

**Statement of
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Under Secretary for Health
Department of Veterans Affairs
before the
United States
House Committee on Veterans' Affairs**

July 21, 2005

Mr. Chairman and Members of the Committee: Thank you for your continuing support and ongoing dialogue regarding the budget forecasting and finances of the Veterans Health Administration. Accompanying me today are Ms. Laura J. Miller, Deputy Under Secretary for Health for Operations and Management and our VHA Chief Financial Officer, Mr. Jimmy Norris.

Background

Mr. Chairman, in considering our budget planning and the request for a FY 2005 supplemental appropriation as well as continuing needs for health services in FY 2006, I'd like to discuss what facts underlie the need for a FY 2005 supplemental request.

FY 2005 Supplemental Request

VA requested a supplemental appropriation in the amount of \$975 million for FY 2005 in June of this year. That supplemental request was needed because our expected forecasted growth, based on the actuarial model, was 2.3 percent. VA discovered in March 2005, that the actual growth had accelerated through mid-year 2005 to 5.2 percent. This was a difference of 2.9 percent

above the original projection. This higher than anticipated demand for VHA services was a major factor driving our need for a supplemental appropriation.

Discrepancy from Projections and Status of Health Care Resources:

Mr. Chairman, as we discussed during your June 23, 2005 hearing, VA uses an actuarial model to forecast patient demand and associated resources needs. Actuarial modeling is the most rational way to project the resource needs of a health care system like the Veterans Health Administration. As I noted at that hearing, this is the approach utilized by the private sector. Unlike the private sector, however, where projections are used to formulate budgets for the next year or even the next "open season," the Federal budget cycle requires budget formulation using data two and one-half to three and one-half years ahead of budget execution.

For example, the data used to formulate the budget for FY 2005 derive from health care utilization in FY 2002; in this case, the last full year of data before the Department's FY 2005 budget formulation began.

Our actuarial model forecasted 2.3% annual growth in healthcare demand in FY 2005. We discovered that growth has accelerated through mid-year 2005, to 5.2% above FY 2004. This constitutes a substantial increase in workload and resource requirements.

As a result, our increased medical care costs in FY 2005 are \$975 million based on increased patient demand and increased utilization of health care services in clinical areas.

I believe that an additional \$1.977 billion above the President's Budget request is needed to continue to provide timely, high quality care to enrolled veterans in FY 2006. This includes \$300 million to replenish carry over funds

being used in FY 2005 to cover the increase in average cost per patient, \$677 million to cover an estimated 2.0 percent increase in the number of patients expected to seek care in FY 2006, \$400 million to recognize the expected cost of providing more costly treatment; and \$600 million to correct for the estimated costs of long-term care.

The Administration has come forward to the Congress with a proposal to provide VA with these additional resources. The total need for both years combined is \$2.952 billion, comprising a FY 2005 supplemental request of \$975 million and a FY 2006 budget amendment of \$1.977 billion. These amounts assume enactment of the policies in the President's Budget. If Congress does not accept any of the policies in the President's Budget, additional resources to offset the cost of those will still be needed.

Planned Improvements:

VA and other Federal agencies like DoD use actuarial modeling to project resource requirements two and one-half to three and one-half years hence. While VA's modeling techniques and methodologies are very advanced, as a consequence of the budget process the "performance envelope" of the model is pushed compared to the private sector, which makes actuarial projections for budgeting for the next year or "open season." Still, the 2.9 percent variance above the number of patients projected is far better than the variances that occurred under the previous system, when budgets were projected simply by inflating an historical base. Nevertheless, we will augment the model's already robust methodologies and work with you to improve the process; indeed we must.

Future planned improvements to the model include obtaining access to data on VA enrollee's use of Medicaid, Tricare, and military treatment facilities; integrating VHA's long-term-care model into the actuarial model, and modeling additional services such as dental care. In addition, we need to continue the progress already made with DoD to better engage them in data sharing and projections regarding OIF/OEF returnees.

To address the average three-year time lag in the budget process, we need to also consider trends in the economy that might not yet be incorporated into past data and the model, but can be adjusted in our budget formulation process. Since VA is a low or no-cost provider, we must better anticipate the effects on our system as the other health care options available to veterans become more costly.

Perhaps, more importantly, the Secretary has committed to quarterly reviews to address resource needs in light of VHA's most current operational experience.

Conclusion

Mr. Chairman, in closing, I believe that the resources requested in the supplemental appropriation for FY 2005 proposed by the Administration and the President's Budget Amendment for FY 2006 reflect the commitment and support by the Administration to the veterans of this nation in meeting the increased demand for VHA health care services.

Thank you for your support of veterans and VA, and the opportunity to testify on this complex issue.