EXAMINING THE QUALITY AND COST OF VA HEALTHCARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
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EXAMINING THE QUALITY AND COST OF VA HEALTHCARE

Wednesday, January 28, 2015

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:15 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [chairman of the subcommittee] presiding.

Present: Representatives Benishek, Bilirakis, Huelskamp, Coffman, Wenstrup, Abraham, Brownley, Takano, Ruiz, Kuster, and O'Rourke.

OPENING STATEMENT OF CHAIRMAN DAN BENISHEK

Dr. BENISHEK. The subcommittee will come to order. Good morning and thank you all for joining us for today's oversight hearing, "Examining the Quality and Cost of VA Healthcare."

This Congress I am honored to return as the chairman of the Subcommittee on Health, and to be joined once again by my colleague and friend Congresswoman Julia Brownley as our ranking member. And Ranking Member Brownley and I are joined by several senior and returning committee members and one freshman, Dr. Ralph Abraham. Five of us are doctors, five of us are veterans, and all of us share the same primary goal: To create a Department of Veterans Affairs Healthcare System that provides timely, accessible, and high-quality care that our veterans can be proud to call their own.

Our work will require open and ongoing cooperation and communication with veterans, stakeholders, and most importantly, VA leaders. Unfortunately, it became painfully apparent last year that the Veterans Health Administration, which operates the VA Healthcare System, was either unable or unwilling to provide basic information about the services it provides.

Using a simplistic equation, dividing the 9.3 million veterans who are enrolled in the VA health system by VHA's annual budget of $57 billion, the VA spends just over $6,000 per veteran patient. However, we know from the VA's own data that fewer than 30 percent of veterans rely on VA for all their healthcare needs, meaning VHA's providing for the total healthcare needs of approximately 2.4 million veterans at a per-patient cost of more than $23,000.

This is obviously a very rough calculation that I am sure the VA will argue fails to take into account certain unique aspects of the veteran population and the VA Healthcare System. However, that

is the granular data that we need in order to move the VA Healthcare System forward.

Recently, the Congressional Budget Office released an analysis comparing the cost of VA health system with the cost of the private sector healthcare system. In their report, the CBO found that, quote, "Limited evidence and substantial uncertainty make it difficult to reach firm conclusions about the VHA's relative costs," unquote. The limited evidence and substantial uncertainty that CBO references is the direct result of the VA's failure to provide the information that is needed to assist policymakers and the public in evaluating the efficiency and the effectiveness of VA services.

VA's lack of transparency is echoed in the disappointing testimony, absent substance or detail, that VA provided for this morning's hearing. Coming on the heels of last year's astounding access and accountability failures, the VA's testimony provided for this hearing is unacceptable, and I have begun examining measures that will require the VA to be much more open with the American people moving forward.

Today's hearing is just the first in what will be a year-long effort by this subcommittee to achieve greater clarity into the cost considerations that impact VA's Healthcare budget and therefore the care our veterans receive.

[PREPARED STATEMENT OF CHAIRMAN DAN BENISHEK APPEARS IN THE APPENDIX]

I thank you all for being here today. And with that, I now recognize Ranking Member Brownley for any opening statement she may have.

Ms. Brownley.

OPENING STATEMENT OF RANKING MEMBER JULIA BROWNLEY

Ms. BROWNLEY. Thank you, Mr. Chairman.

And good morning to everyone, and thank you all for being here today in support of military veterans.

Thank you, Mr. Chairman, for holding this hearing. I look forward to working with you this Congress to better the lives of veterans and their families.

According to the Veterans Health Administration's report, "Blueprint for Excellence," veterans enrolled in the VA Healthcare System have a significantly greater disease burden than the general population, even after accounting for age and gender mix. Forty percent of the nearly 9 million enrollees have service-connected disabilities and their care in fiscal year 2013 accounted for about half of VHA's $54 billion in total obligations. Clearly there is a high reliance on VA Healthcare for veterans who are disabled.

Today, we will examine the quality and cost of VA Healthcare. The Congressional Budget Office released a report late in 2014 that looked at comparing the cost of the veterans healthcare system with private sector costs. What CBO found was that it is very difficult to compared costs because of a variety of factors. Veterans who are enrolled in the VHA system receive most of their healthcare outside the system, about 70 percent. Veterans have different clinical and demographic characteristics, and cost-sharing

requirements are much lower for VA care than for care received from private sector providers.

Another very important point to remember is that VHA's mission is to address the total health of veteran patients, not just provide care for illness or disease. This is a much different approach than the private sector practices.

Additionally, CBO points out in their report that there are differences in financial incentives for providers. For example, most private sector providers, whether in hospitals or physicians practices, generate revenue for each unit of service that they deliver. Because of that, they may have a financial incentive to deliver more services, whereas the VA providers do not.

CBO suggests that an annual report, much like that of the Department of Defense's TRICARE health system, which includes operating statistics, trends among beneficiaries, and their demographics, among other things, would facilitate comparisons between VHA and the private sector. However, these comparisons would still be challenging, in part because private sector data might also be incomplete or unavailable or difficult to make comparisons with VHA data.

Instead of looking at comparing costs to the private sector, I think we should focus on improving access to veteran healthcare, ensure that veterans receive the best care possible, and continue to hold important oversight hearings on the quality and safety of the care provided to veterans. We absolutely need to complete and be transparent in terms of costs within the VA, and there is still much to learn from the private sector and their practices, particularly when it comes to IT and better access to healthcare within the VA.

Thank you, Mr. Chairman. And I yield back.

[PREPARED STATEMENT OF RANKING MEMBER JULIA BROWNLEY APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Ms. Brownley.

We have these votes this morning that we are going to have to go deal with, but I would like to get as much testimony in as possible before we have a recess.

Joining us on our first and only panel is Matthew Goldberg, the deputy assistant director of the National Security Division of the Congressional Budget Office. Carl Blake, the associate executive director for government relations for the Paralyzed Veterans of America, who is testifying today on behalf of the coauthors of The Independent Budget. Louis Celli, Jr., the director of Veterans Affairs and Rehabilitation Division for the American Legion. And Dr. James Tuchschmidt—I hope that is right.

Dr. TUCHSCHMIDT. That is very good.

Dr. BENISHEK. The acting principal deputy under secretary for health for the Department of Veterans Affairs.

Thank you all for being here this morning.

Mr. Goldberg, could you please proceed with your testimony.

STATEMENT OF MATTHEW S. GOLDBERG

Mr. GOLDBERG. Thank you Chairman Benishek and Ranking Member Brownley and members of the subcommittee. Thanks for the opportunity to testify on CBO's understanding of the cost of

healthcare provided to veterans by the Veterans Health Administration, VHA.

CBO regularly examines issues related to veterans healthcare, as well as other benefits that are provided the Veterans Benefits Administration, or VBA. Most recently, in December 2014, CBO released a report to compare the cost of healthcare provided directly at VHA facilities with the cost of private sector care. My submitted statement today reprises that report.

Although the structure of VHA and some published studies suggest that VHA care has been cheaper than care provided by the private sector, limited evidence and substantial uncertainty make it difficult for CBO to reach firm conclusions about those relative costs or whether it would be cheaper to expand veterans' access to healthcare in the future through VHA facilities or in the private sector.

CBO also produces budgetary baselines and cost estimates for legislative proposals that would modify veterans' benefits. Among other measures, over the past 8 months CBO has estimated the budgetary effects of the Veterans Access, Choice and Accountability Act of 2014, including earlier versions of that legislation, and the Department of Veterans Affairs Expiring Authorities Act of 2014, which amended certain portions of the earlier legislation.

In recent years, at the request of both the Senate and House Committees on Veterans' Affairs, CBO has reported on several related topics. First, veterans' disability compensation. Second, the VHA's treatment of post-traumatic stress disorder and traumatic brain injury among recent combat veterans. And third, the potential costs of providing healthcare to veterans of all eras.

Among the many analytical challenges in conducting those studies are the problems CBO sometimes encounters in obtaining appropriate data from the VHA or the VBA. For instance, comparing healthcare costs in the VHA system and the private sector is difficult, partly because the VA has provided limited data to the Congress and the public about its costs and its operational performance.

Additional data, particularly if it was provided on a regular and systematic basis, could help inform policymakers about the efficiency and cost-effectiveness of VHA's services. For example, the Department of Defense, in response to a statutory requirement established in the National Defense Authorization Act for fiscal year 1996, publishes an annual report to the Congress about its healthcare system known as TRICARE. The most recent of those reports contains more than 100 pages of operating statistics, including trends among beneficiaries and the demographics, funding by appropriation category, use and cost of inpatient, outpatient, and pharmacy services, beneficiaries' cost sharing, and patient satisfaction with their care.

A virtue of the annual recurring nature of those reports is that each contains consistent trend data from previous years and a longer data series can be compiled by comparing past years' volumes. A corresponding annual report on VHA, if one existed, would facilitate comparisons between VHA and the private sector.

Another example is CMS, which administers Medicare, through its Research Data Assistance Center provides individual level data

to researchers who can demonstrate the utility of that type of data to their research design, who agree to handle the data in a way that preserves patients' confidentiality, and who consent to possible audits and publication restrictions. That information provided by CMS is used by a wide variety of researchers to study the health of American seniors, the cost of providing their care, and the effectiveness of different treatments in managing their health.

The best study that CBO could identify to compare the cost of healthcare directly provided by VHA with the private sector was published in 2004, based on data from 1999. The authors of that study had access to detailed administrative data from six VHA medical centers and the clinical charts from veterans treated at those centers in 1999.

CBO cannot replicate that study with more recent data, both because it had limited time and resources to perform its analysis and because, with few exceptions, VHA does not make either administrative data or clinical records, even with personal identifiers removed, available to researchers in other government agencies, universities, or elsewhere.

Additional system-wide data from VHA would have facilitated the comparison of costs between VHA and private sector care. For example, it would be useful to know the average salaries, performance pay, and other elements of compensation that VHA provides to its physicians in various specialties and for its other clinicians, the number of patients its clinicians treat per unit of time, for example in a typical week, and the length and intensity of those encounters, and the average prices that VHA pays for pharmaceutical products. But VHA does not report that systematically and publicly.

Again, I thank you, Mr. Chairman, and for inviting me, and I look forward to taking your questions.

Dr. BENISHEK. Thank you very much, Mr. Goldberg.

[THE PREPARED STATEMENT OF MR. GOLDBERG APPEARS IN THE APPENDIX]

Dr. BENISHEK. Mr. Blake, you are now recognized for 5 minutes.

STATEMENT OF CARL BLAKE

Mr. BLAKE. Thank you, Mr. Chairman, Chairman Benishek, Ranking Member Brownley, and members of the subcommittee, on behalf of the four coauthors of The Independent Budget. I would like to thank you for the opportunity to testify today.

We believe that two clear conclusions can be drawn from the CBO report. First comparing the cost of healthcare administered by the VA to care provided by the private sectors is not an apples-to-apples comparison. The second observation that can be drawn from the report is that it expresses no definitive conclusion on the question of which model of healthcare is more cost-effective, and any assertion that it does is simply rhetoric.

The CBO report clearly outlines some important distinctions that further explain why a direct comparison between VA Healthcare and private sector healthcare is difficult, to say the least. Foremost among these distinctions is the fact that VHA serves a patient population that is distinctly different from the general U.S. population. The entire VHA system is designed to address this situation.

Representatives of private sector healthcare organizations have testified to this very issue. In fact, last summer at a hearing before the full House Committee on Veterans' Affairs, a number of the witnesses representing private healthcare organizations and entities expressed their challenge in understanding veterans as patients. They admitted that they would gladly provide services to veterans seeking care, but they also admitted that they could not guarantee care that was veteran specific.

The second major distinction that the IB coauthors believe is the crux of this problem deals with how the VA is funded versus how the private sector determines its funding mechanism. Under ideal circumstances, this would not be a challenge if the administration requested and Congress provided necessary resources to meet all demand placed on the system, but we know that this does not really happen.

Congress has asserted in recent years that it has provided all the resources the administration has requested. The IB cannot dispute that assertion. However, we also know that the administration rarely has requested the resources that VA needed to properly address the demand. We only need to reexamine the unacceptably long wait times and the lack of access to healthcare that was exposed last spring and summer to prove that point.

Deputy Secretary Gibson offered an interesting observation before the full House VA Committee last summer that has long been a complaint of the IB. Secretary Gibson testified at that hearing that the VA has been in the business of managing to budget, not to need. We have the Office of Management and Budget to thank for that fact.

Ultimately, we believe the central question when comparing VA Healthcare to private sector healthcare should focus on the quality and value of care. While we recognize that there is much debate underway about the quality of care being delivered at VA medical facilities around the country, we believe that the private sector healthcare system by and large could not stand up to the same level and intensity of scrutiny that the VA is under.

We will not dispute the idea that timely access to high-quality care remains a clear objective VA is not achieving in a satisfactory manner. Let me repeat that. We will not dispute the idea that timely access to high-quality care remains a clear objective that VA is not achieving in a satisfactory manner.

Access to healthcare, along with the cost and quality of care, are generally considered the three major indicators for evaluating the performance of a healthcare system or provider. Prevalent delays in delivering timely care result in patient dissatisfaction, higher costs, and an increased risk of adverse clinical outcomes.

However, while an argument could be made for primary care or other types of care for some veteran patients to be delivered outside of VA, it is an indisputable fact that most of VA's specialized services, such as spinal cord injury, blinded care, amputee care, and polytrauma care, are incomparable resources that are not duplicated and not successfully sustained in the private sector.

Are there similar systems that attempt to provide this type of care? Yes. But they are not duplicative of what the VA does and not on the same level.

Moreover, the viability of the VA Healthcare System depends upon a fully integrated system in which the organization and management of services are interdependent so that veterans get the care they need, when and where they need it, in a user-friendly way to achieve the desired results and provide value for the resources spent. There certainly could be some question about whether VA care is user friendly these days, but by and large we believe it is. And yet, CBO points out that fully integrated systems are not particularly common in the private sector.

The CBO report in previous discussions and hearings make it clear to the IB coauthors that comparing VA Healthcare and private sector healthcare is at a minimum complicated and at the most a fool's errand. Too many uncontrollable variables would confuse any outcomes or conclusions. A common refrain we hear from those clamoring for increased access is the lack of data from the VA on its services and performance. I won't even disagree with that fact. Clearly they need to be more transparent about the data and information that is available.

However, the CBO report clearly explains that comparisons would be challenging because private sector data also may be incomplete, unavailable, and difficult to make comparable with VHA data. To be clear, the IB coauthors believe that VHA should be more forthcoming with its data that allows a thorough examination of the timeliness and quality of services and the capacity that the VA needs to meet those demands. However, the concern over VA's apparent lack of transparency on data cannot be set aside when the private sector does not always choose to provide the same data.

Again, Mr. Chairman, I would like to thank you for the opportunity to testify, and I would be happy to answer any questions that you may have.

Dr. BENISHEK. Thank you very much for your testimony, Mr. Blake. I truly appreciate your perspective.

[THE PREPARED STATEMENT OF MR. CARL BLAKE APPEARS IN THE APPENDIX]

Dr. BENISHEK. At this time we are going to head off and do our voting. I ask your indulgence for the remaining panel members to wait until we return. We will recess for the time necessary it takes to do this voting. Thank you.

[Recess.]

Dr. BENISHEK. We will call the subcommittee back to order. Is it Celli.

Mr. CELLI. It is Celli.

Dr. BENISHEK. Mr. Celli, would you please proceed with your testimony?

STATEMENT OF LOUIS CELLI JR.

Mr. CELLI. I will, thank you.

And I quote, "All told, CBO expects that if the bill was fully implemented, some veterans would ultimately seek additional care that would cost the Federal Government about $54 billion a year, after accounting for savings to other federal programs . . . Thus, CBO estimates that the implementation of sections 2 and 3 of the House bill would roughly cost $500 million in 2014, $16 billion in 2015, and $28 billion in 2016."

Chairman Benishek, Ranking Member Brownley, and distinguished members of this Health Subcommittee, on behalf of Commander Helm and the 2.4 million members of the American Legion, I thank you and your colleagues for examining CBO's recent analysis in an attempt to achieve greater clarity into the cost considerations impact the VA Healthcare has on its budget, and as well the quality and care and patient satisfaction.

The CBO estimate I just read came from the original estimate from the Veterans Access to Care Act of 2014, a bill that many of us here in this room worked on together. The shocking $54 billion price tag that is quoted, which includes a $7 billion credit based on a discount to other federal programs that CBO talks about, is a savings to the Medicare account, because when Medicare-eligible services are performed by VA, VA is statutorily prohibited from billing Medicare for reimbursement, regardless of whether the care provided was service connected or not. So VA would have to eat those costs as well.

The analysis goes on to say, "Because the bill would increase enrollment in VA Healthcare in 2015 and 2016, the demand for VA Healthcare services would probably increase in 2017 and subsequent years. If lawmakers wanted to accommodate that increase in demand, additional appropriations would be necessary after 2016. This estimate does not include those costs of providing such care and additional services after 2016," end quote.

There has been a lot of discussion over the years that suggests that veterans might be better off if we privatized some or all of VA. The American Legion believes that this concept is shortsighted, prohibitively expensive, and fails to take into consideration the specialized care that veterans receive and deserve at VA.

Those who suggest that veterans would be better off if VA were privatized, we ask only that you take a moment to look at DoD's TRICARE program for retirees, and then let us know if you still think that veterans should trust that a privatized VA would be there for them or their sons and daughters the next time we are all asked to share in some fiscal budget belt tightening.

Veterans have been battling Congress and the administration every year for the past 10 years trying to stave off TRICARE reduction attacks, and every year for the past several years we have been losing more and more of the retirement benefits we spent 20-plus years of our lives working to earn. So now, some think that it might be a good idea to see if we want to start taking more and more services off VA campuses too? Really?

As CBO has clearly demonstrated in past reports, and as highlighted by my written testimony here today regarding this report, despite an embarrassing lack of comprehensive data available from VA, contracted care, even at Medicare rates, which a large number of private providers refuse to accept, will ultimately cost American taxpayers 30 to 40 percent more in the short run and even more long term, because one of the consequences of private care, as CBO and others consistently point out, is less frequent trips to the doctor, resulting in future complications and an overall increase in acute care needs.

In addition to saving taxpayer money and having one of the highest patient satisfaction rates in the industry, VA is a driving factor

in innovative technology and serves as a teaching hospital for hundreds of doctors every year. No commercial healthcare system in the United States can say the same.

Chairman Benishek, Ranking Member Brownley, and members of this committee, the American Legion has worked for more than 80 years to build and support a comprehensive Department of Veterans Affairs worthy of the sacrifices our veterans have made to protect the freedoms every one of us here in the United States and abroad enjoy today. We will continue to work toward that goal with this Secretary and this Congress and with the next hundred Secretaries and Congresses to come. Thank you. And the American Legion looks forward to working with you and your staff as we build a better VA in the 114th Congress.

Dr. BENISHEK. Thank you, Mr. Celli, for your perspective and your testimony.

[THE PREPARED STATEMENT OF MR. LOUIS CELLI APPEARS IN THE APPENDIX]

Dr. BENISHEK. Dr. Tuchschmidt, you are recognized for 5 minutes.

STATEMENT OF JAMES TUCHSCHMIDT

Dr. TUCHSCHMIDT. Thank you. Chairman Benishek, Ranking Member Brownley, and distinguished members of the House Committee on Veterans' Affairs Subcommittee on Health, thank you for the opportunity to discuss with you the Department of Veterans Affairs' cost of healthcare provided to our patients.

VA is committed to providing safe, high-quality, accessible, and efficient healthcare for America's veterans. Our most important mission is to make sure that veterans know that the VA is here to care for them.

Recently the Congressional Budget Office conducted a limited examination of how the costs of healthcare provided by VHA compares with the costs of care provided in the private sector. As stated in the report, distinctive features of the VHA system, such as its mission, mix of enrollees, and financing mechanisms, complicate cost comparisons with other sources of healthcare.

The VHA system is designed to serve a unique patient population, veterans. These veterans have carried the burden of war. As a result, they suffer from a disease burden that is higher than the general population. Many have more than one injury or disability, incurred during their military service. And 40 percent of our patients have a major mental health diagnosis. Others lack social support or face socioeconomic challenges.

This unique patient population has complex needs, and we at the VHA are committed to providing them with really unparalleled care. VHA provides a large social support system to a vulnerable population addressing many of the social and economic causes of poor health. The social programs provided by VHA, our outreach to the homeless and those at risk, fall outside of the typical scope of healthcare provided to patients in the private sector.

VHA's social workers provide individual assistance connecting veterans to a range of resources, such as financial assistance, housing, job training, and the like. Our caregivers support program and our readjustment counseling services provide counseling and finan-

cial support to veterans and their families. Beneficiary travel payments are available to veterans who meet eligibility criteria to help them get to their medical appointments. These are all examples of our mission to address the total health of our veteran population, and it is not simply to take care of illness and disease.

VHA is a world leader in treating combat-related issues and disabilities. We offer access to a variety of services and benefits. Our services are not widely covered under most insurance plans, including Medicare and other public forms of insurance. An example of this is our robust mental health programs, particularly for post-traumatic stress disorder and substance abuse treatment. VHA also provides the most technologically advanced prosthetics for those veterans who need those assistive devices. Some private insurance plans cover prosthetic services, but generally not to the extent and kind that we provide America's veterans.

Veteran care is complex, and these are just some of the reasons why it is challenging, I believe, to fully compare VHA care with private sector. We realize that access to care has been our Achilles heel. We are thankful for the Choice Act, which has provided funding and resources to help us address many of these issues.

We have been working diligently with your staff to discuss the lessons learned and will continue to do so. As the CBO report stated, VHA currently does not publish a yearly report about our healthcare system. I understand that we used to. I don't know what happened to that and why we don't do that anymore. But I commit to you today that we will produce an annual report. We thought the TRICARE report was an outstanding document.

But you have my commitment today to work with your staff, with the veteran service organizations and other stakeholders, to figure out what should be in such a report, and we will produce that report on an annual basis.

I meet with committee staff on a weekly basis to discuss the deployment of the Choice program, and that has, in my opinion, been a fantastic relationship. Certainly helpful to me in terms of understanding intention and collaboratively trying to figure out where we go with that critical program. And you have my commitment today to sit down with your staff and figure out what data you would like to see about the cost of VA healthcare, and we will do our very best to get that together for the committee.

In conclusion, VHA has made I think many distinctive contributions in clinical care, in medical research, and the education of future healthcare providers. VHA recognizes the uniqueness of the veteran's health needs and provides a continuum of services to address not just the medical needs, but the psychosocial needs of this population. We are proud of our documented record in the health industry, and VHA, I believe, provides high-quality, safe, and effective care for veterans.

I thank you for the opportunity to be here today, and I will do my very best to answer your questions.

Dr. BENISHEK. Thank you, Dr. Tuchschmidt.

[THE PREPARED STATEMENT OF DR. JAMES TUCHSCHMIDT APPEARS IN THE APPENDIX]

Dr. BENISHEK. I will now yield myself 5 minutes for questions. And let me just say I really appreciate you guys being here today

and your perspectives, especially from the veteran service organizations.

I worked at the VA for 20 years off and on, and I realize that the VA provides a service to our veterans that can't be duplicated in the private sector. Yet we need to have some sort of idea beyond the total amount of money we are spending at the VA and what we are getting, because, frankly, I have in my career seen a lot of money which I think has been wasted. There are a lot of things that we could do better, that money could be put to use for, and I want to make that happen. With that spirit, I have a couple of questions I want to go for.

Mr. Goldberg, what specific data would you need to see in order for the CBO to complete a better cost comparison between the VA and the private sector?

Mr. GOLDBERG. Mr. Chairman, there are three levels of data that we think would be useful, not only for our work, but for the committee's oversight role, and in fact to bring in the broader research community to look at VA, because just as it has done in DoD and particularly in Medicare, I think that is very healthy, to have a lot of people looking at your system.

So the first level of data would be basic demographic and systemwide data, how many veterans are being seen, what are they being seen for, and to what extent are we providing care for service-connected disabilities and to what extent are we providing care for non-SCDs. In other words, to link up the VBA and the VHA data so they talk to each other. And we can make sure that at a minimum we are caring for the service-connected disabilities. That would be high-level data.

Second level is more detailed data. There would be things like the panel sizes and the compensation rates of the different personnel, the staffing levels by medical specialty. For example, information about facilities, information about overhead and accounting practices. This is finer data that would probably be of interest to us as analysts, not necessarily the broader committee. It is the kind of data that some of it goes a little bit deeper than the TRICARE report, but it is the kind of data that we would really need to take a close look at VHA and ask why is it, what is the plausible case that perhaps VHA is cheaper than the private sector. Well, if we knew about panel sizes, if we knew about how many patients a provider sees in a week, that sort of thing, we could start to tell that story better. That is the second level.

The third level of data would be the kind of data that CMS makes available to researchers as was studied in the Medicare program, individual level data, so that you can actually look at a veteran who is seen in VHA and a veteran who is seen out in purchased care and look at the treatment regimen and look at the number of visits and the costs. And there are privacy issues with providing individual level data, but those issues, I think there is a good precedent in the way that CMS handles the Medicare data. For example, a researcher has to submit a plan how they would use the data, how they would guard the confidentiality. They have to destroy the data often at the end of the project, and there are limitations on cell size that they can report data in, table size, so that we can bring in the broader community.

And it was really an opportunity for natural experiment, because with the Veterans Choice Act we have a lot more veterans who will be seen in the private sector, and there is language in, I think, Section 101 of the Veterans Choice Act that calls for high-level reporting, like how many veterans are being seen. But if we got individual data on the veterans being seen in the private sector, we could ask, if a veteran has a certain condition, like diabetes, and is seen in the VHA, look at utilization, and look at the costs there, and then take a matched group with similar comorbidities and similar demographics that is being seen out in the private sector and see what kind of care they are getting and what the health outcomes are, and to match that would be a great research project.

Dr. BENISHEK. Thank you, but I want to ask another question and there are limits on my time.

Dr. TUCHSCHMIDT. do you know what the average cost for specialty care is for the VA, for example like a routine colonoscopy within the VA versus in the private sector?

Dr. TUCHSCHMIDT. I don't have that in my head. We can probably get that kind of information.

Dr. BENISHEK. I don't think you can. See, that is the whole point of what we are doing here, is that we don't know what it costs to do some of the routine things within the VA, because we have inquired on this in the past, and I think that is the kind of data we need to have, and we need to be able to provide oversight. I agree with these other gentleman here, the VA provides care to our veterans that can't be provided in the private sector. And yet, a lot of the stuff that we do within the VA can be. In those areas I think a comparison is in order so that we can provide the best specialty care for our veterans.

I am unfortunately out of time, so I am going to yield 5 minutes to the ranking member, Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman. And I will try to follow up on your line of questioning here.

Dr. TUCHSCHMIDT. the CBO just gave three recommendations in terms of the type of data that would be helpful to the committee, to the VA, and certainly our oversight going into the future to continuously improve the quality of healthcare to our veterans and with the best amount of efficiencies that we can yield from it. Is that something that you think that you would be able to begin to develop and provide to the committee and I think internally within the VA? In terms of your own decision-making and optimizing that decision-making, it sounds like this kind of data would be very helpful.

Dr. TUCHSCHMIDT. Sure. I am not an expert on our financial and accounting systems, which I think go back to the 1940s, but we do have a cost accounting system. So I think we can actually get the cost per colonoscopy in our system. I think certainly some of our researchers have looked at that level of data in a much more focused way.

But I think that the answer or asking the question what is the cost of care is actually the wrong question to be asking. The question I think is really, what is the return on investment? What is the value that my dollar is buying for us? And I think there are

many issues around case mix and risk adjustment, and just comparing cost is flawed thinking.

And in my mind, value is really about quality divided by cost, right? And when I look at the system that we have in VA, I can tell you that looking at our data, we track the 44 HEDIS measures that everybody in private sector tracks, and if you look at our performance we beat Medicaid, Medicare, and indemnity insurance on every one of them last year. If you are a veteran, you are more likely to be screened for cancer if you are in the VA system. You are more likely to get your diabetes, hypertension, and lipidemia managed appropriately. You are less likely to die from coronary bypass surgery. In fact, if you look at the data, you are 20 percent less likely to die in a VA hospital or have a major adverse event in a VA hospital than if you are in a private hospital.

I think asking the question about what is the cost of care is certainly a legitimate question, as long as we are focused really I think on the value proposition that is here, because I think we do serve a different population of people. And I think efficiency is an extraordinarily reasonable expectation of any system, any healthcare system, including the VA. And I would not hold American healthcare up to that standard, because all of the data shows that American healthcare is probably the most expensive of any industrialized nation with probably the worst outcomes.

I think the questions that are being asked and the data that has been proposed are certainly something that we can go back if we have clear stipulation of what it is. I am more than happy to go back and try and figure out how to get that.

Ms. BROWNLEY. Thank you.

And just then to ask the CBO, based on what was just stated, based on looking at models in terms of yielding the very best value and the best care for our veterans, understanding that we may never get to an apples-to-apples comparison with the private industry, is there a study that you could look at to look at that to help inform us how we are doing. I know it is tough because we are in some sense not comparing ourselves to anything else. But is there a way for you to analyze what the VA just said about being cautious about just strictly looking at cost, not looking at the risk, but determining what is the real value that we are getting on our investment in terms of care for our veterans?

Mr. GOLDBERG. Yes. Let me say two things, if I may. One is, I am heartened by Dr. Tuchschmidt's commitment to provide the kind of data that DoD provides to the oversight committees through the TRICARE report.

In the time we had, and our question from Senator Sanders was pretty narrowly focused on cost, but I would agree with the sentiment in the room that the other side of the equation is to look at the quality of care and satisfaction. That would be a big study. I am not sure I would just divide cost by satisfaction, I think the math is a little harder. But I agree to get a fuller picture you would have to look at all those various aspects, and perhaps we could be helpful to that in future studies.

Ms. BROWNLEY. Thank you.

Mr. Chairman, I yield back.

Dr. Benishek. Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman.

We need to know what procedures cost, and we don't know that right now. And we need transparency, and we don't have that right now in the VA system. And we are talking about a system that, I mean, when you are talking about the quality of care, that just excluded veterans by virtue of manipulating wait lists, appointment wait lists, so that people could get cash bonuses. That is the system that we have. And, quite frankly, I don't think that we have the leadership, supposedly the new leadership in place, new Secretary, is not changing the culture of the VA as far as I can see.

Let me tell you, I deal with healthcare both on the active duty side and on the VA side. And as a marine combat veteran, as a military retiree, I will continue to fight to make sure that our wounded coming back from the battlefields of Afghanistan and potentially now Iraq don't go into the VA system. Right now, our Active Duty, when they are injured in combat, remain on active duty for the rehabilitation. Used to be during Vietnam when the wounded came home they would be stabilized in the military system and then sent on to the VA for the rehabilitation. Now that is not the case.

Until the VA cleans up, until we are able to make sense out of this organization, I want to make sure that our wounded, double amputee above the knees, 2-year rehabilitation, remains on active duty, as a marine, as an airman, as a sailor, as a soldier. That is my obligation to them.

But my obligation to the veterans of this country is to make sure that the VA can function and meet the obligation to our Nation's veterans, which it is not doing in the healthcare system. And we can all gloss it over here. I have heard some great comments about how fine the system is. Let me tell you, you are not talking to the veterans that I am talking to.

So to the Congressional Budget Office, Mr. Goldberg, we got all these comments about how different this population is, but a heart bypass operation, a colonoscopy that was mentioned, I mean procedure by procedure, were you able to discern the costs of those relative to the private sector in the VA system?

Mr. GOLDBERG. Congressman Coffman, we were not able to do that. We had to go to the report that was published in 2004 where the researchers had access to the individual patient records and were able to do that kind of comparison, look at how much it actually cost to provide care in VHA and price it out at Medicare rates. Because we did not have access to that individual patient-level data, we really could not reproduce that study, and so our report basically takes that study from 2004 and asks, is it still relevant today? That is about as far as we could go lacking the kind of data that the researchers had access to back then.

Mr. COFFMAN. Okay.

Well, Dr. Tuchschmidt, you say you are going to provide this information now. I don't know why you haven't provided it in the past, but you are going to now provide it to Congress. Let me tell you this, given the record of the Veterans Administration in providing information to this committee, I absolutely have no confidence in your remarks.

What I believe has to happen is we have to have a mandate from the Congress of the United States to the Veterans Administration on what information that they are going to provide public, that they are going to have to be transparent, and that they are going to have to provide the same information that the Department of Defense provides for the healthcare of our Nation's Active Duty. In Medicare, that population, that information is provided.

But I am disheartened by the testimony today, and I think that certainly it gives a responsibility to this committee to move forward, I believe, with legislation to accomplish, I think, what the CBO has said and what the taxpayers need. And I believe that changes like the Veterans Choice Act actually will make the VA system better by giving veterans an opportunity, if they can't get an appointment within a given wait time, that is excessive, to be able to go outside the system and be compensated and to have that provider compensated on the Medicare rate.

Mr. Chairman, I yield back.

Dr. BENISHEK. Dr. Ruiz, 5 minutes.

Dr. RUIZ. Thank you, Mr. Chairman and Ms. Ranking Member, for holding this hearing. I am honored to again represent my district's veterans on this subcommittee and veterans around the country as well. And I look forward to working with my fellow members to ensure our veterans receive the high-quality, veteran-centered care they have earned.

Last Congress this committee worked hard to create the Veterans Access, Choice and Accountability Act, which expands opportunities for veterans to seek private care if the VA cannot provide the care they need when they need it. I am working currently with medical professionals in high-demand specialties in my district to help my constituents utilize the Choice program, but to maximize the effectiveness of private care we must be able to adequately measure its value against the VA services.

However, making an apples-to-apples comparison between the VA and private sector health system is difficult due to the limited available data, varying methodologies, and divergent patient population. I think one of the things you are stuck with is that in doing a meta-analysis, you don't have the data to determine what procedures cost, but every hospital knows what those procedures are, but you are limited by your own methodology in being able to acquire that information.

It is not if you can compare the VA to private care. It is what will you compare between the VA and private care that is the question presented to us. While cost is important, our number one priority must not be a spreadsheet void of a human story, but the health and well-being of our veterans. And that is something that we can measure in terms of morbidity, mortality, and the performance of different VAs with their hospital performance that can be compared to other private hospitals.

And some hospitals are great, but some hospitals are terrible. And even those that are great have problems with their wait lists. So if you tell a veteran that your VA hospital is great or has good scores or that provides cheap, affordable, good-quality healthcare, but they can't be seen by a physician, then it doesn't matter. So let's take a step back, look at the big picture, and make sure that

we are measuring the right things, that we are providing a high-quality, veteran-centered care. As the CBO remarks, quote, "Cost comparisons do not reflect such important considerations as the quality of the care provided, its effects on patient health, and patient satisfaction with a given healthcare system."

So my question to the CBO, which actually goes in line with your return on investment, is were these costs compared to the cost savings that the care of the VA provides for those who get care and therefore you reduce their morbidity and the severity in future years and compared those cost savings that we have? Does the study look at that?

Mr. GOLDBERG. Dr. Ruiz, it is an excellent question. We were not to do that. But that would be a great follow-on research if the data were available to follow individual veterans, and follow their outcomes. I might say not only for CBO, but for the larger research community it would be a great question.

As I said earlier, if I could restate, the time we had and the narrow focus of the question from Senator Sanders and the data available forced us to look narrowly at cost, recognizing, according to your question, that quality and satisfaction are also important dimensions of the problem, we didn't have time to look at it.

Dr. RUIZ. Well, that is why I want to caution the committee when we look at any cost-benefit analysis because they are full of assumptions and they are full of creative ways to determine what are the costs now and what are the costs in the future that you are saving. And therefore we need to make sure that we incorporate those aspects of not only individual costs for the individual veteran, but for the community, the country, and overall our economy.

The other question is, if we talk about quality care, how do you measure veteran-centered care that we can include as part of this cost-benefit analysis?

Mr. GOLDBERG. Well, there were a lot of quality measures that are used for the healthcare system in general, and VHA has been good about reporting those kinds of measures for their own population. I think the other ——

Dr. RUIZ. Hold on one second. You know, they are good, but many of those are institution-centered measurements, in terms of how many medications you provide or how many, you know. Veteran-centered care is asking the veteran what was their experience, what was their quality, did they receive the medications that they believed was adequately explained and understood, et cetera. So that is what I am talking about in terms of veteran-centered measurements.

Mr. GOLDBERG. I understand. Along those lines what I would say is we have to survey veterans. I am actually not that familiar at the moment with the questions in the survey instruments. But if they don't already, the VA could be asking this question of the veterans, satisfaction kinds of questions, exactly the considerations you have. I am not sure the degree to which that is done. We could check with VA and find out.

Dr. RUIZ. Thank you very much. I am done with my time. I yield back my time.

Dr. BENISHEK. Thank you, Dr. Ruiz.

Mr. Bilirakis, 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it. It really is an honor to serve on this subcommittee. And thank you very much for holding the hearing. And I thank the panel for their testimony.

I want to ask a question for Dr. Tuchschmidt.

Doctor, in your testimony you state the VA has surveyed 72,000 veterans each month on their patient experiences since 2002. Does that number reflect how many surveys were sent out or how many were answered and returned?

Dr. TUCHSCHMIDT. That is the number, I believe, of surveys that we sent out to veterans. We have in general about, I am going to say, about a 40 percent response rate, I think, on the mailed surveys that we have.

We are moving right now actually to beginning to get satisfaction surveys at the point of care. So we will get much more real-time feedback. We are putting it on our kiosk. We put them on TV screens actually in our hospitals. We are working actually to put them on handheld devices that we can either provide in our waiting rooms or that they can use on their own phones.

We do a lot of satisfaction survey, have for a long time, and publish that data. You know, when you look——

Mr. BILIRAKIS. Do you make the data public?

Dr. TUCHSCHMIDT. The data is publicly available.

Mr. BILIRAKIS. How can my constituents access that data?

Dr. TUCHSCHMIDT. I am happy to get it for them, absolutely.

Mr. BILIRAKIS. Can they go to a particular Web site?

Dr. TUCHSCHMIDT. So if you go to our Web site you will be able to look at that data.

Mr. BILIRAKIS. They can access the data?

Dr. TUCHSCHMIDT. I am pretty sure that it is there.

Mr. BILIRAKIS. Okay. Well, get back to me on that.

Give me an example of maybe a question. Can they write comments on this survey or is it A, B, C?

Dr. TUCHSCHMIDT. I believe they can write comments on the survey, but it is also a set of questions about your experience with your clinician. So we can tie that data actually back now to individual primary care teams.

That data shows actually that veterans say—so they have two issues really. I will start with the poor end of the spectrum, which is access. So we know access has been an issue. And the second one is really I would put in the category of coordination of care, of kind of knowing what the next steps in my care process is.

I think that when you look at overall in terms of their satisfaction with their experience, and of course there is heterogeneity in the population of responses that we get back, but generally people are very satisfied with the quality of the care and the experience of that care once they get in the system. So clearly getting in, getting access, both in terms of how quickly I can get an appointment, but then also how timely does that happen when I get there, how long do I have to wait in the waiting room, have been challenges for us. But we collect that data, and I will make sure that your staff have a link to that——

Mr. BILIRAKIS. Yes, please get that. I would like that available for the subcommittee. I know my constituents need to see it.

Dr. TUCHSCHMIDT. Absolutely, we will get you that.

Mr. BILIRAKIS. Give me the Web site as well. You gave me that 40 percent figure of the 72,000, I want to get that confirmed as well.

Dr. TUCHSCHMIDT. Sure, absolutely.

Mr. BILIRAKIS. Thank you.

The next question is for Mr. Goldberg. Have you done any analysis on how, if at all, the Affordable Care Act has impacted the cost of care provided by the VA health system?

Mr. GOLDBERG. Actually, Mr. Bilirakis, we have not done that analysis. We understand that VHA counts as minimum medical coverage and so alleviates the need for veterans to pay a penalty. But the data are just coming in, it is early, and we do not have that analysis yet.

Mr. BILIRAKIS. Do you anticipate having an analysis——

Mr. GOLDBERG. In the next few years——

Mr. BILIRAKIS [continuing]. In the near future?

Mr. GOLDBERG. In the next few years I am hoping to get that.

Mr. BILIRAKIS. In the next?

Mr. GOLDBERG. Do we have a timeline?

I will have to get back to you on what is a reasonable timeline. We don't have enough data yet to answer that question.

Mr. BILIRAKIS. Please.

Mr. GOLDBERG. But I will get you a timeline.

Mr. BILIRAKIS. Please do.

Mr. GOLDBERG. Thank you very much. I yield back, Mr. Chairman.

Dr. BENISHEK. Thank you.

I will call upon the gentlewoman from New Hampshire, Ms. Kuster.

Ms. KUSTER. Thank you very much, Mr. Chairman. and, again, it is an honor to serve on this committee, and I appreciate all the time and effort.

It is interesting listening to my colleagues' comments because I share the concerns, but I have reached a slightly different conclusion than Mr. Coffman about what this all means. This is a field that I am familiar with in the private sector and this type of analysis is very difficult to come by. This triangle of cost, quality, and access has been a major challenge all over the country. And really that is what the Affordable Care Act is all about, how do we increase access to high-quality care and make sure we are getting the value preposition that Dr. Tuchschmidt is discussing.

So I want to focus in on that a little bit, talking about the design of such a study, how would you tease out. And I want to pick up on my colleague Dr. Ruiz's comments about the cost savings. It is a touchy subject up here, but a little bit like dynamic scoring, where we know now from the private sector, if you take something like rehospitalization, the cost to the system for not providing, first of all, access to high-quality care in a timely way, but second of all, to managing the recovery process.

So elderly patients that get a hip replacement go home and don't have sufficient home care services and end up falling again and

they land back in the hospital. And that is the core of where the Affordable Care Act came from, is that the hospitals were getting paid for every reentry, right, so money is coming over the transom, nobody is focused on that.

But what we know as consumers, as taxpayers, if you can provide the care at home and avoid the rehospitalization, it is much less costly and, oh, by the way, people feel better. They get better.

And so I guess I would just open it up, if any of you have experience in that type of analysis—maybe start with Mr. Goldberg—and what types of information would be helpful.

Granted, they are elusive in both the private sector and the public sector, but as the flow of information increases over the next few years, what can we look at to focus in on that value proposition so that, as Members of Congress, we can protect the taxpayers' funds and serve the best interests of our veteran population?

Mr. GOLDBERG. That is a great question, and it is one we have struggled with not only for care for veterans but in the bigger healthcare system.

The logic might seem compelling that avoiding rehospitalizations, for example, not only makes the patients better but would save money. It has been very hard for us to find evidence, statistical evidence, in studies to quantify that effect.

So, while most people would think as a matter of public policy you want to avoid the rehospitalizations and the like, it has been very hard for us to find that effect in the data we have looked at—not specifically at VHA, because we have not had those data yet, but for the bigger healthcare system. It is an ongoing research subject. It is very hard to tease out that effect.

Ms. KUSTER. Are there other examples, though?

For example, I know in New Hampshire in workers' compensation we were able to bring down the costs dramatically by getting people the treatment that they needed in a more timely way rather than delaying care, which had been, sort of, the managed-care model of trying to keep people from getting the surgery, keep going back to PT, keep going to back to PT.

Instead, if you get the care in a timely way, make the right diagnosis, that you can get people back on the job. And, as I say, the silver lining is you feel better. You are cured from—or any of the type of chronic illnesses—diabetes, obesity, all of the measures—and maybe, Dr. Tuchschmidt, if you want to comment on——

Dr. TUCHSCHMIDT. Well, I was just going to say, you know, I mean, I think doing these studies is incredibly difficult. In getting ready for this, I had an opportunity to talk with some of our research people. I mean, it is incredibly difficult when they sit down to try and do this work.

I actually think that Dr. Ruiz made one of the most important points for me, which is the point I think you are making, and that is that managing chronic disease today has a future savings. It avoids——

Ms. KUSTER. Yes.

Dr. TUCHSCHMIDT. Savings in terms of fewer legs amputated, fewer patients on dialysis, fewer people who are blind because of retinopathy. And that is, you know, I think, a very complicated piece of the puzzle.

And when you look at our patient population, I mean, our average veteran enrolled in our system has 10 major chronic conditions.

Ms. KUSTER. Yeah.

Dr. TUCHSCHMIDT. That is not private healthcare.

Ms. KUSTER. Right.

Dr. TUCHSCHMIDT. When you look at the dually enrolled veteran who is enrolled in the VA and Medicare, it is up over 13—highest I have seen is 19—chronic conditions in those patients.

And, interestingly enough, when you look at the studies that have combined Medicare and VA data to do that and look at that, the overlap of those diagnostic codes, the HCCs, for which we are treating the patient and Medicare is treating the patient are extraordinarily different. And it only overlaps in about two of conditions at the individual patient level.

So I think that, you know, we have a patient population that has an enormous amount of chronic disease, particularly as they age. And thinking about the cost of the intervention today is fine, but then what is the value, not just in terms of, you know, I don't have to pay for that amputation or that dialysis, but in terms of quality of life, improving the lives of American veterans.

Ms. KUSTER. Right. Well, thank you. My time is well up, but that is a point that I would like to keep focused on going forward.

Thank you.

Dr. BENISHEK. Thank you.

Dr. Abraham.

Dr. ABRAHAM. Yes, sir.

This will be for the good doctor and Mr. Goldberg.

I will make a comment first, that we are talking about the quality of cost of the healthcare, and I think we are getting a little bit confused.

It is fairly easy, certainly in the private sector—because, up until 4 weeks ago, I was a practicing physician in family practice, seeing VA patients in concert with the local VA clinic.

The chair asked about the cost of a colonoscopy. Well, that is a pretty objective test. You are talking managing chronic disease—diabetes, long-term hypertension, long-term congestive heart failure. So I understand that is hard to measure. But it is not hard to get figures, I don't think, on the cost of a procedure—a chest x-ray, a CBC—and compare that to the private sector.

The question is—I guess for you, Doc—on the VA providers, the doctors, the nurse practitioners, the PA, are there computer data that they are given to show that the treatment that they have given that particular veteran is working and is the best treatment for the best cost?

Dr. TUCHSCHMIDT. So we provide our clinicians a lot of feedback on all of our performance goals, right? So we measure all the HEDIS metrics on performance. We measure satisfaction on our patients. I mean, we have, actually, the last time I saw, 200-and-something things that we count. And we do provide feedback to our clinicians, and we have been working, actually, on more sophisticated ways of displaying and providing that information back.

You know, I think that a lot of it is about system performance, though. It is not individual performance, right? So it is, how do we perform as a system? And, certainly, the individual clinician con-

tributes to that performance, but it is really a collective thing. And many of our clinicians, while they have individual effort contributed to those things, don't control space and the number of support staff, et cetera, et cetera. But they do get information back about global system performance.

Dr. ABRAHAM. It is like what Dr. Ruiz mentioned. Certainly, there are different hospitals that perform much differently across this Nation. Some have great ratings, and some have very poor ratings.

I will refer back to the private sector. Every quarter, every 3 months, I would get a detailed evaluation of my performance, comparing me to the peers within the insurance systems, whether it be Blue Cross, whatever. Every month, I would get however many insurance companies we had gone along with.

And I am just thinking, it should not be that difficult in the VA system to compare doctors among their peers and doctors among the different hospitals with the VA to see which ones are rising to the top and then which ones maybe are more mediocre.

Dr. TUCHSCHMIDT. We do that. So I am happy to have our staff come over and brief you on our SAIL—it is called our SAIL report. So we have a data tool that displays that information graphically, and you can drill down into that data. And I am happy to have somebody come over and show you that tool.

Dr. ABRAHAM. Thank you. I appreciate that.

And going back to the objective colonoscopy, CBC, as compared to the more subjective chronic management over years of a chronic disease, where are we going in that direction? What is happening in the near future to try to resolve those issues?

Dr. TUCHSCHMIDT. So we do have a cost accounting system; it is called DSS. And both people's time is allocated in that system as well as dollars. You know, I don't have it with me, but I am pretty confident that we can come up with a cost for a colonoscopy. I am sure my CFO is sitting back there about ready to strangle me when I get back. But I am pretty confident that our systems would allow us to produce that data.

Dr. ABRAHAM. Okay. Thank you.

And I yield back.

Dr. BENISHEK. Thank you.

Dr. Wenstrup.

Dr. WENSTRUP. Thank you, Mr. Chairman.

You know, we talk a lot about the cost. Obviously, that is one of the things we are here to talk about today. And you can measure, maybe, cost per RVU, relative value unit, right?

So can you tell me what goes into determining how much you are spending per RVU produced, either per hospital or across the VA? What numbers go into that?

Mr. GOLDBERG. Could I defer to Dr. Tuchschmidt on that? I think he is probably in a better position to answer that question.

Dr. WENSTRUP. Okay. Sure.

Dr. TUCHSCHMIDT. Sure.

So we do measure RVU data, and I can actually get you some costs per RVU——

Dr. WENSTRUP. That is not what I am asking. I am asking what goes in to determine how much it costs the VA per RVU. In other

words, is it just what you paid the physician? Is it what you paid the physician and all the staff per RVU? Is it what you paid the physician, the staff, the administration per RVU? Is it what you paid the physician, staff, administration, and what your bills are for the physical plant that you are working in?

Because, in private practice, if I have a free place to have my clinic, I would do a little better than if I am paying for my own building or paying rent.

So when we are talking about costs, I mean, I am looking at the big picture here. When you talk about how much it costs per RVU, I would like to know what are you actually including in that cost. Because, to me, physical plant and everything else comes into play.

Dr. TUCHSCHMIDT. Yes. So I think, actually, you could probably calculate it multiple ways. You could do the fully allocated cost per RVU. You can do salary cost per RVU. And we benchmark with MGMA and UMHM standards, which is against take-home salaries of clinicians and——

Dr. WENSTRUP. I guess what I would like to see within the VA hospitals is just start with the standard, put down how many RVUs were produced in all the VA hospitals and clinics across the country and what was the bill for everything—everything.

Dr. TUCHSCHMIDT. So we have our SPARC tool. I think you have seen that tool. So we have our SPARC tool, which looks at the RVU data, and it has cost data in there as well. And it is also marked against access at the local site for GI or whatever it might be.

So we do have that information, and we are going out and getting that data independently validated. So we have a contract with Grant Thornton to look at the tool and the methodology and how we are doing the math to tell us whether, in fact, you know, we have done this in a reasonable way, against industry standards or whether, you know, we have made up something that doesn't fly.

Dr. WENSTRUP. So someone could tell us—it would be just one number—how much it costs per RVU across the entire VA, including all of your expenses.

Dr. TUCHSCHMIDT. I will try and get that.

Dr. WENSTRUP. I think that would be a good landmark.

Another question I have for you is, are there areas that you think that the VA—because there are areas I think the VA could be centers of excellence compared to other sectors, especially things that are military-specific.

Do you think that we should have a focus toward some of those, such as TBI, PTSD, the effects of agent orange? And, as you said, a lot of the comorbidities—so many of the patients, compared to the regular population, have comorbidities.

Dr. TUCHSCHMIDT. That is right.

Dr. WENSTRUP. That can be another center of excellence.

And prosthetics, for example, do you think that we should have a focus towards that in our VAs?

In other words, are there things that you think the VA can do better than anyone else?

Dr. TUCHSCHMIDT. Well, I think——

Dr. WENSTRUP. In the long term.

Dr. TUCHSCHMIDT. I think there are things that we do do better than anybody else. And I think your suggestion, Congressman, is a great one.

We do have those centers today. So we have centers of excellence in spinal cord injury and in TBI around the country that are both engaged in clinical care as well as in research and training, you know, future healthcare providers. Those are all part of our mission. So we do have those.

And, you know, I think looking at where are the things that we do really well and, quite frankly, where are some of the things maybe as a system we don't do so well but a center of excellence could help drive that.

We have taken that model through our query process, where we have funded, for a couple decades, actually, centers for translational research, to go out and say, okay, what are the best practices in managing congestive heart failure, and how do we then, as a system, figure out how to deploy that and get it from the bench to the bedside. Because if we can't get it to the point of care, all that knowledge and expertise doesn't really help us.

So I think the suggestion that you have made is an excellent one.

Dr. WENSTRUP. And I am just thinking of our long-term focus here and what we want the VA to look like down the road. And those are areas where, because of the patient population, the VA can be better than just the everyday setting. But there may be other things that we say, we can let that go, because that can be done down the street, Anywhere, USA, so maybe we don't need to focus that much on that in the VA in particular.

Just a thought. And I am always curious to get the feedback on that. Thank you.

And I yield back my time.

Dr. BENISHEK. Thank you, Dr. Wenstrup. Dr. Huelskamp five minutes.

Dr. HUELSKAMP. Thank you, Mr. Chairman.

I appreciate the hearing on this matter, although I will note, I think we have had numerous hearings with the same conclusion, which is: We are not for sure what we know, but we are trying to find out a little bit more.

And near as I can tell from the four folks on the panel, if you ask the question, are we getting good-quality care, we are not for sure. Is it cheaper or more expensive in a private setting? Well, we are not for sure.

But I want to follow up and dissect a little bit more—first of all, I want to know from VA, what percent of your care is spent on the specialized care that Mr. Blake mentioned?

Dr. TUCHSCHMIDT. On the specialized care for?

Dr. HUELSKAMP. Mr. Blake made reference to the specialties that are provided by VA that are not accessible elsewhere. What percent of your total care is for that type of care?

Dr. TUCHSCHMIDT. I will have to take that for the record and get you a number, which I am happy to do. I think it depends a little bit on what you put in that category of stuff.

Dr. HUELSKAMP. Yes.

Dr. TUCHSCHMIDT. But we can get you a breakdown specifically around the——

Dr. HUELSKAMP. Yeah. And I understand the difficulty. I mean, that is why we are here today, because that is the kind of question that I thought we would have a ready, accessible answer and say, okay, yeah, we know.

Is it in 10 percent? Twenty-five percent? Five percent? Any guesstimates there at all just for today? I understand we will get something for the record.

Dr. TUCHSCHMIDT. I think it is much higher than that, actually. It is over 35 percent, I think, of our total costs go into treating service-connected disabilities.

Dr. HUELSKAMP. That is only available at the VA. Okay. And I will look forward to hearing a little more on that.

Dr. TUCHSCHMIDT. I want to turn and ask Mr. Goldberg with CBO, in the CBO score of the Vet Choice bill that we passed, the provisions dealing with choice, if I remember correctly, $8.16 billion of the cost of that bill was for the vet choice over the next 2 years.

Can you dissect that a little bit more for the committee? Because, as I understood from the CBO report, you don't know if it is more or less expensive in the private sector. And so how do you know it is going to cost $8 billion more? What proportion of that $8 billion is attributable to access, greater access? Or are you saying it is just more expensive?

Can you shed a little light on that? I mean, that was a very big number. And, in my district, actually, I believe it is cheaper and better for vet choice, but you are saying it is a lot more expensive. Can you describe and dissect that?

Mr. GOLDBERG. Unfortunately, I am not the best person to describe that. So if I could take that for the record, and we could get you a breakdown on that.

Dr. HUELSKAMP. I would appreciate that.

Dr. TUCHSCHMIDT. And do that in light of your statements that we are not for sure, we don't know, we don't have good enough data to compare that. So, I mean, you might come back and say, it was all about additional access, all about reduced waiting time.

Because what I hope in the long term is, instead of worrying about necessarily what the studies say and what experts in Washington, D.C., say or some big university, some big hospital, what I am worried about is what my constituents say. And, frankly—and my district is different than others—they are tired of driving 200, 300 miles for care that they could get right down the road at their local hospital.

And the VA has not been very helpful in making that happen. And we are slowly implementing this, but what I have heard lately from the VA is soon that 2-year period will be up and then we go back to the old way of doing things, which is restricting choice rather than expanding choice.

And so I would like to allow veterans and their families to make those choices. So if we could find out what proportion of your estimate—again, $8.16 billion for veterans' choice is a pretty hard thing to pass around here again. And so I want to know what that means in the future and how you arrived at that figure, because I really can't pull that out of the data.

One thing I will note, as well, for the CBO and the VA and for the chairman, as well—again, glad that you had this hearing, but

we have had a multitude of hearings where I think we have—the summary of hearing after hearing on data issues is the data is not valid and not reliable. And then, every time, somebody comes back and says, well, we think we know this information.

But the core of this problem was we were being told things, as Members of Congress, that didn't match up with what was really happening—you know, that there was no waiting time, that we have taken care of all these veterans—which led to a real catastrophe, came to a head about a year ago. So I want to keep that in mind.

I look forward to the data from both the VA and CBO, because I want to put those together. We want to know what it is really going to cost.

But then, you know, I think the crux of the matter is that we have an entire system, in comparison, called the Medicare system, where you don't drive to one hospital to get medical care in the entire congressional district. I mean, people would be outraged. But we make veterans in my district, every single one of them, if they want care, they have to drive to a hospital outside a congressional district. That is two-thirds of the State of Kansas. And my goal will continue to be to make certain they can go to 1 of 70 community hospitals and get their care that they deserve rather than driving hundreds of miles.

So I appreciate it. And we are going to continue to work on this, Mr. Chairman. I look forward to the data from our conferees.

Dr. BENISHEK. Thank you, Dr. Huelskamp.

I want to thank all the Members here this morning and to the witnesses as well.

We are just starting to look into this issue. And I know that we could go on and on with questions today, but, you know, I am, frankly, disappointed with the VA. We want to talk about the cost of healthcare within the VA.

Dr. TUCHSCHMIDT. you mentioned you have a lot of data, but yet you didn't give us any data in your written testimony. I am very disappointed.

We are going to really work on trying to, pass some legislation, and I would appreciate the rest of your help to be able to, actually mandate the fact that VA presents data similar to what the DoD is doing with TRICARE, at least to get a handle on what is happening with our costs.

I know that we are going to continue to work on this issue in our committee to get input from everyone on the committee and in the private sector and from the VSOs, as well, as to how we should proceed with this. But I think the American people need to know a little bit more about what is happening in the VA so that we can provide better care for our veterans.

We may be submitting some further questions for the record. I would appreciate your assistance in getting that stuff done.

Dr. BENISHEK. If there are no further questions, then you all are now excused.

I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

Dr. BENISHEK. I would like to once again thank all the witnesses and the audience members for joining us here this morning.

And the hearing is now adjourned.

[Whereupon, at 12:03 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF THE CHAIRMAN DAN BENISHEK M.D.

Good morning and thank you all for joining us for today's oversight hearing, "Examining the Quality and Cost of VA Healthcare."

This Congress, I am honored to return as the Chairman of the Subcommittee on Health and to be joined once again by my colleague and friend—Congresswoman Julia Brownley as our Ranking Member.

Ranking Member Brownley and I are joined by several senior and returning Committee Members and one freshman—Dr. Ralph Abraham.

Five of us are doctors, five of us are veterans, and all of us share the same primary goal—to create a Department of Veterans Affairs (VA) healthcare system that provides timely, accessible, and high-quality care that our veterans can be proud to call their own.

Our work will require open and ongoing cooperation and communication with veterans, stakeholders, and—most importantly—VA leaders.

Unfortunately, it became painfully apparent to me last year that the Veterans Health Administration (VHA)—which operates the VA Healthcare System—was either unable or unwilling to provide basic information about the services it provides.

Using a simplistic equation—dividing the 9.3 million veterans who are enrolled in the VA healthcare System by VHA's annual budget of $57 billion—VA spends just over $6,000 per veteran patient.

However, we know from VA's own data that fewer than 30 percent of veterans rely on VA for all of their healthcare needs, meaning VHA is only providing for the total healthcare needs of approximately 2.4 million veterans at a per patient cost of more than $23,000.

This is obviously a rough calculation that—as I am sure VA will argue—fails to take into account certain unique aspects of the veteran population and VA Healthcare System.

However, that is the kind of granular data that we need in order to move the VA Healthcare System forward.

Recently, the Congressional Budget Office (CBO) released an analysis comparing the costs of the VA Healthcare System with the costs of private sector healthcare systems.

In their report, CBO found that, quote " . . . limited evidence and substantial uncertainty make it difficult to reach firm conclusions about [VHA's] relative costs . . . " end quote.

The "limited evidence" and "substantial uncertainty" that CBO references is the direct result of VA's failure to provide the information that is needed to assist policymakers and the public in evaluating the efficiency and effectiveness of VA's services.

VA's lack of transparency is echoed in the disappointing testimony—absent substance or detail—that VA provided for this morning's hearing.

Coming on the heels of last year's astounding access and accountability failures, VA's testimony provided for this hearing is unacceptable and I have begun examining measures that would require VA to be much more open with the American people moving forward.

Today's hearing is just the first in what will be a year-long effort by this Subcommittee to achieve greater clarity into the cost considerations that impact VA's healthcare budget and, therefore, the care our veterans receive. I thank you all for being here today.

PREPARED STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Good morning. Thank you all for being here today in support of military veterans.

Thank you, Mr. Chairman, for holding this hearing. I look forward to working with you this Congress to better the lives of veterans and their families.

According to the Veterans Health Administration's report Blueprint for Excellence, veterans enrolled in the VA Healthcare System have a significantly greater disease burden than the general population, even after accounting for the age and gender mix. Forty percent of the nearly 9 million enrollees have service-connected disabilities, and their care, in Fiscal Year 2013, accounted for about half of VHA's $54 billion in total obligations.

Clearly there is a high reliance on VA Healthcare for veterans who are disabled.

Today we will examine the quality and cost of VA healthcare. The Congressional Budget Office released a report late in 2014 that looked at comparing the costs of the veterans' healthcare system with private sector costs.

What CBO found was that it is very difficult to compare costs because of a variety of factors. Veterans who are enrolled in the VHA system receive most of their healthcare outside that system—about 70 percent. Veterans have different clinical and demographic characteristics, and cost-sharing requirements are much lower for VA care than for care received from private-sector providers.

Another very important point to remember is that VHA's mission is to address the total health of veteran patients, not just provide care for illness or disease. This is a much different approach than the private sector practices.

Additionally, CBO points out in their report that there are differences in financial incentives for providers. For example, most private-sector providers, whether in hospitals or physicians practices, generate revenues for each unit of service that they deliver. Because of that, they have a financial incentive to deliver more services, whereas the VA providers do not.

CBO suggests that an annual report, much like that of the Department of Defense's TRICARE health system, which includes operating statistics, trends among beneficiaries and their demographics, among other things, would facilitate comparisons between VHA and the private sector. However, these comparisons would still be challenging, in part because private-sector data might also be incomplete, unavailable, or difficult to make comparisons with VHA data.

Instead of looking at comparing costs to the private sector, I think we should focus on improving access to veterans healthcare, ensure that veterans receive the best care possible, and continue to hold important oversight hearings on the quality and safety of the care provided to veterans.

We absolutely need complete transparency in terms of costs within the VA, and there is still much to learn from the private sector and their practices—particularly when it comes to IT and better access to healthcare within the VA.

Thank you Mr. Chairman and I yield back my time.

Testimony

Comparing the Costs of the Veterans' Health Care System With Private-Sector Costs

Matthew S. Goldberg
Deputy Assistant Director
National Security Division

Before the
Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives

January 28, 2015

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee, thank you for the opportunity to testify on the Congressional Budget Office's understanding of the costs of health care provided to veterans by the Veterans Health Administration (VHA).

CBO regularly examines issues related to veterans' health care as well as other benefits that are provided by the Veterans Benefits Administration (VBA). Most recently, in December 2014, CBO released a report that compared the costs of health care provided directly at VHA facilities with the costs of private-sector care. My submitted statement today reprises that report, *Comparing the Costs of the Veterans' Health Care System with Private-Sector Costs*. Although the structure of VHA and some published studies suggest that VHA care has been cheaper than care provided by the private sector, limited evidence and substantial uncertainty made it difficult for CBO to reach firm conclusions about those relative costs or about whether it would be cheaper to expand veterans' access to health care in the future through VHA facilities or the private sector. Uncertainty about relative costs in the future is compounded by uncertainty about how VHA would structure contracts with private-sector providers.

CBO also produces budgetary baselines and cost estimates for legislative proposals that would modify veterans' benefits. Among other measures, over the past eight months CBO has estimated the budgetary effects of the Veterans Access, Choice, and Accountability Act of 2014 (H.R. 3230, enacted as Public Law 113-146), including earlier versions of that legislation, and the Department of Veterans Affairs Expiring Authorities Act of 2014 (H.R. 5404, enacted as P.L. 113-175), which contained several amendments to P.L. 113-146.

In recent years, at the request of the Senate and House Committees on Veterans' Affairs, CBO has reported on several related topics:

- Veterans' disability compensation,[1]
- VHA's treatment of post-traumatic stress disorder and traumatic brain injury among recent combat veterans,[2] and
- The potential costs of providing health care to veterans of all eras.[3]

Among the many analytical challenges in conducting those studies are the problems CBO sometimes encounters in obtaining appropriate data from VHA or VBA. For instance, comparing health care costs in the VHA system and the private sector is difficult partly because the Department of Veterans Affairs (VA), which runs VHA, has provided limited data to the Congress and the public about its costs and operational performance.

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[1]Congressional Budget Office, *Veterans' Disability Compensation: Trends and Policy Options* (August 2014), www.cbo.gov/publication/45615.

[2]Congressional Budget Office, *The Veterans Health Administration's Treatment of PTSD and Traumatic Brain Injury Among Recent Combat Veterans* (February 2012), www.cbo.gov/publication/42969.

[3]Congressional Budget Office, *Potential Costs of Veterans' Health Care* (October 2010), www.cbo.gov/publication/21773; and Congressional Budget Office, *Potential Growth Paths for Medical Spending by the Department of Veterans Affairs* (July 2006), www.cbo.gov/publication/17962.

Additional data, particularly if it was provided on a regular and systematic basis, could help inform policymakers about the efficiency and cost-effectiveness of VHA's services. For example, the Department of Defense publishes an annual report to the Congress about its health care system, known as TRICARE (in response to a statutory requirement established in the National Defense Authorization Act for Fiscal Year 1996). The most recent of those reports contains more than 100 pages of operating statistics, including trends among beneficiaries and their demographics; funding by appropriation category; use and costs of inpatient, outpatient, and pharmacy services; beneficiaries' cost sharing; and patients' satisfaction with their care.[4] A virtue of the annual, recurring nature of those reports is that each contains consistent trend data from the previous few years, and longer data series can be compiled by comparing past years' volumes. A corresponding annual report on VHA—if one existed—would facilitate comparisons between VHA and the private sector. However, such comparisons would still be challenging, in part because private-sector data might also be incomplete, unavailable, or difficult to make comparable with VHA data.

The best study CBO could identify that compared the costs of health care directly provided by VHA with private-sector care was published in 2004, based on data from 1999. The authors of that study had access to detailed administrative data from six VHA medical centers and the clinical charts from the veterans treated at those centers in 1999.[5] CBO could not replicate that study with more recent data, both because it had limited time and resources to perform its analysis and because, with few exceptions, VHA does not make either existing administrative data or clinical records (even with personal identifying information removed) available to researchers in other government agencies, universities, or elsewhere. Additional systemwide data from VHA would have facilitated the comparison of costs for care provided directly by VHA with the costs for care offered by the private sector. For example, it would be useful to know the average salaries, performance pay, and other elements of compensation that VHA provides for its physicians in various specialties and for its other clinicians; the number of patients its clinicians treat per unit of time (for example, in a typical week) and the length and intensity of those encounters; and the average prices it pays for pharmaceutical products—but VHA does not report that information publicly.

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[4]See Department of Defense, *Evaluation of the TRICARE Program—Access, Cost, and Quality: Fiscal Year 2014 Report to Congress* (March 2014), http://go.usa.gov/vFc4.

[5]Gary N. Nugent and others, "Value for Taxpayers' Dollars: What VA Care Would Cost at Medicare Prices," *Medical Care Research and Review*, vol. 61, no. 4 (November 2004), pp. 495–508, http://dx.doi.org/10.1177/1077558704269795.

Comparing the Costs of the Veterans' Health Care System With Private-Sector Costs

Summary

Legislation enacted in 2014 calls for the Veterans Health Administration (VHA) to expand the availability of health care to eligible veterans. That legislation provided temporary funding to expand VHA's capacity to deliver care and to increase the amount of care purchased from the private sector.

The Congressional Budget Office (CBO) has conducted a limited examination of how the costs of health care provided by VHA compare with the costs of care provided in the private sector. Although the structure of VHA and published studies suggest that VHA care has been cheaper than care provided by the private sector, limited evidence and substantial uncertainty make it difficult to reach firm conclusions about those relative costs or about whether it would be cheaper to expand veterans' access to health care in the future through VHA facilities or the private sector. Uncertainty about relative costs in the future is compounded by uncertainty about how VHA would structure contracts with private-sector providers.

This report briefly describes some of the features that distinguish the health care system run by VHA from health care provided in the private sector. It also examines the available evidence about the relative costs of VHA and private-sector care and explores possible reasons why costs might differ in the two settings and why they can be difficult to compare. Finally, CBO briefly considers some factors that could influence the cost-effectiveness of alternative means of expanding health care services to veterans in the future.

What Has Previous Research Concluded?

Distinctive features of the VHA system—such as its mission, mix of enrollees, and financing mechanism—complicate cost comparisons with other sources of health care. One useful analytic approach, which was most carefully and comprehensively employed by researchers in 2004, estimates what costs would be if private-sector doctors, hospitals, and other health care providers supplied the same number and types of services as those actually delivered by VHA. Similar to earlier studies, those researchers concluded that the health care provided by VHA generally cost less than would equivalent care provided in the private sector, even though the comparison used Medicare's relatively low payment rates for private-sector doctors and hospitals.

How Applicable Are Previous Findings Now?

Whether such findings can be extrapolated to the present is uncertain, for several reasons. The limited number of comprehensive studies that have been done and the complexity of the research methods contribute to uncertainty about their conclusions. In addition, previous research has generally relied on cost information from 1999 or earlier, but changes since then in the VHA system and the health care sector as a whole could produce different results today. Such differences could go in either direction, which increases the range of uncertainty.

Another complication is that past studies do not fully explain why VHA care might be less expensive than private-sector care—making it hard to tell whether the same considerations apply now—and do not address whether patients would get the same amount and mix of services in both systems. More broadly,

cost comparisons do not reflect such important considerations as the quality of the care provided, its effects on patients' health, and patients' satisfaction with a given health care system. Thus, even if VHA care was less expensive, determining whether that care was a better value would still be difficult.

Why Might Costs Differ Between VHA and the Private Sector?

CBO's analysis indicates that VHA pays lower prices for pharmaceutical products than private-sector health care systems do (largely because of federal price controls) and may also pay less to doctors. For other medical goods and services, however, CBO could not determine whether VHA or the private sector has lower unit costs. In addition to any differences in prices per service, veterans might receive a larger amount or more complex mix of services if they were treated by private-sector doctors and hospitals than by VHA because those providers have stronger financial incentives to deliver more expensive care. At the same time, having the government provide health care through VHA may not be efficient. All of those factors make it hard to draw firm conclusions about relative costs.

Even if VHA currently provided care at a lower cost than the private sector, expanding the VHA system might not be cheaper in the longer term than increasing the use of private-sector providers. That would depend on the manner in which VHA chose to expand its own staff and facilities or the terms of any contracts it arranged for care with private-sector providers. One key consideration would be the relative flexibility that those contracts gave VHA to adapt to future changes in the population of veterans, the number of veterans who enrolled in the VHA system, and the medical services they used.

What Additional Information Would Help in Comparing Costs?

Comparing health care costs in the VHA system and the private sector is difficult partly because the Department of Veterans Affairs (VA), which runs VHA, has provided limited data to the Congress and the public about its costs and operational performance. Additional data, particularly if it was provided on a regular and systematic basis, could help inform policymakers about the efficiency and cost-effectiveness of VHA's services.

For example, the Department of Defense publishes an annual report to the Congress about its health care system, known as TRICARE (in response to a statutory requirement established in the National Defense Authorization Act for Fiscal Year 1996). The most recent of those reports contains more than 100 pages of operating statistics, including trends among beneficiaries and their demographics; funding by appropriation category; use and costs of inpatient, outpatient, and pharmacy services; beneficiaries' cost sharing; and patients' satisfaction with their care.[1] A virtue of the annual, recurring nature of those reports is that each contains consistent trend data from the previous few years, and longer data series can be compiled by comparing past years' volumes. A corresponding annual report on VHA—if one existed—would facilitate comparisons between VHA and the private sector. However, such comparisons would still be challenging, in part because private-sector data might also be incomplete, unavailable, or difficult to make comparable with VHA data.

[1]See Department of Defense, *Evaluation of the TRICARE Program—Access, Cost, and Quality: Fiscal Year 2014 Report to Congress* (March 2014), http://go.usa.gov/vEc4.

Distinctive Features of VHA's Health Care System

The system of medical centers and other facilities operated by the Veterans Health Administration has several distinctive features that make cost comparisons with other health care systems difficult. For one, the VHA system is designed to serve a unique patient population: former members of the armed forces who served on active duty. Veterans must enroll to receive care from VHA, and when they do so, they are placed in one of eight priority groups reflecting any disabilities they may have, their income, and other factors.[2] Many of VHA's enrollees have injuries or disabilities that were incurred or aggravated during military service. Of the estimated 22 million living veterans in the United States, nearly 9 million were enrolled in VHA in 2013. About 40 percent of those enrollees had either a service-connected disability or a severe impairment; those veterans accounted for about half of VHA's $54 billion in total spending that year.

Another unique feature of VHA is that it is funded through annual appropriation acts, so unlike an entitlement program—in which the government would be obligated to provide all of the health care that enrolled veterans demanded—VHA's budget and subsequent outlays are determined by lawmakers. In an effort to keep its spending within its budget, VHA has restricted the enrollment of some higher-income veterans who do not have service-connected disabilities. By contrast, payments for most health care services outside VHA, whether provided through public or private insurance programs, are generally triggered whenever care is delivered and are not subject to formal budget constraints.

A third distinctive feature of VHA is that it provides the vast majority of its care directly through the facilities it operates. Because veterans are dispersed across the country, some of them may have to travel relatively long distances to obtain care at a VHA facility. However, VHA has also traditionally paid for some care delivered by private providers—for instance, when veterans do not live near VHA facilities. In 2013, those payments accounted for about 10 percent of VHA's budget. As a result of legislation enacted in August 2014, VHA is implementing a new system to pay for privately provided care for enrollees who could not obtain appointments at VHA facilities in a timely manner or who live beyond a certain distance from those facilities (as discussed further below).

The mix of services and benefits that veterans receive from VHA also differs somewhat from the mix covered by typical health insurance plans. For example, enrollees rely heavily on VHA for some types of specialized mental health care, such as treatment for post-traumatic stress disorder or substance abuse. Although private insurance plans may cover those services, that coverage may not be as extensive as VHA's, and VHA usually provides such services at no cost to veterans. In addition, several other services provided by VHA may fall outside the typical scope of health care provided to patients in the private sector. For instance, veterans may receive assistance from a social worker or reimbursement for nonemergency transportation costs, and some of their family members may receive counseling or financial support.

Another key feature of VHA care is that enrollees pay no premiums or enrollment fees and little or nothing out of pocket for that care. In 2013, VHA enrollees spent an average of about $100 on copayments (or roughly 2 percent of the costs of their care). By contrast, most enrollees in Part B of

[2] The highest priority group consists of veterans who have the severest service-connected disabilities; the lowest priority group consists of higher-income veterans who have no compensable service-connected disabilities. In addition to income, other factors that determine priority include special circumstances such as having been a prisoner of war.

Medicare (which covers physicians' services) paid premiums of just over $100 per month in 2013 and are typically responsible for paying 20 percent of the costs for their care. The lack of premiums or enrollment fees for VHA care, even for veterans with relatively high income, has two competing effects on program costs and thus on cost comparisons. On the one hand, the lack of premiums and enrollment fees encourages more veterans to enroll, which would raise total spending (if VHA's budget was set or increased accordingly). On the other hand, the absence of enrollment fees may also encourage veterans with fewer health problems—who might not value VHA benefits as highly—to enroll in the system, which would tend to lower the average cost per VHA enrollee.

Although the absence of premiums and enrollment fees should not affect the amount of care that veterans seek once they have enrolled, the extremely low copayments probably increase that demand. However, research suggests that among some segments of the general population—such as the elderly, those with chronic conditions, and those with low income—the prospect of higher out-of-pocket costs may cause people to cut back on preventive care or on the appropriate use of medications, resulting in greater need for acute care services later on.[3] Therefore, although its relatively low out-of-pocket costs probably increase costs for VHA in the short run, there may be some offsetting savings over the longer run because many VHA enrollees belong to those segments of the population. Further, VHA is more likely than private insurers to capture those longer-term savings because veterans generally remain enrolled in VHA for life, even if they receive only a portion of their care from that system.

In addition, VHA has other notable features that may affect cost comparisons, such as its payment arrangements for prescription drugs and physicians and its overall system for delivering care. Those features are discussed in more detail later in this report.

Comparisons With Private-Sector Costs

One approach for comparing the costs of different health care systems is to look at average costs per enrollee in each system, but for several reasons that method is not appropriate in the case of VHA. An alternative method is to estimate what the services provided by VHA would cost at prices paid to private-sector doctors, hospitals, and other providers of health care goods and services. That approach provides more useful information but still presents many challenges.

Comparing Average Costs per Enrollee

In CBO's view, comparing the average costs of an enrollee in the VHA system with those of an enrollee in a private health insurance plan—or in another government health care program, such as Medicare or Medicaid—can be misleading for several reasons:

- Veterans who are enrolled in the VHA system receive most of their health care outside that system—typically about 70 percent, according to information provided by VHA. As a result, VHA's average cost per enrollee understates the full annual cost of a veteran's health care. Moreover, about half of veterans enrolled in VHA are also enrolled in Medicare or Medicaid, and

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

many others have a private insurance plan, further complicating comparisons with average costs per enrollee in those programs and plans.

- The veterans seeking VHA care have different clinical and demographic characteristics than people using private-sector care. For example, in 2012, most veterans with severe service-connected disabilities sought health care from VHA, and the average age of VHA enrollees was about 62. A recent study found that VHA patients (primarily older men) had much higher rates of many chronic health problems—such as high blood pressure, diabetes, and depression—than the U.S. patient population as a whole.[4]

- As noted above, cost-sharing requirements are much lower for VHA care than for care received from private-sector providers—which both increases the amount of care that veterans seek and means that VHA pays a larger share of the resulting costs of care than Medicare or private insurance plans do.

- Veterans may have difficulty obtaining VHA care because its facilities are not conveniently located or the waiting times are long—a problem that received considerable attention in 2014. As a result, veterans may use less VHA care and more private-sector care than they would otherwise.

- Calculations of average annual costs per VHA enrollee are generally based on the agency's appropriation for medical care, which raises two accounting issues. First, those medical care accounts do not include some costs that are reflected in private-sector spending, such as malpractice insurance payments and awards, construction and capital expenses, and information technology costs. (Those types of costs are covered in separate VA or federal accounts, such as VA's construction accounts, and could be included along with operating costs to provide a more comprehensive analysis.) Second, VHA's medical care accounts include the costs of some services and programs not typically provided by the private sector, such as travel reimbursement and financial support for family members.

In principle, careful studies could take into account those complicating factors, but in practice, doing so is very difficult. CBO is unaware of any studies that have controlled for all of the systematic differences that arise when comparing costs per enrollee in VHA and costs per person for private-sector care.

Comparing Costs to Provide the Same Services

A better approach that some researchers have taken is to estimate how much private doctors, hospitals, and other entities would be paid for the goods and services currently provided by VHA. Such comparisons are still challenging because researchers must identify the specific services provided by VHA, find comparable service codes in private-sector payment systems, estimate total payments for those services using private-sector payment rates, and then compare those total payments with total costs in the VHA system. Yet, that approach avoids several of the fundamental analytical problems of cost comparisons listed above by estimating prices for the actual bundle of services that veterans receive.

Very few studies have applied such a rigorous methodology, however. Several studies from the 1970s and 1980s compared VHA's costs for inpatient care with costs in private-sector hospitals and generally

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

concluded that VHA's costs were lower, but those studies used less thorough research methods. By 2000, only two studies had attempted to calculate the costs of the services VHA provided using private-sector payment rates, and those studies were limited to the costs of inpatient care and excluded the costs of clinicians.[5] The studies estimated that VHA's inpatient care cost about 10 percent less, on average, than comparable services in the private sector.

Subsequently, researchers conducted a careful and comprehensive study to examine the full range of services provided by VHA. That study, using data from 1999, estimated what VHA's inpatient care, outpatient care, and other patient services would have cost if supplied by private-sector providers at Medicare's payment rates.[6] The analysis also accounted for VHA's overhead costs, including costs for research support, interest on capital assets, information technology, and medical malpractice. The study examined six VHA medical centers closely and allocated resources on the basis of administrative data and detailed chart reviews. (Those estimates provided the basis for national-level estimates for the agency's entire system.)

Key Findings. That study concluded that delivering VHA's services through private-sector providers would have cost more overall at the six medical centers studied and at the national level, although the results varied depending on the types of care involved. For the six centers, the study estimated the following differences:

- The full range of services that VHA provided in 1999 would have cost about 21 percent more if those services had been delivered through the private sector at Medicare's payment rates.
- Inpatient care (excluding costs for nursing homes and rehabilitation facilities) would have cost about 16 percent more if it had been purchased at Medicare's rates.
- The outpatient care provided by VHA would have cost about 11 percent more if it had been provided at Medicare's prices.
- Prescription drugs would have cost about 70 percent more using a combination of Medicaid's and Medicare's payment methods. That difference alone accounted for almost half of the net difference in overall costs.[7]

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[5]For an overview of the studies, see Ann M. Hendricks, Dahlia K. Remler, and Mark J. Prashker, "More or Less? Methods to Compare VA and Non-VA Health Care Costs," *Medical Care*, vol. 37, no. 4 (April 1999), pp. AS54–AS62, http://tinyurl.com/l6c4rn9; and Gary N. Nugent and Ann M. Hendricks, "Estimating Private Sector Values for VA Health Care: An Overview," *Medical Care*, vol. 41, no. 6 (June 2003), pp. II-2–II-10, http://tinyurl.com/pqwy42c.

[6]That research is summarized in Gary N. Nugent and others, "Value for Taxpayers' Dollars: What VA Care Would Cost at Medicare Prices," *Medical Care Research and Review*, vol. 61, no. 4 (December 2004), pp. 495–508, http://dx.doi.org/10.1177/1077558704269795.

[7]Nationwide, the study estimated that the total costs for VHA's services in 1999 would have been about 17 percent higher if those services had been provided at Medicare's payment rates. For in-patient care, however, the nationwide estimates were the opposite of the estimates for the six centers: Costs would have been 10 percent lower if they had been priced at Medicare's rates—that is, VHA's inpatient costs were higher. Nationwide, the outpatient care provided by VHA would have cost about 30 percent more if it had been provided at Medicare's prices. The authors speculated that the difference between the national and local results reflected VHA costs at the national level that could not be priced using less detailed data. (For prescription drug costs, the results were the same at the national level and the local level.)

Using Medicare's payment rates as the primary basis for comparison had important effects on those results. In particular, Medicare's payment rates for doctors and hospitals are generally much lower than those of commercial insurance plans—an average of about 20 percent lower for physicians' services and about 30 percent lower for hospital services, according to recent estimates.[8] Consequently, the difference between VHA's costs and private-sector costs would have been much larger if the comparison had been made using those commercial payment rates.

Limitations. Although that study had many strengths, its authors acknowledged that their results could either underestimate or overestimate the costs of providing care for veterans at Medicare's payment rates. On the one hand, the researchers examined certain individual records for each medical service that a patient received at a VHA center to find the closest set of diagnosis and procedure codes as if a bill were being prepared for submission to Medicare, but they still found that they "could not price many services...for which a private sector system would charge."[9] The costs of those services were still counted as costs for VHA but were not included when calculating costs at Medicare's payment rates, which means that VHA's cost advantage may have been underestimated. On the other hand, the study's authors noted that the prices paid by Medicare for the prescription drugs it covered at that time were higher than the prices paid by private insurance plans, which tilted the cost analysis in VHA's favor. Differences in accounting practices could also have affected the cost comparison, although the direction of that bias is not obvious. For example, VHA's accounting system might regard an admission to an inpatient facility followed by treatment at a rehabilitation facility as a single "stay," whereas other accounting systems might regard them as two distinct stays.

Another concern about that study is that it used data that are now 15 years old. Since then, VHA, Medicare, and the national health care market have changed in several ways that could affect cost comparisons, although it is not clear whether those changes would widen or narrow the cost differences. First, VHA's spending (adjusted to remove the effects of inflation) has roughly doubled since 2000, while Medicare spending and national health expenditures have also increased sharply. Second, the VHA system has shifted from focusing on inpatient care to providing more outpatient services; it is unclear whether VHA has maintained a cost advantage for out-patient services as it has expanded those services. Third, the mix of VHA patients has changed, with an influx of younger veterans returning from Iraq and Afghanistan and the aging of the Vietnam War veterans. Finally, Medicare now pays for drugs differently than it did then and covers outpatient drugs, while many other changes have occurred that affect payment rates for other services under Medicare and private health insurance.

By contrast to the study above, other research published in 2009 compared VHA's spending to an estimate of costs for treating veterans in the private sector and found that VHA's costs were "considerably higher"; in CBO's judgment, though, the methodology of this newer study is relatively weak.[10] The study relied on survey data rather than detailed reviews of administrative data and medical charts to estimate which specific services veterans received from VHA, and then sought to price those services at private-

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[8]See Centers for Medicare & Medicaid Services, *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections* (December 2012), pp. 66–67, http://tinyurl.com/krz6qnc (PDF, 684 KB).

[9]Gary N. Nugent and others, "Value for Taxpayers' Dollars: What VA Care Would Cost at Medicare Prices," *Medical Care Research and Review*, vol. 61, no. 4 (December 2004), p. 505, http://dx.doi.org/10.1177/1077558704269795.

[10]See William B. Weeks and others, "Does the VA Offer Good Health Care Value?" *Journal of Health Care Finance*, vol. 35, no. 4 (Summer 2009), pp. 1–12.

sector rates. However, the Medical Expenditure Panel Survey (MEPS) on which that analysis was based does not seek to capture all of the inpatient and out-patient costs incurred by VHA, and it is known to underestimate total spending on health care somewhat and to undercount high-cost cases in particular.[11] Adjusting the study's results to account for those differences could largely offset its reported gap in costs. More important, MEPS does not generally capture services (such as those provided in VHA hospitals) that are not paid on a fee-for-service basis, but instead imputes what those services were using data on seemingly similar patients treated in other settings. How well the results reflect the services actually provided to veterans is thus unclear. In light of those limitations, CBO concluded that the 2004 study cited above, which included detailed chart reviews of VHA care, had a more reliable methodology.

Recently, problems that some veterans have had in obtaining timely access to care at VHA facilities have also come to light, resulting in the enactment of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146). Under that law, VHA will increase its use of contracts with private-sector providers in the near term; it also plans to hire additional medical personnel and expand its capabilities to provide in-house care over the next several years. Those changes and the other factors described above mean that cost comparisons made now or in the future could have different results than the studies conducted earlier.

Reasons That VHA's Costs May Differ

To help understand the results and implications of the studies discussed above, CBO considered three significant differences between the VHA and private-sector health care systems: input costs, financial incentives for providers, and the systems used to deliver care. The effects of those factors are difficult to predict accurately, so their overall effects on costs could not be determined precisely.

Two points provide useful context for this analysis. First, health care spending can be viewed as the outcome of the number of units of service provided, the average complexity or mix of services provided, and the average cost per unit. Therefore, the following discussion addresses the effect of differences between the VHA and private-sector health care systems along those dimensions. Second, the number of units of service provided depends in part on the cost-sharing arrangements that patients face, which affects their demand for care. For the purposes of this discussion, CBO assumed that veterans would have the same cost-sharing rules for private-sector care as they do for care delivered in VHA facilities. Thus, CBO assumed that a veteran's demand for health care would be about the same in either setting, although some differences could still occur because of factors such as proximity or ease of making appointments. Nevertheless, the amount and mix of medical services provided could differ under the two arrangements, as described below, because private-sector providers have financial incentives to deliver more care and often lack mechanisms to coordinate patients' care.

Differences in Input Costs

Although VHA and the private sector use largely the same types of resources to provide health care services, the quantities, mix, and prices of those inputs may differ. Key inputs for health care include pharmaceutical products, physicians and other types of personnel, facilities (hospitals and clinics), and

[11]See Didem Bernard and others, "Reconciling Medical Expenditure Estimates From the MEPS and NHEA," *Medicare and Medicaid Research Review*, vol. 2, no. 4 (December 2012), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4006479/; and Thomas M. Selden and Merrile Sing, "The Distribution of Public Spending for Health Care in the United States, 2002," *Health Affairs*, vol. 27, no. 5 (September 2008), pp. w349–w359, http://content.healthaffairs.org/content/27/5/w349.full.

medical equipment. CBO estimates that VHA has a clear cost advantage over private-sector providers for pharmaceutical products and may also have a cost advantage for physicians; CBO examined the relative costs of facilities but could not reach a firm conclusion about them. For other inputs—such as nurses, administrative staff, and medical equipment—further research would be necessary to determine whether VHA or private-sector providers had a cost advantage. Because VHA and private-sector providers generally purchase those inputs in the same markets and VHA does not enjoy any statutory or regulatory cost advantages for them (as it does for pharmaceutical products), there is no obvious reason that either system would have lower costs for those inputs.

Costs for Pharmaceutical Products. Largely because of federal price controls, VHA's pharmaceutical costs are significantly lower than those of private health care systems. Two caps set in legislation mean that the maximum price that VHA pays for a drug is either the best commercial price net of certain discounts and rebates or the average price paid by pharmacies minus a large statutory discount, whichever is lower. VHA receives additional discounts if drug prices rise faster than general inflation (which they have generally done). VHA negotiates further discounts with drugmakers for the drugs included on its formulary (or list of preferred drugs), and in return steers its enrollees to use those drugs. In a 2005 study, CBO calculated that certain federal purchasers—including VHA and the Department of Defense—paid roughly half as much for brand-name drugs as retail pharmacies did, on average.[12]

Costs for Physicians. VHA's primary care physicians (including those practicing general internal medicine and family medicine) are probably paid roughly the same salaries as their peers in the private sector; however, many specialists in the VHA system appear to receive lower salaries than their private-sector counterparts. Base salaries for VHA's physicians are broadly determined by statute, although physicians are also eligible for performance pay (up to $15,000 a year). Federal regulations set an annual salary range for VHA's primary care physicians of about $100,000 to $245,000 (excluding bonuses). Specialists may earn more, but their total salary and bonuses are capped at $400,000 annually.[13]

Although salaries account for a large share of physicians' total compensation, benefits—such as pension contributions and health and malpractice insurance—are also important. However, comparing those costs at VHA and in the private sector is difficult, partly because limited data are available on physicians' noncash compensation and partly because their compensation arrangements can be complex. Like other federal workers, VHA's physicians may be entitled to a defined benefit pension, but that type of retirement benefit has been waning in the private sector. In addition, VHA's physicians are not liable for damages from malpractice suits—and thus do not need to purchase malpractice insurance; instead, patients may sue the federal government under the Federal Tort Claims Act for damages related to VHA

[12]See Congressional Budget Office, *Prices for Brand-Name Drugs Under Selected Federal Programs* (June 2005), www.cbo.gov/publication/16634.

[13]In 2013, average salaries (excluding performance pay) for physicians in some of the most common fields at VHA were $182,000 for general internal medicine, $193,000 for psychiatry, $209,000 for emergency medicine, and $259,000 for general surgery. (In September 2014, VA announced a proposed increase of $20,000 to $35,000 in annual pay ranges for physicians who provide care to veterans at VHA facilities.) By comparison, two recent surveys of cash compensation for private-sector physicians reported averages of $188,000 and $198,000 for general internal medicine, $197,000 and $217,000 for psychiatry, $272,000 and $311,000 for emergency medicine, and $295,000 and $354,000 for general surgery. Surprisingly, the survey with the higher figures covered only salaries, whereas the survey with the lower figures also included bonuses and profit-sharing arrangements; see Leslie Kane and Carol Peckham, *Medscape Physician Compensation Report 2014* (Medscape, April 2014), http://tinyurl.com/ou4c5gt, and Merritt Hawkins, *2014 Review of Physician and Advanced Practitioner Recruiting Incentives* (Merritt Hawkins, 2014), http://tinyurl.com/oczpa9m (PDF, 1.6 KB).

care, and any settlements are paid by the Treasury from its Judgment Fund.[14] Private-sector physicians, by contrast, incur significant costs for malpractice insurance. Estimates of annual malpractice premiums for physicians vary, but according to a 2011 survey, premiums averaged roughly $12,000 for primary care doctors and $30,000 for surgeons.[15] If private-sector physicians must bear those costs themselves, rather than having the premiums paid by their employer, they are likely to demand a higher salary than equivalent physicians at VHA.

VHA's physicians might be willing to accept lower compensation for several other reasons. Working for a salary involves less financial risk than owning or being a partner in a medical practice. Salaried doctors also may have less intensive or more predictable schedules or fewer administrative duties, so they may require less in average compensation. One survey found that salaried physicians made about 20 percent less than self-employed physicians, with much larger differences for specialists than for primary care doctors.[16] In addition, some reports have indicated that a primary care doctor at VHA is supposed to have about 1,200 patients, compared with an average of 2,000 or more for private doctors.[17] However, in the time available for this analysis, CBO was not able to determine how workloads for VHA's physicians compare with workloads in the private sector—a comparison that would need to account for any differences in the mix and average sickness of patients seen and in the number of visits per patient.

Costs for Facilities. Little information is available about VHA's operating costs for its physical structures or about how those costs compare with private-sector costs. Many of the hospitals in the VHA system are old. Rather than build new ones, VHA tends to refurbish its hospitals and purchase new equipment. In addition, with its increased emphasis on outpatient care, VHA has opened hundreds of community-based outpatient clinics in the past 15 years, many in places that were not served by existing VHA hospitals. VHA is subject to complex regulations governing construction, contracting, and hiring; though the same thing may be true for private hospitals in many locations, such complexity makes determining differences in facility costs difficult. Both VHA and private-sector hospitals report that about 65 percent of their beds are occupied on an average day. Although occupancy is a fairly crude measure of efficiency, those figures suggest that hospital facilities are used with roughly equal efficiency in both systems.

Differences in Financial Incentives for Providers

Most private-sector providers, whether hospitals or physicians, generate revenues for each unit of service that they deliver. Thus, they have a financial incentive to deliver more services. Although there is disagreement about the size of that effect, most health analysts conclude that fee-for-service payments to

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[14]In the recent past, paid malpractice claims were equivalent to less than 0.1 percent of VHA's annual budget. In the private sector, by comparison, premiums for malpractice insurance constitute a considerable expense; by one estimate, total premiums for doctors, nurses, hospitals, and other entities represented about 2 percent of total health care spending in 2009.

[15]See Jeffrey Bendix, "Malpractice Premiums Continue Their Downward Trend for Most Physicians," *Medical Economics* (November 25, 2012), http://tinyurl.com/lautqwz.

[16]See Leslie Kane and Carol Peckham, *Medscape Physician Compensation Report 2014* (Medscape, April 2014), http://tinyurl.com/ou4c5gt.

[17]See David C. Mohr, Justin K. Benzer, and Gary J. Young, "Provider Workload and Quality of Care in Primary Care Settings: Moderating Role of Relational Climate," *Medical Care*, vol. 51, no. 1 (January 2013), pp. 108–114, http://tinyurl.com/nh2ppqg; and G. Caleb Alexander, Jacob Kurlander, and Matthew K. Wynia, "Physicians in Retainer ("Concierge") Practice: A National Survey of Physician, Patient, and Practice Characteristics," *Journal of General Internal Medicine*, vol. 20, no. 12 (December 2005), pp. 1079–1083, http://dx.doi.org/10.1111/j.1525-1497.2005.0233.x.

physicians lead them to provide more services and more expensive services, some of which may be duplicative or otherwise unnecessary.[18] As discussed above, many private-sector doctors receive a salary, but their bonuses may be linked to the number of services they provide or the amount of revenue they generate. Similarly, hospitals sometimes receive a fixed payment per admission, but they still have a financial incentive to generate more admissions, and they are often paid more when they provide more complex (and more costly) treatments during those admissions.[19] In addition, private-sector physicians may have a financial stake in hospitals, surgical centers, diagnostic centers, or other clinics, giving them an incentive to refer patients to those facilities for additional services. (Partly to offset such incentives and to discourage overuse of health care, insurance companies typically require enrollees to share in the costs of their care or impose administrative hurdles that enrollees must clear to receive some covered services.)

VHA, by contrast, has its budget determined in advance through annual appropriations, so it does not have any incentive to increase the volume or intensity of services it provides in a given year to boost its revenues. Although VHA's budget is not simply the product of the number of enrollees and a fixed annual payment per enrollee, the projected number of enrollees is nonetheless a major factor in the development of VHA's annual budget requests. In some ways, therefore, VHA's funding is analogous to a health insurance plan that receives "capitated" (or fixed) annual payments per enrollee and thus has a strong incentive to keep costs in line with that payment. If its funds run short, VHA could seek emergency or supplemental appropriations from lawmakers—but lawmakers might not approve such requests. Further, because VHA pays its doctors primarily on a salary basis, those physicians have limited or no financial incentives to provide more expensive or potentially unnecessary treatment. However, VHA's physicians also lack strong financial incentives to see as many patients as their private-sector counterparts. More broadly, VHA could limit the provision of services to enrollees and let them seek care from another source, so its incentives to control the total costs of veterans' care may not be as strong as those that a fully capitated health plan would face.

Differences in Delivery Systems

Two features of VHA's delivery of care distinguish it from most medical care that people in the United States receive: That care is delivered through an integrated health care system, and the system is owned and operated by the federal government. Both of those features may affect the relative costs of VHA and private-sector care.

Integrated Delivery. VHA operates one of the largest integrated health care delivery systems in the United States. Although there is no standard definition of an integrated health care system, such systems generally provide a full range of services—including primary and specialty care, inpatient care, and pharmacy services—and have either a single ownership structure or strong financial ties among the participating organizations. Such systems may also seek to coordinate the care that patients receive from different providers within the system and may take some degree of responsibility for delivering good care

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

[19]For example, hospitals are paid more under Medicare when patients have a heart bypass operation than when they receive an angioplasty or other less intensive treatment. For additional discussion, see Mark McClellan, "Hospital Reimbursement Incentives: An Empirical Analysis," *Journal of Economics and Management Strategy*, vol. 6, no. 1 (Spring 1997), pp. 91–128, http://dx.doi.org/10.1111/j.1430-9134.1997.00091.x.

and improving their patients' overall health. According to a recent estimate, a substantial number of integrated delivery systems were operating in the United States in the late 2000s, with a total enrollment of about 40 million people; prominent examples include Kaiser Permanente, Geisinger Health System, and the Mayo Clinic.[20] For the most part, however, doctors and hospitals in the private sector are not integrated.

Integrated health care systems generally have several features that, at least theoretically, should enable them to deliver less expensive or higher-quality care than nonintegrated providers:

- Comprehensive medical records are accessible to all providers and in all care locations, providing better information on which to make clinical decisions and making it easier to avoid delivering duplicative or potentially conflicting services;
- Collaboration among doctors and coordination of care among locations should be easier for both doctors and patients when the care is all provided "under one roof"; and
- Doctors' performance can be measured (and correspondingly rewarded) using factors that contribute to the overall health and improvement of patients, such as timely provision of care and adherence to treatment guidelines.

Although the available evidence is limited, integrated delivery systems appear to have lower average use of services per patient, so they probably have lower costs as well.[21] A major study conducted in the late 1970s and early 1980s, the RAND Health Insurance Experiment, concluded that health care spending was about 30 percent lower for participants treated by an integrated delivery system, which received capitated payments, than for participants whose providers were not integrated and were paid on a fee-for-service basis.[22] However, that study was conducted more than 30 years ago and reflects the experience of only one integrated delivery system. Most recent studies of integrated systems have not addressed costs directly. A systematic review of the research literature found only five peer-reviewed studies that compared use of services between integrated and nonintegrated systems.[23] Four of those studies found that patients used fewer services in integrated delivery systems. (Many more studies have concluded that integrated systems improved the quality of care.)

Federal Ownership and Management. A related consideration is whether and how federal operation of the VHA system affects its relative costs and efficiency. For example, regulations that govern the hiring and firing of federal employees probably make it harder for VHA to deal with personnel who do not

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[20]See Alain C. Enthoven, "Integrated Delivery Systems: The Cure for Fragmentation," *American Journal of Managed Care*, vol. 15, no. 10 (December 2009), pp. s284–s290, http://tinyurl.com/kqv2duc.

[21]Lower utilization might not translate into lower costs if the prices that integrated health plans charged were higher. The studies cited above, however, indicate that VHA has lower costs per unit of service, so costs under its integrated system are probably lower.

[22]See Willard G. Manning and others, "Health Insurance and the Demand for Medical Care: Evidence From a Randomized Experiment," RAND Report R-3476-HHS (February 1988), www.rand.org/content/dam/rand/pubs/reports/2005/R3476.pdf (4.66 MB). In that comparison, neither enrollees in the integrated system nor people receiving fee-for-service care faced any cost-sharing requirements.

[23]Wenke Hwang and others, "Effects of Integrated Delivery System on Cost and Quality," *American Journal of Managed Care*, vol. 19, no. 5 (May 2013), pp. e175–e184, http://tinyurl.com/lgpsf2f.

perform at expected levels, or to expand or contract its workforce, than is the case for private-sector health care systems. (Recent legislation has relaxed some of those regulations for certain classes of senior executives but not for practicing medical staff.) Similarly, VHA may have greater difficulty closing or shrinking facilities when their use declines. More broadly, VHA facilities do not have the same incentives as private health care systems to control their costs and thus may not operate as efficiently.[24]

At the same time, the efficiency of private-sector health care systems is often the subject of debate. Most hospitals are nonprofit organizations, so they may not have strong incentives to control their costs. Perhaps more important, many of the markets in which hospitals operate, and some of the markets in which physicians work, are not very competitive, with just one or a few providers dominating the market.[25] Lack of competitive pressure may also weaken providers' incentives to control their costs.

The Relative Costs of Expanding VHA Services

In response to concerns about veterans' access to VHA care, lawmakers enacted the Veterans Access, Choice, and Accountability Act in August 2014. That law provides an additional $10 billion in funding over three years for medical care to treat veterans outside VHA facilities if those veterans are unable to schedule appointments at VHA facilities within the department's goals for waiting times or if they live more than a specified distance from the nearest VHA facility.[26] That law also provides $5 billion in funding that will allow VHA to hire more medical staff and expand its capabilities to provide in-house care over the next several years.

VHA's experiences under that legislated expansion could provide an opportunity to collect and disseminate new and useful information. The previous cost comparisons discussed above shed light on whether the care provided by VHA could theoretically be provided more cost-effectively outside its system. However, if VHA were to substantially expand its use of private-sector providers over the longer term, the terms of the contracts that VHA sets up would help to determine the cost-effectiveness of that approach. Some issues that VHA would need to address include the bundle of services to be provided to veterans through the private sector and the payment rates for private providers—including options such as whether to use capitated payments or to establish fee-for-service payment rates linked to those of Medicare or another program. (Under the 2014 legislation, Medicare rates generally apply.) Those considerations would have to be balanced against the costs of expanding VHA's existing infrastructure. Although the Department of Veterans Affairs projects that the population of veterans will decline, it

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[24]See Joseph E. Stiglitz, *Economics of the Public Sector*, 3rd ed. (W.W. Norton, 2000), pp. 189–213; and Robert H. Wessel, "Privatization in the United States," *Business Economics*, vol. 30, no. 4 (October 1995), pp. 45–50, www.jstor.org/stable/23487734.

[25]See Robert A. Berenson and others, "The Growing Power of Some Providers to Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed," *Health Affairs*, vol. 31, no. 5 (May 2012), pp. 973–981, http://content.healthaffairs.org/content/31/5/973.abstract; Martin Gaynor and Robert J. Town, "Chapter 9: Competition in Health Care Markets," in Mark V. Pauly, Thomas G. McGuire, and Pedro P. Barros, eds., *Handbook of Health Economics*, vol. 2 (Elsevier B.V., 2011), pp. 499–637, http://www.sciencedirect.com/science/handbooks/15740064; and Laurence C. Baker and others, "Physician Practice Competition and Prices Paid by Private Insurers for Office Visits," *Journal of the American Medical Association*, vol. 312, no. 16 (October 22/29, 2014), pp. 1653–1662, http://jama.jamanetwork.com/article.aspx?articleid=1917436.

[26]For CBO's estimates of the budgetary effects of that legislation, see Congressional Budget Office, letter to the Honorable Bernie Sanders providing an estimate for H.R. 3230, the Veterans Access, Choice, and Accountability Act of 2014 (July 29, 2014), www.cbo.gov/publication/45601.

expects VHA enrollment to rise slightly over the next decade before returning to current levels.[27] Nevertheless, increasing VHA's capacity might not be cost-effective in an era when the population of veterans is shrinking, because there would probably be considerable resistance to closing VHA facilities once they were built.

The choice between expanding VHA facilities and expanding care for veterans through the private sector involves other considerations besides costs, including the quality of the care that veterans receive. VHA ranks highly among health care providers by some objective measures of quality (such as low infection rates and high vaccination rates).[28] However, some studies have found no differences in health outcomes—or worse outcomes for some types of care—at VHA facilities than in the private sector. Moreover, as in the private sector, some measures of health outcomes vary among VHA hospitals, but many important outcomes and other dimensions of health care quality are generally hard to measure.[29] As a result, CBO was not able to incorporate a careful consideration of quality in this limited examination of how VHA care compares with care provided in the private sector.

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[27]For those population estimates, see Department of Veterans Affairs, "Veteran Population," www.va.gov/vetdata/Veteran_Population.asp.

[28]See Phillip Longman, *Best Care Anywhere: Why VA Health Care Is Better Than Yours* (PoliPointPress, 2007); and Department of Veterans Affairs, *VHA Facility Quality and Safety Report, Fiscal Year 2012 Data* (December 2013), pp. 12–17, http://tinyurl.com/oj8e7xz (PDF, 5.6 KB).

[29]See Amal N. Trivedi and others, "Systematic Review: Comparison of the Quality of Medical Care in Veterans Affairs and Non-Veterans Affairs Settings," *Medical Care*, vol. 49, no. 1 (January 2011), pp. 76–88, http://tinyurl.com/nj26vto; William B. Weeks and others, "Reducing Avoidable Deaths Among Veterans: Directing Private-Sector Surgical Care to High-Performance Hospitals," *American Journal of Public Health*, vol. 97, no. 12 (December 2007), pp. 2186–2192, http://dx.doi.org/10.2105/AJPH.2007.115337; and Department of Veterans Affairs, "Quality of Care: How Does Your Medical Center Perform?" (accessed September 10, 2014), www.va.gov/QUALITYOFCARE/aspire-app.asp.

About This Document

The Congressional Budget Office's report, *Comparing the Costs of the Veterans' Health Care System With Private-Sector Costs*, released on December 10, 2014, was prepared in response to a request by the former Chairman of the Senate Committee on Veterans' Affairs. In keeping with CBO's mandate to provide objective, impartial analysis, that report makes no recommendations.

Elizabeth Bass, Philip Ellis, and Heidi Golding wrote the report with guidance from David Mosher and Matthew Goldberg. Jared Maeda contributed to the analysis, and Linda Bilheimer, Ann Futrell, Theresa Gullo and Sarah Jennings of CBO provided helpful comments. Jeffrey Kling and Robert Sunshine reviewed the report, Christian Howlett edited it, and Maureen Costantino and Jeanine Rees prepared it for publication.

This testimony reprises the report released last month. Both the report and the testimony are available on CBO's website (www.cbo.gov/publication/49763 and www.cbo.gov/publications/49905 respectively).

STATEMENT OF CARL BLAKE

ASSOCIATE EXECUTIVE DIRECTOR FOR GOVERNMENT RELATIONS

PARALYZED VETERANS OF AMERICA

ON BEHALF OF

THE CO-AUTHORS OF THE INDEPENDENT BUDGET

FOR THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

CONCERNING

THE COSTS OF CARE:

VA HEALTH CARE AND THE PRIVATE SECTOR

JANUARY 28, 2015

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Fiscal Year 2014

No federal grants or contracts received.

Fiscal Year 2013

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

Disclosure of Foreign Payments

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

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

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

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

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

STATEMENT OF
LOUIS CELLI, JR., DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
"EXAMINING THE QUALITY AND COST OF VA HEALTH CARE"

JANUARY 28, 2015

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

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

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

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

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

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

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

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

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

Important points of the study

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

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[3] CBO Analysis, page 1

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

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

This report states:

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

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

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

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

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[5] Gary N. Nugent and others, "Value for Taxpayers' Dollars: What VA Care Would Cost at Medicare Prices," Medical Care Research and Review, vol. 61, no. 4 (December 2004), p. 505, http://dx.doi.org/10.1177/1077558704269795.

[6] VHAC-"A Continued Assessment of Delays in VA Medical Care and Preventable Veteran Deaths" April 9, 2014

[7] Resolution No. 128: Increase the Transparency of the Veterans Benefits Administration's Claims Processing; Resolution No. 150: Strategic Capital Investment Planning Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STATEMENT OF DR. JAMES TUCHSCHMIDT, M.D.,
ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON VETERANS' AFFAIRS
January 28, 2015

Chairman Benishek, Ranking Member Brownley, and Distinguished Members of the House Committee on Veterans' Affairs Subcommittee on Health, thank you for the opportunity to discuss with you the Department of Veterans Affairs (VA) cost of health care provided to Veteran patients.

Quality and Patient Satisfaction

VA is committed to providing the highest quality and safest health care for Veterans. Our most important mission is to make sure Veterans know VA is here to care for them. We want Veterans to feel safe walking into VA facilities, and I expect our employees to provide Veterans with the highest quality care while living VA's I-CARE values of Integrity, Commitment, Advocacy, Respect, and Excellence. That is our standard. Veterans deserve to have full faith in us.

As the Veterans Health Administration (VHA) enters 2015, everyone in the VA health care system will be focused on the *Blueprint for Excellence.* The *Blueprint for Excellence* is our guide for improving VHA health care through specific strategies and actions. Implementing this Blueprint positions VHA as Veterans' best health care choice by providing both excellent health care and an excellent experience of care. Two key elements at the forefront of VHA's implementation efforts are to improve access to health care and to provide an exceptional patient experience, every time.

VA is committed to providing high quality, proactive, personalized, patient-driven, Veteran-centric care to Veterans and strives to improve our services. No eligible Veteran should ever have to say we could not meet their needs. VHA has comparable

or superior patient satisfaction and safety levels, according to Centers for Medicare and Medicaid Services Hospital Compare (http://Medicare.gov/hospitalcompare), as the private sector. VHA matches or exceeds the performance of the private sector in the following recognized areas:

- Outpatient care – management of hypertension, diabetes, and other conditions as defined in National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness and Information Data Set measures, as reported in VHA's Annual Quality and Safety Reports. (www.va.gov/health/HospitalReportCard.asp).
- Inpatient care – Medicare's measures for quality of care and mortality (www.Medicare.gov/Hospitalcompare).

VHA currently administers multiple surveys to assess a Veteran's experience with his or her care. The Survey of Healthcare Experience of Patients (SHEP) program is VA's largest system-wide effort, now surveying over 72,000 Veterans each month, to assess patient experiences with VHA care since 2002. SHEP results clearly show that access remains the greatest opportunity for improvement.

The American Customer Satisfaction Index (ACSI), an independent survey, is the Nation's only uniform, cross-industry measure of customer satisfaction, providing benchmarking between the public and private sectors. According to the American ACSI survey, VHA has consistently outperformed the Hospital Industry for 10 years in a row in both the Inpatient and Outpatient settings. While Veterans tell us we can and should do better with access to services, VA has topped private sector hospitals in overall satisfaction for a full decade. The ACSI is shown below:

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
VHA Inpatients	81	84	83	84	83	85	84	85	85	84	84
VHA Outpatients	80	83	80	82	83	81	83	82	83	82	82
Private Sector Hospitals	73	86	71	74	77	75	77	73	76	76	78

* Source: American Customer Satisfaction Index

Cost of Care

According to their December 2014 report, *Comparing the Costs of the Veterans' Health Care System With Private-Sector Costs*, the Congressional Budget Office (CBO) conducted a limited examination of how the costs of health care provided by VHA compares with the costs of care provided in the private sector.

As stated in the CBO report, distinctive features of the VHA system—such as its mission, mix of enrollees, and financing mechanism— complicate cost comparisons with other sources of health care.

The VHA system is designed to serve a unique patient population: former members of the Armed Forces who served their country. Veterans must enroll to receive care from VHA, and when they do, they are placed in one of eight priority groups reflecting disabilities they may have, their income, and other factors. Many of VHA's enrollees have injuries or disabilities that were incurred or aggravated during military service. Of the estimated 22 million living Veterans in the United States, nearly 9 million were enrolled in VHA in FY 2013. About 40 percent of those enrollees had service-connected disabilities, and their care accounted for about half of VHA's $54 billion in total obligations in FY 2013.

The vast majority of care provided by VHA is provided directly through our facilities. Veterans are geographically dispersed across the country, and therefore, some may be required to travel relatively long distances to obtain care at one of our facilities. VA provides beneficiary travel payments to Veterans who meet eligibility criteria, a benefit not found in other health care systems.

As CBO has specified, VHA has also traditionally paid for some care delivered by private sector providers—for instance, when VA is unable to provide needed care to certain Veterans. In FY 2013, those payments accounted for about 10 percent of VHA's medical care budget. As a result of the Veterans Access, Choice, and Accountability Act of 2014, we have implemented a new program to pay for health care provided by

eligible providers outside the VA system for eligible Veterans who meet certain wait-time or distance standards.

The mix of services and benefits that Veterans receive from VHA also differs somewhat from the mix covered by typical health insurance plans. As stated in the report, an example of this is that enrollees rely heavily on VHA for some types of specialized mental health care, such as treatment for post-traumatic stress disorder or substance abuse. VA has recognized certain diseases and other health problems as presumptive diseases associated with exposure to Agent Orange or other herbicides during military service. VA also provides technologically advanced prosthetic devices to eligible Veterans who need them. Although private insurance plans may cover prosthetic services, their coverage may not be as extensive as VHA's, and VHA usually provides such services at no cost to Veterans.

In addition, many other services provided by VHA may fall outside the typical scope of health care provided to patients in the private sector. For example, Veterans may receive individualized assistance from a social worker (case manager) or, as mentioned above, reimbursement for nonemergency transportation costs. Some family members of Veterans may receive counseling or financial support (i.e., the Caregivers Support Program as well as Readjustment Counseling Services through the Vet Center Program). Also, in contrast to private sector health plans, VHA provides extensive support and services to address many of the social and economic causes of poor health—homelessness, for example—that are not typically included in other health care plans. Our clinical and psychosocial outreach shows up in VHA's total health care costs, because our mission is to address the total health of our Veteran patients, not simply to provide care for illness or disease.

All of these unique aspects of VHA care are contributing factors as to why it is a challenge to fully compare VHA care with care provided in the private sector.

Conclusion

Mr. Chairman, VA is Veteran-centric, and VHA delivers patient-centric healthcare. We are proud of our documented record in the health care industry for providing high quality, safe, and effective care. Veteran patients' satisfaction survey results for VA were comparable or superior to those for non-VA facilities. We remain dedicated to providing the best Veteran-centric care possible, and our work and mission will never be done.

Thank you for the opportunity to appear before you today, I am prepared to answer any questions you may have.

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