STATEMENT OF
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BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
"EXAMINING THE QUALITY AND COST OF VA HEALTH CARE"

JANUARY 28, 2015

Chairman Benishek, Ranking Member Brownley and distinguished Members of the Health Subcommittee, on behalf of Commander Helm and the 2.4 million members of The American Legion, I thank you and your colleagues for examining the recent analysis of health care costs by the Congressional Budget Office in an attempt to achieve greater clarity into the cost considerations that impact VA's health care budget, as well as the quality of care and patient satisfaction.

Normally The American Legion focuses our testimony predominantly on field work and primary research evidence. This hearing was precipitated by the December 2014 Congressional Budget Office (CBO) report "Comparing the Cost of the Veterans' Health Care System With Private-Sector Costs", and calls on us to evaluate the provided data against the data collected by The American Legion in an effort to determine how the quality and cost of VA provided care is comparatively more or less medically efficient, and more or less cost efficient than non-VA provided care that would be offered at taxpayer expense.

The CBO was asked to conduct an examination of how the costs of health care provided by the Veterans Health Administration (VHA) compare with the costs of care provided by the private sector. With the lack of evidence, and substantial uncertainty, CBO had difficulty reaching any firm conclusions to determine if it would be cheaper to expand veterans' access to VHA facilities or private sector facilities. However, if CBO is looking for a baseline by which to estimate the cost of non-VA care, they need look no further than their own library of published reports when in June of 2014, they estimated the cost of outsourcing VA care to exceed $50 billion[1] over 5 years, or roughly $10 billion dollars per year, just to eliminate the backlog of veterans waiting more than 30 days to see a VA doctor. One important point to keep in mind is that this $50 billion represents an additional $10 billion per year to VHA's already existing $65 billion annual budget, and this measure was only designed to serve less than one percent of VA's total patient population. After reducing eligibility and constricting payments not to exceed Medicare rates, and a couple of other adjustments, CBO was able to come back with a second score that trimmed about $15 billion from the figure and came in with a second estimate of $35 billion.[2]

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[1] CBO Initial Analysis of H.R. 3230, the Veteran Access to Care Act of 2014 http://www.cbo.gov/publication/45453

[2] CBO's 2nd Analysis of H.R. 3230, the Veteran Access to Care Act of 2014 http://www.cbo.gov/publication/45521

It is important to note that previous research has concluded that "the health care provided by VHA generally cost less than would equivalent care provided in the private sector.[3]" Nevertheless, it has been difficult for these studies to fully explain why VHA care may be cheaper.

According to CBO's analysis, a number of factors help explain why VHA cost may differ from private sector healthcare include:

- VHA pays lower for "pharmaceutical products" (pg. 2)
- VHA serves a "unique patient population" (pg. 2)
- VHA is funded by "annual appropriation acts"(pg. 3)
- VHA "provides the vast majority of its care directly through the facilities it operates" (pg. 3)
- VHA has a "mix of services and benefits that veterans receive" (pg. 3) and
- VHA "enrollees pay no premiums or enrollment fees and little or nothing out of pocket for that care" (pg. 3).

CBO's analysis also states the claim, that VA "has provided limited data to Congress and the public about its costs and operational performance. The overarching theme of the study is clear – CBO needs more data in order to make recommendations or be able to come to any credible conclusion.

Important points of the study

1. Most evidence presented supports the assertion that VA is less expensive than both Medicare and private healthcare solutions
2. The report states that it relies on data analytics between 1999 and earlier, and is unable to confirm that the same cost saving conditions still exist. It also mentions VA's overhaul in the early 1990's, the reform that was led by then Undersecretary for Health Kenneth Kizer that transformed VHA into the world-class healthcare system that it is today, but fails to point out that the reports that support VA's cost savings analyses were conducted after this transformation, which represents one of the largest public investments in VHA in history.
3. The analysis indicates that VHA represents a cost savings when comparing physician care, and pharmaceuticals, but was unable to compare "other medical goods and services".
4. CBO recognizes that private-sector physicians are financially motivated to deliver a larger amount of services which typically represent duplication or unnecessary expenses, and further finds that private-sector providers have strong financial incentives to provide more expensive care than VHA providers, who have no such incentives[4].

[3] CBO Analysis, page 1

[4] See James C. Robinson, "Theory and Practice in the Design of Physician Payment Incentives," Milbank Quarterly, vol. 79, no. 2 (June 2001), pp. 149–177, http://dx.doi.org/10.1111/1468- 0009.00202; and Heike Hennig-Schmidt, Reinhard Selten, and Daniel Wiesen, "How Payment Systems Affect Physicians' Provision Behaviour—An Experimental Investigation," Journal of Health Economics, vol. 30, no. 4 (July 2011), pp. 637–646, http://dx.doi.org/10.1016/j.jhealeco.2011.05.001.

5. While providing more services and reimbursements, VA costs are lower than Medicare costs "but they still found that they "could not price many services...for which a private sector system would charge."[5] The costs of those services were still counted as costs for VHA but were not included when calculating costs at Medicare's payment rates, which means that VHA's cost advantage may have been underestimated."
6. The full range of services that VHA provided in 1999 would have cost about 21 percent more if those services had been delivered through the private sector at Medicare's payment rates (pg. 5).
7. Inpatient care (excluding costs for nursing homes and rehabilitation facilities) would have cost about 16 percent more if it had been purchased at Medicare's rates (pg. 5).
8. The outpatient care provided by VHA would have cost about 11 percent more if it had been provided at Medicare's prices (pg. 5).
9. Prescription drugs would have cost about 70 percent more using a combination of Medicaid's and Medicare's payment methods (pg. 5).

This report states:

> *"Even if VHA currently provided care at a lower cost than the private sector, expanding the VHA system might not be cheaper in the longer term than increasing the use of private-sector providers. That would depend on the manner in which VHA chose to expand its own staff and facilities or the terms of any contracts it arranged for care with private-sector providers."*

Yet if over the past 50 years VHA has proven to be a better financial investment than private-sector care, then provided adequate congressional oversight, diligent metric reporting and transparency, and continued stakeholder involvement, there is no reason to believe that VHA services would now reverse its trend and somehow end up costing taxpayers more for care than the rising costs associated with private-sector care.

On page 2, CBO questions the efficiency of VHA provided care, but offers no evidence to suggest that VHA has ever been inefficient, or less than efficient than non-VA provided care, only suggesting that "VHA may not be efficient". Missing from the report is any indication that CBO consulted directly with VA to request additional information and rendered their limited analysis based only on secondary research from third party studies and congressional reports.

CBO then suggests that an annual report similar to the one that DOD produces relative to TRICARE would help policymakers evaluate cost efficiencies, and The American Legion agrees. Additional data, particularly if it was provided on a regular and systematic basis, could help inform policymakers about the efficiency and cost-effectiveness of VHA's services". The American Legion, through testimony[6], and resolution[7], has consistently called upon the VA to

[5] Gary N. Nugent and others, "Value for Taxpayers' Dollars: What VA Care Would Cost at Medicare Prices," Medical Care Research and Review, vol. 61, no. 4 (December 2004), p. 505, http://dx.doi.org/10.1177/1077558704269795.
[6] VHAC-"A Continued Assessment of Delays in VA Medical Care and Preventable Veteran Deaths" April 9, 2014
[7] Resolution No. 128: Increase the Transparency of the Veterans Benefits Administration's Claims Processing; Resolution No. 150: Strategic Capital Investment Planning Program

remain transparent in all aspects of data reporting. This is why we support H.R. 216 introduced by Ranking Member Brown, the Department of Veterans Affairs Budget Planning Reform Act.

This legislation would direct the Secretary of Veterans Affairs to submit annually to Congress a future-years veterans program reflecting estimated expenditures and proposed appropriations included in the budget for that fiscal year. It would require each program to set forth a five-year VA plan to address the U.S. commitment to veterans and the resources necessary to meet that commitment. Further, the bill requires the Secretary, in 2019 and in a quadrennial manner thereafter, to conduct a review of the strategy for meeting such commitment and resources requirement. This bill also requires the Secretary to designate a Chief Strategy Officer to advise the Secretary on long-range VA strategy and implications and directs the Secretary to study (through an independent contractor) and report to the veterans committees on the functions and organizational structure of the Office of the Secretary and the VA, including the most efficient and economical allocation and structure for assisting the Secretary in carrying out duties and responsibilities.

In the report, CBO highlights the need for specialty care and specifically mentions mental health care, Posttraumatic Stress Disorder (PTSD) treatment, and substance abuse counseling and "other services…that may fall outside the typical scope of healthcare provided to patients in the private sector." These "other services" include extensive burn surgeries and therapy, physical reconstructive surgery, traumatic brain injuries stemming from concussive blast or physical trauma, and prosthetic care, just to name a few.

During the 12th through the 15th of January 2015 The American Legion conducted a Veterans Benefits Center (VBC) outreach event in Tampa and St. Petersburg, Florida. During the event The American Legion, together with VA staff, assisted more than 250 veterans with donations of comfort items, claims assistance, access to emergency services, and assistance with specialty care, homelessness service, women veterans' needs, claims legal assistance, and family assistance needs. We worked with local American Legion posts, our Department Service Officers, the CW Bill Young (formerly Bay Pines) VA Medical Center, their domiciliary, the local homeless shelter that assists veterans, and the James A. Haley VA Tampa Polytrauma Rehabilitation Center. During our work with the veterans who receive services from these facilities, we learned firsthand how the specialized attention and focus that VA places on veteran specific needs results in increased quality of life for these veterans, and further reduces extension of long term outpatient services in many cases.

One key factor pointed out by CBO's report quotes Gary N. Nugent and others, "Value for Taxpayers' Dollars; What VA Care Would Cost at Medicare Prices"[8] while discussing how the cost savings of VHA may be even greater than displayed in their data due to "VHA's accounting system" and how they "might regard an admission to an inpatient facility followed by treatment at a rehabilitation facility as a single "stay", whereas other accounting systems might regard them as two distinct stays", The American Legion saw expanded evidence of this first hand at the Tampa Polytrauma center, in their rehabilitative suite. At this VA center, patients recovering from severe and in most cases multiple complicated injuries spend an average of several weeks,

[8] Medical Care Research and Reviews, Vol. 61, no. 4 (December 2004), p.505
http://dx.doi.org/10.1177/1077558704269795

months, or in some of the worst cases, years going through inpatient rehabilitation. According to the Chief of Medicine there, patients who benefit from sufficient uninterrupted inpatient rehabilitative care experience much greater return to normal functionality, greater long term health, and have fewer episodes of chronic complications due to their injuries. As opposed to private care, which can become cost prohibitive to remain in a rehabilitative service for extended periods of time, veterans in these VA facilities are not under any insurance constraints or financial pressures to shorten critically important rehabilitation therapy. Further, following their specific rehabilitation, these veterans then move to an independent living dormitory where they practice living independently in a supervised environment so that they can identify challenges they will face after they leave the hospital, and gain the confidence they need to leave the hospital with less anxiety.

On page 3 of the report, CBO outlines the difference in out-of-pocket expenses between VA patients, and the copayments exhibited by Medicare Part B patients. CBO reports that "[i]n 2013 VHA enrollees spent an average of about $100 on copayments (or roughly 2 percent of the costs of their care). By contrast, most enrollees in Part B of Medicare (which covers physicians' services) paid premiums of just over $100 per month in 2013 and are typically responsible for paying 20 percent of the costs for their care." So, according to these statistics, the cost per VA patient in 2013 was $5,000 ($100 = 2% of $5,000), while Medicare patients, who are a similar cohort to VA's aging population, consumed $60,000 ($100/month x 12 = $1,200 = 20% of $60,000) in medical care that same year, which represents a cost that is 12 times greater than VA's patients. CBO's analysis of the average VA patient concludes:

> *"The veterans seeking VHA care have different clinical and demographic characteristics than people using private-sector care. For example, in 2012, most veterans with severe service-connected disabilities sought health care from VHA, and the average age of VHA enrollees was about 62. A recent study found that VHA patients (primarily older men) had much higher rates of many chronic health problems—such as high blood pressure, diabetes, and depression—than the U.S. patient population as a whole."*[9]

CBO goes on to point out that patients who suffer higher out-of-pocket costs are more likely to cut back on needed medical care. This statement suggests that if Medicare were to offer the full complement of services enjoyed by VA patients, the burden on Medicare would be even greater. Under CBO's heading "Comparing Average Costs per Enrollee" CBO states;

> *"Veterans who are enrolled in the VHA system receive most of their health care outside that system— typically about 70 percent, according to information provided by VHA. As a result, VHA's average cost per enrollee understates the full annual cost of a veteran's health care. Moreover, about half of veterans enrolled in VHA are also enrolled in Medicare or Medicaid, and many others have a private insurance plan, further complicating comparisons with average costs per enrollee in those programs and plans."*

[9] Sarah Klein, The Veterans Health Administration: Implementing Patient-Centered Medical Homes in the Nation's Largest Integrated Delivery System (Commonwealth Fund, September 2011), http://tinyurl.com/q2jm9yb.

The percentage of care received per veteran through VA is irrelevant for this analysis unless CBO is suggesting that VA patients are seeking less expensive types of care from VA than they are through Medicare, but that assumption would conflict with CBO's opinion that:

> *"However, research suggests that among some segments of the general population—such as the elderly, those with chronic conditions, and those with low income—the prospect of higher out-of-pocket costs may cause people to cut back on preventive care or on the appropriate use of medications, resulting in greater need for acute care services later on*[10]*. Therefore, although its relatively low out-of-pocket costs probably increase costs for VHA in the short run, there may be some offsetting savings over the longer run because many VHA enrollees belong to those segments of the population. Further, VHA is more likely than private insurers to capture those longer-term savings because veterans generally remain enrolled in VHA for life, even if they receive only a portion of their care from that system."*

While trying to compare dissimilar cost structures, CBO indicates that part of the problem is "VHA's medical care accounts include the costs of some services and programs not typically provided by the private sector, such as travel reimbursement and financial support for family members," however those costs will remain regardless of where the veteran receives their care as directed under title 38 USC Chapter 17.

In their analysis, while trying to understand why VHA costs may differ from that of privately provided care, CBO assumes on page 7 for future analysis of calculations:

> *"[T]hat veterans would have the same cost-sharing rules for private-sector care as they do for care delivered in VHA facilities. Thus, CBO assumed that a veteran's demand for health care would be about the same in either setting, although some differences could still occur because of factors such as proximity or ease of making appointments. Nevertheless, the amount and mix of medical services provided could differ under the* two *arrangements, as described below, because private-sector providers have financial incentives to deliver more care and often lack mechanisms to coordinate patients' care."*

This assumption will skew all future conclusions drawn by CBO in this analysis because supposing that veterans will suffer greater cost burdens at VA facilities in the future would require a prediction that Congress is planning on fundamentally changing the way VA care is offered to future veterans getting their care on VA campuses. By resolution The American Legion adamantly opposes such a suggestion[11] and since neither this nor any Congress in history has introduced legislation that would raise the out-of-pocket costs of VA healthcare to that which would be commensurate with private healthcare insurance, making this assumption for the purpose of attempting to create a common denominator is fundamentally flawed.

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[10] For an overview of that research, see Katherine Swartz, Cost-Sharing: Effects on Spending and Outcomes, Research Synthesis Report 20 (Robert Wood Johnson Foundation, December 2010), http://tinyurl.com/mxc3ue9; and Michael E. Chernew and Joseph P. Newhouse, "What Does the RAND Health Insurance Experiment Tell Us About the Impact of Patient Cost Sharing on Health Outcomes?" American Journal of Managed Care, vol.14, no. 7 (July 2008), http://tinyurl.com/n247vg7.

[11] Resolution No. 234: Co-Payments and Enrollment Fees for Priority Groups 7 & 8 http://archive.legion.org/bitstream/handle/123456789/3573/2014N234.pdf?sequence=1

The report further credits VA with pharmaceutical savings based on "statutory or regulatory" cost controls. This assertion is misleading because it suggests that the federal government has created laws that order private companies to sell their fair market goods at a reduced rate for the sole benefit of government purchase – this is not the case. Federal procurement, which is guided by statute and the Federal Acquisition Regulation, requires the federal government to always seek the best possible deal, or most preferred price, on behalf of the American taxpayer. These controls are put in place to protect the government from being over charged, and allow the government to take advantage of its enormous buying power, similar to any large company. This law applies equally across the federal procurement landscape.

Another example of VA's advantage is highlighted in the report under malpractice insurance premiums. CBO points out that VHA is not subject to malpractice premiums for VA employees. This is a clear advantage VA possesses, and in the private sector it is referred to as being "self-insured", a common practice for larger companies who opt not to purchase commercial insurance as opposed to risking the exposure of law suits levied against them.

In conclusion, The United States has the most comprehensive system of assistance for veterans of any nation in the world, with roots that can be traced back to 1636, when the pilgrims of Plymouth Colony were at war with the Pequot Indians. Plymouth Colony passed a law that stated that disabled soldiers would be supported by the colony. Later, in 1776 the Continental Congress encouraged enlistments during the Revolutionary War by providing pensions to disabled soldiers, and in 1811 the federal government authorized the first medical facility for veterans. The history of America's commitment to care for those who serve dates back to the very roots of the nation's founding.

In 1930 The American Legion began its support for VA even before there was a VA by lobbying Congress to "consolidate and coordinate Government activities affecting war veterans." by creating the Veterans Administration as a federal administration. Again in 1988 The American Legion further lobbied Congress to elevate VA to a cabinet level department as the Department of Veterans Affairs. The American Legion sees the value that VA provides every day through our casework with individual veterans, our more than three quarters of a million volunteers that shoe up to VA facilities across the country daily, and through our many programs and services that assist veterans with their rehabilitative needs, reintegration and readjustment needs, through our millions of dollars of charitable donations and financial support for veterans given annually, and through the 20 plus national programs and hundreds of local programs that are staffed by Legionnaires all across the United States of America, in Europe, the South Pacific, and the Middle East.

The American Legion thanks this committee for holding this important hearing to analyze and evaluate the care and value of the Department of Veterans Affairs. We have a vested interest in this department, and will do everything in our power to ensure that it remains safe and healthy for today's veteran, and all future veterans who step up to raise their right hands to "Support and defend the Constitution of The United States, against all enemies, foreign and domestic", and who have pledged life and limb to do just that.

Questions concerning this testimony can be directed to The American Legion Legislative Division (202) 861-2700, or lprovost@legion.org