem, and I think the employee morale in the VA has gone down in the last several years because of the budget process and the inability to replace the staff and to get the staff that is needed to take care of the veterans.

Chairman AKAKA. Mr. Violante, after hearing you, you did use the word "mandatory." Is your Partnership proposing an entitlement to VA health care for veterans? If so, what effects do you think this would have on the overall Federal budget process, including on the role of this Committee and the Appropriations Committee, as well?

Mr. VIOLANTE. Well, Mr. Chairman, first of all, we are not asking for an individual entitlement. The entitlement is to the VA. It is a Department entitlement. There is a distinction. We are not changing in any way how VA provides services, who they provide them to, or the benefit package. It doesn't entitle me as a service-connected disabled veteran to go anywhere I want to go for care. It requires me still to go to the VA.

What it does do is provide VA with a sufficient level of funding. It also provides predictability and it provides timeliness. We have heard earlier about some of the funding situations that Congress is going to have to deal with if they move the VA health care discretionary funding to a mandatory account. There are pay-go implications. We would hope that Congress could somehow use the money that is being saved on the discretionary side to offset the costs.

Congress is going to have to deal with the costs of health care. We have heard it from the first witnesses, including former Chairman Smith. It is going to continue to cost our government quite a bit of money to fund veterans' care and we can't see how VA can sustain its programs under the current system.

Chairman AKAKA. Let me ask both of you the simple question that to which you have alluded. Would you agree that the amount for VA for next year—now coming out of both the Senate and the House—is it adequate?

Mr. VIOLANTE. I think we believe that the level of funding that you are considering right now is in line with what we believe VA's needs are. Our concerns, again, are when is VA going to receive that money or know, in fact, what amount they are getting it. So that is still a concern. But certainly, the level of funding is adequate, and we greatly appreciate all the hard work that went into reaching that level of funding. It is very helpful. Six billion dollars more for health care is line with what we believe VA needs.

Chairman AKAKA. Thank you very much. Mr. Cox?

Mr. COX. AFGE is very excited about the budget that we have seen for the VA and applaud all the Members of Congress for their efforts and work on that. But again, we would like to see that

budget delivered today so that we can begin preparing and the staff is prepared, but also there is still an element of caution because every day, we are creating brand new veterans and making a 40-, 50-, or greater-year commitment. And these veterans, as Dr. Kizer and others said earlier, are going to require a great deal of specified care and services, and to anticipate those needs, I am not sure that anyone has the ability to calculate all of that.

But we are excited about the funding, and the employees nationwide, from housekeeping aides to doctors and nurses, you know, have an element of joy in their heart that there is going to be greater funding, that they can go out and do their job every day serving veterans.

Chairman AKAKA. Thank you very much, and I want to thank both of you for your statements. You have been very helpful. I ask you to convey our best wishes to the groups that you represent. Thank you.

Mr. COX. Thank you.

Mr. VIOLANTE. And thank you, Mr. Chairman. We appreciate it.

Chairman AKAKA. I am very pleased to welcome the Honorable Michael J. Kussman, VA's current Under Secretary for Health, and his colleagues as today's third panel. Dr. Kussman is accompanied by Patricia Vandenberg, Assistant Deputy Secretary for Health for Policy and Planning, and Paul Kearns, Veterans Health Administration Chief Financial Officer. I want to thank you all for being here with us today and for being so patient.

Dr. Kussman, your full statement will appear in the record of this hearing, so will you please begin with your statement.

STATEMENT OF MICHAEL J. KUSSMAN, M.D, M.S., M.A.C.P., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PATRICIA VANDENBERG, ASSISTANT DEPUTY SECRETARY FOR HEALTH FOR POLICY AND PLANNING, DEPARTMENT OF VETERANS AFFAIRS; AND PAUL KEARNS, CHIEF FINANCIAL OFFICER, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Dr. KUSSMAN. Well, aloha, Mr. Chairman. I guess you are the only one here, so I don't have to acknowledge the other Members of the Committee. But before I get into my prepared remarks, I would like to make a quick comment.

I am very thankful of the first two panels because I really appreciated their continual validation of the quality of care and the magnificent work of the 200,000 people who work for me in the Veterans Health Administration, so I truly appreciate that.

I would also like to say that, Dr. Reinhardt is not here, but I would also like to thank his son for his magnificent service in defense of our country on the Global War on Terrorism. He is truly an American hero.

Mr. Chairman, thank you for the opportunity to discuss the Department of Veterans Affairs' current funding process for its medical care program, including budget formulation, Congressional appropriations, and alternatives to the existing process, such as moving such funding from the mandatory side of the Federal ledger.

Joining me today is Paul Kearns, Chief Financial Officer of the Veterans Health Administration, and Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning. And again, thank you for submitting my written testimony for the record.

Prior to enactment of the Veterans Health Care Eligibility Reform Act of 1996, the VA's medical care budgets were based on past expenditures adjusted for inflation. This historical approach, however, was inconsistent with the practices of large, integrated, private sector health plans, which VA began to resemble as we transformed into an integrated system of care, providing a full range of comprehensive health services. For this new model of health care delivery, the VA adopted a rational and predictive budget to meet the needs of veterans. These budgets are able, then, to continually adjust budgetary projections to account for shifting trends in the veteran population, increasing demands for services, and escalating costs of health care.

Pivotal to this entire enterprise is the VA Enrollee Health Care Demand Model, which develops estimates of future veteran enrollment, enrollees' expected utilization for 55 health care services, and costs associated with utilization. The model projects future demand for health care services based on private sector benchmarks adjusted for the unique demographic and health care characteristics of the veteran population in the veteran VA health care system. Each year, the model is updated with the latest data on enrollment, health care service utilization, and service costs. VA has integrated the model projection into our financial and management processes.

VA believes the use of actuarial projections for budget development is the most rational way to project the resource needs of our veterans. As noted earlier, this approach is consistent with the private sector.

Unlike the private sector, VA must develop budgets 2½ to 3 years into the future. Furthermore, VA receives its medical care budget in three separate appropriations: Medical services, medical administration, and medical facilities. The Congress created this funding structure in 2004, replacing the previous single appropriations structure. This change has significantly increased operational complexity without improving financial accounting accuracy. In addition, the new structure has introduced unintended inefficiencies and increased complexities into the VA's budget management processes and procedures.

There are two commonly considered alternatives to the existing appropriations process. First, VA's current multiple appropriations could be combined into a single medical care appropriation. The second option is the one that we have heard on mandatory funding. A single appropriation for medical care would enable VA managers at every medical center and network to optimize resources flexibly and ensure timely delivery of high-quality care to veterans.

We believe the other alternative, mandatory funding, would not be in the best interests of our veterans. Since there is no concrete proposal describing in detail how a mandatory funding approach would actually work, we can only hypothesize about its effects. However, a mandatory funding approach, in our view, is neither re-

flective nor adaptable to changes in enrollee priority level and age mix, enrollee morbidity and mortality, enrollee reliance, and advances in state-of-the-art technologies and medical practices. Additionally, a mandatory funding approach potentially limits the ability of either the executive or legislative branches of government to match policy with financial circumstances or to execute its inherent oversight responsibility.

VA believes the current processes of budget formulation provides the best methodology for estimating the VHA budget. However, a return to a single appropriation would significantly improve VHA's ability to deliver timely, high-quality health care to our Nation's veterans.

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

[The prepared statement of Dr. Kussman follows:]

PREPARED STATEMENT OF MICHAEL J. KUSSMAN, M.D, M.S., M.A.C.P., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

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

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

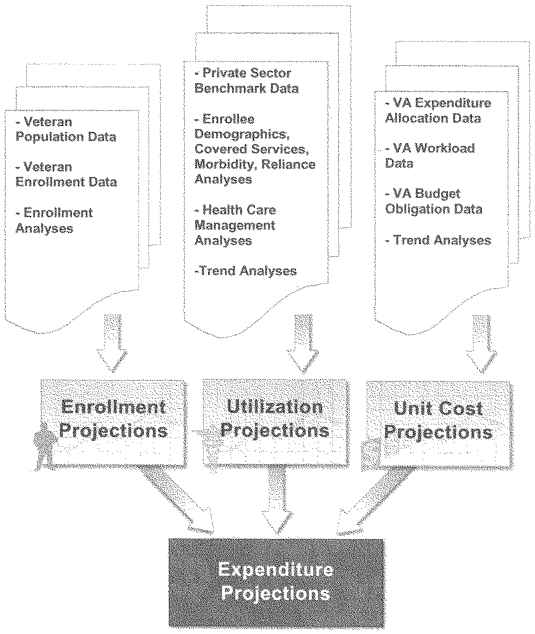
Prior to eligibility reform, VA medical care budgets were based on historical expenditures that were adjusted for inflation and increases were based on new initiatives. However, this historical-based approach was not consistent with the practices of large, integrated, private-sector health plans. The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

CURRENT FUNDING PROCESS VA'S ENROLLEE HEALTH CARE DEMAND MODEL

The VA Enrollee Health Care Demand Model (model) develops estimates of future veteran enrollment, enrollees' expected utilization for 55 health care services, and the costs associated with that utilization. These projections are available by fiscal year, enrollment priority, age, Veterans Integrated Service Network (VISN), market, and facility and are provided for a 20–year period. This produces over 40,000 individual utilization and budget estimates per year.

The model provides risk-adjustment and reflects enrollees' morbidity, mortality, and changing health care needs as they age. Because many enrollees have other health care options, the model reflects how much care enrollees receive from the VA health care system versus other providers. This is known as VA reliance. Enrollee reliance on VA is assessed using VA and Medicare data and a survey of VA enroll-

ees. The VA/Medicare data match provides VA with enrollees' actual use of VA and Medicare services, while the survey provides detailed responses from enrollees regarding private health insurance and use of VA and non-VA health care. The graphic on the next page provides a conceptual overview of the actuarial model and the key data and analyses supporting it.



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

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

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

VA has integrated the model projections into our financial and management processes. Eighty-four percent of the VA health care budget request for FY 2008 was based on these detailed actuarial projections; the remaining sixteen percent is for health programs not yet included in the actuarial projections because of the unique characteristics of these programs. Some examples include: readjustment counseling,

dental services, the foreign medical program, and non-veteran medical care (such as CHAMPVA and spina bifida). The budget estimates for these programs are developed by the respective program managers.

VA believes the use of actuarial projections to develop its budget estimates is the most rational way to project the resource needs for our veterans. As noted earlier, this approach is utilized by the private sector. Unlike the private sector, however, where projections are used to formulate budgets for the next year or even the next "open season," the Federal budget cycle requires budget formulation using data 2½ to 3 years ahead of budget execution.

CONGRESSIONAL APPROPRIATIONS

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

ALTERNATIVES TO THE EXISTING PROCESS

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

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

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

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

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

Chairman AKAKA. Thank you very much, Dr. Kussman.

We have heard today strong testimony about the budget failures of recent years, the inability of VA managers to plan ahead, the uncertainty, and the impact on care. I realize that you are required to support the current process, but in your personal view, do you believe that VA employees and ultimately VA patients are well served by it?

Dr. KUSSMAN. Sir, the real issue is do we get adequate funding to do the job that we are supposed to do in any way that you choose to do it. I believe that we are getting adequate funding. With your support and the Administration's support, we have been very appreciative of the very significant increases in the budget over the last couple of years.

As I mentioned in my both prepared and oral testimony, there are some things that would allow us to be more efficient and better in our development of our budgets, such as the single appropriation

and other things of that sort that would allow us to be more flexible and nimble in our ability to do the role that we are expected to do.

Chairman AKAKA. Yes. Dr. Kussman, please describe to me your approach for providing the best possible care to every patient and at the same time dealing with pressure from OMB to limit spending on health care.

Dr. KUSSMAN. Sir, as you know and I testified, I think, in my confirmation process, my job is to be straightforward and honest and assess what I believe and the Veterans Health Administration believes is our needs to take care of our veterans. That is a passion of mine, as you know. We are committed to doing that.

The process is that we then go through OMB and ultimately the Administration and to the Congress. Over the last couple of years, particularly in 2007 and 2008—2006 and 2007, we are not in 2008 yet, I don't think, maybe—we formed, I believe, an unprecedented and close relationship with OMB. We go there on a monthly basis with these two members of my staff and others to go over with them on our monthly review of where we are. They understand, I think, much better what we are doing and our assessment process and we believe that the 2008 budget, as approved, was really unprecedented in its accuracy with what we had requested and it was a very good budget.

Chairman AKAKA. Dr. Kussman, you have heard other Members today mention once veterans come in the door, they get the best care, but accessibility is one of the problems that veterans have. But I do note that the quality of care is good, and it has been good over the years.

I truly believe that VA health care is largely a success story. VA facilities have been more successful than private sector providers in holding down costs while providing quality care. In your view, does VA provide a better return on each dollar than Medicare, Medicaid, or the private sector? And additionally, is VA an economical way to provide health care services?

Dr. KUSSMAN. Mr. Chairman, I don't know if it would be presumptuous of me to say that we are better than anybody else in the country, but I believe that the performance standards and data confirm that we lead the country in our ability to provide services. I have a passion and truly believe that if you are a veteran in this country, you have a much better chance of getting the full depth and breadth of services that you need as a veteran than if you were in any other delivery system in the country.

We are very efficient in delivering our care. I think we give a magnificent "bang for our buck," so to speak, and I am very proud of the delivery of care, not only the quality, but the caring attitude that our 200,000 people provide.

Chairman AKAKA. I think you know that the Committee has been working hard on what we are calling "seamless transition" between active and civilian life. I have been working diligently on this. Part of this is changing because people at VA and DOD are starting to talk, as you mentioned here. I was so glad to hear a report that Gordon England and Gordon Mansfield have been chatting on some of these seamless transition issues. So that is really great, and I

hope that continues to go on. As it does, it will certainly help our cause.

Dr. Kussman, do you anticipate that VA's resource needs will follow the general trend in U.S. health care and continue to grow at over 5 percent annually for the foreseeable future?

Dr. KUSSMAN. I believe that the growth in expenditures for health care is a mix of inflation that is just a price that you have to pay to keep business going and then a combination of the needs that are for new services, new enrollees, new techniques, and things of that sort. I believe that we are consistent, generally, with the civilian community for the total amount of expenditures being in that range.

Chairman AKAKA. Well, we really appreciate what you are doing and we look forward to working together to try to improve care. We are looking and focusing on invisible wounds, we really need to help to put together policy that can deal with these. Mental health issues affect people and their families. So it is something that is serious.

And so I thank you for what you are doing and what VA is doing and I look forward to continuing to work with you and to continue to try to help our veterans.

Dr. KUSSMAN. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much.

We again have come to the close of another good hearing of three panels, and I would like to thank all of our witnesses for joining us today. I want you to know that we do appreciate your taking time to share your views on the VA health care budget. Without question, this will help us to make VA the best in our country. Thank you very much.

This hearing is adjourned.

[Whereupon, at 11:52 a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF JOSEPH M. MANLEY, VA MEDICAL CENTER DIRECTOR (RETIRED), ON BEHALF OF "FUNDING FOR VA HEALTHCARE"

Mr. Chairman and Members of the Committee:

Thank you for giving me the opportunity share my perspective on the VA budgeting process and its impact on providing healthcare to our Nation's veterans. I am Joseph Manley, the former Director of the VA Medical Center in Spokane, Washington. I retired in 2007 after 35 years of VA service. As a VA manager, I had the opportunity to work at all levels of the organization from coast to coast, including large and small VA hospitals, in urban and rural settings and in senior staff positions at our national headquarters. I am also a veteran having retired at the rank of Full Colonel after 25 years of active and reserve duty with the U.S. Army.

I would like to state for the record that I am not submitting this document to find fault or place blame with any individuals. I am proud of my VA service and feel fortunate to have had the privilege of working with the dedicated and professional people of the Department of Veterans Affairs. I believe that there are systemic problems within the governmental budgeting process that create undesirable outcomes and prevent good people from doing their jobs and providing the services the veterans of our Nation rightfully deserve.

The reasons for the budgeting system failures are complex and varied but some of the key drivers are: the political nature of the Governmental budget process; the lack of multiyear appropriations; the lack of real time data on VA workload and demand; and the lack of an accurate internal budget distribution mechanism. I believe that all of these shortcomings could be resolved if the government decided to fund veterans' healthcare as an *entitlement* and base reimbursement for the VA system on enrollment (HMO model) and/or the actual work performed (fee for service model).

For the past 13 years, I served as the Director of the Spokane VA Medical Center. This primary and secondary care hospital is the only VA facility serving the needs of veterans living throughout a 60,000 square mile region of Eastern Washington, Northern Idaho and Western Montana (a geographical area the size of the state of Pennsylvania).

During my tenure, the number of patients seeking care at the Spokane VA medical center grew at a rate of more than 10 percent per year due to declines in the economy of the region (mining, timber and farming) and to the growth and aging of the veteran population. A third of our patients traveled more than 100 miles (one way) to obtain primary care from the VA. Patients needing specialty care, such as, neurosurgery, orthopedics, neurology, radiation therapy, etc., were forced to travel an additional 300 miles (one way) to our nearest VA tertiary care centers in Seattle or Portland, Oregon. The VA was the only affordable health care option for most of this deserving population and it troubled my staff greatly when we were not able to meet the patent's needs in a timely manner, nor were we able to provide services within a reasonable distance from the patient's home.

In all but one year of my tenure as Director, we began the budget cycle in a continuing resolution. With employment and other expenditures restricted to the prior year budget levels, there was no way to adequately meet the continuing waves of new patients and to properly maintain operations at the facility. As a result, we were forced to defer capital expenditures, delay employment, restrict local purchases, limit maintenance and otherwise constrain costs for the first half of the year. Worst of all, when funds ran short, we were forced to place veterans on waiting lists for our services. At one point, we had over 3,000 veterans who had waited a year or more for their initial medical appointment.

The availability of drop money or budget increases late in the year triggered frantic efforts to purchase equipment, implement construction projects and catch up on patient care that had been delayed by the funding constraints. Unfortunately, the

"lean" years often ran for 3–4 consecutive years and we were forced to helplessly watch waiting lists grow as our physical plant declined. When the situation grew extreme, our appeals for supplemental funding would be politically recognized and we would see a couple of years of relief.

The uncertainty of budgeting at the Congressional level was compounded by management actions within the VA. At the national level, the VA Headquarters often required that enhancements be made to existing programs or that new programs be implemented at the local level without an increase in funding to pay for the new service. These unfunded mandates were often in response to Congressional pressures or to appease a special interest group. Whatever the impetus for the new initiatives, the result was erosion in our ability to properly support our existing core services.

As you know, the Congress provides the VA with resources via the appropriation process. Once the VA has received these lump sums, they divide the resources among the 22 Networks and program offices on a "zero sum" basis. The VA's national budget allocation model theoretically divides the resources among the Networks based upon each Network's actual workload from a prior year. This modeling process has many flaws (workload data for the model is not real time, the allocation process is often distorted by agency imposed caps, corridors and ceilings, etc.), but overall, the allocation process does appear to slowly shift money from areas of the country with declining patient workload to areas of growth.

While each Network's share of the national budget is based upon this workload model, the parceling of money to the individual medical centers within each Network is left to the discretion of the individual Network director. To my knowledge, no two Networks use the same method for determining what resources their medical centers will receive. Most of the Networks have changed their allocation processes over the past 10 years, some multiple times. All of this creates uncertainty among the VA staff and prevents any meaningful long term planning at the local level.

During my tenure at Spokane, I worked for four Network Directors. Each of these individuals had a different set of priorities, each faced differing problems and each had a different budgeting style. For example, one felt that Education and Research within the Network was inadequately supported, so he reduced the medical center clinical allocations to shift money to support these endeavors. Another of my Network Directors felt that patients needing high cost tertiary care was a priority, so he shifted money from the rural hospitals to the urban centers. A third felt that sub-specialty care was a priority and spent large amounts of the Network budget purchasing these services at inflated prices in the community.

The current Network Director has recognized the need for primary care services in rural areas and to increase access—thus, he is shifting significant amounts of money within the Network to open Community Based Outpatient Clinics and to expand services at those medical centers experiencing increased enrollment or who have low penetration rates for the veteran populations of their respective geographical areas.

Please don't misunderstand me—I am not faulting any of my past leaders for their decisions. I think their actions were properly motivated and well intentioned. The real problems were insufficient resources overall and the absence of a sophisticated allocation system; so they were forced to respond to recognized organizational shortcomings as best they could with the limited means at their disposal.

The VA has one of the most advanced electronic medical records systems in the world. If the Congress has the will to act on mandatory funding, I believe that our electronic record could be adapted to create a real time, workload based reimbursement mechanism at the medical center level to "pay" each facility for the work that is actually performed. This would ensure that each of our medical centers is appropriately funded for the services provided to our Nation's veterans. By utilizing a single, uniform payer approach for VA Healthcare, further adjustments, supplementals, and other budgeting actions would no longer be needed unless the Congress desired to add programs or services. VA Medical Center Directors would also be held to the same accountability as their community counterparts—that is to operate using sound business principles and deliver high quality services in a timely manner.

Thank you for considering my views on this subject. This concludes my statement.

FORMER VA OFFICIAL'S PERSPECTIVE ON VA HEALTH CARE APPROPRIATIONS OPERATIONAL DIFFICULTIES AND POLITICAL DEMANDS

For as long as I can remember during my career as a senior executive in either VA Central Office or at the four VA Medical Centers (health care systems) that I had the privilege of directing, VA funding and the appropriations process is a proc-

ess no effective business would tolerate. I believe it will require great political will for there to be substantial improvements, especially given the pay go and discretionary nature of VA health care funding.

In the 1980s and early 1990s VA appropriations were insufficient to maintain current services (in several years the appropriation did not even cover approved cost of living and pay increases) and supplementals were expected as a "way of doing business."

In certain years VA was ordered through appropriations language to maintain employment floors. In one instance a Chief Medical Director refused to order the field to maintain the employment floor as there was insufficient money to do so. VA was "rewarded" by a slashing of the MAMOE appropriation.

In the mid 1990s, the practice of expecting supplementals changed. Proposed VA funding levels at the "mark" provided VA by OMB were still insufficient. The "mark" was increased in at least three years before the President's request was finalized only after the Secretary made direct appeal to the President.

Since the mid 1990s appropriations have rarely been passed by the beginning of the fiscal year. This fact leads to numerous operational difficulties. Most years facilities were required to operate at the prior year level until the appropriation passed, despite inflation and increased patient demand. Hiring freezes were typical and patient delays were common, equipment and other needed purchasing was delayed. In many years the appropriation was not passed for at least 6 months after the fiscal year began. In some of those years there were substantial increases so management of staffing, inventories, and other significant purchasing was very ineffective. With sometimes very large sums included in the new appropriation we were many times guided to have no carry over funds. So we'd buy ahead pharmacy and medical supplies inventories that were not required at the moment in order to use those funds. In years where there was so much money that it was inevitable to have unobligated funds at the end of the fiscal year carry-overs were requested. Most times OMB or the Congress or both would expect the carry over as an offset for the current budget year. Getting "two bites out of the apple" was politically convenient, but practically the money could have been well managed had it been approved at the beginning of the fiscal year.

The Fiscal Year 2005 Budget, in my view, was a typical situation that got out of hand. The OMB mark and ultimate President's request was far short of current services. Even though I had left the VA, when I learned of the number proposed around September of 2004, well before the President's request was approved. I knew, as did many of my former VA colleagues, the request was in my estimate $1–$1.3 billion short of current services. I attended with dismay the appropriations hearings where VA testified there were sufficient funds, only to then suggest the big gap in money was suddenly discovered in April or May due to insufficient consideration of the demand from OEF/OIF. I'd suggest that was a political smoke screen.

In one year without an appropriation or a continuing resolution facilities were required to identify "non-essential" staff, they were furloughed without pay, while "essential" staff continued to work. The non-essential staff was ultimately made whole, but the effect of determining "non-essential" staff had a significant negative impact on morale.

There were several years where money was "earmarked" for special purposes. Probably well intended but, frequently dysfunctional at an operational level as those local situations differed widely in terms of patient demand for particular services.

VA health care budgeting is a very complex issue. Changes in eligibility and the absence of a defined population of beneficiaries who will be served will always contribute to uncertainty about demand and lead to errors in budget estimation. Facilities struggle with priorities, while at the same time having to deal with eligible patients for which there are many times insufficient funds. To deny access to care based on a low priority is not a simple or sometimes medically ethical practice. VA facility staff face this dilemma every day.

There is frequently a disconnect between authorizing and appropriations committees. Authorizing committees legislate new programs, but they sometimes didn't get appropriated. We used to refer to these programs as unfunded mandates.

In other situations access is determined based on funds available. During the period of dramatic increases in the number of Community Based Outpatient Clinics oftentimes directors were faced with absolute enrollment limits, e.g., as Director at Charleston when we opened the CBOC in Myrtle Beach we had enough money for approximately 3,500 patients. When we enrolled that panel we stopped accepting new patients, as there was insufficient money to add more. Rather than outright deny the patients we told them they could be seen in Charleston, a two-hour or

more drive depending on time of day. We knew most of those patients would not want to drive to Charleston so they'd seek other sources for their care.

[Note: Robert A. Perreault held the following positions at VA: VHA Chief Business Officer, VACO, 2002–2003; Director, VAMC Charleston, SC 2000–2002; Director, VAMC Atlanta, GA 1995–2000; Director, Health Care Reform, VACO 1994–1995; Director, VAMC Philadelphia, PA 1993–1994; Director, VAMC Newington, CT 1990–1993; Executive Assistant to the Chief Medical Director, VACO 1989–1990.]