FUNDING THE U.S. DEPARTMENT OF VETERANS AFFAIRS OF THE FUTURE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

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CONTENTS

October 3, 2007

	Page
Funding the U.S. Department of Veterans Affairs of the Future	1

OPENING STATEMENTS

Chairman Bob Filner	1
Prepared statement of Chairman Filner	42
Hon. Steve Buyer, Ranking Republican Member, prepared statement of	43
Hon. Phil Hare	2
Hon. Cliff Stearns	4
Hon. Richard H. Baker	5
Hon. Stephanie Herseth Sandlin	13
Prepared statement of Congresswoman Herseth Sandlin	44
Hon. Ciro D. Rodriguez	20
Hon. John Boozman	21
Hon. Harry E. Mitchell, prepared statement of	44
Hon. Jeff Miller, prepared statement of	45
Hon. Ginny Brown-Waite, prepared statement of	45

WITNESSES

U.S. Department of Veterans Affairs, W. Paul Kearns III, FACHE, FHFMA, CPA, Chief Financial Officer, Veterans Health Administration	35
Prepared statement of Mr. Kearns	60

Aaron, Henry J., Ph.D., Bruce and Virginia MacLaury Senior Fellow, Brookings Institution	25
Prepared statement of Mr. Aaron	52
Center on Budget and Policy Priorities, Richard Kogan, Senior Fellow	27
Prepared statement of Mr. Kogan	57
Partnership for Veterans Health Care Budget Reform, Joseph A. Violante, National Legislative Director, Disabled American Veterans	6
Prepared statement of Mr. Violante	46

MATERIAL SUBMITTED FOR THE RECORD

Post Hearing Questions and Responses for the Record:

Hon. Bob Filner, Chairman, Committee on Veterans' Affairs, to Joseph Violante, National Legislative Director, Disabled American Veterans, letter dated October 18, 2007	63
Hon. Bob Filner, Chairman, Committee on Veterans' Affairs, to Henry J. Aaron, Ph.D., Bruce and Virginia MacLaury Senior Fellow, Brookings Institution, letter dated October 18, 2007	66
Hon. Bob Filner, Chairman, Committee on Veterans' Affairs, to Richard Kogan, Senior Fellow, Center on Budget and Policy Priorities, letter dated October 18, 2007	67

FUNDING THE U.S. DEPARTMENT OF VETERANS AFFAIRS OF THE FUTURE

WEDNESDAY, OCTOBER 3, 2007

U. S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The Committee met, pursuant to notice, at 10:02 a.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Snyder, Michaud, Herseth Sandlin, Mitchell, Hall, Hare, Rodriguez, Donnelly, McNerney, Space, Walz, Buyer, Stearns, Moran, Baker, Brown of South Carolina, Miller, Boozman, Brown-Waite, Turner, and Bilirakis.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. Good morning. This hearing of the Committee on Veterans' Affairs of the House of Representatives is called to order for a very important subject, funding the U.S. Department of Veterans Affairs (VA) for the future, how are we going to meet the incredible demands that are on the VA in terms of our funding mechanisms. The issue of so-called mandatory funding, assured funding, is on the table.

I am going to yield to Mr. Hare to make an opening statement or to have his opening statement because he has taken the leadership following his predecessor, former Member Lane Evans, on this issue.

I think there are 2 main reasons why we should do it. Number 1, it takes the politics out of providing healthcare to our veterans where the Executive and the Legislative Branches, Senate, and the House, Republicans, and Democrats pick numbers and keep accusing each other of not doing enough. Let us get that out of the process.

And, second, we would not be in the position we are in today, on October 3rd, the third day of the fiscal year, and there is no fiscal year 2008 budget beyond the Continuing Resolution for the VA or any other agency.

I had hoped that we would fund the VA on time. We owe it to our veterans to do that. That has not been the case. With mandatory funding, we would not be in this position.

Mr. Hare, thank you for your leadership. Thank you for introducing the bill that brings us there. And I would yield to you for your opening statement.

[The prepared statement of Chairman Filner appears on p. 42.]

OPENING STATEMENT OF HON. PHIL HARE

Mr. HARE. Thank you, Mr. Chairman. Thank you for your indulgence of being able to make this statement.

I am extremely pleased that the Committee is examining future funding of the VA and that so much discussion is focused on mandatory funding.

With our continued presence in Iraq and Afghanistan, it has become obvious that a new generation of brave men and women are coming home and will require substantial healthcare through the VA for generations to come.

I am proud to have introduced H.R. 2514, the "Assured Funding for Veterans Healthcare Act," which currently has 87 cosponsors. This is a legislative priority that I inherited from my good friend, predecessor, and former Ranking Member of this Committee, Congressman Lane Evans.

Simply put, this bill would require that funding for veterans' healthcare become mandatory rather than subjected to the discretionary appropriations battle every year. With Congress being on average 105 days late in completing the funding bills, the Veterans Health Administration (VHA) is often stuck in a holding pattern, unable to plan, unable to provide care because it does not know how much money it will have to spend.

This must stop. I do not believe there is a more pressing issue this Committee should focus on than assured funding for veterans' healthcare.

Need I remind all of us that the VA actually ran out of money the last 2 years suffering shortfalls of $1 billion in 2005 and $2 billion in 2006.

Due to the passage of the "Veterans Healthcare Eligibility Reform Act of 1996," the VA enrolled patient population surged from 2.9 million in 1996 to 7.7 million in 2005, a 172-percent increase.

However, appropriated funding for VA medical care has barely increased over 50 percent from $16.6 billion in 1990 to $34 billion in 2007. The VA has received on average only a 5 percent increase in appropriations over the last 8 years.

However, VA's Under Secretary for Health testified that the VA requires at a minimum approximately a 14-percent increase annually just to maintain current services.

I am proud that this Congress passed a fiscal year 2008 budget that includes the largest increase in veterans' healthcare funding in the 77-year history of the VA. However, we cannot rely on future Congresses to be as smart, which is why we need assured funding.

We must all remember that while we are talking about dollars and cents, we are talking about people. These are more than just numbers. Funding shortfalls have real life or death consequences. They can take away our ability to provide an injured soldier with a prosthetic leg or treat a Marine suffering from traumatic brain injury (TBI), people who have honorably and courageously fought for our freedom.

As Mr. Violante will mention in his written testimony, the demands being placed upon the VHA by the soldiers returning from Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) are, and will continue to be, enormous. We must ensure that our troops receive the care they deserve and that this care will not be subject to an uncertain, unstable, and commonly delayed appropriations process.

Soldiers returning today are wounded in ways never seen before. TBI, polytrauma, post traumatic stress disorder (PTSD), amputees are no longer exceptions but the reality. Life-saving research, long-term care and planning and prosthetics development will be key components of the VA of the future and these goals and the demands of the VHA simply cannot be met by discretionary funding.

Mandatory funding, as proposed in H.R. 2514, will give the VHA the funds and, more importantly, the ability to better manage its assets and ensure adequate staffing. It will provide assured care for our veterans, not just as much care as we can afford in a fiscal year.

Allowing the VHA to know its budget, plan for the future, and spread costs out over numerous years will increase the efficiency and effectiveness of the VHA.

Critics question whether or not we can afford assured funding. I ask them, can we afford not to? Let me make something very clear. When it comes to the brave men and women who risked their lives for our Nation, we should spare no expense.

The operation under which the VA has created a highly efficient, high-quality, state-of-the-art healthcare system would not be changed under my bill. Eligibility requirements, enrollment management, budgetary oversight, and a benefits package would remain as enacted by Public Law 104–262.

Mandatory funding would assure the funding of those enrolled, create a mechanism to pay for the increased use of the system, guarantee care, and eliminate budgetary shortfalls in the VHA that leave veterans waiting for care.

Never before has there been a more critical moment for Congress to act. I urge this Committee to pass the "Assured Funding for Veterans Healthcare Act," and I want to commend the Chairman of this Committee for his support on this bill.

Thank you, Mr. Chairman, for giving me the opportunity to do my opening statement. Thank you.

The CHAIRMAN. Thank you, Mr. Hare. And without objection, my opening statement and all other Members of the Committee will be included in the record.

Mr. Buyer, you are recognized.

Mr. BUYER. I ask that my opening statement be submitted for the record and yield back.

[The prepared statement of Congressman Buyer appears on p. 43.]

The CHAIRMAN. I thank the Ranking Member.

Mr. STEARNS. Mr. Chairman, as I understand, we can have opening statements?

The CHAIRMAN. I was not planning on that, but if you would like to.

Mr. STEARNS. Oh, sure. I would not mind if that is possible.

The CHAIRMAN. All right. Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

The CHAIRMAN. You are so convincing.

OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. So convincing. Obviously this is an important hearing. This issue is not new. It was brought in previous Congresses and it has support obviously in some Members of Congress.

We know that doing this will be a big change for us as a Veterans' Affairs Committee itself. There is many that will argue that leaving the VA funding to the annual appropriation process results in this uncertainty and shortfall of funds and, therefore, as the gentleman indicated, the changing of the funding would be a mandatory funding to ensure that the access and quality of VA programs are assured. I think we all want that.

But I do have some concerns with this proposal. The underlying goal and ideal I support and I think it is something, as I mentioned, we can all agree upon. I certainly consider the healthcare services for this dedicated population of Americans one of the most essential debts owed by this Nation. We should and will ensure that all veterans who are in need of healthcare are taken care of.

But people will complain about the current system. It is not perfect. Well, obviously it is not perfect, but it is improving.

Following the budget shortfalls in fiscal year 2005 and 2006, Congress simply passed supplemental funding to cover those affected areas. In addition, the VA has implemented a new budget model that incorporates a risk-adjusted formula anticipating the changing healthcare needs as our veterans age.

I am pleased that in our work here in Congress, we have increased the VA budget appropriations by an average of 8 percent each year from the year 2000 to 2006.

What I am concerned about the proposed solution, while well-intended, might have the opposite unintended effects. As long as Congress has the opportunity to hear from veterans every year, every year, we have hearings on the budget, review circumstances, and consider these needs, then appropriate as needed based on this annual consideration. We have great flexibility, my colleagues.

If we implement a formula to allow for mandatory funding as we are considering today, we lose that ability to periodically evaluate the needs that each one of us has in our district. In a given year, Congress might wish to provide more for veterans than a static formula might allow.

And here is a very important point. Being a new mandatory entitlement program, VA funding would become subject to PAYGO rules. Moving the VA funding to a mandatory entitlement would make it compete against other entitlement programs such as Medicare, Medicaid, Social Security. PAYGO rules would mandate that any increase in funds that we consider for the VA fine, offsetting costs in one of these other programs or offset by increasing taxes.

Therefore, I think, Mr. Chairman, it is important to have this hearing. I think we should look at this seriously. It is a complex issue. But I look forward to our panel of witnesses today and the impact and assured funding that is necessary so that all the veterans can benefit.

And I thank you for your——

The CHAIRMAN. Thank you, Mr. Stearns.

Mr. Rodriguez, any opening statement?

Mr. RODRIGUEZ. No, thank you. I will reserve my time.

The CHAIRMAN. Mr. Brown?
Dr. Snyder.
Mr. SNYDER. No, thank you.
The CHAIRMAN. Okay. Mr. Baker.

OPENING STATEMENT OF HON. RICHARD H. BAKER

Mr. BAKER. Mr. Chairman, I appreciate the expedited proceedings. I just want to be very brief and make a couple of comments.

I think how we best meet veterans' needs going forward is certainly an appropriate subject of discussion. Whatever resolution we reach is, I am sure, the best considered interest by this Committee as we all hope.

More troops are coming home every day and we all want all of them home as quickly as possible. And the only certainty in this business is the need for veterans' services will continue to escalate, not deteriorate.

There is a bit of irony in this discussion, however, in that this Committee has done its work. We passed out a very good bill. In fact, the House floor passed our measure on June 15th by a 409 to 2 vote. And this is really the notable achievement. The Senate, the Senate has actually passed something. And they passed a MilCon Appropriations bill 92 to 1 back in September.

Another notable bit. This is one of the few subjects in which I have not heard the White House use the veto word. The President would actually sign this bill. So we have the House and Senate historically acting. We have the White House not threatening a veto.

The Senate has appointed conferees and, yet, in our search to find a sense of urgency to assist troops in future years, the House has yet to appoint the conferees on this critically important matter. While we are all debating the right strategy in the Iraq War, this is one that is sitting right there teed up ready to go.

And, Mr. Chairman, I would hope the Committee would call on the leadership for whatever reason to insist on the appointment of conferees. Let us get this work done. Let us at least get this one bill done because of its vital importance to our vets.

And with that, I yield back and thanks for the courtesy of the statement.

Mr. BROWN OF SOUTH CAROLINA. Mr. Chairman, if I might add on that same subject, I believe the numbers that make $37 billion a day we deprive in our veterans every day the President does not sign that bill.

Mr. BAKER. The gentleman is correct. And it is also the highest amount of assistance ever appropriated by the Congress for veterans' assistance in the VA history. So this is a big deal.

Thank you.

The CHAIRMAN. Thank you, Mr. Baker.

In fact, I have done what you suggested to our leadership, urged that to happen. And as I said in my opening remarks, I had hoped we would do that. I would agree with you.

Mr. BAKER. However we can bring focus to bear from our side, Mr. Chairman, I want to be of help.

The CHAIRMAN. Thank you.

Mr. Space, any opening remarks?

Mr. SPACE. No.

The CHAIRMAN. Mr. Bilirakis.

Mr. BILIRAKIS. No.

The CHAIRMAN. Thank you for growing some hair before you returned here. It was not a pretty sight before.

Mr. Violante, thank you for being here. I know it is unusual not to be surrounded by your comrades. I hope you can handle this one alone. You are speaking not only, of course, for the Disabled American Veterans for which you serve as National Legislative Director, but on behalf of the Partnership for Veterans Health Care Budget Reform.

And because you represent that coalition, you will have 10 minutes to present your views. And your written statement will be made a part of the record. Thank you for being here and thank you for your leadership on this.

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

Mr. VIOLANTE. Thank you, Mr. Chairman and Members of the Committee. Thank you for this opportunity to testify on the future of veterans' healthcare funding.

I am testifying on behalf of the Partnership, as you said, for Veterans Health Care Budget Reform made up of 9 national veteran service organizations (VSOs).

Firstly, I would like to begin by thanking you, Mr. Chairman, and all the Members of this Committee for holding this hearing.

Fourteen years ago, the original Partnership for Healthcare Reform urged Congress to address and reform the basic discretionary appropriations system for funding VA healthcare.

Today we remain unified in this position. We all agree that the VA healthcare system must be protected for millions of veterans who depend on it now as their only healthcare resources and will do so for many decades.

As we have done several times already this year, the Partnership would like to acknowledge and applaud the support of this Committee and the Members of the House who have voted to increase VA healthcare funding in recent years and, in particular, for this year's prospective increase of $6 billion.

But as has been noted, the new fiscal year, fiscal year 2008, has already begun and we have no appropriation for VA. We are now in the third day of VA's functioning under a Continuing Resolution, a situation that has endured for 17 of the past 19 years.

Over the past 5 years, VA's appropriation has been late by an average of 105 days or 3½ months. How late will it be this year?

Mr. Chairman, a lack of an appropriation means that none of the prospective increase for VA healthcare that you and your colleagues supported for fiscal year 2008 is actually helping veterans today. None of VA's directors or department heads can use the prospective increase in funding to improve the delivery of healthcare to veterans today. No new equipment can be procured. No new personnel can be hired. No services can be expanded.

Despite the fact that the prospective increase is supported or at least not opposed by both sides of the aisle, both Houses of Congress and both ends of Pennsylvania Avenue, we still have no appropriation.

In the past 19 years, we have had a Democratic President with a Republican Congress, a Republican President with a Democratic Congress, a Republican President with a Republican Congress, and a Democratic President with a Democratic Congress. And only twice could they get the job done on time. Even at a time of war when obligations to America's veterans are clearer than ever, VA healthcare funding is still late.

Is there really any doubt that it is the system for funding VA healthcare that is broken?

Mr. Chairman, 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 would 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, contract for services, procure equipment and supplies, and conduct planning and administrative matters across a wide path of necessary and even routine matters.

Congress can only fully solve this problem by enacting real reform that results in sufficiency, predictability, and timeliness of VA healthcare funding. I want to repeat that again because it is important. Sufficiency, predictability, and timeliness of VA healthcare funding.

In past Congresses, we have worked with both chambers to craft legislation that would solve this problem. The current version of that bill is H.R. 2514, the "Assured Funding for Veterans Healthcare Act," introduced by the Honorable Phil Hare of Illinois and 77 original cosponsors including you, Mr. Chairman, and several Members of this Committee. The bill now has 85 cosponsors and the Partnership's full endorsement.

Opponents of this reform have made a number of charges, specifically that it would create a new entitlement, that Congress would lose its oversight power, and that it would cost too much. The Partnership rejects these skeptics.

Shifting VA healthcare to a mandatory status would not create an individual entitlement for veterans nor would it change the current benefit package. Many 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 healthcare.

Most importantly, the Partnership rejects the argument that it would cost too much. Funding VA healthcare is a continuing cost of war and our National defense.

At a Senate hearing in July on the same subject, Dr. Ewe Reinhardt, a distinguished Professor of Economics at Princeton University pointed out that the increase in VA healthcare over the past decade is less than that of private healthcare systems, Medicare, and the overall national average for healthcare. Dr. Reinhardt made persuasive arguments for the proposition that the VA system can be sustained and is affordable and that it would be more efficient with funding through a mandatory rather than a discretionary system.

I commend this testimony and that of other witnesses to this Committee.

Mr. Chairman, our goal is to ensure sufficient funding is made available to provide healthcare services to veterans whom VA enrolls, no more, no less. Today and in the future, there is so much at stake. A young American servicemember wounded today, particularly one with severe injuries such as limb loss, blindness, or traumatic brain injury, must be able to rely on VA healthcare 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 system, 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.

Mr. Chairman, Members of the Committee, the Partnership is looking to this Committee to move forward with legislation to create a mandatory and guaranteed funding system for VA healthcare to become effective in 2009.

If the Committee chooses a different method than offered in H.R. 2514, the Partnership will study that proposal to determine whether it meets our 3 key standards for reform, sufficiency, timeliness, and predictability. If that alternative measure meets our standards, the Partnership will support it with a great deal of enthusiasm and appreciation. If it does not, we will tell you why. The time for change is now. We ask all of you to please stand up for veterans.

And, again, I know we are going to have testimony from other witnesses who are going to talk about this bill as an entitlement. And, again, I could not disagree more strongly that it is not an individual entitlement. It does not change the way in which VA provides care or to whom it provides care. So I would ask the Members of this Committee to understand that fact.

Again, thank you for holding this crucial and long-awaited hearing. I will be pleased to answer your questions. Thank you.

[The prepared statement of Mr. Violante appears on p. 46.]

The CHAIRMAN. Thank you, Mr. Violante, and thank you for your long-time leadership on this.

Mr. Stearns had some objections. One, I think, is not real, that is limiting this Committee or the Congress' flexibility. Obviously we could do whatever we want in addition to any assured funding or if any needs arise, we could act and change any formula. I do not think it in any way limits the flexibility.

The one thing he did mention that I thought we ought to think about is the effect of the PAYGO rules. We are not in competition with other mandatory funding because all mandatory funding comes first.

But in terms of any changes that may occur and offsets required, how would you answer Mr. Stearns' objection about the PAYGO situation?

Mr. VIOLANTE. Well, my understanding is that PAYGO would be applicable, but Congress has a way of doing things that need to be done when they need to be done without following the rules that they have in place.

You know, we have enough money for a lot of programs. We could certainly find the necessary money to support this change from a discretionary to a mandatory pot.

The CHAIRMAN. Okay. By the way, another thing that we need to consider as a Committee because the situation is moving rapidly, is that the President asked for a supplemental on the war totaling almost $200 billion. That does not include the cost of the injuries produced by that war. And I think we ought to demand that the supplemental for the war include a supplemental for the warrior, even if it is long term. These costs obviously do not happen in the current fiscal year, but they are there.

And I think the President and this Administration is vastly understating the cost of the war by not including the long-term effects that the war produces, including injured veterans. So I do hope we can move on this. As you know, there are institutional objections. But I would hope we would move on that.

I would call on Mr. Buyer for his 5 minutes.

Mr. BUYER. Thank you.

A couple of things really jumped out at me when I read your statement. One of them in particular when you mentioned the "Balanced Budget Act of 1997" and you blame the "Balanced Budget Act" on flatlining of budgets and, therefore, Congress created a system that put it into crisis.

What a warped dimension in which you define the world back then. The reason I say that so strongly is I recall all this. I recall back in 1997 that what we did is we took the third-party medical collections that were going to the Treasury and we said, no, you, the VA, get to keep them. You do not recognize that point.

The other point we did is in the "Balanced Budget Act," we exempted the VA. We exempted the VA in "Balanced Budget Act." So do not blame the "Balanced Budget Act."

And you do not even mention them, i.e., the Clinton Administration. You do not do that at all. Now, I compliment the Clinton Administration, in particular Ken Kizer who was there at the time, and you know this, restructuring the program.

But when you do not do those kinds of things in your statement, it bothers me. So I just want to bring that to your attention.

The other thing is that very cleverly, you bring up Gail Wilensky or the Co-Chair of her task force. The reason I use cleverly is that you excerpted particular statements to make it appear as though that Presidential task force was in support of what you are advocating here today.

Well, I have her testimony. So I go back to read her testimony on page 25. This is a hearing of the Committee of Veterans' Affairs, the First Session of the 108th Congress, June 3rd, 2003. In response to then Chairman Simmons, Ms. Wilensky testifies there is no recommendation for mandatory funding. Cleverly written in your statement.

The other thing I would like to ask, is it not true that with mandatory funding, Congress would be able to change the funding formula or place caps on spending through the budget reconciliation language which would limit spending?

Mr. VIOLANTE. I am sorry?

Mr. BUYER. Is it not true that with mandatory funding, Congress would be able to change the funding formula or place caps on spending through budget reconciliation language?

Mr. VIOLANTE. I am still having a problem. You are reading something that——

Mr. BUYER. What I am saying is when we go through budget reconciliation with the House and the Senate, it addresses mandatory programs. So if we do not exempt the VA like we did back in the "Balanced Budget Act," it is subject to caps. So I guess I will give it as a statement rather than as a question.

Mr. VIOLANTE. Well, having VA exempted during the "Balanced Budget Act," I do not recall that because maybe it was on the mandatory side, but it certainly was not on the discretionary side because VA——

Mr. BUYER. We did.

Mr. VIOLANTE [continuing]. Did not receive any additional funding.

Mr. BUYER. We exempted Social Security benefits, veterans' programs, net interest, and low-income programs.

Is it not true that Congress would need to take money from other Federal programs or increase taxes to meet the increased share of the Federal budget going to the VA for healthcare if we adopted mandatory spending?

Mr. VIOLANTE. Under your rules, you would. You would have to find savings from other programs or other avenues to save money.

Mr. BUYER. Currently there are about 7.9 million enrollees, but only 5.5 million veterans are using the VA healthcare system. The mandatory formula is based on the number of enrollees in the healthcare system.

Would we not be basing the budget on this extra 2.4 million veterans who do not use the healthcare system?

Mr. VIOLANTE. Well, the way the formula is set up, the per capita basis is based on enrollees. I think if you were to change that formula, you could use unique patients or those who are using the system and probably still come out ahead of where we are now.

But the idea was, I mean, obviously the per capita cost per enrollee is less than the per capita cost per user. So either way, it does not make a difference. You are still coming to the same end result.

Mr. BUYER. I have had difficulty in getting the Disabled American Veterans as an organization to take a position on this Committee on a party line vote having overturned the Hartness decision.

What is the position of the Disabled American Veterans with regard to denying a pension benefit to wartime, elderly, indigent, disabled, or homebound veterans?

Mr. VIOLANTE. Mr. Chairman, as we have explained to your staff and we are in the process of responding to you in writing, DAV does not take positions on pension issues. We do have concerns and we have shared that with the leadership of the House that we would not like to see the funds taken from a change in the court ruling in Hartness to be used for other than U.S. veterans programs.

Mr. BUYER. Thank you.

I yield back.

The CHAIRMAN. Mr. Michaud, you are recognized for 5 minutes.

Mr. MICHAUD. Thank you very much, Mr. Chairman, Mr. Ranking Member, for having this hearing today because I think it is extremely important that we finally talk about mandatory funding or assured funding, whatever you want to call it, because I do think there is a problem out there as far as the timing when the VA receives their budget. And I think there has to be some assurance that they will get their budget on time.

My question is, hearing your testimony that you are not really wedded to the idea in this legislation, you are more concerned about a process where we go from here on out and you are amenable to whatever that process is as long as it meets some of your criteria.

When you look at the funding formula within the VA system, do you have any specific recommendations on how that could or should be changed?

Mr. VIOLANTE. Yes. To answer your question, we are not married to that formula. There could be changes to it as I pointed out with Mr. Buyer. I think VA would be ahead of where it is now even if you were to change that formula to use the users or unique patients as VA refers to them in that equation.

Senator Stabenow has introduced legislation over in the Senate that would create a hybrid which would provide a certain level of discretionary funding. Using the same formula, it would then determine what additional needs VA would need on October 1st. And they would know beforehand what that additional money would be and they would receive it on October 1st.

That is another means to accomplish what we are trying to accomplish and there are other avenues out there. Advanced budgeting comes to mind. There are other ways to ensure that we meet the sufficiency, timeliness, and predictability requirements that we have.

Mr. MICHAUD. When you look at the Senate legislation compared to this one, which is DAV's or the organizations you represent, what is your preference, the Senate version or the House version or either one will do?

Mr. VIOLANTE. Well, with the Senate version again there, it makes it a little more palatable for appropriators because they still have part of that money coming through their Subcommittees or Committees.

For us, I think either one accomplishes our goals. The House version, H.R. 2514, certainly takes any of the politics out of it that could still go on with the Senate amendment if the appropriators decide to try to cut discretionary to match the increase in the mandatory side.

Mr. MICHAUD. Thank you.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Brown.

Mr. Stearns.

Mr. STEARNS. Yes. Thank you, Mr. Chairman.

And, Mr. Violante, thank you for testifying here. And I just assure you that all of us on both sides just want to do the right thing and we appreciate your courage for coming here to talk about this. You have your particular point of view.

And as the Chairman mentioned, one of the concerns I had was the PAYGO rules. And I think you indicated that we should probably just waive those. You might have said it more diplomatically, but I think that is what you are saying.

Mr. VIOLANTE. That would certainly be nice. It would help us immensely.

Mr. STEARNS. Yeah. Now, the Congressional Budget Office (CBO) has come out and indicated this bill would cost half a trillion dollars. And I guess the question would be, under that scenario, assuming they are approximately correct, where would Congress get this money under the PAYGO rules? And you can see that would be, even as the Chairman recognized in his comments, that still is a problem. And your solution would be, I guess, just to waive the PAYGO rule for the mandatory for veterans.

Mr. VIOLANTE. That would be my suggestion. Now, again, this is Congress' rule.

Mr. STEARNS. Right.

Mr. VIOLANTE. Not mine. I believe that regardless of what we do at this point in time, our government is going to continue to pay out money. I believe that half a trillion dollars is incorrect. I disagree with CBO's estimate on that.

Mr. STEARNS. Okay. I understand.

Mr. VIOLANTE. But the thought is that this money is going to be paid out. Professor Bilmes from Harvard has said that the cost just for new veterans coming into the system over their lifetime is going to be $350 billion to $700 billion. Regardless of the price tag, we have to pay it.

Mr. STEARNS. On another matter, the Chairman has instituted these joint hearings between the Senate and the House to review the budget every year. But that would no longer be necessary. And I think as a Member of Congress and others probably enjoy those joint hearings, have the opportunity to talk about, and I think veterans have an opportunity to talk about their problems.

Now, this particular mandatory spending, as I understand it, does not include construction or research. Is that your understanding?

Mr. VIOLANTE. Yes.

Mr. STEARNS. Now, so construction and medical and prosthetic research would still be subject to annual appropriations is the way we understand it.

So to use your own language in your opening statement, predictability, timeliness, reliability, still they would not be fulfilled under your opening statement because these two very important areas, research and construction, would have to still be appropriated. Is that the way you understand it?

Mr. VIOLANTE. That is correct. And the thought behind that was to not include that in the mandatory program. We would not be adverse to it, but——

Mr. STEARNS. I guess my question is, would you like to include construction and research in the mandatory program?

Mr. VIOLANTE. Certainly I think there is a strong argument that could be made for construction. But the thought was in an effort to keep down the overall costs of mandatory funding and to provide Congress with the discretion to work with VA on their needs for construction, it was left out of the legislation.

Mr. STEARNS. Yeah. And maybe the idea is that Members of Congress would like to have a say in their Congressional districts where this money is being spent. Many of them are touring the facilities. And if you leave it to the bureaucracy or the Veterans Administration perhaps the flexibility that I brought up in my opening statement would not be there.

So I submit that getting these construction funding, updating for facilities that are important, I think is the responsibility of Congress and not the bureaucrats.

The last area I wanted to talk to you about is the VA system, as many of us know, is inefficient in many areas. And my colleagues have had bills. We have talked about how long it takes for the appeal process and for the processing of claims.

Do you think the efficiency would increase under a mandatory funding rather than us supervising overview, bringing the Secretary in, and talking about these problems?

It seems to me that the care and performance and the innovative management that would be necessary might be lost under an automatic funding that Congress has no control over.

Mr. VIOLANTE. I would disagree with that statement. I think it would provide Congress with more opportunity to do oversight to ensure that the money that VA was receiving was being properly used.

Right now we spend an awful lot of time fighting on what that amount is going to be and there is not enough time spent on efficiencies. And I do not believe that just getting a mandatory funding stream will stop VA from trying to be efficient in spending this money wisely. And, again, Congress still has oversight of that.

Mr. STEARNS. My last point is just my experience here in Congress, the power of the purse is pretty powerful. If you control the purse, you control a lot better than if you do not. And I think we see that with our children. We see that in business that the power of the purse is such that you get things done better than if you just have automatic spending.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Ms. Herseth Sandlin.

OPENING STATEMENT OF HON. STEPHANIE HERSETH SANDLIN

Ms. HERSETH SANDLIN. Thank you, Mr. Chairman. I want to commend you for having this hearing.

And I want to commend Mr. Violante for his testimony. I am 1 of the 85 cosponsors of this bill and I am pleased to know that the DAV and the Partnership are open to other proposals because I think, you know, we are all trying to figure out a way to make the current system better. We are forming the budget process.

We had hearings in the last Congress under Ranking Member Buyer that took a look at the formula and whether or not we can improve that formula given that at that time, there did not seem to be momentum behind the assured funding proposal.

I think now, you know, in the world of PAYGO, those of us who want to move to mandatory spending recognize that that is a hurdle to cross whether, as you suggested, the rules are waived or whether, you know, there are some difficult decisions and taking a closer look at the CBO estimate based on how many years of spending over the next 5 we anticipate in discretionary spending. And, of course, looking at how we use a formula for predictability, as you state, is one of the key standards in how we reform this process is what we have to grapple with.

And so I would just encourage you, Mr. Violante, and the rest of the Partnership while waiving PAYGO rules is always a possibility, we have not done it yet. And we want to make sure that we are working closely with you so that we can perhaps achieve both objectives, reforming this budget process and doing it within PAYGO.

And so I would just encourage us to continue a dialog on how we move either to the assured funding bill of Mr. Hare's or Senator Stabenow's proposal and that is a hybrid to work through some of those other budget issues because in the world of PAYGO, it is the world of priorities.

And I think we have done pretty well in this Congress of identifying priorities. We certainly have done it in the discretionary spending process as well that is reflected in the prioritization of healthcare for our Nation's veterans.

But what we need to focus on today and next week and next month is how in this Congress, in the 110th, do we protect ourselves, the country, our veterans from the potential neglect in future Congresses of the need for spending on healthcare for veterans when the pressure is off, so to speak, when the current conflict ends and hopefully we are at a time of peace because care for veterans is a cost of national security whether we are at war or whether we are at peace.

And that is why I think that this hearing is so important today, so that we can identify and reiterate the problems with the current system. As the Chairman said, it is reflected in the fact that it is October 3rd and we still do not have appropriations for fiscal year 2008 other than the Continuing Resolution.

And as some of the questions already posed to you have indicated, there may be problems, similar budget pressures or even some political pressures that come into bear in a mandatory system, but do we improve the process by making it direct spending? Is it improvement to reform the process in that way because it does a better job of meeting sufficiency, timeliness, and, of course, the predictability that you mentioned?

And I also appreciate the point that you made about oversight. We do spend a lot of time on a number of issues in this Committee. But in my opinion, in past Congresses, I think we have certainly been more aggressive in our oversight in this Congress, but it would free us up in some ways if it were mandatory spending to then get at the cost efficiencies, to really get it through oversight of how the money is being spent.

I would raise, as an example, the issue of the money, the increases in money that we have spent for PTSD and mental health counseling for veterans. Some of the questions that have been raised since that money was allocated, how many case workers have they hired versus how many supervisors and people in mid-level management, how many people have been hired to actually treat the veterans day to day on the ground in the medical centers across the country.

So as we raise those issues based on either changes to formulas or other decisions that we would make in the mandatory sphere, I agree with you that it would be an improvement, although not without some pitfalls that we have to be aware of, not without some problems in the budget process, but clearly an improvement from the current situation, particularly given the historical background that you provide at the outset of your testimony.

So thank you. And, again, we will look forward to working with you on some of the issues, the hurdle of PAYGO to see if we can find a way across that as we continue to debate the proposals.

Thank you, Mr. Chairman. I yield back.

[The prepared statement of Ms. Herseth Sandlin appears on p. 44.]

The CHAIRMAN. Thank you.

Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you, Mr. Chairman. Thank you very much for being here and presenting your views on mandatory funding.

Jeff Miller from the panhandle and I go back and forth each year as to who has the highest number of veterans. So obviously veterans' care and veterans' healthcare is very important to both of us.

Mandatory funding would obviously be very costly. And Representative Stearns mentioned the amount.

Are you advocating an increased tax or I know it is Congress' role to find the money, but where would you suggest cutting?

Mr. VIOLANTE. It is not my job. Again, I mean, that is Congressional rules that you have to deal with. My belief is that caring for veterans is a continuing cost of war. If we could find the money to continue to prosecute this war, we should be able to find the money to care for those men and women and or older generations of veterans who need this care.

I mean, I cannot tell you, you know, to cut taxes or to increase taxes——

Ms. BROWN-WAITE. It would be increased. It would not be cut.

Mr. VIOLANTE. I mean, that is not what I am here for.

Ms. BROWN-WAITE. Let me ask you a question. If we go home and we are talking to veterans' groups and, you know, mandatory funding really does sound like a good thing, it is kind of like the—in Florida, we passed Bullet Train until people found out how much it cost and then they quickly repealed it because taxpayers realized how much it would cost.

So if I say to the veteran, well, it may require raising taxes, I do not think I would get a very positive response from the veterans in my district. I do not represent a wealthy area. Maybe the other coast of Florida, maybe those veterans would be more inclined to say tax me more, but I do not think that because of the cost here.

Now, have you considered anything such as a phase-in of mandatory funding?

Mr. VIOLANTE. As I mentioned in my statement, we are willing to discuss any mechanism that will meet the requirements and that is sufficiency, timeliness, and predictability. If we can achieve those 3 goals, we do not care what is done to get us to that point.

But the problem right now is, as I said earlier, we are at war. There is great support for the MilCon bill in both the House and Senate and we still do not have an appropriations bill. So something needs to change.

Ms. BROWN-WAITE. Well, sir, obviously the people in charge have not taken that action. People have not even been appointed to a Committee for the conference. And that is wrong. I do not want to see the VA back to the 2007 funding. I want to see that increase there. That is obviously out of this side of the aisle's control.

I think we have mutual goals in certainly wanting to have a healthcare system that is adequate.

Before this hearing, I called my various hospitals and clinics and found that every OIF and OEF veteran is being seen within 30 days. And, you know, I would encourage other Members to do the same thing, to track that. And they are doing that with a growing population. And I am very glad to see that that is happening and I hope that it is happening around the country.

And with that, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you.

I am not sure that is happening around the country. There was, I think, an Inspector General's report on these waiting times and how they may be manipulated. And I know from personal testimony that some hospitals are responding to our concern for waiting times by just having people call back and not keeping any real list. So you cannot judge it——

Ms. BROWN-WAITE. Mr. Chairman, if you will yield?

The CHAIRMAN. Yes.

Ms. BROWN-WAITE. I found the same thing. When I first got elected, I tracked this. I dogged it. And I was wise to what they were doing and the games that they were playing. Both Tampa, as well as Gainesville, know that we track this regularly. They are not playing the games. And I also checked with veterans in my district also.

The CHAIRMAN. Thank you for your leadership there.

Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman, and thank you for holding this hearing because this is an issue that is not only very important to veterans' groups and veterans and the Congress, but it is also very complicated.

And I think you put together a series of panels today that helps sort this out involving both people within the veteran service organization community but also think tankers and from the VA because I think it is real important.

I have just a couple questions. I tried to find it in your written statement. I think you used the phrase that agencies, the VA is severely impaired, I think was your word when it comes to hiring and those kinds of things. And I can understand that when you are not sure what your budget is going to be and you are trying to hire, you know, a cardiac surgeon or something and we think the funding is going to be there but we are not a hundred percent sure, it makes recruiting hard.

But those kinds of concerns, I mean, it is a bit of the nature of government; is it not? You know, I think that is one of the arguments people argue for going to a 2-year budget cycle.

The VA is not the only group that has that problem. Almost all of government has that problem whether it is State or Federal. And I mean, if we use that argument, we would say somehow we ought to go to a formula-like system where every tax dollar flows in, tax dollar flows out. We come in here and meet and nibble around the edges.

Is that not kind of the nature of government, kind of some built-in inefficiency that is going to be hard to overcome and provide the kind of oversight and scrutiny that the public expects?

Mr. VIOLANTE. Well, certainly it is the nature of government. But what we are talking about here are men and women, less than 10 percent of our population who have served our country and for whatever reason need the VA for their healthcare.

I think that trumps any other issue that needs to be looked at aside from ensuring that young men and women who are fighting our wars are properly equipped.

Mr. SNYDER. Well, I mean, you know, I am a veteran. I share your concern about that, but I think we need to be careful about overstating. I would think the people that do food safety, I think the American public would not like all the meat inspectors to be laid off or food and safety inspectors.

They want to know that toys are safe. That is a big issue right now. Do we have adequate funding. I think you can go through a lot of different branches of agencies and say, I mean, as a veteran who has a baby, these things that involve toy safety are important to me.

So I think we need to recognize there is a built-in, inherent inefficiency of government that is part of the system of checks and balances. So when I hear you say severe impairment, well, maybe that is a bit of an overstatement because the reality is the funding is going to come through.

I know we have got this discussion going on with a speaker about how to approach the President on these bills and his threats of vetoes on appropriations bills and what is the best package to put together. That is part of the dance that goes on in terms of coming up with what the American people expect from their elected representatives. But I do not know that there is any magic way of getting rid of that inherent inefficiency.

With regard to the PAYGO rules, when you first suggested, and I understand that they could be waived, they are our rules, and there was a little bit of a snickering in the audience and the Members. The reality is the PAYGO rules are real rules. And I think you have probably been involved on the Armed Services Committee.

I mean, I am no longer the Chairman of the Personnel Subcommittee, but those are real rules and, you know, the intent is that we will indeed pay for things. Good things for our men and women in uniform and their families, we are going to find a way to pay for that, and hopefully that does not run up the budget deficit.

And so there are things we would like to do whether it is, you know, GI Bill or Survivor Benefit Plan or we had to deal with it on TRICARE and those kinds of things. We had to find money. That is why the President, when he comes out with these budgets with these efficiency wedges, it really puts us in a bind because we have to somehow find funding for those under our rules. And so they are not easily waived.

And I think we will get to our second panel that will discuss the impact of PAYGO rules are both good and bad on mandatory funding, but it is not going to be a solution to that challenge if we were to go this route in Mr. Hare's bill just to say, well, we can just waive them because we certainly have not waived them on some of the issues that you and I probably are in agreement with with regard to some of the benefits for our retirees from the military.

I think the research was mentioned. I think the staff pointed out under Mr. Hare's bill, research probably is included. It includes all the functions, but that is of great concern to a lot of Members of the Committee.

But I appreciate you being here today because I think it is a very important issue. And you have certainly acknowledged the complexities of it.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Snyder.

Mr. Turner.

Mr. TURNER. Thank you, Mr. Chairman. I want to thank you for holding this hearing and for the discussion that is occurring because this certainly is an important issue.

I want to say that I agree with Mr. Snyder and I agree with Ms. Herseth Sandlin that the discussion between the two of them of the points that they raise are exactly the type of deliberative discussion that you need to undertake when looking at an issue like this.

And I appreciate in your testimony that you recognize that. You have in your testimony even in budget years like this one when the anticipated level of funding for VA healthcare appears to be sufficient, your acknowledgement of the work that this Committee is doing and that this Congress is doing in rising to the need of funding what our veterans require.

In looking at this, obviously we all struggle with the issue that nationally, everyone is currently aware and discussing the budgetary pressures on this country and whether or not we can withstand the spending levels that we currently have and how we are going to shift our priorities and/or find resources to fund those priorities.

In that context, a proposal like this being brought forth at this time is certainly seen in that light and is, therefore, difficult.

But on the PAYGO rules, one of the issues that obviously is throughout your discussion that you are responding to and even those that come after you on this panel, discussed the issue of the effect that this would have on increased spending. And the perception is that this would have additional and increased costs.

Could you speak to that for a moment because I think the issue of undertaking increased costs at a time when we are acknowledging that, you know, our funding currently appears to be sufficient for what we are responding to, I know that remains a big concern.

Mr. VIOLANTE. Thank you. You know, the problem is I think the factors that CBO is putting into their numbers. I mean, as I mentioned, we do not see a large influx of veterans coming to the VA for healthcare just because you change the funding mechanism. It does not provide them with anything different.

So I think in that regard, they are inflating the number of veterans who will come and use the system and we disagree.

And, again, to get back to, you know, the PAYGO rules, I mean, there are areas that Congress can go after. There is, you know, pork barrel spending that uses almost as much as or more than we pay for VA healthcare. It is just a matter of where our priorities are and are we ready to make sure that veterans do not have to wait extended periods of time to receive their healthcare.

Mr. TURNER. And you certainly do have that commitment by everyone sitting on this Committee. But it certainly is important to discuss this.

And, Mr. Chairman, I really appreciate you having brought this forward because the security of funding and how it impacts the agency year to year is one that needs to be addressed regardless of whether or not this bill is adopted. So thank you, Mr. Chairman.

The CHAIRMAN. I am almost tempted to say I wish the concern with PAYGO was expressed when we come up with a supplemental for the war.

Mr. SNYDER. Is it appropriate to ask just a question of staff——

The CHAIRMAN. Go ahead.

Mr. SNYDER [continuing]. Because Mr. Violante said something, and I get confused real fast on these PAYGO rules, when he talked about pork projects which is appropriate. I am not getting on to you about that at all. We all have our own projects that we would just as soon not see in the budget or somebody else's project. We want ours in.

But can the staff help us? If we go to a mandatory funding, almost all that we have referred to as earmarks, that is discretionary funding; is it not? And that would not be able to be a source, that would not under the PAYGO rules be an appropriate source of mandatory funding. Now, why is that? Because that is one-time money.

And under the rules, we want to say—now, you have got to be honest with the American people—you have got to find an offset that will be there for whatever the rules say years to come. So I think that is one of those complexities. I understand why you would bring it up. But am I correct on that?

Mr. TUCKER. Yes, sir. To offset mandatory spending, you have to offset it with other mandatory programs.

Mr. SNYDER. And that is the challenge we have had in the Armed Services Committee trying to find, you know, SBP. We say, well, here is some funding. But, no, that is only good for 1 year. Now, what are you going to do for the rest of us? So that is one of the challenges we have.

Mr. MILLER. Mr. Chairman.

Mr. RODRIGUEZ. Mr. Chairman.

The CHAIRMAN. Mr. Rodriguez, please.

Mr. MILLER. Mr. Chairman, I have a question, I am sorry, before we get too far.

I am confused by the statement that you made prior to Mr. Snyder talking about PAYGO for the war. Is that an implication that you support the tax that was just discussed yesterday or——

The CHAIRMAN. Mr. Miller, you are so clever.

Mr. RODRIGUEZ. Mr. Chairman——

The CHAIRMAN. No, it does not. But I would just say that you are getting away with not discussing how we are going to pay for the war.

Mr. RODRIGUEZ. Mr. Chairman.

The CHAIRMAN. Mr. Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you. I gather this is my 5 minutes. Thank you.

Let me first of all say that, I guess on the PAYGO and on the war, if you look at the history, this is the first war, and I would ask you to look in the record, if I am wrong, I am willing to eat my words, but this is one of the first wars that we do not have a tax to pay for.

And one of the things that we are failing to understand is that war and the security of the Nation and its veterans are the same so that in terms of responding to the needs, in terms of the equipment that they need and the services that they need during and after ought to be part of that process.

And I am concerned. I mean, here we have an agency that has been with us how many decades, you know? You know——

Mr. VIOLANTE. You mean the Department?

Mr. RODRIGUEZ. Yes.

Mr. VIOLANTE. Since the thirties.

Mr. RODRIGUEZ. Since the thirties and, yet, we fail to fund it directly. That means that it does have an impact in terms of efficiency. It does have an impact in terms of what you can expect or not expect. And that to me, I find it as ridiculous and we have to come up to the plate.

But we have to look at it from the perspective that these are our soldiers that were there when we needed them. They need us now, when they reach their twilight years or right after and we are talking about PAYGO. If we talk about PAYGO, my God, let us talk about the obligation that each one of us has here in addition to the young people that are out there fighting the war to pay for it.

And, you know, if we do the right thing, part of this is also if you look at it in conjunction with our veterans, it also reflects on the difficulty of trying to get young people to sign up to defend this country because of how we treat those veterans after they return. That is part of it.

None of us want to look at a draft. But, my God, you know, the way things are going. I just had a young person who is going to be going to Iraq for the fifth time, for the fifth time. And so is that right for them to carry that kind of burden? At what point do we look, and I know we are trying to get others to come in, but part of doing the right thing is taking care of them after they come back. And I know that is difficult to do.

I think we can come to grips with, you know, some form of direct funding so that they can at least say this is how much we are going to get, but we also need an investment in ourselves in terms of our infrastructure.

What happened in Walter Reed, I know it is not VA. It is the U.S. Department of Defense. But it is not an isolated situation. We got to do the right thing for our infrastructure, for our soldiers, just like we have to do the right thing for our infrastructure for this Nation as a whole.

And part of this effort, you know, and I am real pleased that we have had an opportunity to begin to dialog about this issue which should have been dialogued a long time ago, and it is something that needs to happen.

And I agree totally with PAYGO. But I also believe that part of the war is part of that effort. And that needs to be paid for. And I also believe that along with the supplemental is all the emergency items in terms of the disasters that are occurring in this country and also the number of soldiers that are coming back that we are not dealing with.

And so I look forward to moving on this legislation. And whichever way it goes, I like the idea that you talked about in terms of something that is efficient, something that is predictable, and at least something that you ought to expect in terms of timeliness that ought to be there.

And, once again, thank you. And I apologize. I am going to have to cut out and go to actually one of the Presidential debates that is occurring right now in the morning. But thank you very much for bringing forth that legislation. I look forward to it getting out of here and passing and doing the right thing that has not been done since its inception. Thank you.

The CHAIRMAN. Thank you, Mr. Rodriguez.

Mr. Boozman.

OPENING STATEMENT OF HON. JOHN BOOZMAN

Mr. BOOZMAN. Thank you, Mr. Chairman. And, again, thanks to you and the Ranking Member for holding this hearing. It really is very important. We have talked about it for a long time and it has come up. And I appreciate your testimony.

One thing that I guess is a problem for me, what I want very much is adequate funding for the things that we are trying to do. Mandatory funding does not necessarily mean adequate. I think that you and others would argue that some of our, you know, perhaps our pension that we are paying out for individuals, some of the disability payments that we pay out for certain things, those are mandatory funding in the VA system. And, yet, you could argue that, you know, they have not kept pace with time and they are not adequate. See what I am saying? In other words, mandatory funding has not solved the problem of adequate funding in those cases.

So, again, I look forward to the rest of the panel and we can talk about these things. But what I want, like I say, very, very much is adequate funding. I do think, and I appreciate what Dr. Snyder, you know, said and agree with that, I think as we look at the hospital aspect, you know, we might have a little different situation.

Now, with the highway bill, I am on Transportation, we do that over a 5-year period because highway projects are major projects that you need to have, you know, the surety in building roads, major projects that the funding stream is going to be there.

So, again, I would be very interested in looking at, you know, maybe longer times for certain things or whatever. But like I say, it is a very, very good discussion to have and you have done a good job of representing the case that you are representing.

So thank you very much. I really do not have any questions. You know, if you want to comment on that, that would be fine. Like I say, my concern is adequate and mandatory are not the same, you know, and I think we are confusing that, you know, as I hear the comments here. Again, I think we have got instances of mandatory funding within the system right now that are not right, you know, we need to raise that. That is a whole separate issue.

So if we do that with the, you know, healthcare, then we are not talking necessarily about adequate funding.

Mr. VIOLANTE. And I understand your comparison with compensation. I mean, that is in place and I know it is being looked at by the Veterans Disability Commission, which will report out today, which agrees with you, I think, because they are talking about a quality of life factor that should be added.

But to get back to the healthcare side, I think if you were to take this formula and take it back to the year 2000 as if it would have passed then, I think what you would see is whether you used the formula with enrollees or with unique patients you are probably ahead of where VA is today or at any time during that period, so I think this formula, while it is not perfect, does address the adequacy also.

The CHAIRMAN. Thank you, Mr. Boozman.

Mr. Mitchell.

Mr. Hall.

Mr. HALL. Thank you, Mr. Chairman.

And, Mr. Violante, I want to thank you for your service and for your testimony here today.

The numbers that you cite in your written testimony for life-time cost of care for those injured physically and/or psychologically in Afghanistan and Iraq may be low in my opinion.

Our Subcommittee heard testimony from some experts who estimated a trillion dollars, this was in May, if the war stopped then for the cost of life-time care for traumatic brain injury victims, PTSD victims, spinal cord, and amputation cases.

And so I am very concerned that the American public has not yet been told loudly enough or by the right people or are not situated that it has registered with them that they can add that trillion dollars to the cost of whatever, you know, $600 billion or whatever it is plus this latest request for $192 or approximately $200 billion more.

And just by way of comment, you know, all of us up here have our projects that we may or may not consider pork barrel. Some of them in my case are to take care of the students who are children of West Point faculty, go to a school next to West Point in the

Highland Falls school district which is only allowed to tax 7 percent of the surface area of the town because West Point and other Federal entities own 93 percent of the land area in that town.

So their budget was just rejected because it was a 30-percent increase and rather than having the children of West Point faculty educated in a school which has cuts in arts and music and increases in class sizes and out-of-date computer systems and so on and so forth, I asked for and was able to get a Member item or earmark or whatever you want to call it that would at least for 1 year, that is not assured funding, but for 1 year to close the gap for that school and for those students and for those families.

So some of these things, you know, the Guppy Museum and the Bridge to Nowhere, I think we can all agree on there are cases that are excessive or unreasonable.

I just wanted to ask you a couple of quick questions about your testimony. Under the myths and reality section, you say that a myth under mandatory funding program, VA would no longer have an incentive to find efficiencies. And you answer that by saying the VA's central office would still be responsible for ensuring local managers are using funds appropriately and efficiently.

Now, I am a sponsor of H.R. 2514, but I want to ask you still, how you think that the VA's CO, the central office, would be able to ensure the necessary incentives are in place to provide cost-effective care when budgets are determined solely on the number of veterans enrolled?

Mr. VIOLANTE. Well, again, I do not think you would take that incentive away. Plus, as I mentioned earlier, I think it would free up more of Congress' time to provide oversight to ensure that VA was properly spending this money and looking for efficiencies that may be available.

I just cannot believe that VA at any level would not care about trying to find ways to do it more effectively and efficiently regardless of how the funding is coming in.

Mr. HALL. Okay. I just also wanted to say that, you know, in the short term in terms of finding offsets for PAYGO that we might consider the radar system in the Czech Republic for the anti-missile system in Poland as a possible lower priority than taking care of our veterans, especially in light of the fact that all the tests for that missile system have been rigged in a non real world way.

But testing aside, in light of the concerns you raise about adjusting or augmenting the formula for mandatory funding once it is established, how confident is the Partnership that establishing a base of 130 percent of fiscal 2006 obligations would be sufficient?

Mr. VIOLANTE. We think it is sufficient. In fact, again, looking at different mechanisms, I had my staff go back and take out that increase and do it as if the legislation had passed in 2001 or 2000 without that factor in there. And, again, VA is still ahead of where it is now regardless of how you change that formula or remove that.

But that was built in to ensure that in the change-over period, the year before mandatory funding would actually come in, that VA would have a sufficient increase. I think now with the baseline being where it is at, that could be relooked at and Congress could determine what might be an appropriate increase for that interim period if you go that way.

Mr. HALL. Thank you, sir.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Hall.

Mr. Miller.

Mr. MILLER. This question may have been asked and this is serious. Can you help me understand what the holdup is in the conference process from the House side in appointing conferees budgetarily? And I am asking the question because, you know, we are past October 1st and we do need to move forward. Are you aware of what is going on, Mr. Chairman?

The CHAIRMAN. No. Is anybody aware? No.

As you know, you had the problem for the last 12 years and now we have the problem. And it is one of the wonderful challenges of divided government.

Mr. MILLER. But I mean, is not the issue right now that the Senate has appointed their conferees and we have not in the House?

The CHAIRMAN. No. The issue is that the President has threatened to veto 10 out of the 12 Appropriations bills and we are trying to figure out a way to get the Appropriations bills passed and signed by the President.

Mr. MILLER. So both bills, the House has passed it and the Senate has passed it. The Senate has appointed their conferees. The House has not. And I am not trying to be political. I am really not.

The CHAIRMAN. Come on.

Mr. MILLER. You know, I thought the process in this Committee, you might have been a little more forthcoming with Mr. Buyer not in the room with us because I am not trying to be argumentative. I do not know. And I am spooked about an omnibus bill. I think most all of us are. And I am just trying to find out why, you know, regardless of what the Administration says, I mean, we have to do our work. And you are part of the leadership and I am just wondering what the process is.

The CHAIRMAN. Well, I mean, as I said at the beginning before you were here, I have personally urged that this bill, the bill containing veterans and military construction, go forward because the President agreed to sign it. So I——

Mr. MILLER. And I am glad you acknowledge that because the President has said that——

The CHAIRMAN. Right. I would urge that that go forward now.

Mr. MILLER. Okay.

The CHAIRMAN. The leadership has taken another position on that.

Mr. MILLER. And in this Committee and I think we all will agree, we all want to find the common ground to do the thing that is right. You know, we need to get past the jabs back and forth at each other. You know, yes, the war is unpopular in many instances and one side gets, you know, some traction out of supporting it. Some get traction out of not supporting it.

But on this Committee, and I think we all will agree, we are trying to do what is best for the veterans' issues and we all have our own ways of getting there. And philosophically, I am sure that some of us agree and some of us do not agree. I hope that really we can sit down and work this process. And I know that you are committed to doing it and you know from discussions with Members privately that we are committed to doing the same thing. And I appreciate you holding these hearings so we have an opportunity to sit down in a public forum and air them. But, you know, I for one am hopeful that we all can move past the partisanship side of things and not accusing you or anybody. We are just as guilty on our side. I mean, let us get together and get this done and make it happen. And I know the Democrats and the Republicans are committed on both sides to making it happen.

Thank you.

The CHAIRMAN. Thank you, Mr. Miller. I would agree with your statement. Thank you.

Mr. Violante, thank you so much for your part and your leadership of your coalition. And we will be in discussions obviously for quite a bit.

Any last words before we call the next panel?

Mr. VIOLANTE. Other than thank you for holding this hearing, I think it is an important first step in getting this dialog moving and getting this situation corrected. So I would like to thank you, Mr. Chairman, and all the Members of this Committee, for their time and effort on this issue.

The CHAIRMAN. Thank you.

Panel 2 consists of Henry Aaron, a Senior Fellow from the Brookings Institution, and Richard Kogan, a Senior Fellow from the Center on Budget and Policy Priorities. Thank you for being with us.

Mr. Aaron, we appreciate your long holding of the homerun record and we are sorry that it has been broken. But you have landed apparently in good stead at the Brookings Institution, so we are happy to have you here. Make sure your button is pressed, the green light is on there, and you talk directly into the microphone.

STATEMENTS OF HENRY J. AARON, PH.D., BRUCE AND VIRGINIA MACLAURY SENIOR FELLOW, BROOKINGS INSTITUTION; AND RICHARD KOGAN, SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES

STATEMENT OF HENRY J. AARON

Mr. AARON. Thank you. Thank you very much for inviting me today.

Since you mentioned my homerun record, I was invited to play at a celebrity golf tournament by Phyllis George. Unfortunately I had to tell her that I do not play golf.

The CHAIRMAN. Can you move it closer to you.

Mr. AARON. Let me begin by expressing my general agreement with the goals that Mr. Violante set forth. I am not going to read my testimony. I hope that it can be placed in the record.

The CHAIRMAN. Without objection, it will be.

Mr. AARON. The late appropriations to which he referred that have been custom for so many years undoubtedly create very serious problems for all of the affected agencies.

That said, the VA of late has been doing a very good job with the funding it has been given.

In my testimony, I refer to a number of studies that indicate that despite the problems created by late appropriations, the VA now is delivering better healthcare than the average American receives. It is delivering better healthcare than the typical Medicare beneficiary receives.

So, could things be better? Undoubtedly. Have they improved greatly? Yes, they have. And the standard of care delivered by the VA is quite high.

In my testimony, I go at some length into the budgetary issues that are raised by a conversion from discretionary to mandatory of the Veterans Health Administration funding.

A number of references have been made to the estimates of the Congressional Budget Office. Some may think they are too high. It is entirely possible they are too low. The logic behind them, however, I think, deserves some emphasis.

The logic behind the CBO estimates that spending would greatly increase if the program was converted to mandatory status is that the VA would have powerful and noble motivations for trying to draw in and enroll as many additional veterans as possible. It would have such motivations because each new enrollee would bring additional funding that would enable the VHA to do the mission it has been charged with carrying out.

This is not a suggestion of venal motivation. It is a suggestion that good administrators would try to secure additional funding to carry out the duties with which they are charged.

The numbers that emerge from the CBO estimate, I think, should be compared to other additions to healthcare spending that Congress is now being asked to consider and that are going to be or already are highly controversial. Budgets are limited. We cannot spend as much as we want on everything. And tradeoffs have to be made. That is your job. You were elected to make them.

But I suggested two comparisons with the additional funding that would result if CBO's estimates of the effect of switching to mandatory spending are correct.

The CBO estimate is that on an annual basis, the added costs would be somewhere in the range of $45 to $50 billion a year over the next 5 years. Let me stress I have not seen a specific estimate of H.R. 2514. I tried to adjust the estimates put out a couple of years ago for H.R. 515 that was introduced in 2005. I may be too high. I may be too low in those numbers. They are in the ballpark, $45 to $50 billion.

By comparison, we are currently embroiled in a major debate over whether we can afford an additional $7 billion a year for the Child Health Insurance Program. We will be embroiled in a big debate about whether to allow the full reductions in reimbursements to physicians under the Medicare Program to take effect. If instead physician fees are increased by 1 percentage point, that would cost an additional $5 to $6 billion a year.

The question that I think we all have to address is what the tradeoffs are among those and other spending priorities that the Nation has. We each have our opinion on that matter. Mine is that the two alternatives, the State Children's Health Insurance Program (SCHIP) increase and the adjustment in physician fees, actually deserve higher priority than would result——

The CHAIRMAN. Could you summarize your——

Mr. AARON. Yes, I will. I will [continuing]. By the shift in funding to mandatory spending.

[The prepared statement of Mr. Aaron appears on p. 52.]

The CHAIRMAN. Mr. Kogan.

STATEMENT OF RICHARD KOGAN

Mr. KOGAN. Mr. Chairman, Mr. Stearns, thank you for inviting me to testify on how healthcare for veterans should be funded in the future.

Let me start by acknowledging that I am not an expert on veterans' healthcare. I am, however, an expert in the Congressional Budget process.

Is the funding for veterans' healthcare more likely to be adequate and predictable if it is converted to an entitlement payment? My answer is that we simply cannot know for sure. This answer is intended as a caution, a yellow light, not a red light.

Let me explain. Under the current budget process, veterans' healthcare competes against a range of other discretionary programs, education, transportation, natural resources, so on. Converting veterans' health funding into an entitlement is intended both to increase the amount of veterans' healthcare funding and to shield it from the competition I have just described.

But if veterans' healthcare were converted into an entitlement, current budget rules would prohibit Congress from ever enacting legislation to make that entitlement payment more generous unless Congress simultaneously made offsetting cuts in some other entitlement or raised an equal amount of taxes. This is the Pay-As-You-Go rule.

Let me play out some of the ramifications of the Pay-As-You-Go rule. Firstly, converting veterans' healthcare into an entitlement would by itself violate that rule. Note that the elimination of discretionary funding for VA healthcare does not count as an acceptable offset.

Second, because the Pay-As-You-Go rule puts high barriers in the way of any future entitlement increases, you had better be sure that the formula is adequately generous to begin with.

Okay. Let us assume that a PAYGO waiver is granted, the President's opposition is overcome, and a bill as generous as H.R. 2514 is enacted. This leads to my third point.

The Congressional Research Service, CBO, the U.S. Government Accountability Office, and others would then issue studies pointing out the relative generosity of the new veterans' healthcare entitlement. The desire of governors or physicians or Congress to increase Medicaid or Medicare or SCHIP funding may then tempt Congress to look to reductions in this new generous veterans' health entitlement as a source of PAYGO offsets.

Most significantly, any extension of the Bush tax cuts is a tax cut relative to current law because those tax cuts were enacted as temporary. Therefore, any extension of the Bush tax cuts entails finding PAYGO offsets. If you succeed in establishing a veterans' healthcare entitlement formula that is as generous as the advocates hope, it may well become a tempting source of offsets for those hoping to extend some or all of the Bush tax cuts.

More generally, as I see it, if you convert veterans' healthcare into a more generous entitlement, you would get a bigger boat to sail in, but by moving in the Pay-As-You-Go ocean, the water may become deeper, the voyage stormier, and the sharks bigger and hungrier.

Okay. Let us go beyond the Pay-As-You-Go rule. It is just a rule. Maybe it will be repealed. The Republicans in Congress did not like it over the last 3 or 4 years. If they regain the Majority, perhaps it will be repealed.

Nonetheless, experts who examine overall budget trends are unanimous that eventually taxes will have to be raised or budget programs will have to be cut or some combination by very substantial amounts.

Respected columnists who popularized this grim long-term outlook, people such as David Broder or Robert Samueleson, habitually call it an entitlement problem. One effect of this simplified style of discourse is that it leads to simplistic and destructive so-called solutions.

For example, a very tight entitlement cap included in the "Family Budget Protection Act" endorsed by the Republican Study Committee. That cap would be so tight that very substantial cuts would be required in entitlements each year to avoid a breach and the cap is backed up by automatic annual sequesters.

Whether or not Congress enacts such an entitlement cap, it may create an entitlement commission or the leaders of Congress may sit down with the new President to negotiate a mega deal including tax increases and entitlement cuts.

In that case, new discretionary caps would surely be negotiated, but a discretionary veterans' health program would not be specifically targeted and would remain free to compete with other discretionary programs.

A veterans' health entitlement, however, would be on the negotiating table along with Medicare and Medicaid and SCHIP and cuts in other entitlements and tax increases. The funding for this veterans' healthcare entitlement would be decided by those negotiators.

Moreover, Congress would presumably use the existing Congressional Budget process to implement whatever deal is negotiated. That budget process includes the reconciliation process, a reconciliation directive in which selected Committees including this Committee could be directed to cut entitlements in their jurisdiction by specified amounts. If Committees do not meet their reconciliation targets, the Budget Committee makes the cuts instead.

All the cuts from each Committees are then combined into an omnibus reconciliation bill managed by the Budget Committee. In the Senate, this reconciliation bill is protected from filibuster.

In short, in the world of entitlement caps or leadership mega deals, you run two great risks. You may lose control over your own programs and in any case, the tide of required cuts may sweep over even popular programs such as veterans' healthcare. Cuts in veterans' health entitlement might become just a single title in an omnibus fast track, must-pass bill.

Mr. Chairman, let me close with one short observation. The long-term pressures on Federal programs come about because of a threatened explosion of Federal debt. Advocates in favor of Federal programs including the Partnership must also become advocates of the taxes needed to finance those programs.

Even if there are no Pay As You Go rules, simple arithmetic and elementary economics demands this outcome. If you desire effective Federal programs but are unwilling to pay for them, then you ultimately will not get them. You cannot be pro-veteran and anti-tax, at least not using honest arithmetic.

Thank you very much.

[The prepared statement of Mr. Kogan appears on p. 57.]

The CHAIRMAN. Thank you very much.

We are having votes very shortly, so I will have just one quick question, Mr. Kogan and Mr. Aaron.

You said a lot about, you know, is this going to work and you really spent most of your time giving the negative aspect of it. However, the problem is not only veterans' group, but the VA itself where they deliver the service have been forced to operate with inadequate budgets because Congress has not done its job in passing the budget.

So my question is, how do we solve the problem? If you do not like the bill before us today, what is your solution?

Mr. KOGAN. Let me perhaps disabuse you of one assumption. I think that if veterans' healthcare is to be made an entitlement, the bill before you, H.R. 2514, is a rational and thoughtful way to do it, perhaps overly generous.

The whole point of my testimony was not that it was a bad bill or even that it is inappropriate to set a per capita cap funding mechanism for our veterans' healthcare, not at all.

My whole point is that under normal budget processes, that does not free you from risk. It does not free you from competition and that the competition you will be in may be a big and frightening competition in which the decisions are made not by this Committee but by mega negotiators who are operating over your heads.

The CHAIRMAN. Would you comment on, I believe, Mr. Boozman's suggestion whether or not we should go to a 2-year budget or a 5-year budget and update the budget as we go along so the VA will know that they will have adequate funding?

Mr. AARON. Actually, Mr. Kogan and I have been having an e-mail traffic over the past couple of days on this very subject. That was a possibility that I suggested as an imperfect step in the direction of dealing with the very real problems that you have described.

What I had in mind was not what is conventionally called a 2-year budget but a rolling 2-year budget so that each year, you appropriate for the current or the prospective fiscal year and the one after and the next year, you revisit the second year and then add in another.

That approach, it seems to me, ameliorates but does not completely solve the problems that you have been describing. Obviously you would face the political challenge of persuading Members of other Committees that your program deserved this treatment and theirs did not unless you were to reform the entire budget process.

The CHAIRMAN. Thank you.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

Mr. Kogan, would mandatory funding ensure appropriations will be enacted on time because the first panel indicated he wanted sufficiency, he wanted predictability, he wanted timeliness? My question is, would mandatory funding do that?

Mr. KOGAN. Well, mandatory funding, of course, will not ensure that discretionary appropriations will be created on time. But every Continuing Resolution (CR) that I have seen for the last decade or so has included a proviso that all mandatory programs that otherwise flow through the Appropriations Committee automatically get whatever the mandate calls for. For example, Medicaid and food stamps are not at any risk merely because they are under a CR.

Mr. STEARNS. But you mentioned the loss of control, tide of cuts that would be swept over it because of omnibus budget bills. So you point out some very nuance but difficult things if mandatory funding is implemented.

Mr. KOGAN. That is right. In essence, I am suggesting that if the current appropriations process is viewed as a frying pan, the budget reconciliation process should be viewed as a fire and that you jump from one solving your frying pan problems, but jump into another problem, the reconciliation process used to implement mega deals or even mini deals or even to avoid entitlement caps which is also slow, difficult, and political.

Mr. STEARNS. Can I ask you to give a yes or no answer. Would you cosponsor the bill, Mr. Hare's bill to make the veterans' budget mandatory except for construction and research? Yes or no?

Mr. KOGAN. No.

Mr. STEARNS. Okay. That is all. Okay.

Now, let me just say to my colleagues, he would not cosponsor this bill. This is a man who has 21 years on the staff of the Committee on the Budget of the United States House of Representatives and most recently as Director of Budget Policy. This is a man from his opening statement understands the nuances here and has the technical expertise that none of us really have to understand the implications. And he has given his reply.

In all deference to this side, as I understand, you were under Democrats, you were working under Democrats.

Mr. KOGAN. That is correct.

Mr. STEARNS. So I mean, I admire your honesty here. At the same time, we have the majority of the Democrats on this Committee are supporting this mandatory.

Now, Mr. Aaron, let me talk to you if you do not mind. I read your opening statement and it appears to me that you are saying, this is from your opening statement, against this background, should funding for the VHA be converted from a discretionary to a mandatory account. The answer, I believe, that it should not if I read your opening statement despite the genuine claim that veterans have on public support for their healthcare and excellent record and delivery of high quality care.

So if I read this correctly, then you are also saying that you do not support the idea of mandatory spending.

Mr. AARON. I am not against the idea of mandatory spending. I was against this particular application of it.

Mr. STEARNS. Okay. So if I ask you the question yes or no, would you support the Hare bill for mandatory, what would be your answer?

Mr. AARON. I answered it in my testimony.

Mr. STEARNS. Yeah, no.

Mr. AARON. No.

Mr. STEARNS. No. Okay. Now, I say to my colleagues before we go to vote, the Veterans Administration is on the third panel. We might not get back. The Veterans Administration has come out against mandatory funding. They do not think it would be in the best interest of the veterans. That is what they are saying. And that is an important thing. They know their system. They have indicated here strongly that the mandatory funding approach would not give them the adaptation they need to take care of their veterans.

So I think, Mr. Chairman, in light of these two remarkably well-educated and experienced individuals, they both indicated this particular bill, there might be others, this particular bill is not the bill that they would support. And I thank them.

Mr. Chairman, I guess I have got maybe 30 seconds.

Mr. Kogan, you know what entitlement means. You know what the word entitlement means. When I talk about entitlement for Social Security and Medicare, aren't I talking about a different type of entitlement than if I said entitlement for mandatory spending? Is there a difference, because with Medicare, you know, there is a fee-for-service involved?

And what I am trying to understand is an individual entitlement to a payment for them, it is mandatory funding is a formula annually driven by payment to a government agency in this case. It is a government agency taking care of the veterans all paid for by government. Would this be a different type of entitlement? I am on to something, but I am not sure what it is.

Mr. KOGAN. No. You are on to something that is important. The word entitlement applies in both cases, but entitlements should appropriately be subdivided between individual entitlements which this would not be and entitlement payments to government units. SCHIP is an example of an entitlement payment to State governments. Individual people who are eligible for SCHIP nonetheless are not entitled to enroll if the States do not have enough money.

Mr. STEARNS. Okay. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Dr. Snyder.

Mr. SNYDER. Ms. Herseth Sandlin was here before I was.

The CHAIRMAN. Ms. Herseth Sandlin.

Ms. HERSETH SANDLIN. Thank you. And I thank Dr. Snyder.

Just for point of clarification, today's hearing is on funding the VA of the future, not specifically Mr. Hare's bill, although we appreciate your input and we appreciate your candid responses to Mr. Stearns' questions.

But from your testimony, Mr. Kogan, while you may not cosponsor the bill if you were a Member of Congress, you are not sure. I mean, you are just pointing caution here. You are not necessarily sure that moving to mandatory spending would be worse than what we are doing. It may very well ameliorate some of the problems that we are facing.

But the e-mail traffic between the two of you at least seems to reflect the fact that you would agree, would you not, that there are problems that we need to address and whether it is a complete restructuring and reform of the budget process or what we do in particular with veterans' healthcare spending, that there are better ways to do the budget than what we are doing?

Mr. KOGAN. Thank you for the opportunity you have given me to do more than say yes or no. Mr. Stearns must have been an effective prosecutor.

The reason I would not have sponsored this if I were a Member of Congress, which will, of course, never happen, is twofold. Firstly, I think it is overly generous. And the second is that it is not paid for. I strongly believe, and the Center on Budget strongly believes, in the concept behind the Pay-As-You-Go rule and its specific application in this case.

However, if this bill were less generous and if it included a title raising taxes on me that fully paid for it and other people in my income bracket that fully paid for it, then I would be willing to cosponsor it because I do believe that mandatory funding in the form of capitation payments to a government agency that administers healthcare is in concept a pretty good way to go.

Ms. HERSETH SANDLIN. Thank you.

Mr. Aaron, did you have a comment?

Mr. AARON. Well, I just wanted to say that I think that the challenge that the VA faces looking into the future is a formidable one. They are doing invaluable work meeting our obligations to veterans and finding ways to fund that organization in a way that enables them to operate as efficiently as possible merits very high priority. And I would align myself with the comments that Mr. Kogan just made.

Ms. HERSETH SANDLIN. Just because we do have pending votes, let me make the point that the broader issue here for the country and healthcare spending is the context I think that we have to evaluate some of this discussion in as well. And I would imagine that you are aware that the VA health system spending grew less rapidly than did spending in the rest of the U.S. health system in the past decade. At least some studies bear that out.

And if you do want to comment on that issue, but also, Mr. Kogan, if you could just elaborate either now or in written testimony just what it is exactly about the proposal—well, maybe if you could just elaborate on overly generous, you know, to provide some specifics because I am a little wary about that statement when it comes to—I mean, what exactly is overly generous when it comes to ensuring adequate healthcare for veterans or, you know, we are having this discussion now on SCHIP, and so forth? Are we talking about the number of enrollees? Are we talking about the breadth of the services provided to veterans?

Mr. KOGAN. No. As I say, I am not an expert on veterans' healthcare. But when I looked at the CBO cost estimate of this bill or actually of the previous bill, H.R. 515, it struck me that it would provide real increases in resources totaling about 80 percent over 3 years before the funding would then start rising at a more moderate pace of about 5 percent per year.

And it is not clear to me that the VA, the Veterans Administration, the Veterans Health Administration is currently underfunded by almost 45 percent which is what those numbers imply. Perhaps that was the case a few years ago. It is no longer the case now. And I think the first witness said as much. Given the higher base, you do not need as big a bump-up.

Ms. HERSETH SANDLIN. Thank you.

The CHAIRMAN. Mr. Boozman.

Mr. BOOZMAN. Thank you.

Again, I appreciate your testimony. I think you have really given me good insight. And I understand these things are just not as simple as they appear on the surface.

One thing you said, Mr. Kogan, is that you could not be anti-tax and be for veterans. And I guess are you saying if you look back at the periods in the country where taxes were higher, the veterans were taken better care of? I mean, that is as opposed to—I do not think that has anything do with it in the sense that it does and it does not. But it is a matter of priority more than anything else.

But would you say that if you looked back over the periods when we had higher taxes that—Mr. Aaron, you know, just said earlier, and I agree totally, we have worked really hard in the last several years, everyone working together, Republicans and Democrats, to get the quality of the healthcare up, you know. I guess to me, that is an unfair statement.

Mr. KOGAN. I certainly do not know that much about the history of how veterans were taken care of. You know, I think of the very expansive GI Bill that occurred right after World War II and that seemed to be the greatest need at the time.

But it is also the case that, and Mr. Aaron knows far more about this than I do, that the nature of medical care is radically different from what it was even 10 years ago, much less 20 or 30, and it is much more expensive.

And if we as a nation are going to provide medical care through government financing in one way or another for Medicare, for Medicaid, for SCHIP, for veterans, for the military through TRICARE, ultimately, I think we have an obligation. Well, arithmetic and economics says that we cannot deficit finance that forever.

And so unless we are going to eviscerate other Federal activities, transportation, healthcare, and so on, we have to fess up to the fact that if we like these, if we think these are good and worthwhile, then we should be willing to pay for them. I personally am. I may be the only witness who answered a question by saying raise my taxes.

And if that is not a majority opinion among witnesses and among the public, that is fine. It is a democracy. But then the public has to settle for the fact that government services will not be as generous as they might otherwise want.

Mr. BOOZMAN. And, again, I am not being argumentative at all. I guess the only problem that I have with that statement is you could say, you know, if you are for children, you know, you cannot be against taxes. If you are for, you know, the transportation system that is wearing out in this country, the bridges and things like that, you cannot be against—but the reality is, and you with your budget experience much more than me, it is a matter of priority more than anything.

And I think, you know, we are dealt the cards that we have, you know, as far as the money that we have. And that is the job of this Committee is to advocate for veterans regardless of the—you know, sometimes we do not necessarily agree with the funding stream, but, you know, you do the best you can with the moneys that are coming in. And that is to me more a matter of priority versus anything. But any interest that a guy has, you could say the same statement, you know, that you are against kids or you are against whatever.

Mr. KOGAN. You are certainly not the Ways and Means Committee. You simply do not have jurisdiction over the many entitlements that they spend money on and the many tax entitlements, tax breaks that they create.

But if we look just at the latter, there is something like $600 to $800 billion per year in tax preferences and deductions and exemptions in the Tax Code that could be whittled away without raising marginal tax rates.

That falls into the setting priorities framework which you have laid out. Yes, we have to choose. You cannot give everything to everybody. You cannot give every tax break that everybody wants or every government funding program that everybody wants without ultimately running into a collision that leads to a debt explosion.

Mr. BOOZMAN. Right. Again, thank you very much for your testimony.

The CHAIRMAN. Thank you.

Dr. Snyder.

Mr. SNYDER. Quick question for the record. I would like, Mr. Chairman, Mr. Violante to have the opportunity to respond in writing in response to my question, any rebuttal or discussion he or his group that he represents might have in response to these two good witnesses here. Make that a question for the record and work with staff and distribute it to the Members.

Thank you.

The CHAIRMAN. No problem.

Since there are no other questions, I would like to release the second panel.

We will be in recess for approximately a half hour till the votes are taken. Thank you.

[Recess.]

The CHAIRMAN. I would like to call this hearing back to order. We have our third and final panel for today.

Paul Kearns, III, who is the Chief Financial Officer (CFO) for the Veterans Health Administration in the Department of Veterans Affairs; accompanied by Patricia Vandenberg, who is the Assistant Deputy Under Secretary for Health for Policy and Planning. I would like to welcome the third panel here today.

And we will start off with you, Mr. Kearns.

STATEMENT OF W. PAUL KEARNS III, FACHE, FHFMA, CPA, CHIEF FINANCIAL OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PATRICIA VANDENBERG, MHA, BSN, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND PLANNING, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. KEARNS. Thank you, Mr. Chairman, for the opportunity to discuss the Department of Veterans Affairs current funding process for its medical 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 is Patricia Vandenberg, the Assistant Deputy Under Secretary for Health for Policy and Planning.

I would like to request that my written statement be submitted for the record, and I have a few short remarks.

The CHAIRMAN. Without objection.

Mr. KEARNS. Prior to the enactment of the "Veterans Healthcare Eligibility Reform Act 1996," VA medical care budgets were based on past expenditures adjusted for inflation. This historic approach was inconsistent with the practices of large, integrated, private-sector healthcare plans which VA began to resemble as it transformed into an integrated system of care for providing a full range of comprehensive healthcare services.

The VA decided to adopt the private-sector practice of using healthcare actuarial projections to predict future demand for healthcare services and incorporate those estimates into our annual budget request. This enables our budget request to account for shifting trends in veteran population, changes in demand for services, and escalating costs of healthcare.

Our annual budget request is based on the VA enrollee healthcare demand model which develops estimates of future veteran enrollment, veterans' expected utilization for over 55 distinct healthcare services, and the costs associated with utilization.

This involves over 40,000 variables that are part of our budget estimate. The budget estimate includes the future demand for healthcare services based on private-sector benchmarks adjusted for unique demographic and healthcare characteristics of our veteran population and the VA healthcare system.

Each year, the budget request is updated with the latest data on enrollment, healthcare service utilization, and service costs.

VA believes that the use of actuarial projections for budget development is the most rational way to estimate the resource needs for our veterans and this approach is consistent with the private sector.

Unlike the private sector, however, the VA must develop its budgets 2½ to 3 years into the future. Furthermore, VA receives its medical care budget in 3 separate appropriations, medical services, medical administration, and medical facilities.

The Congress created the 3 appropriation funding structure in 2004 replacing the previous single appropriation structure. This change has significantly increased operational complexity without improving financial accounting accuracy.

In addition, it has introduced unintended inefficiencies and increased complexities into VA's budget management processes and procedures.

Two alternatives to the existing appropriation process are, first, to combine VA's current multiple appropriations into a single medical care appropriation and, second, to adopt mandatory funding.

We believe a single appropriation for medical care would enable VA managers at every medical center and network to optimize resource flexibility and ensure the timely delivery of healthcare services to our veterans.

We believe the other alternative, mandatory funding, would not be in the interest of our veterans because it is neither reflective of, nor adaptive to, the changes in our veteran enrollment priority levels, age, morbidity, mortality, and reliance on VA. And it does not address advances in the state-of-the-art technologies in medical practice.

VA believes that the current process of annual budget formulation provides the best methodology for estimating the budget needs for our Nation's veterans.

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

[The prepared statement of Mr. Kearns appears on p. 60.]

The CHAIRMAN. Thank you very much.

So you believe the model that they are using now to determine the needs within the VA system is a pretty good model?

Mr. KEARNS. We do, yes, sir.

The CHAIRMAN. Does that model get adjusted on its way through the process by the Office of Management and Budget (OMB)?

Mr. KEARNS. The model accounts for approximately 84 percent of our budget requests. The remaining 16 percent is developed separately. It is not in the model right now.

However, when we get that total request, we submit it to the Department and to OMB and we have been very successful in the recent past of having that request honored.

The CHAIRMAN. The 85 percent?

Mr. KEARNS. No. The entire, the 100 percent.

The CHAIRMAN. The 100 percent?

Mr. KEARNS. Yes.

The CHAIRMAN. If it is such a good model then and it is being adopted, then why have we seen such shortfalls?

Mr. KEARNS. I think the shortfalls you are referring to, sir, were in 2005 and 2006. At that time, we had proposed policies that were not able to be effected or implemented in the budget year. That also included the proposal for the enrollment fees at that time which were offset in the budget.

We have stopped that practice in future budgets. In the budget for fiscal year 2008, we have stopped that practice. So I am referring to the most current submission that have gone before the Congress. We feel that we have corrected those past situations that created the budget shortfalls.

The CHAIRMAN. So the current model you are using, when VHA and OMB, you, you have received what that model said you needed?

Mr. KEARNS. Yes, sir.

The CHAIRMAN. You made reference to 16 percent. You said 84 percent and 16 percent. What does that 16 percent encompass?

Mr. KEARNS. The 16 percent basically encompasses areas that we have not yet included in the actuarial projections. It is our long-term care, dental, and the CHAMPVA benefits. Now, we are moving as we go forward to try and attempt to include more of those areas under the model into the actuarial projections.

I think Ms. Vandenberg can address that too.

Ms. VANDENBERG. Is there a particular question? I think that as Mr. Kearns indicated, we are attempting to migrate those services that are not currently covered by the model into the model.

And we have seen over the last year, especially as we have been very vigilant in tracking the projected to actual experience, we are able to identify areas where there are variances and understand what gives rise to those variances. So the model definitely is evolving.

The CHAIRMAN. And would you have any objection as you move forward in the next budget cycle to share with the Committee the actual model before it goes anywhere? If the Department is adopting it and OMB is adopting it, then there should be no problem where Members of Congress can actually see what is really go on. Would there be a problem sharing that with the Committee?

Mr. KEARNS. I would have to check with the Department. But from our perspective, no, sir.

The CHAIRMAN. Part of the problem that we see, even if we do accept the model and provide the adequate funding within the budget cycle, it is the timeliness of when that budget comes about that in and of itself causes a problem within the veteran system.

I have talked to different administrators throughout the country and timeliness is an issue. I am not sure. How do you think that we as Members of Congress can, if we accept the model and decide not to do the mandatory funding, how can we make sure that we have a system so that the funding is there in a timely manner?

Mr. KEARNS. Well, sir, we would greatly appreciate, as I am sure every other government agency would, having our budget on 1 October. That has not been the case normally.

We are subjected to the rules of the Continuing Resolution. And as long as it is not a protracted one, I think we will live within them. And we are hopeful that this year, the CR through the 16th of November will not go beyond that. But the longer the CR, there are challenges.

The CHAIRMAN. Would you comment on having a, it was brought up earlier, a 2-year or a 5-year type of budget cycle that is not mandatory.

Mr. KEARNS. I think that is an interesting concept, sir, and certainly we are not prepared to address the specifics of it. We would have to see. But it certainly would be interesting to look at, I would think, and to evaluate.

The CHAIRMAN. In your model, you said you do a model that is based on what, a 3-year or is it a 5-year model?

Mr. KEARNS. Well, we actually do out-year projections. But in the budget, we only use the budget year, sir, and then we update it each year.

The CHAIRMAN. Okay. So if you used your 5-year model, said this is what the model is, we can say, well, this is a 5-year budget or a 3-year or whatever it is, and then as you update while waiting for the new budget cycle to come into effect, at least you will have some assurance that what your budget will be because Congress will already have passed, say, a 2- or a 3-year or 5-year budget.

Mr. KEARNS. I think we would have to evaluate that. Like I said, sir, not knowing the specifics, I think it is an interesting concept, though, I mean, in principle.

The CHAIRMAN. Okay. Let me try to clarify that thought process. I will just use a 2-year cycle. We will take, say, the model, this is what it is going to be for the next 2 years. Congress will pass an appropriation bill for 2 years. This is what it is. The next year, Congress will look at the update on the model for that second year and if it is changed, then we can pass a budget reflecting that change. However, if the budget is not adopted in time, you will operate under the initial budget.

Now, under that concept, what is the downside?

Mr. KEARNS. Well, first of all, as I pointed out, the model does not address a hundred percent of the budget yet and it probably would not for the immediate future.

The other issue would be probably the rules for CR would have to be modified or changed, the normal rules that we operate under for that second year, you know, assuming that there was no— but——

The CHAIRMAN. But the budget would already be in place for that second year.

Mr. KEARNS. Okay. If it was appropriated that way, then, yes, sir. We would at least have that authority to operate under.

The CHAIRMAN. You had mentioned all the departments are not a hundred percent in yet. What timeframe will it be to get a hundred percent of the Department into the formula?

Mr. KEARNS. I am not sure that we have got a specific timeframe. We are hopeful to include in this next year as we develop the fiscal year 2009 budget the dental portion, dental services into that. Then that would leave two other large pieces that would be outside.

And right now we do not have any specific plans of how soon that could be incorporated. They are so different and distinct from the normal healthcare services that we just want to make sure that as we bring them in that we are doing the correct thing.

The CHAIRMAN. Okay. I know some of the Members are still stuck on the floor, so I will turn it over if you have any questions you might have on the Minority side.

Ms. DUNN. Well, just one question. You know, currently the way VA appropriations work, they fund not only the direct services to the eligible veterans, but the cost of the system, the facilities, construction, and so forth.

Under, you know, a static mandatory funding formula, the costs would increase on factors outside the system like inflation, economic conditions, and so forth.

Do you feel like that would create a mismatch between the amount of funding and the actual cost of running the veterans healthcare system?

Mr. KEARNS. I am not quite sure I understand the question. I am sorry.

Ms. DUNN. Well, you use a budget model——

Mr. KEARNS. Yes.

Ms. DUNN [continuing]. That looks at age, morbidity, and so forth.

Mr. KEARNS. Yes, we do.

Ms. DUNN. But the funding formula under the mandatory system would be just based on the number of enrolled veterans.

Mr. KEARNS. And that is why we are concerned about that, that it is not as complex and would not pick up the nuances and the changes in our population and the services and be updated each year as ours is. And I think that is one of the concerns that we would have.

The CHAIRMAN. Would you comment on the legislation that is currently pending over in the Senate as far as the hybrid legislation dealing with this.

Mr. KEARNS. I do not think we are prepared to do that at this time, sir.

The CHAIRMAN. Have you seen it?

Mr. KEARNS. Not specifically, no, sir.

The CHAIRMAN. I would be interested in your comment because I think there is a lot of interest to help, you know, with this problem year after year. And it is not any one particular party. I think both parties, we heard earlier, have been at fault. But I think there has to be some middle ground where we can work to make sure veterans do get the healthcare that they need in a timely manner.

Counsel?

Mr. TUCKER. Yes. Two quick questions, Mr. Kearns.

By necessity, you use data that is 2, sometimes 3 years old. For example, in the fiscal year 2008 budget submission, you had to use fiscal year 2006 actuals as part of your modeling. So obviously those figures have to be, what you are getting out of the model has to be, tweaked in order to address current situations, returning servicemembers, unexpected costs, things of that nature.

And in addition, as you stated, only 84 percent of your budget really is accounted for by the model. There are concerns by many veterans' groups and many veterans that there are political decisions being made subsequent to what the model produces that tend to underestimate demand and lower your budget as it works through the budget process over in the executive branch.

Can you comment on what steps you can take to ensure that what the model is providing is accurate and accurately reflects your needs for the coming year.

Mr. KEARNS. Well, regarding the age of the data, the data that we use, we began the budget process in the April, May timeframe as we develop our estimates. We used the most recent completed fiscal year at that time. So it is the most current data that is available.

Part of the process is just the timeline that we need to develop and submit the budget to Congress. So we are using the most current data that is available.

The other issue, based on the results of the experience that we had in 2005 and 2006, we have been working very closely since that time, since that occurrence with the Department and with OMB to monitor our execution of the budget, first of all, the development of the budget and then the execution.

We meet monthly with OMB. So I think there is a much better understanding on both parts of the requirements and we have not experienced those types of problems since that time.

Mr. TUCKER. And if I may, sir, one more.

Other than changing your appropriations account structure back to the one account, medical care account, as CFO of the VA, what are the 3 biggest concerns or issues or problems you have with the current funding mechanism, the discretionary funding mechanism? What are those? Do you have any suggestions on how to improve that mechanism and how to make your life a little easier and make the VA a little more effective and efficient?

Mr. KEARNS. I think the concern we addressed in our statement, the largest concern is not necessarily with the current process. It is with the budget structure, its the 3 appropriation structure.

It complicates operations particularly at the medical facility level. It has broken one, if you would, line of business which is healthcare delivery services into 3 components as though they were separate and distinct and not interactive and, yet, if you are running the medical facility as a Director, you have to integrate all of those 3 components together as though they were one.

So from that perspective, although we have been successful in working with the 3 appropriations structure, it has greatly increased the complexity at all levels of our organization. So that would be the one change I would suggest.

Mr. TUCKER. Any additional changes or is that just the one you can think of right now?

Mr. KEARNS. You know, we are comfortable with the current process. We would like much shorter CR periods if that is possible, too, I mean, as I am sure everybody would. But other than that, no.

The CHAIRMAN. Actually, I do not want any CR periods. I mean, there is no reason why we should not get our work done on time. But, unfortunately, politics does enter into it regardless of who is in power.

And I think it is very important that we look at what the goal is. And the goal is to make sure that our veterans receive the proper and adequate funding on a timely basis. And whichever way we can provide that, I think we have to look at it.

One of the things I keep telling my staff all the time is to think outside the box. You know, there is a problem here. The problem is the VA is not getting their budgets on time. Sometimes it is inadequate. So how do you solve that problem? And that is what I would ask the VA to really look at. If you do not like the proposals in front of you, how can we deal with it that we can do that?

So we are looking forward to working with you and want to thank you once again for coming here today and I also want to thank once again the previous two panels.

If there are no other questions, the hearing will be closed.

Mr. KEARNS. Thank you, sir. We appreciate the support of the Committee. Thank you.

The CHAIRMAN. Thank you.

[Whereupon, at 12:49 p.m., the Committee was adjourned.]

APPENDIX

Prepared Statement of Hon. Bob Filner
Chairman, Full Committee on Veterans' Affairs

The Committee on Veterans' Affairs will come to order. I would like to thank the Members of the Committee, our witnesses, and all those in the audience for being here today.

In general, there are two types of federal spending—mandatory, or direct spending, and discretionary spending. Discretionary spending is subject to annual Congressional determinations regarding funding levels.

When we think about what the Federal government does, most of these activities are financed by discretionary spending. Direct spending, also known as "entitlement spending," is governed by eligibility rules and criteria, and includes Medicare and Social Security.

For fiscal year 2008, the House-passed VA funding bill provides $43.2 billion for discretionary spending, of which $37.1 billion is for the four accounts that comprise the Veterans Health Administration. This bill provides $44.5 billion for mandatory spending, including $41.2 billion for the payment of compensation and pension benefits.

There is a widespread perception that the current manner in which we fund veterans' healthcare is broken, and must be fixed.

The VA currently utilizes the "VA Enrollee Healthcare Demand Model" to estimate its healthcare needs.

Although utilizing an actuarial model to predict healthcare spending may arguably be an improvement over the old system of utilizing a current services model, there are concerns that this model does not accurately reflect the true costs of caring for veterans.

There are concerns that even if the model is accurate, decisions regarding budget requests made subsequently underestimate the real need. This leads to budget shortfalls as experienced by the VA in previous years, most notably in 2005 and inadequate budget requests, requests that must be augmented by Congress. The bottom line is that each year we see VA struggling to do more and more with a budget that does not quite keep up.

In addition to concerns over the adequacy of the VA's healthcare budget, there are concerns that the failure to provide this funding at the start of the fiscal year hinders the VA's efforts to plan and to spend its resources in the most advantageous manner.

These concerns have led a number of veterans' groups to propose that VA funding be switched from the discretionary side of the federal ledger and placed on the mandatory side of the ledger.

VA healthcare funding would be provided subject to a formula. Proponents argue that by doing so, VA funding would be needs-based and removed from the vicissitudes of the annual budget process.

This was a legislative issue championed by our former colleague on this Committee, Lane Evans. It is an issue now championed by the successor to Mr. Evans' seat, Mr. Hare.

We do not debate VA funding in a vacuum—whether the VA is funded by discretionary or direct spending has long-term implications regarding our fiscal ability to fund veterans' healthcare and to meet the obligations that our government must meet.

The Congressional Budget Office, in testimony before another Committee earlier this year, stated that VA medical spending would increase from $35 billion in fiscal year 2007 to $66 billion in 2025 "or 88 percent cumulative real growth." This figure was 50 percent greater than the VA's assumptions. If VA's growth rate continued at the level of the growth of appropriations in recent years, then VA healthcare would "triple in real terms, reaching $108 billion in inflation-adjusted dollars by 2025."

How will the VA fare in the future when forced to compete with other discretionary spending programs?

There are concerns that as a nation we are facing a crisis in mandatory spending in the coming decades. In 2006, mandatory programs made up 53 percent of the federal budget, discretionary programs 38 percent, and interest 9 percent. In 1962, discretionary spending made up 68 percent of the federal budget and mandatory spending 26 percent.

The Administration claims, in its FY 2008 budget submission, that "by 2040 spending . . . on mandatory programs will crowd out all discretionary spending—for defense, homeland security, or education—unless we take steps to reform these programs."

The Administration paints a bleak picture, a picture that may, or may not, be accurate. Are we indeed facing a future where discretionary programs like veterans' healthcare are at risk because of the explosion of entitlement spending? If the VA was funded by mandatory spending would it be affected by efforts to rein in mandatory spending in the future?

The 110th Congress has instituted strict pay-as-you-go (PAYGO) mechanisms that require offsets for any new direct spending. There are concerns that in the future we may face mandatory spending caps or even discretionary spending caps as we struggle with moving the federal budget toward balance.

Today, we begin the discussion on how best to fund the VA of the future, how best to meet the needs of returning servicemembers, and our veterans from previous conflicts. This may mean that we stick with the current discretionary funding mechanism, perhaps with an expectation that we will see more accurate budget submissions in the future, budget submissions that acknowledge the true costs of providing healthcare and do not, year-after-year, underestimate demand or rely on Congress to come up with extra resources because those resources have not been requested.

Perhaps it is time, within the current discretionary funding framework, to explore how to increase alternative funding streams, such as seriously looking at the issue of Medicare subvention or increasing the effectiveness and efficiency of the VA's third-party collections efforts. Or maybe it is indeed time to fund VA healthcare in the manner that other federal healthcare programs are funded, by direct spending.

The new fiscal year began on Monday. Both the House of Representatives and the Senate have passed historic increases for veterans' programs. Currently, the VA is being funded under a continuing resolution that is scheduled to run until November 16,2007. It has been over a decade since the VA did not have to rely on a CR. I am hopeful we will not face the situation faced earlier this year when the VA did not get its fiscal year 2007 funding in place until February 15, 2007.

Whichever method we ultimately decide upon, I know I speak for all of us that we are committed to finding a manner that accurately reflects the needs of veterans, and provides the VA with a steady and sufficient stream of resources to enable it to meet its requirements and care for our veterans.

Prepared Statement of Hon. Steve Buyer, Ranking Republican Member, a Representative in Congress from the State of Indiana

Thank you Mr. Chairman.

Placing Department of Veterans Affairs (VA) healthcare under a mandatory funding program would subject it to PAYGO offsets and in put it in direct competition with Medicare and Medicaid.

I cannot understand why some organizations are so eager to make such a radical change that would risk jeopardizing our Nation's largest and finest healthcare system.

It's especially perplexing to me that some of these same organizations recommend a cautious, measured approach to fixing VA's claims processing system.

Why would you recommend radical changes for a system that is widely praised by numerous sources, while recommending incremental changes for a system that, by your own definition, is in a state of crisis?

The inconsistency is astounding . . .

Mandatory funding for VA would create a new type of entitlement program, an entitlement program for the second largest department in the federal government, not an individual.

I believe the downside to such a change, as so well-explained in Mr. Kogan's written testimony, outweighs the potential positives.

Entitlements have great emotional appeal because they appear to offer something for nothing.

On the surface, entitlement programs appear to offer a smooth funding process that is automatic.

Entitlements are so politically appealing that it is tempting to expand them under the guise of providing an ever-increasing security blanket that makes our citizens more reliant on government programs.

As Mr. Kogan will aptly points out, that is hardly the case.

I would also note that Mr. Aaron from the Brookings Institute, hardly a bastion of conservatism, opposes mandatory funding.

Proponents of mandatory funding ignore that the recent successes of the VA healthcare system took place under a discretionary funding system.

Proponents of mandatory funding often cite Medicare and Medicaid as examples of how we should fund veterans' healthcare.

I find it notable that Mr. Kogan refers to those programs as "stingy" despite their entitlement status.

Mr. Chairman, we must resist the urge to respond emotionally and risk making irrational changes that may jeopardize VA healthcare.

Our obligation to provide care for our veterans can best be fulfilled if the funding system is within our jurisdiction where we can make necessary, rapid adjustments.

I strongly oppose the notion of abrogating this responsibility.

Prepared Statement of Hon. Stephanie Herseth Sandlin, a Representative in Congress from the State of South Dakota

Thank you to everyone for being here. I congratulate Chairman Filner for holding today's hearing to examine one of the most important issues confronting this Committee and our Nation's veterans—the funding process for the Department of Veterans Affairs.

I believe the increased level of funding provided by the House and Senate will go a long ways to helping address some of the VA's chronic problems. However, while the Department of Veterans Affairs and Congress have made some tremendous improvements to VA funding in recent years, there continues to be room for improvement and analysis of the process. This point is revealed by the fact that we have again begun a new fiscal year without the passage of a new VA appropriations bill.

Now, as the wars in Iraq and Afghanistan are producing a new generation of sick and wounded veterans, it is time for Congress to address the adequacy, timeliness, and reliability of VA healthcare funding.

I am pleased that we have the opportunity to hear from today's panelists and am grateful to have the opportunity to hear your suggestions and answers to the critical issues involved. I look forward to hearing your testimonies.

Again, I want to thank everyone for taking the time to be here and discuss these important matters.

Prepared Statement of Hon. Harry E. Mitchell, a Representative in Congress from the State of Arizona

Thank you Mr. Chairman.

I would also like to thank our distinguished panels for joining us today to discuss spending priorities for the VA going forward.

We took a big step earlier this year by passing a VA appropriations bill which made the single-largest investment in veterans' healthcare in the 77-year history of the agency.

I am very proud of that legislation, and I know it will make a difference in the lives of millions of veterans and their families.

And while it represents an important step forward, I think we can all agree that we need to do more.

This afternoon, the Veterans Disability Commission will release its final report, which will contain important recommendations for how we can ensure that *all* disabled veterans get the resources they need. Next week our Committee will have an opportunity to hear from some of the members of the Commission, and I am eager to hear about what they have found.

Unfortunately, we already know that our veterans are facing a host of challenges. They're encountering increased wait times for care, questions about the safety of their personal information, and difficulties accessing their medical records from the Department of Defense, just to name a few. We have an obligation to work together to address these issues.

We also have an obligation to provide the resources necessary to help veterans cope with the new and different kinds of injuries they are suffering in Iraq and Afghanistan. We need to ensure that they have access to treatments for traumatic brain injury and post-traumatic stress disorder, as well as the latest in prosthetic technology.

We clearly have a lot of work to do, and that's why I am looking forward to today's hearing. I yield back.

**Prepared Statement of Hon. Jeff Miller,
a Representative in Congress from the State of Florida**

Thank you, Mr. Chairman.

Ensuring that the men and women of our armed forces, to whom we owe so much, have timely access to the best healthcare is of the utmost importance to me.

As we look ahead to the future of VA healthcare, we see a new generation of veterans combined with veterans of past wars. These veterans will have different needs, and we must ensure VA has the resources and ability to serve all of their healthcare requirements.

VA has faced tremendous challenges in the past few years with the rapid increase in demand for VA healthcare. VA's inability to meet its own access standards and the fiscal year 2005 budget shortfall has given rise to veterans groups to urge Congress to move VA healthcare from its current discretionary appropriation to a mandatory spending authority. They see this as a solution to avoiding uncertainties of the annual appropriations process and ensure all eligible and enrolled veterans may gain and retain access to VA healthcare programs.

I believe it is the wrong solution. While it is understandable that groups would want "guaranteed" funding, there is no guarantee that a mandatory funding mechanism would enhance resources for veterans' medical care.

Mandatory funding proposals would fund VA through a formula that takes into account the number of enrolled and veterans eligible for VA medical care, and the consumer price index. These concepts have not been tested, and to implement an untested formula could lead to significant risks and unintended consequences for veterans' healthcare. As the veteran population declines, it could even result in under funding VA healthcare in the future and threaten the long-term viability of the VA to provide care to the highest priority severely disabled veterans Further, these funding mechanisms do not provide for VA research or construction, which are integral pieces of the Veterans Health Administration. Under the current discretionary funding structure, Congress has acted to improve the VA budget process and passed record spending levels for veterans' healthcare.

Our most effective tool for enforcing change at the VA is our legislative authority to hold VA accountable through the "power of the purse". A rigid mandatory funding formula would provide absolutely no incentive for VA to realize higher performance standards or maximize the use of its own resources.

Mr. Chairman, our responsibility is not to take the politically appealing route—it is to provide our veterans with a sustainable system of benefits now, and in the future. Especially at this time when our military is so heavily engaged in fighting the war on terror, Congress must retain the right and ability to oversee VA's healthcare system and adjust the level of funding to the rapidly changing needs of the veteran population.

Thank you and I yield back the balance of my time.

**Prepared Statement of Hon. Ginny Brown-Waite,
a Representative in Congress from the State of Florida**

Thank you Mr. Chairman.

I want to thank all of our witnesses here today for testifying before this Committee.

Under current law, the Department of Veterans Affairs' programs are funded through both mandatory and discretionary spending authorities. Cash benefit programs like compensation and pensions, survivor and readjustment benefits are examples of mandatory spending programs; whereas, VA healthcare, medical facility construction, medical research and administration costs are examples of discretionary funding.

We are here today to discuss whether it would be financially prudent and in the best interest of veterans across the country to make VA healthcare programs a mandatory spending item. I know that VA healthcare experienced funding shortfalls in FY 2005 and FY 2006 and that this has led some to believe that in the future VA healthcare should be made into a mandatory spending program. Opinions vary as to whether this change would be a good idea or not, so I look forward to hearing what the witnesses before us today have to add to this debate.

Once again, I welcome you to the hearing and look forward to hearing your thoughts on the issue before us today.

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) healthcare system. I am testifying not only on behalf of Disabled American Veterans (DAV), but also the eight other national veterans service organizations that along with DAV, make up the *Partnership for Veterans Health Care Budget Reform:* 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.

We would like to begin by thanking you, Chairman Filner, for holding this hearing, and all the Members of the Committee who are here today to examine the critical issues involved. For more than a decade the Partnership has urged Congress to address and reform the basic discretionary appropriations system of funding VA healthcare. We all agree that the VA healthcare system must be protected for millions of veterans who depend on it now as their *only* healthcare resource and will do so for many decades. Our hope is that today's hearing becomes a key moment toward achieving that goal.

As we have done several times already this year, the Partnership would like to acknowledge and applaud the support of this Committee, your Appropriations Committee colleagues, and all Members of the House who have elevated VA discretionary healthcare funding over the past several budget cycles, and in particular for this year's prospective increase of $6 billion in additional healthcare funding. But, it can't have escaped the notice of anyone in this room that the new fiscal year, FY 2008, has already begun and once again we have no new VA appropriation. We are now in the third day of fiscal year 2008 without Congressional approval of a regular appropriation for the Department of Veterans Affairs, which is functioning under a Continuing Resolution. We have been in this same situation—beginning a new fiscal year without new VA appropriations—in 13 of the past 14 years. In fact, over the past five years, the VA appropriation has been late by an average of 105 days, or 3½ months.

The lack of an appropriation means that none of the prospective increase for VA healthcare in FY 2008, that we are all so grateful for, is actually helping veterans today; and we have no idea when it will. None of VA's VISN Directors, medical center directors, clinic directors, or department heads can use the prospective increase in funding to improve the delivery of healthcare to veterans today. No new equipment can be procured, no new personnel can be hired, and no services can be expanded until Congress and the President finish their annual job of enacting VA's appropriation. Even at a time of war, when the obligations to America's veterans are clearer than ever, we cannot get the VA appropriation on time.

Despite the fact that the prospective increase in funding is supported, or at least not opposed, by both sides of the aisle, both Houses of Congress and both ends of Pennsylvania Avenue, we still have no new appropriation. Is there really any doubt that the system for funding VA healthcare is broken? Even in budget years—like this one—when the anticipated level of funding for VA healthcare appears to be sufficient, the lack of timeliness and predictability undermine the overall effect of those gains. That is simply intolerable. We hope that this Committee will agree that Congress can only fully solve this problem by enacting real reform that results in sufficiency, predictability and timeliness of VA healthcare funding.

The problem is not just about how much, but equally if not more so about how the budget process works. Each year the President proposes a 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, submitted to the Budget Committees, that Committee establishes a Concurrent Resolution as a blueprint to execute that budget. The Appropriations Committees allocates funds to carry out the purposes of that budget, guided by the Concurrent Resolution. The whole Congress and the President underwrite this system. It is intended to be a balanced system, and it works well in most cases. But for a variety of reasons, it no longer works in the case of VA healthcare.

No matter how accurate and precise the formulation methodology for the VA budget may be, the budget process itself impacts the sufficiency of the final outcome. For example, although the federal budget process is designed to accommodate multiple reviews and approvals, it is cumbersome and long, requiring multiple levels of review (within the Veterans Health Administration; the VA; the Office of Management and Budget; Congressional Authorizing Committees (House and Senate); Congressional Budget Committees (House and Senate) and Congressional Appropriations Committees (House and Senate). At minimum, 21 months are consumed from initial formulation to the start of the fiscal year concerned. The final budget, after numerous tactical adjustments, often lacks a clear strategic direction. Updates in needs estimates during the 21-month span are *not* encouraged after review officials lock on to their approved levels. Finally, the enactment of the appropriations act is predictably late—as in our current dilemma for this fiscal year—over issues unrelated to VA healthcare.

Mr. Chairman, as a result of perennially inadequate budget submissions from Presidents of both political parties; annual Continuing Resolutions in lieu of approved appropriations; late arriving appropriations; offsets and across-the-board reductions; and the injection of supplemental and even "dire emergency supplemental" appropriations, VA has been unable to manage or plan the delivery of care to veterans as effectively as it could have done. We challenge this Committee to identify an American business that could operate successfully and remain viable if, in 13 of 14 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 13 out of 14 fiscal years beginning with Continuing Resolutions, including this year, creating a number of 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 more than a decade. The Partnership believes this situation needn't exist, and that Congress can make vast improvements with funding reform legislation.

The wars in Iraq and Afghanistan are producing a new generation of wounded, sick and disabled veterans, and some severe types at polytrauma levels never seen before in warfare. A young American wounded in Central Asia today with brain injury, limb loss, or blindness will need the VA healthcare system for the remainder of their lives. The goal of the Partnership is to see a long-term solution formed for funding VA healthcare 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 healthcare system, any reform must include *sufficiency, predictability, and timeliness* of VA healthcare funding.

In past Congresses, we have worked with both chambers' Veterans' Affairs Committees to craft legislation that we believed would solve this problem, if enacted. The current version of that bill is H.R. 2514, the Assured Funding for Veterans Healthcare Act, introduced on May 24, 2007 by the Honorable Phil Hare of Illinois and 77 original cosponsors, including Chairman Bob Filner and several other Members of the Committee: Representatives Corrine Brown, Stephanie Herseth Sandlin, John Hall, Michael Doyle, Shelley Berkley, Ciro Rodriguez, and Zach Space. The bill now has 85 cosponsors and the Partnership's full endorsement.

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 your normal appropriations decisions. Please also consider the Administration's efforts to explain to Congress why VA found itself deficient by billions of dollars in each of those years. These acknowledgements were often very reluctantly made. In one case, the President was reduced to formally requesting *two* VA budget amendments from Congress within only a few days of each other.

Some Members have opposed mandatory funding claiming it would be too costly; 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 *one percent* of the government's total expenditure since that date. 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 of Government predicted that federal outlays for veterans of the wars in Afghanistan and Iraq would 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.

On July 25, the Senate Committee on Veterans' Affairs held a hearing on VA healthcare funding, the first hearing of its kind. A number of key witnesses testified at that hearing in addition to the Partnership, including the former Chairman of this Committee, the Honorable Christopher H. Smith; the former Under Secretary for Health, the Honorable Kenneth W. Kizer; four retired VA medical center directors; Mr. J. David Cox, National Secretary-Treasurer of the American Federation of Government Employees (VA's largest employee union); and, Dr. Ewe Reinhardt, a distinguished professor of economics at Princeton University. All the witnesses urged the Senate to reform funding for VA healthcare. In particular, we want to call your attention to Dr. Reinhardt's statement on VA healthcare and its place in American public policy. Dr. Reinhardt made persuasive arguments for the propositions that the VA system can be sustained and is affordable, and that it would be more efficient if funded through a mandatory, rather than discretionary system.

The Partnership Calls for Action

Mr. Chairman, from today's hearing, after considering the testimony of witnesses here as well as those who addressed the Senate Committee, we ask the Committee in your fiscal year 2009 Views and Estimates to the Budget Committee that you notify them of your intention to report legislation creating a mandatory and guaranteed funding system for VA healthcare in 2009, and that you recommend that the Budget reserve sufficient funds to make that seminal change next year. If the Committee chooses a different method for effecting this change than offered in H.R. 2514, we will examine that proposal to determine whether it meets our three essential standards for reform: *sufficiency, predictability, and timeliness* of funding for VA healthcare. 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 Healthcare Eligibility Reform Act 1996,* Public Law 104–262, which changed eligibility requirements and that paved the way for improved healthcare for veterans. Greater numbers of veterans became eligible for healthcare 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 healthcare 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 healthcare 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 healthcare system. As a result, millions of veterans enrolled in VA healthcare for the first time in their lives. A decade later, VA healthcare is a remarkable success story of how to transform a troubled and overburdened system

[1] The creation of the new VISN's began in 1995 in anticipation of the passage of the Act.

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 healthcare 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 healthcare 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 healthcare operations would still be dependent upon appropriated resources.[2] As early as 1993, the Partnership urged Congress to "guarantee" funding for VA healthcare if Congress decided to reform eligibility for that care. Unlike other healthcare 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 healthcare system, a more comprehensive healthcare benefit and high quality, safe healthcare services. However, gaining and keeping access to that system is a continuing dilemma due to the uncertainty of duration of an individual'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 officials are constrained from publicly stating their true needs.

Most importantly, eligibility reform eliminated fragmented care provisions in the statutes 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 healthcare 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 out-pacing 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 healthcare 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 healthcare under that policy. The then-Ranking Member of the this 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 healthcare from their healthcare 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 healthcare enrollment at the beginning of 2003 also must be taken into context. While VA was in the midst of unprecedented systemic—even revolutionary, change, Congress passed the Balanced Budget Act (BBA) 1997, Public Law 105–33. That Act was intended to flat-line domestic discretionary federal spending, across the board, including funding for VA healthcare. As the effects of the BBA took hold during the three-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 Senate counterpart, Congress relented and provided VA healthcare a supplemental appropriation of $1.7

[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.)

billion. Nevertheless, the 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 six 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 by law, closed new enrollments of PG8 veterans and set out a plan to get the waiting list under control.

Another consideration important to this discussion is that the BBA also authorized a 10-site "Medicare subvention" demonstration project within the Department of Defense (DoD) healthcare 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 for 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.

Congress must also consider the implications of the anticipated policy change that would extend eligibility for all OEF/OIF veterans to access VA healthcare services from two to five years. In addition, changes in the weapons of warfare and advances in battlefield medicine have resulted in significant numbers of surviving, but traumatically wounded, servicemembers. The demands that are placing, and will continue to place on the VA system, including the need for expanded polytrauma treatment and rehabilitation programs, must be considered.

President's Task Force

An additional perspective to consider with respect to your addressing funding reform is that of the President's Task Force to Improve Healthcare 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:

> *"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.*

> *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 healthcare. 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.

The question about PG8 veterans reenrolling in VA healthcare is not a question only about them and their needs for healthcare. It is also a larger question about the sufficiency, predictability and timeliness of the current system of funding VA healthcare. Until those reforms are enacted to guarantee that on October 1 of each year, VA will have a known budget in hand, the means and methods to spend those funds in accordance with need, and that VA's budget will be based on a sound methodology, we are concerned about immediate readmission of PG8 veterans.

Mr. Chairman, we have heard over and again a number of reasons as to why converting VA healthcare to mandatory funding would fail, whether from the bill we recommended or through other models to achieve that goal. We list below some of those criticisms, with our response for your consideration. We hope you will review those issues as you consider this reform.

MYTHS and REALITY

MYTH: *Congress would lose oversight over the VA healthcare 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 healthcare services—as it does with other federal mandatory programs.

Guaranteed funding for VA healthcare would free Members 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 healthcare.*

REALITY: The Assured Funding for Veterans Healthcare Act would shift the current funding for VA healthcare 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 healthcare system to all veterans.*

REALITY: The Healthcare Eligibility Reform Act 1996 theoretically opened the VA healthcare system to all 24 million veterans; however, it was never anticipated that all veterans would seek or need VA healthcare. 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 healthcare.

MYTH: *Guaranteed funding for VA healthcare 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 sufficient resources to treat veterans actually using the system.

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

REALITY: Among the 7.9 million enrollees in the VA healthcare 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 healthcare system can be maintained even if VA only treats service-connected veterans or the so-called "core group," Priority Groups 1–6.*

REALITY: VA healthcare should be maintained and priorities 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 healthcare 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 healthcare 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 healthcare 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 healthcare. 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 healthcare services when veterans need it. It is not intended to provide excess funding for veterans healthcare. VA Central Office (VACO) would still be responsible for ensuring local managers are using funds appropriately and efficiently. Network 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.

Conclusion

In closing, Mr. Chairman and Members of the Committee, we ask for your leadership and commitment to resolve this keystone issue in veterans' affairs. The long-term solution to VA's funding problems requires strong leadership from this Committee and this Congress. We urge you, as leaders in veterans' health and financial policy, to remember the needs of America's veterans and take action to remedy this serious problem.

Mr. Chairman, we would like to note that all of the member organizations of the Partnership have adopted statements or resolutions urging funding reform in VA healthcare.

We hope as you debate this crucial matter the Committee will recognize that our organizations are united in our interest in calling for basic budget reform.

This concludes our testimony. Again, the Partnership appreciates the opportunity to present testimony, and we thank the Committee for its continuing support for veterans, especially those who are sick and disabled as a result of serving the Nation.

Prepared Statement of Henry J. Aaron, Ph.D.** Bruce and Virginia MacLaury Senior Fellow Brookings Institution

Mr. Chairman:

Thank you for the invitation to testify today on the proposal to convert funding for the Veterans Health Administration (VHA) from a discretionary to mandatory basis. In the course of my remarks, I should like to stress four points:

First, the VHA faces an unusually difficult challenge—it must deliver an extraordinarily wide range of services to highly diverse populations. The VHA provides ordinary primary, secondary, and tertiary somatic medicine, as well as mental health services. One of its most important responsibilities is to offer a subtle combination of physical therapy, mental health services, and somatic treatment to victims of spinal cord and traumatic brain injury.

Second, the VHA has performed remarkably well of late. Inspired management has transformed the VHA from being the poster-child for low-quality medical care into a model organization that delivers higher quality healthcare than the average of private healthcare providers and does so at a comparatively reasonable price.

Third, the budget of the VHA is part of the long roster of federally financed healthcare services. The cost of federal healthcare obligations is projected under current law to increase enormously. In fact, growth of these programs accounts for more than all of the long-term deficits recently to which the Congressional Budget Office and various private analysts have recently drawn attention. Put more positively, if the Nation deals with the imbalance between projected revenues and spending for healthcare, revenues at current levels are projected to be sufficient to pay for all other anticipated government commitments, including all Social Security benefits promised under current law.

** The views expressed here are my own and do not necessarily represent those of the trustees, officers, or other staff of the Brookings Institution.

Fourth, proposals to boost federal healthcare spending abound. Not all can be funded without unduly raising federal spending. Different groups would benefit from each of these proposed increases. Sensible budgeting requires a comparison of these competing claims. Unfortunately, Congressional Committee structure inhibits such comparisons. To illustrate this problem, I list three such candidates for increased spending. For what it is worth, my judgment is that the priority of converting VHA spending into mandatory funding ranks below the other two possible uses of federal funds.

I

The VHA administers more than 1,200 hospitals, outpatient clinics, nursing homes, and rehabilitation facilities.[1] These facilities comprise one of the largest healthcare delivery networks in the United States, with revenues approximating those of the largest private domestic healthcare system, Kaiser Permanente.

The statutory clientele of the VHA, currently more than 23 million veterans, is enormously varied in its needs. It includes veterans who have crippling service-connected spinal-cord and brain injuries that prevent them from earning a living or taking care of themselves. It includes other veterans who, despite serious service connected disabilities, support themselves and their families. It includes veterans with comparatively minor service connected disabilities that have no bearing on their current activities. It includes veterans with no service related disability whatsoever who currently have low incomes. And, finally, it includes, millions of veterans who have no service connected disability and have what is normally regarded as an adequate income.

America owes its thanks to all military veterans for their service to this Nation. All took time from civilian lives to help protect the rest of us. But it in no way diminishes the contribution made by those veterans who came home healthy and uninjured and have prospered to say that the Nation owes a special debt to those who suffer daily physical reminders of their service. This sense of priority is reflected in the VA healthcare priority groups.

It is also manifest in the use that each of these groups makes of the VA health system. More than half of veterans in priority groups 1, 2, and 3 are enrolled in the VA health system, just under half of priority groups 4 and 5, about one-third of groups 6 and 7, and less than 20 percent of group 8. The VHA is particularly good at treating those conditions that peculiarly affect veterans, and veterans turn disproportionately to the VHA for care of these conditions. This pattern reflects a match of need and expertise. Other veterans choose healthcare providers from the private sector.

II

The Veterans Health Administration has undergone a remarkable transformation since 1995. At the time, critics charged the VHA with high cost, low quality, providing the wrong mix of services for its clientele, and poor accessibility. The key reforms included reorganizing numerous separate providers into veterans integrated service networks (VISNs) that received budgets from which responsible officials had to manage variety of service providers. Budget authority was shifted to where veterans were most numerous. These reforms gave the VHA authority to bargain over the prices of pharmaceutical products that, linked to the VHA's size, gives it more clout than virtually any other single purchaser. The performance of the VISNs is measured and advertised around the VHA and VISN managers receive bonuses for good performance.[2] These quite business-like incentives illustrate an important proposition: government can achieve the efficiencies normally associated with private businesses if its managers are given the flexibility and incentives to operate effectively.

Unfortunately, Congress has interfered with the VHA's administrative freedoms in various ways and has made efficient administration more difficult than it needs to be. Congress has prevented the VHA from contracting with one or a few suppliers of some products whose prices are lowest. The late completion of work on budgets and the all-too-frequent use of continuing resolutions has hampered efficient hiring and other planning.

On a more positive note, the VHA has gone further and faster in introducing electronic medical records (EMR) than have most private healthcare providers. EMR

[1] Sidath Piranga Panangala, "Veterans' Medical Care: FY 2008 Appropriations," CRS Report for Congress, 25 June 2007, p.3.

[2] Adam Oliver, "The Veterans Health Administration: An American Success Story?" *The Millbank Quarterly,* vol. 85, no. 1, 2007, pp. 5–35.

could be introduced expeditiously because VHA management had centralized control, something that is lacking in nearly all of the private U.S. healthcare system. And it proceeded as fast as it did also because the VHA also had adequate financial backing—an estimated $300 million for wiring, $450 million for computers, and $485 million a year (an average of $90 per patient) in upkeep.[3] The VHA experience illustrates why all the talk about electronic health records for the private sector has produced so few results. In contrast to the money that the VHA had to back its EMR 'play,' the legislation that created Office of the National Coordinator for Health Information Technology stipulated that no additional funds would be appropriated to support its activities. One would be hard pressed to find a better example of 'you get what you pay for.'

Objective measures indicate that the quality of care provided by the VHA at least equals that of private sector health services. One study that found that two-thirds of VA patients but only 51 percent of privately served patients receive all indicated care when they see a doctor or visit a hospital.[4] Another study reported that the VHA provided better care in 12 of 13 categories than private providers rendered to Medicare patients.[5]

These comparisons clearly indicate that the VHA has come a long way since the days when the quality of its care was almost universally criticized. They are also consistent with a view that, at least in the case of healthcare, a well-managed public agency, authorized by Congress to operate in a business-like manner, can deliver care as good as or better than that rendered by the private sector *as currently organized.* No doubt improvements in efficiency similar to those of the VHA could have been achieved in the private sector if current administrative arrangements were altered. Alas, the currently fragmented organization of private providers and payers alike deprives most of them of the capacity to execute the reforms that centralized management made possible in the VHA.

III

Governments—federal, state, and local—now directly account for 47 percent of national healthcare spending and an even larger share—56 percent—of hospital spending. The full role of governments is even larger than those numbers suggest, because premiums paid by employers for their employees are partially offset by the revenues forgone as a result of the exclusion of this portion of consumption from all tax, corporate or individual.

Although it is already large, the public share in the cost of healthcare is certain to increase. Growth of healthcare spending has outpaced the growth of income by an average of 2.7 percentage points a year for more than four decades. A gap of similar size is likely to persist. The rate at which the menu of beneficial medical interventions increases is not expected to slow as the genomic revolution, nanotechnology, and personalized medicine proceed. Furthermore, the population is aging. The financial burden of supporting healthcare for the elderly disproportionately falls on the public.[6] The proportion of the population covered by public programs will increase. Furthermore, the value of the exclusion from tax of privately financed health insurance premiums will continue to grow faster than income does.

What is insufficiently understood, in my opinion, is that meeting this challenge will require a transformation of *both* publicly and privately financed healthcare. Measures to slow the growth of both public and private healthcare spending and to boost taxes will be necessary. This Nation has come to a national consensus that Americans—old and young, with and without disabilities, rich and poor—should enjoy similar—*not identical, but similar*—access to healthcare. Hospitals and physicians treat all patients similarly; indeed, if they do not, they are—and *should* be—open to successful suit for malpractice. That the polity would long tolerate cuts in either Medicare or Medicaid sufficient to significantly lower the rate of growth of

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[3] Oliver, p. 20.

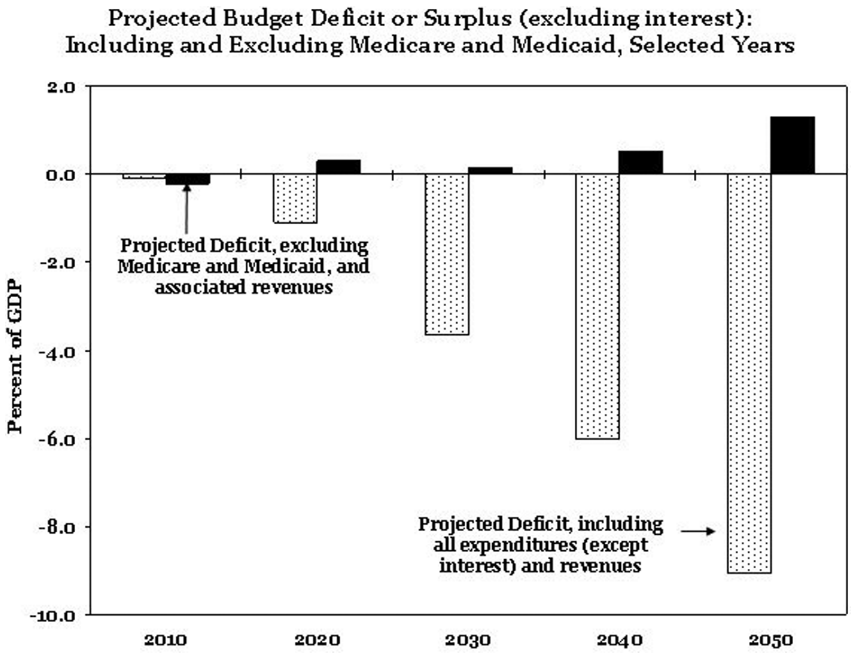
[4] Stephen Asch et al., "Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a national Sample," *Annals of Internal Medicine,* vol. 141, no. 12 (21 December 2004), pp. 938–945.

[5] A. K. Jha, et al., "Effect of the Transformation of the Veterans Affairs Healthcare System on the Quality of Care," *New England Journal of Medicine,* vol. 348, no. 22, pp. 2218–2227. Patients covered by Medicare received better care than those covered by commercial insurance in eight of twelve categories where comparisons were possible. Patients covered by Medicaid consistently received poor services.

[6] The statement in the text is a factual, not normative. Even if the Nation embarked on a policy to require the elderly, or most of them, to save enough to pay for the healthcare they will use in retirement, the transition to such a system would take decades. Whether such a policy shift would be desirable is irrelevant to the text statement.

spending is, in my view, an insult to the generosity and compassion of the American people.

What is also inadequately understood is that successfully balancing public spending for and revenues dedicated to healthcare would eliminate any long-term budget problem, based on the best current projections. The following figure shows the long-term budget projections of the Congressional Budget Office, adjusted for healthcare spending statistics available early this year.



The dotted bars show projected primary budget deficits, as a percentage of gross domestic product. The primary budget deficit is the difference between total spending other than interest on the debt and total revenues. If the primary budget deficit were to balloon, as shown here, the actual situation would be far worse than indicated. As the ratio of debt to GDP increased, interest payments would grow for two reasons, which interact multiplicatively. Firstly, there would be more debt on which to pay interest. Second, the interest rate at which the government can borrow would rise as lenders become apprehensive that the government will be able to meet future debt service obligations. The result would be explosive increases in interest payments.

The figure also shows projections of the primary budget if one subtracts projected government spending on Medicare and Medicaid, earmarked taxes, and a share of general revenues equal to the current support level. This difference is shown in solid black bars. As is apparent, if the impact of rising spending on Medicare and Medicaid in excess of revenues is eliminated, there is no projected deficit. Current projections indicate that a small surplus would emerge. In other words, if the Nation deals with its healthcare financing problem, the remaining revenues under current law would be adequate to cover all projected private spending, including all Social Security benefits promised under current law.

Let me hasten to emphasize that long-term projections are never exactly right. They simply extrapolate the implications of current assumptions. Small differences in those assumptions compounded over enough years can produce large differences, but mean little. Projections are useful when they show large imbalances and broad trends. This figure clearly indicates two realities that should shape current fiscal debate.

- *The Nation faces large long-term deficits under current policy.*

- *The Nation does not face an overall fiscal crisis or an entitlement crisis: it faces a big healthcare financing problem* that should lead to a vigorous national debate on much healthcare we want and how to pay for it.

IV

Against this background, should funding for the VHA be converted from a discretionary to mandatory account? The answer, I believe, is that it should not, despite the genuine claim that veterans have on public support for their healthcare and the excellent record in delivery high quality healthcare at a reasonable price that the VHA has established in recent years.

- This switch would create incentives for undue expansion of the VHA.
- This expansion would very likely not be consistent with the longer term objectives of reforming the overall healthcare system.
- Finally, the conversion would likely boost federal spending at a time when other increases in federal healthcare spending would yield greater benefits.

At present, the VHA annually receives a fixed appropriation set by Congress based on the president's budget. If VHA funding were mandatory, it would presumably be based on actual enrollment multiplied by a sum set to approximate the per person cost of providing care to enrollees. This is the system proposed in H.R. 2514. Baseline spending is to be set at a percentage of past spending—130 percent in H.R. 2514. Future funding would be based on baseline, per capita spending multiplied by enrollment in the VHA system in the preceding year multiplied by an index—the CPI in H.R. 2514.[7]

Such a system would likely create powerful incentives for the VHA to enroll as many veterans as possible, whether or not new enrollees use VHA services as much as current enrollees or even whether they use them at all. In fact, incentives would be strongest to enroll those expected *not* to use VHA services, as the resulting addition to budget would encourage VHA administrators to enhance services to entice others to join. As funding increases, the VHA would be able to enrich services, encouraging both current and new enrollees to increase the proportion of healthcare they seek from the VHA. The VHA now enrolls only about one-third and annually serves just over one-fifth of all veterans. Furthermore, nearly 80 percent have non-VHA health insurance coverage from public or private sources.

These facts mean that the potential for increasing VHA service levels is vast. The Congressional Budget Office, using similar reasoning, has estimated that converting the VHA to mandatory funding on the lines of the 2005 proposal would roughly double total spending. Some drop in spending under other government programs would occur, but, according to the Congressional Budget Office estimates of H.R. 515 submitted in 2005, which resembles H.R. 2514 submitted this year, the offsets would be modest.[8]

To be sure, converting the VHA to mandatory funding would not entirely insulate it from budgetary pressures. Congress could cut the per person funding amount or exclude certain groups of veterans from the formula used for computing annual funding. The funding formula contained in H.R. 2514 could be modified to hold down spending. But I think such modifications are unlikely to gain much traction.

Is an increase in VHA funding the best way to increase healthcare spending? Is it likely to move healthcare delivery in a direction that the Nation is likely to follow? If the answer to these questions is 'yes,' then this budgetary commitment is justified. Each of us will have views on the answers to these questions. Mine is that the answers are 'no.'

The VHA is the nearest approximation in the United States to the British National Health Service, a publicly funded entity that directly employs most healthcare providers. That form of organization differs from the U.S. norm—third party payment to private hospitals, physicians, and other providers. It is unlikely to be widely adopted in the United States. Little support exists anywhere on the political spectrum for turning healthcare providers into public employees. All strategies for extending coverage—tax incentives, state initiatives, single-payer, employer mandate, individual mandate—call for payments to private hospitals, physicians, and other providers. To encourage an increased fraction of the U.S. population to receive an

[7] The choice of index has an important bearing on how rapidly funding grows in the long term. H.R. 515, introduced in 2005, proposed to use a healthcare index, which would have resulted in more rapid growth in spending than would occur under H.R. 2514.

[8] Based on H.R. 515 introduced in 2005, spending on Medicare, Medicaid, and the Federal Employees Health Benefits Program would fall initially by about 5 percent of the increase in VHA spending, growing to about 7 percent after ten years. Congressional Budget Office, Cost Estimate, H.R. 515, "Assured Funding for Veterans Healthcare Act of 2005, July 25, 2005."

increased proportion of its care from a system based on publicly employed and managed providers would be a step away from any future national system.

Furthermore, Congress is duty bound to weigh the relative merits of various proposals to boost public spending on healthcare. Such comparisons are difficult given the prevailing Committee structure of the U.S. Congress, but it is right to make them.

- At present, Congress has just sent to the president a proposal to extend the *State Child Health Insurance Program,* at an annual cost of approximately *$7 billion* over the next five years.
- Congress will likely prevent the full scheduled cut in physician reimbursement under Medicare from taking effect. CBO has estimated that the *cost of raising physician reimbursements 1 percentage point* instead of cutting them, as required under current law, would boost spending by an annual average of *$4.8–$6 billion* over the next five years.
- I have not seen a cost estimate for *H.R. 2514.* Adjusting the estimate for H.R. 515 for the passage of time and the change of index for per person costs, leads to an estimate of increased *annual outlay of $45–50 billion* over the next five years.

The current budgetary climate will not readily accommodate spending increases that boost the budget deficit. Indeed, part of the controversy surrounding SCHIP is its cost, despite the fact that it would be offset by increased tobacco taxes. Furthermore, making VHA funding mandatory would not be offset by reduced spending elsewhere or by increased revenues. It is not yet clear whether any added spending to avoid reductions in physician reimbursements under Medicare will be offset. But what is clear is that the deficit increasing effect of H.R. 2514 is vastly larger than that of either of the other two bills.

On substantive grounds, and contrary to allegations of some of its critics, the SCHIP bill builds on and reinforces the private provision of healthcare. SCHIP has enjoyed bipartisan support since its enactment in 1997. Avoiding the full reduction in physician reimbursements under Medicare is necessary in order to discourage significant and possibly catastrophic defections by physicians from being participating providers or even participating at all in the Medicare Program at all. Both uses of public funds reinforce established ways of providing healthcare to dependent populations, building on a public private partnership. Both these measures should enjoy far higher priority than does H.R. 2514.

Prepared Statement of Richard Kogan, Senior Fellow Center on Budget and Policy Priorities

Mr. Chairman, Mr. Buyer, thank you for inviting me to testify on how healthcare for veterans should be funded in the future. Let me start by acknowledging that I am not an expert on healthcare, much less veterans' healthcare. I am, however, an expert in the congressional budget process; the budget process was one of my portfolios during the 21 years I served on the staff of the House Budget Committee.

The question before this Committee is whether the amount of funding the Veterans Health Administration receives each year is more likely to be adequate and predictable if the funding is provided by the annual appropriation of discretionary budget authority—as is currently the case—or instead by a mandatory or entitlement payment of some kind.

My answer is that we simply do not know for sure. This answer is intended as a caution: a yellow light, not a red light. Caution is advisable because of the law of unintended consequences. Let me explain.

Under the current budget process, veterans' healthcare must compete against a wide range of other discretionary programs—education, transportation, natural resources, scientific research, the Pentagon, the IRS, and so forth. The total amount of funding available for all these discretionary programs is established annually in a congressional budget plan, which can decrease, freeze, or increase that dollar limit each year as it sees fit. (A president, likewise, can freely advocate decreases, freezes, or increases.)

Converting veterans' health funding into an entitlement is intended both to increase the amount of healthcare funding and to shield it from the competition I have just described. But there is always competition for scarce resources—scarce tax dollars—and congressional budget rules are designed to mediate that competition. Here's how budget rules would apply if veterans' health were converted into an entitlement. In such a case, current budget rules would prohibit Congress from ever enacting legislation to make that entitlement payment more generous—unless Congress simultaneously made offsetting cuts in some other entitlement, such as Medicare or farm price supports or unemployment compensation or military retirement or even veterans disability payments, or unless Congress raised an equal amount of taxes. This is the Pay-As-You-Go Rule.

Let me play out some of the ramifications of the Pay-As-You-Go Rule.

- Firstly, converting veterans' healthcare into an entitlement would by itself violate the Pay-As-You-Go rule, regardless of the kind of entitlement or its funding level—unless of course you cut some other entitlement by an equivalent amount or raise taxes by an equivalent amount. I assume you will not eliminate the Compensation and Pensions programs in order to establish a healthcare entitlement, nor should you; it is not in your jurisdiction to raise taxes or cut entitlements created by other Committees; and it is unlikely that the Ways and Means Committee will *volunteer* a tax increase to cover the cost of the veterans healthcare entitlement.

  Note that the elimination of discretionary funding for veterans' healthcare *does not count* as an acceptable "offset" for the creation of entitlement funding. And even if the Budget Committees and the Leadership were willing to bend the rules and allow the elimination of discretionary funding to count as an offset, that offset would only cover healthcare funding at levels in the existing baseline, which grows only with inflation, about 2% per year; you've done a lot better than that under the existing system.
- Second, because the Pay-As-You-Go Rule puts high barriers in the way of any *future* enhancement of the entitlement formula you initially establish, you had better be sure that the formula is adequately generous to begin with. (But as I have just noted, establishing a generous entitlement formula would also violate the Pay-As-You-Go rule).
- The proposal advocated by the Partnership for Veterans Health Care Budget Reform, embodied in H.R. 2514, certainly qualifies as a generous formula, so let's imagine for the sake of argument that you are granted a one-time PAYGO waiver in the House and Senate, have the votes to overcome presidential opposition, and so enact that bill. This leads to my third point: the Congressional Research Service, the Congressional Budget Office, the Government Accountability Office, and others will issue studies comparing the relative generosity of the new veterans' health entitlement to, for example, the relative stinginess of Medicaid, which is the stingiest of all healthcare payers. The governors unanimously and ardently desire greater federal matching payments for Medicaid, and may look to reductions in the new veterans' health entitlement as a source of PAYGO offsets.

  Or CRS, CBO, and GAO might compare the generosity of the veterans' health entitlement with the stinginess of the Children's Health Insurance Program—SCHIP—whose current funding cap is so tight that the program could lose 15% of its enrollees this coming year simply for lack of funding, and whose proposed cap is so tight under the President's budget that the number of children served by SCHIP will actually fall by 840,000 by 2012 at the same time that the number of uninsured children rises.

  And there are pressures to increase Medicare, as well—to provide a "physicians update" that would avoid the scheduled 10% cut in the Medicare reimbursement rate for physicians, or to help fill in the so-called "doughnut hole" in the prescription drug benefit, just to name two.

  Most significantly, there is always pressure to cut taxes. Under the Pay-As-You-Go rule, the standard against which entitlement increases or tax cuts is measured is current law. Thus, any extension of the Bush tax cuts in whole or in part is a tax cut relative to current law, because those tax cuts were enacted as temporary provisions. Extending *any* of the Bush tax cuts thus entails finding offsets—acceptable alternative tax increases or entitlement cuts. So if you have succeeded in establishing a veterans' healthcare entitlement formula that is as generous as the advocates hope, it will surely become a tempting target for those with other priorities, including those hoping to extend some or all of the Bush tax cuts.

In summary, under current rules, veterans' healthcare competes for funding each year against other discretionary programs within a overall dollar limit that generally grows from year to year, sometimes by noticeable amounts. It competes within the Appropriations Committees, whose members feel an institutional need to support each of the 12 appropriations bills. Admittedly there is also competition among the 12 Subcommittees, but the ethos of the Appropriations Committees limits the turf battles somewhat; it is considered wrong to lead fights against other appropriations bills in favor of your own.

If veterans' healthcare becomes an entitlement, however, it will be on its own; each other Committee could becomes a predator looking to the "overly generous" veterans' healthcare entitlement as a source of possible PAYGO offsets. There is no institutional loyalty that would mitigate such turf battles. And potential predators would include interest groups and advocacy communities that are at least as powerful as those against whom veterans' health now competes—for example, the health insurance lobby or especially the advocates of tax cuts.

As I see it, you would get a bigger boat to sail in, but by moving from the discretionary ocean to the Pay-As-You-Go ocean, the water may become deeper, your voyage stormier, and the sharks bigger and hungrier.

Now let us look beyond the Pay-As-You-Go rule. Experts who examine overall budget trends are very concerned about the future; the budget situation starts to deteriorate significantly in roughly two decades. The Comptroller General, the Director of CBO, experts at the Brookings Institution, nonpartisan budgeting groups such as the Concord Coalition, the Committee for Economic Development, the Committee for a Responsible Federal Budget, and my own employer, the Center on Budget and Policy Priorities, have all warned repeatedly about the unsustainability of existing budget policies over the long term. Put simply, relative to a simple extension of existing policy, taxes will have to be raised or budget programs will have to be cut (or some combination of the two), and by very substantial amounts. Our analysis shows that to get us through 2050 without increasing the ratio of debt to the economy, we would need to raise taxes or cut programs immediately, by an amount equivalent to 18 percent of projected revenues. And the longer we delayed, the larger the tax increases or program cuts would need to be.

Respected columnists who popularize this grim long-term outlook—people such as David Broder or Robert Samueleson—habitually refer to the problematic long-term budget picture as an "entitlement problem." This is probably intended as a useful simplification, but I view it as a rhetorical trap. The Comptroller General sometimes falls into this trap, as well. One effect of this simplified style of discourse is that it leads to simplistic and destructive so-called solutions. One such example is the "entitlement cap" included in the Family Budget Protection Act, designed by Representative Jeb Hensarling and endorsed by the Republican Study Committee. Most simply, this proposal would establish a statutory cap on the aggregate amount of entitlement expenditures each year; the cap would be so tight that very substantial cuts would be required in entitlements each year to avoid a breach; and if Congress did not voluntarily choose which entitlements to cut and enact those required cuts each year, then almost all entitlements would be automatically and permanently cut across-the-board. Each successive year, the hunt for entitlement cuts would begin again.

I should add that the procedures under which Congress would voluntarily make the required entitlement cuts would presumably be the existing congressional budget process. If entitlement cuts were needed to meet the Hensarling entitlement cap, the congressional budget resolution would surely contain a "reconciliation directive" in which selected Committees, including this Committee, would be directed to cut entitlements in their jurisdiction by specified amounts. By tradition, if a Committee doesn't meet its reconciliation target, the Budget Committee makes the cuts instead. All the cuts from each of the Committees are then combined into an omnibus "reconciliation" bill, managed by the Budget Committees. In the Senate, this reconciliation bill is protected from filibuster. In short, in a world of entitlement caps, you run two great risks: you may lose control of your own programs, and in any case, the tide of required cuts may sweep over even a very popular program such veterans' healthcare; cuts in the veterans' health entitlement might become just a single title in an omnibus, fast track, must-pass bill.

As I said, discussion of an "entitlement crisis" is over-simplified and proposals such as entitlement caps are misguided and simplistic. But even the most sophisticated discussion of the long-term budget picture will focus, very appropriately, on the rising cost of healthcare. After all, innately rising healthcare costs, more than the recent increase in the severity of the medical problems that veterans suffer, are the main reason that increased funding is needed. According to our projections, if it were not for the fact that healthcare costs are rising faster than GDP throughout all of the society, there would be no long-term budget problems. The mere aging of the population is not by itself sufficient to overwhelm the budget. It is healthcare costs, not demographics, that are already putting the U.S. budget, the VHA's budget, state budgets, and the budgets of businesses and families, under strain.

In this context, the current treatment of veterans' healthcare might arguably provide the program with a sort of haven. If an "entitlement commission" is established, or if the leaders of Congress sit down with a new President to negotiate a mega-deal including tax increases and entitlement cuts, the fate of discretionary programs might be viewed as a less important backwater. Surely new discretionary caps will be negotiated, but a *discretionary* veterans' health program will not be specifically targeted and will remain free to compete with other discretionary programs. A veterans' health *entitlement,* however, will be on the negotiating table along with Medicare, Medicaid, and SCHIP, and along with cuts in other entitlements and tax increases. The funding for this veterans healthcare entitlement would be decided by the negotiators.

Conclusion

Entitlement status for veterans' healthcare on its surface appears likely to provide a substantial funding increase and a guaranteed and predictable level of annual funding. This is what you strive for. But 1) such a status will be difficult to achieve since it violates the House and Senate Pay-As-You-Go rules; 2) those rules will increase the importance of achieving a big increase in funding right from the start; 3) paradoxically, such a big increase could quickly make veterans' health funding a target for "offsets" for other Committees with PAYGO problems; 4) such PAYGO problems are certain to arise shortly, if only because many people desire that at least some of the Bush tax cuts be extended past their scheduled expiration date in 2010; 5) the long-term budget picture is sufficiently problematic that significant deficit reduction will need to be enacted in the future; 6) the Congressional Budget Act includes a special "reconciliation" process that is particularly effective in targeting entitlements for cuts and over which individual entitlement Committees have little or no control; 7) over-generalized talk about an "entitlement crisis" can lead to wrongheaded ideas like entitlement caps and automatic entitlement sequesters; and finally, 8) any major bipartisan deficit reduction negotiation is bound to focus, quite appropriately, on health entitlements. Given all this, I am sure that enactment of an entitlement formula for funding veterans healthcare will not *guarantee* predictable funding each year—at the least, you will have to fight off competitors looking to you for offsets. I suspect that entitlement status, in the unlikely event that you could achieve it, *will* provide more funding than you would otherwise have gotten, but for only a limited number of years: eventually, budget forces will place all healthcare entitlements squarely in the cross-hairs of high-ranking leaders negotiating blockbuster budget deals.

One final thought: the long-term pressure on federal programs comes because of a threatened explosion of federal debt. A debt explosion cannot be allowed, unless the U.S. aspires to become a large banana republic. Advocates of federal programs, including the Partnership for Veterans Health Care Budget Reform, must also become advocates of the taxes needed to finance these programs. Even if there were no Pay-As-You-Go rule, simple arithmetic and elementary economics demands this outcome. If you desire effective federal programs but are unwilling to pay for them, then you ultimately won't get them. You cannot be pro-veteran and anti-tax, at least not using honest arithmetic.

Prepared Statement of W. Paul Kearns III, FACHE, FHFMA, CPA
Chief Financial Officer, Veterans Health Administration
U.S. Department of Veterans Affairs

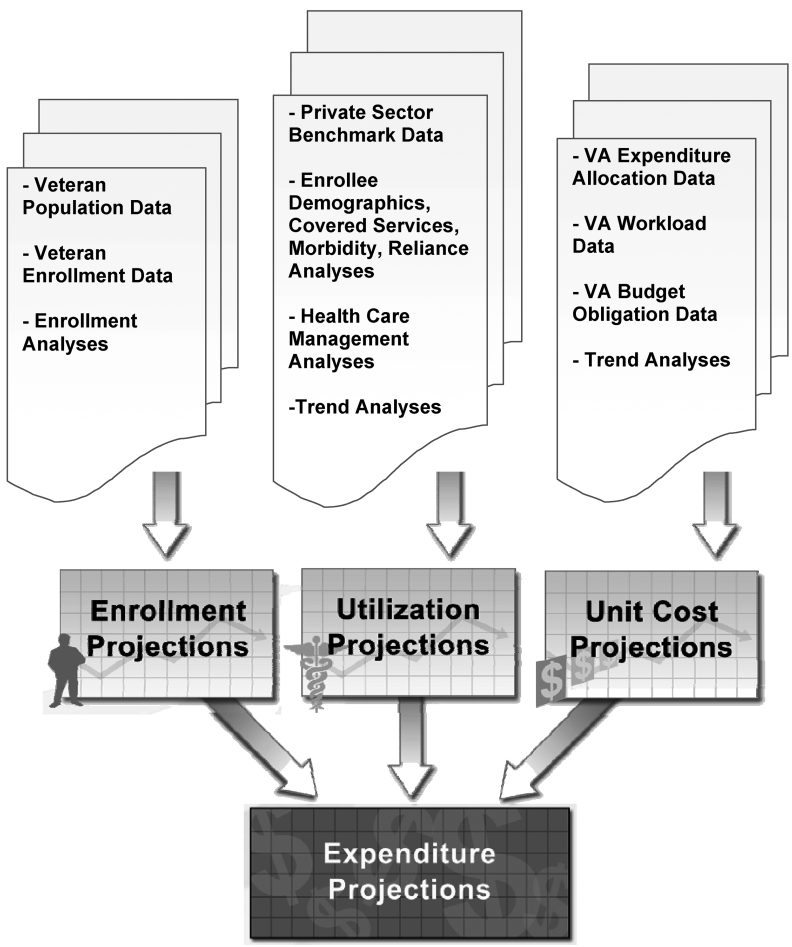
Mr. Chairman and Members of the Committee, good morning and thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) current funding process for its medical care program including budget formulation, Congressional appropriations, and alternatives to the existing process, such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

Following the enactment of the Veteran's Healthcare Eligibility Reform Act 1996, VA's healthcare 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 healthcare services to its enrollees. The focus on health promotion, disease prevention, and chronic disease management has produced more effective and more efficient healthcare for our Nation's veterans. As a result, the range of healthcare services utilized by VA patients began to mirror that of other large healthcare plans. Therefore, VA decided to follow private sector practice of large healthcare plans and use a healthcare actuary to help predict future demand for healthcare services. Mr. Chairman, transforming VA from an inpatient, hospital-based system to a fully integrated healthcare system has enabled VA to take a leadership position in healthcare 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 healthcare 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 healthcare, e.g., pharmaceuticals and changing utilization of healthcare services.

Current Funding Process VA's Enrollee Healthcare Demand Model

The VA Enrollee Healthcare Demand Model (model) develops estimates of future veteran enrollment, enrollees' expected utilization for 55 healthcare 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 healthcare needs as they age. Because many enrollees have other healthcare options, the model reflects how much care enrollees receive from the VA healthcare system versus other providers. This is known as VA reliance. Enrollee reliance on VA is assessed using VA and Medicare data and a survey of VA enrollees. The VA/Medicare data match provides VA with enrollees' actual use of VA and Medicare services, while the survey provides detailed responses from enrollees regarding private health insurance and use of VA and non-VA healthcare. 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 healthcare services based on private sector utilization benchmarks adjusted for the unique demographic and health characteristics of the veteran population and the VA healthcare system. The actuarial data on which these benchmarks are based represent the healthcare 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 healthcare utilization, cost, and intensity trends. These trends reflect historical experience and expected changes in the entire healthcare industry and are adjusted to reflect the unique nature of the VA healthcare 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, healthcare 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 healthcare budget request for FY 2008 was based on these detailed actuarial projections; the remaining 16 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' healthcare.

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 healthcare to veterans. It would also reduce the complexity of current financial management processes and procedures.

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

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

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

Committee on Veterans' Affairs
Washington, DC
October 18, 2007

Mr. Joe Violante
National Legislative Director
Disabled American Veterans
807 Maine Avenue, SW
Washington, DC 20024

Dear Joe:

In reference to our Full Committee hearing "Funding the VA of the Future" on October 3, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on November 15, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

DT:ds

Responses to Questions from the Honorable Bob Filner
Chairman of the Committee on Veteran's Affairs
Following the Hearing of October 3, 2007
"Funding the VA of the Future"

Question 1. *The Partnership for Veterans' Health Care Budget Reform's statement includes, in a section entitled "Myths and Realities," the following:*

Myth: Under a mandatory funding program, VA would no longer have an incentive to find efficiencies [.]"

And you answer that "VA Central Office (VACO) would still be responsible for ensuring local managers are using funds appropriately and efficiently."

In practical terms, what steps could VACO take to ensure that necessary incentives remain to provide cost-effective care when VA budgets are determined solely on the number of veterans enrolled in the system?

Response: The above referenced 'myth and reality', which is reproduced below in its entirety, includes steps VACO can take to ensure necessary incentives remain to provide high quality cost-effective care. Furthermore, VA, much like Medicare and Medicaid, must consider the universe of patients for which it is responsible. In VA's case, it is responsible for all veterans enrolled in its healthcare system and therefore utilizes this population in determining, among other things, its annual budget proposal submitted to Congress.

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 healthcare services when veterans need it. Mandatory funding for veterans healthcare is based on a formula that includes the number of enrolled patients and a per capita amount for each patient. It is not intended to provide excess funding for veterans healthcare. Under this method, inefficiencies in spending would be easily revealed.

VA Central Office (VACO) would still be responsible for local managers using funds appropriately and efficiently. Hospital directors would still be required to meet performance standards and third-party collection goals. Current checks and balances will help ensure accountability. VACO provides monetary incentives to local managers who meet their goals and strive for the most efficient ways of delivering high quality healthcare to our Nation's veterans.

Finally, VACO would continue to evaluate local mangers and distribute allocations to Veterans Integrated Service Networks based on need and performance.

VACO can use a number of incentives to continue providing what some have called, the "best care anywhere." For example, monetary incentives are given to local managers and leaders who meet their goals and strive for the most efficient ways of delivering high quality healthcare to our Nation's veterans.

Performance and strategic plans that involve VA, Congress and the veteran community must be in place to produce medical care that is safe, effective, patient-centered, timely, efficient and equitable. Furthermore, these outcomes must be benchmarked to measure progress. VACO must ensure continued use of VHA's exceptional patient safety program; use of evidence based medicine, care coordination, and inter-disciplinary healthcare teams, expand chronic disease management initiatives and health promotion and disease prevention programs, and advance its electronic health record. In essence, we recommend the continued improvement of VA's performance measures and monitors in addition to supporting such offices as VA's National Center for Patient Safety, Office of Quality and Performance, and the continued evolution of VHA information technology, which should be aligned toward and, more importantly, involves its end users.

Regardless of how VA healthcare is funded, neither VA, nor the Administration, nor Congress is constrained in exercising proper management and oversight of the system in order to achieve maximum efficiency.

Question 2. Adequacy of Funding Formula: *The funding formula put forward in H.R. 2514 is meant to cover the "programs, functions, and activities of the veterans Health Administration." This would include research funding but exclude construction funding.*

How would mandatory funding ensure sufficient resources for VA research?

Are you concerned that VA may not have sufficient funding to embark on a construction program in order to meet the increased demand for services that many envision as occurring under a mandatory funding regime?

Response: Under the mandatory funding proposal, H.R. 2514, VA medical and prosthetic research is already included in the baseline calculation upon which annual increases in funding are determined. As the mandatory funding formula provides increased resources to meet increased need for such services, VA research funding would be increased commensurately.

DAV and others, including *The Independent Budget* (of which DAV is a member), have long been concerned that VA has not been receiving sufficient construction funding. Over the past decade, VA construction funding—both major and minor—has not been sufficient to meet the identified need to preserve and maintain VA's infrastructure. Throughout the CARES process, VA operated under a de factor moratorium on construction which led to a construction backlog, including numerous projects necessary for safety reasons.

In July 2004, then-VA Secretary Principi testified before the House Veterans' Affairs Subcommittee on Health and said that CARES "reflects a need for additional investments of approximately $1 billion per year for the next five years to modernize VA's medical infrastructure and enhance veterans' access to care." Since that statement, the amount actually appropriated for construction has fallen far short.

The FY 2008 *Independent Budget* noted that in 2006, with CARES no longer holding back construction, Congress did authorize new construction projects in P.L. 109–461, however we remained concerned that VA's construction needs were not being fully addressed by Congress or the Administration.

Regardless of how VA healthcare is funded, there must be sufficient funding provided to construction accounts in order to maintain an infrastructure capable of delivering medical care to enrolled veterans seeking such care.

Question 3. Adequacy of Discretionary Funding: *Since FY 1998, and including the proposed increases for FY 2008, the number of unique VA patients has in-*

creased by 70 percent, and VA funding has increased by 114 percent. During this period, Medicare funding has increased by 77 percent.

In light of this increase in the VA's healthcare budget, is the Partnership's major concern over the timeliness and predictability of discretionary funding, or is the Partnership concerned that discretionary funding will never provide the level of resources you believe the VA needs?

Response: The Partnership remains equally concerned about both the sufficiency of funding for veterans healthcare as well as the timeliness and predictability of such funding. Without satisfying all three criteria, VA will continue to be challenged in meeting the healthcare needs of our Nation's veterans.

As noted in our testimony, the continued failure to deliver VA's funding on time year after year has significant negative consequences on the ability of VA to manage and plan the most effective and efficient healthcare system possible. As of this date, 1½ months into the new fiscal year, VA remains without an enacted 2008 appropriation, and thus without the full benefit of the anticipated increase.

While we recognize that VA healthcare funding has increased significantly over recent years, particularly the past couple of years, we do not believe that the increase in funding over the past decade has kept pace with the demand for and cost of providing healthcare to enrolled veterans.

First, the question implies that an increase in VA's patient workload is directly comparable to an increase in funding—without accounting for other factors, such as increases in the cost of providing services. For example, the consumer price index (CPI) for medical care between 1998 and 2007 rose by more than 40 percent. While this is not directly applicable to VA-delivered healthcare, there must be some accounting for the increased cost of providing medical services. In addition, many other factors, including patient mix, morbidity, complexity and intensity of care need to be factored into any determination of whether VA is being provided sufficient resource to meet demand for such.

Second, the question implies that a comparison between the overall increase in funding for VA healthcare and the increase in the overall funding for Medicare need not take into account comparative increases in workload. As noted above, the number of patients treated by VA has increased by at least 70 percent over the past decade; the number of Medicare beneficiaries over the same period is significantly less. Again, there are a number of other factors that must be examined in order to make a valid comparison.

One such valid comparison was testified to by Dr. Uwe Reinhardt at the October 3 hearing. Dr. Reinhardt noted that between 1997 and 2007 the-percent increase in VA healthcare spending (100%) was less than that of Medicare (110%) or private health insurance (124%).

The Partnership for Veterans Health Care Budget Reform believes there exist inherent flaws in the current discretionary funding process for veterans medical care that will continue to manifest themselves, notwithstanding a few recent years in which the funding increases were significant. For this reason, and in order to provide predictability and timeliness, we continue to support reform of the VA healthcare funding process through mandatory funding, or some combination or hybrid of mandatory and discretionary funding processes.

Committee on Veterans' Affairs
Washington, DC
October 18, 2007

Henry J. Aaron, Ph.D.
Senior Fellow, Economic Studies
The Bruce and Virginia MacLaury Chair
The Brookings Institution
1775 Massachusetts Ave., NW
Washington, DC 20036

Dear Henry:

In reference to our Full Committee hearing "Funding the VA of the Future" on October 3, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on November 15, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

DT:ds

Question from the Honorable Bob Filner
For Henry J. Aaron
Before the Committee on Veterans' Affairs Hearing
"Funding the VA of the Future"
October 3, 2007

National Healthcare Reform

It seems that one of your reservations regarding switching VA healthcare to a program financed by mandatory spending is that by doing so we might be creating an incentive for the VA to attempt to enroll a greater proportion of the 25 million veterans' population. You characterize the VA healthcare system as being "the nearest approximation in the United States to the British National Health" and state that there seems to be little public support for turning providers into public employees. You state that all strategies for extending coverage involve payments to private providers and hospitals. Finally, you state that "to encourage an increased fraction of the U.S. population to receive an increased proportion of its care from a system based on publicly employed and managed providers would be a step away from any future national system."

The VA healthcare system is a safety net system. Would not expanding the number of veterans receiving care from the VA, and cost-effective care at that, provide a better opportunity to attempt to reform the rest of our healthcare system?

Response:

Getting to reform of the whole healthcare system is, of course, the central issue. The sooner that happens, the better, assuming that the reform moves in a sensible direction.

But that event is not one that can reliably be expected to happen any time soon. So, in the meantime, there is the additional question of how the federal government should spend its limited resources for healthcare to maximize societal benefit. There are groups among the population of veterans who deserve public support as much as or more than any in our population. But not all veterans have an equal claim on public support. Those who continually bear the pain and disability of past wounds must be helped. Other groups in society also merit public assistance, however. We all have our priorities, and a compelling case can be made for many groups. I listed SCHIP in my testimony because I believe that children should have access to healthcare—financed by their parents, if they can afford it, but financed by the public if parents cannot afford it or even if they simply fail to meet their obligations.

The VHA now does a very good job with the resources that it has. That was not always true. But it is organized in a way that full-scale health reform is unlikely, in my view, to follow.

For both reasons—the importance of caring for such other groups as children, and the fact that VA is not likely to be a model for overall reform—I think that one should be careful adopting a funding change that is likely, as estimated by the Congressional Budget Office, to result in a large increase in funding, much of which will go to cover services for veterans in relatively low priority categories.

I do not say any of this lightly, as I understand and respect the Nation's obligations to veterans who have served our Nation. But choices must be made.

Committee on Veterans' Affairs
Washington, DC
October 18, 2007

Mr. Richard Kogan
Senior Fellow
Center on Budget and Policy Priorities
820 First Street, NE, Suite 510
Washington, DC 20002

Dear Richard:

In reference to our Full Committee hearing "Funding the VA of the Future" on October 3, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on November 15, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

DT:ds

Questions from the Honorable Bob Filner
For Richard Kogan
Before the Committee on Veterans' Affairs Hearing
"Funding the VA of the Future"
October 3, 2007

Question:

Discretionary Funding a "Safe Haven"

You express concern that a veterans' health entitlement would be included on the negotiating table with Medicare, Medicaid, and SCHIP and other cuts in entitlement programs when Congress tackles the effects of rising healthcare costs and entitlement spending. You argue that keeping healthcare as a discretionary program would shield it from any future entitlement cuts. You also believe that in the future we will see new discretionary spending caps.

If our long-term budget problem is indeed driven by rising healthcare costs, should we not expect future attempts to rein in veterans' healthcare spending no matter how it is funded?

Answer:

I agree with your conclusion—that we will very likely see future attempts to rein in veterans' healthcare spending whether it is funded as a discretionary appropriation or as an entitlement. My testimony was intended to refute the notion, put forth by some organizations that advocate entitlement status for this funding, that such a status would provide *known, guaranteed,* and *adequate* amounts of funding each year. My point was that entitlement status certainly would *not* provide a guaranteed amount, since the pressure to rein in healthcare costs in the federal budget is bound to increase and because the congressional budget process includes a mechanism—a “reconciliation directive,” which may be attached to annual congressional budget plans—that can force any Committee, including yours, to cut back entitlements within its jurisdiction.

In summary, I believe that funding for veterans’ medical care will always be competing for scarce resources. If the program continues to be funded as an annual, discretionary appropriation, it will continue to compete with other such appropriations—e.g., for education, infrastructure, housing, or biomedical research. If the program is funded as an entitlement, it will compete with Medicare, Medicaid, Veterans’ Compensation, military and civil services retirement, and so on. It is a judgment call about which pool of sharks provides fiercer competition, and my testimony suggests that one should not dismiss the possibility that the entitlement pool might be even riskier over the long run.

There is, however, one clear advantage of entitlement funding: delayed annual appropriations bills and the resulting stop-gap funding at freeze levels in a so-called “continuing resolution” *does not affect entitlement programs.*

I have two objections to the bill advocates of entitlement funding have recently proposed. Firstly, the increase in funding called for in that bill is so large—because the base level of funding from which the calculation is made has increased rapidly in the last year—that the formula now likely constitutes over-funding relative to need. Second, whether or not the bill constitutes over-funding, its increased costs should be offset under the Pay-As-You-Go rule, because long-term deficit projections are sufficiently grim that Congress should not pass legislation making them worse. In short, if increased funding for veterans healthcare is worth doing, as I believe it is, then it is also worth paying for.

If these two objections are addressed, then it seems to me that the structure of the proposed entitlement funding is thoughtful, realistic, and flexible, and the proposal to convert to entitlement funding is worth enacting, despite the fact that neither the proposed bill nor any other bill can guarantee a known and adequate amount of funding in advance.

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