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PARALYZED VETERANS OF AMERICA

ON BEHALF OF

THE CO-AUTHORS OF THE INDEPENDENT BUDGET

FOR THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

CONCERNING

THE COSTS OF CARE:

VA HEALTH CARE AND THE PRIVATE SECTOR

JANUARY 28, 2015

Chairman Benishek, Ranking Member Brownley, and members of the Subcommittee, on behalf of the four co-authors of *The Independent Budget* (IB)—AMVETS, DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars (VFW), I am pleased to be here today to present our views on the recent Congressional Budget Office (CBO) report entitled: "*Comparing the Costs of The Veterans' Health Care System with Private-Sector Costs*." In light of the debate over the past year concerning the expansion of purchased care outside of the Department of Veterans Affairs (VA), we appreciate the Subcommittee's attempting to examine this issue.

We believe that two clear conclusions can be drawn from the CBO report. First, comparing the cost of health care administered by the VA to the cost of private-sector health care is not an "apples-to-apples" comparison. In fact, the CBO points out a number of factors that suggest that trying to compare VA health care and private-sector health care is essentially a fool's errand. I will address a number of these points in this testimony.

The second observation that can be drawn from this report is that it expresses no definitive conclusion on the question of which model of health care is more cost-effective. Ironically, when this report was released, we witnessed a number of interested groups and media reports suggest the report concludes that VA health care is not more cost-effective, and by extension not higher quality than private-sector health care. However, the CBO report makes no such finding. In fact, we believe the report reaffirms in many ways the value and uniqueness of VA health care.

While we appreciate the concept that the delivery of cost-effective, high quality health care should be equated across all sources of health care, such a notion ignores the many factors that make VA health care unique. The CBO report clearly outlines some important distinctions that further explain why a direct comparison between VA health care and private-sector care is difficult to say the least. Foremost among these distinctions is the fact that the Veterans Health Administration (VHA) serves a patient population markedly different than the general U.S. population. The entire VHA system is designed to address this distinction. However, the nature of the private patient population and the types of health care services that people in general typically seek are different from veterans' health care experiences or needs. To exemplify the differences, VHA has struggled in recent years to reposition itself to better serve the health care needs of women veterans, and especially for those in their childbearing years. Women constitute a major block of patient workload in the private sector, but since September 11, 2001, women have joined the armed forces in unprecedented numbers and are now a rapidly growing presence in VA health care. Alternatively, VA does not generally treat childhood illnesses, injuries or diseases, but these are a mainstay of private health care.

Representatives of private-sector health care organizations have testified to this very issue. At a hearing before the full House VA Committee last summer, a number of the witnesses representing private health care entities expressed their challenge in understanding veterans as patients. They admitted that they would gladly provide services to veterans seeking care, but they could not guarantee care that would be veteran-specific. Most private sector health care entities do not mount services and programs that are aligned to provide the types of care particularly demanded by veterans.

This point often gets at the heart of the discussion about physician patient panels. Proponents of private-sector health care continue to complain about the seemingly unsatisfactory number of patients that VA physicians treat individually. The CBO report suggests that VHA primary care practitioners see an average of 1,200 patients per panel, while private physicians see an average of 2,000 patients. However, CBO emphasizes that a more thorough examination of workloads for both entities should be completed before any conclusions can be drawn. The CBO explains that it is important to evaluate the case-mix and average morbidity of patients seen and the number of visits by those patients in each setting.

The second major distinction that the IB co-authors believe is the crux of the problems that the VA health care system has faced in recent years is the fact that the VHA is funded through an annual, prospective appropriations process. Under ideal circumstances, this would not be a challenge if the Administration requested and Congress provided the necessary resources to meet all projected health care demand from veterans. But we know that this does not happen. Congress has asserted in recent years that it has provided all of the resources that the Administration requested. The IB does not dispute that assertion. However, we also know that the Administration rarely has requested the resources VA needed to properly address known demand. We only need to reexamine the unacceptably long wait times and lack of access to health care that was exposed last spring and summer to prove that point, and that in an unprecedented act, the 113rd Congress appropriated $17.5 billion to remedy the crisis.

Deputy Secretary Gibson offered an interesting observation before the full House VA Committee last year that has long been a complaint of the IB. Secretary Gibson testified that VA has been in

the business of "managing to budget, not to need." We have the Office of Management and Budget to thank for this fact. The VA health care system has been held hostage by this type of policy that places it at a disadvantage to provide timely, quality health care when compared to private-sector health care systems, hospitals, and individual groups and practices that do not operate in the same environment, and would be hard pressed to even understand it. As stated in the CBO report: "…payments for most health care services outside VHA, whether provided through public or private insurance programs, are generally triggered whenever care is delivered and are not subject to formal budget constraints."

Ultimately, we believe the central question when comparing VA health care to private-sector health care should focus on the quality and value of care. While we recognize that there is much debate underway about the quality of care being delivered at VA medical facilities around the country, we believe that private-sector health care systems by and large could not stand up to the same level or intensity of scrutiny VA is under. We will not dispute the idea that timely access to high quality health care services remains a clear objective that the VA is not achieving in a satisfactory manner. Access to health care, along with the cost and quality of that care, are generally considered the three major indicators for evaluating the performance of a health care system or provider. Prevalent delays in delivering timely care result in patient dissatisfaction, higher costs, and increased risk for adverse clinical consequences.

Moreover, while an argument could be made for primary care for some veteran patients to be delivered outside of VA, it is an indisputable fact that most of VA's specialized services—spinal cord injury care, amputee care, blinded care, polytrauma care, etc.—are incomparable resources that could not be duplicated and successfully sustained in the private sector. Establishing a scenario whereby veterans could choose to leave the VA health care system under the guise of more cost-effective care being available elsewhere, would place the entire VA system of care at risk. Former VA Secretary Anthony Principi wrote in the *Wall Street Journal* why the concept of private-sector care is not a viable long-term solution to the problems facing the VA health care system:

> *"Vouchers (a previously proposed component of private-sector care) are not necessary to ensure high-quality health care…While this may have value in areas with long waiting lists, it raises serious questions. The VA system is valuable because it is able to provide specialized health care for the unique medical issues that veterans face, such as prosthetic care, spinal-cord injury and mental-health care. If there is too great a clamor for vouchers to be used in outside hospitals and clinics, the VA system will fail for lack of patients and funds, and the nation would lose a unique health-care asset."*

These services do not function in a vacuum. The viability of the VA health care system depends upon a fully integrated system in which the organization and management of services are interdependent so that veterans get the care they need, when and where they need it, in a user-friendly way, to achieve the desired results and provide value for the resources spent. Sending veterans into the private health care marketplace would serve only to support part of this principle while it would undermine others. Similarly, contract care simply is not a viable option for veterans with complex, catastrophic, and specialized health care needs. Sending these individuals outside of the VA would actually place their health at significant risk while abrogating VA of the responsibility to ensure timely delivery of high quality health care for our nation's veterans. This is not to suggest that leveraging coordinated, purchased care is not part of the solution to the known access problems in VA. However, granting veterans access to the private-sector, particularly when nothing guarantees that private care is more cost-effective or of greater value and higher quality, should not come at the expense of the existing health care system and the veterans who rely almost solely on the VA for their health care and maintenance of their health.

As the CBO report points out, the VHA operates one of the largest integrated health care systems in the United States. Veterans who access VA health care, particularly those with specialized health care needs, benefit from this integration. An important aspect of this integrated system is the coordination of care from different clinicians to provide services that are not disjointed for the veteran patient and through which the veteran patient can easily navigate. CBO states that integrated health care systems (such as VA) offer several features that should enable them to

deliver less expensive and higher quality care than non-integrated providers. Those features include:

- Comprehensive medical records that are accessible to all providers in all care locations.
- Collaboration among physicians and coordination of care among locations.
- Physicians' performance can be measured using factors that contribute to the overall health and improvement of patients.

However, CBO explains that while there are a number of integrated delivery systems in the U.S. (such as Kaiser Permanente and the Mayo Clinic), "for the most part…doctors and hospitals in the private sector are not integrated." If CBO's point about the largely non-integrated private-sector health care marketplace is the U.S. norm, we question whether that is really the optimal setting for veterans to receive their care? Although it already possesses the attributes of integration, can the VA health care system improve upon each of these features that define an integrated system? The answer is unequivocally "yes." However, VA cannot achieve continuing improvements in integrated care if its resource base is insufficient for the patient care demands VA faces.

In the book *Best Care Anywhere Why VA Health Care is Better Than Yours*, author Phillip Longman offers an interesting analysis of how the business of providing health care is at odds with the need to provide quality health care. Longman asks, "With the exception of the VA, what do most health care providers get paid to do? Provide health?" His startling answer is, "They get paid to provide treatments…as a private practice physician, [he] got paid for treating patients, not for keeping them well or helping them to recover." This is the complication that arises from the business of health care whereby private-sector providers earn income from the delivery of services, the more, the better (for business and cash-flow purposes). This is a challenge from which the VA is largely exempt. The VA health care is by-and-large not incentivized to cycle patients through a mill, or to over-treat, or over-prescribe, because no reimbursement follows.

Proponents of private-sector health care for veterans also overlook the fact that VA health care providers treat veterans in a holistic manner, and throughout the course of their lives. While

many individuals (including most veterans) have family physicians and primary care practices with whom they maintain relationships for long periods, they generally are not involved in holistic care.

The IB co-authors believe that the quality of VA health care is generally excellent, as long as it is accessible. In fact, as mentioned previously, VA patient satisfaction surveys reflect that more than 85 percent of veterans receiving care directly from the VA rate that care excellent (a number that surpasses satisfaction rates in the private-sector). The fact is that the most common complaint from veterans who are seeking care or who have already received care in the VA is timeliness. We believe that veterans want to receive their care from the VA. This is not to suggest that purchased care does not play a role in the delivery of health care services for veterans when necessary. But why is there a concerted effort to push that care into the private-sector? Much like the concept of "choice" provided by P.L. 113-146, the "Veterans' Access to Care Through Choice, Accountability, and Transparency Act (VACAA)," we question the motivations of such an effort. We believe that the more than eight million veterans who have enrolled in VA health care and the nearly seven million veterans who are unique users have made a choice to rely on VA. We would suggest the same about the nearly 13 million veterans who are not enrolled in VA health care. They are provided for elsewhere. These statistics suggest to the IB co-authors that a concerted effort must be made to strengthen the existing VA system to meet the health care demands of the veterans who are seeking care directly from VA.

The CBO report and previous discussions and hearings make it clear to the IB co-authors that comparing VA health care and private-sector health care is at minimum complicated, if not outright impossible. Too many uncontrollable variables would confuse any outcomes or conclusions from such a study. A common refrain we hear from those clamoring for increased access to private health care services is the lack of data from the VA on its services and performance. However, CBO raises an important point that further explains the difficulty with comparing VA health care and private-sector care. The CBO report explains that comparisons would be challenging because private-sector data are also incomplete, unavailable, and difficult to make comparable with VHA data. To be clear, the IB co-authors believe that VHA should be far more forthcoming with data that allows for a thorough examination of the timeliness and

quality of its services, and the capacities VA maintains to meet these requirements. However, the concern over VA's apparent lack of transparency on data cannot be set aside when the private sector cannot, and often does not attempt to, produce the same information.

Once again, we appreciate the Subcommittee's focusing on this important issue. As the delivery of non-VA health care for veterans evolves, particularly in light of the VACAA and the expansion of Non-VA Purchased Care and the Patient-Centered Community Care (PC3) program, it will be important for Congress and the Administration to continuously evaluate the cost-effectiveness of the funds being spent. In the end, the most important factor will be the quality and value of health care delivered in as timely a manner as possible to veterans who are eligible to receive it.

This concludes my testimony. I, and the co-authors of *The Independent Budget*, will be happy to answer any questions you may have.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2014

No federal grants or contracts received.

Fiscal Year 2013

National Council on Disability — Contract for Services — $35,000.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

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Carl Blake is the Associate Executive Director for Government Relations for Paralyzed Veterans of America (PVA) at PVA's National Office in Washington, D.C. He is responsible for the planning, coordination, and implementation of PVA's National Legislative and Advocacy Program agendas with the United States Congress and federal departments and agencies. He develops and executes PVA's Washington agenda in areas of budget, appropriations, health care, and veterans' benefits issues, as well as disability civil rights. He also represents PVA to federal agencies including the Department of Defense, Department of Labor, Small Business Administration, the Department of Transportation, Department of Justice, and the Office of Personnel Management. He coordinates all activities with PVA's Association of Chapter Government Relations Directors as well with PVA's Executive Committee, Board of Directors, and senior leadership.

Carl was raised in Woodford, Virginia. He attended the United States Military Academy at West Point, New York. He received a Bachelor of Science Degree from the Military Academy in May 1998.

Upon graduation from the Military Academy, he was commissioned as a Second Lieutenant in the Infantry in the United States Army. He was assigned to the 2nd Battalion, 504th Parachute Infantry Regiment (1st Brigade) of the 82nd Airborne Division at Fort Bragg, North Carolina. He graduated from Infantry Officer Basic Course, U.S. Army Ranger School, U.S. Army Airborne School, and Air Assault School. His awards include the Army Commendation Medal, Expert Infantryman's Badge, and German Parachutist Badge. Carl retired from the military in October 2000 due to injuries suffered during a parachute training exercise.

Carl is a member of the Virginia-Mid-Atlantic chapter of the Paralyzed Veterans of America.

Carl lives in Fredericksburg, Virginia with his wife Venus, son Jonathan and daughter Brooke.