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VA HEALTH CARE

Challenges in Budget Formulation and Issues Surrounding the Proposal for Advance Appropriations

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Highlights of [GAO-09-664T](#), a testimony before the Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

The Department of Veterans Affairs (VA) estimates it will provide health care to 5.8 million patients with appropriations of about \$41 billion in fiscal year 2009. It provides a range of services, including primary care, outpatient and inpatient services, long-term care, and prescription drugs. VA formulates its health care budget by developing annual estimates of its likely spending for all its health care programs and services, and includes these estimates in its annual congressional budget justification.

GAO was asked to discuss budgeting for VA health care. As agreed, this statement addresses (1) challenges VA faces in formulating its health care budget and (2) issues surrounding the possibility of providing advance appropriations for VA health care.

This testimony is based on prior GAO work, including *VA Health Care: Budget Formulation and Reporting on Budget Execution Need Improvement* ([GAO-06-958](#)) (Sept. 2006); *VA Health Care: Long-Term Care Strategic Planning and Budgeting Need Improvement* ([GAO-09-145](#)) (Jan. 2009); and *VA Health Care: Challenges in Budget Formulation and Execution* ([GAO-09-459T](#)) (Mar. 2009); and on GAO reviews of budgets, budget resolutions, and related legislative documents. We discussed the contents of this statement with VA officials.

[View GAO-09-664T or key components.](#)
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VA HEALTH CARE

Challenges in Budget Formulation and Issues Surrounding the Proposal for Advance Appropriations

What GAO Found

GAO's prior work highlights some of the challenges VA faces in formulating its budget: obtaining sufficient data for useful budget projections, making accurate calculations, and making realistic assumptions. For example, GAO's 2006 report on VA's overall health care budget found that VA underestimated the cost of serving veterans returning from military operations in Iraq and Afghanistan. According to VA officials, the agency did not have sufficient data from the Department of Defense, but VA subsequently began receiving the needed data monthly rather than quarterly. In addition, VA made calculation errors when estimating the effect of its proposed fiscal year 2006 nursing home policy, and this contributed to requests for supplemental funding. GAO recommended that VA strengthen its internal controls to better ensure the accuracy of calculations used to prepare budget requests. VA agreed and, for its fiscal year 2009 budget justification, had an independent actuarial firm validate savings estimates from proposals to increase fees for certain types of health care coverage. In January 2009, GAO found that VA's assumptions about the cost of providing long-term care appeared unreliable given that assumed cost increases were lower than VA's recent spending experience and guidance provided by the Office of Management and Budget. GAO recommended that VA use assumptions consistent with recent experience or report the rationale for alternative cost assumptions. In a March 23, 2009, letter to GAO, VA stated that it concurred and would implement this recommendation for future budget submissions.

The provision of advance appropriations would "use up" discretionary budget authority for the next year and so limit Congress's flexibility to respond to changing priorities and needs. While providing funds for 2 years in a single appropriations act provides certainty about some funds, the longer projection period increases the uncertainty of the data and projections used. If VA is expected to submit its budget proposal for health care for 2 years, the lead time for the second year would be 30 months. This additional lead time increases the uncertainty of the estimates and could worsen the challenges VA already faces when formulating its health care budget.

Given the challenges VA faces in formulating its health care budget and the changing nature of health care, proposals to change the availability of the appropriations it receives deserve careful scrutiny. Providing advance appropriations will not mitigate or solve the problems we have reported regarding data, calculations, or assumptions in developing VA's health care budget. Nor will it address any link between cost growth and program design. Congressional oversight will continue to be critical.

Mr. Chairman and Members of the Committee:

We are pleased to be here today as the committee considers issues in budgeting and funding for the Department of Veterans Affairs (VA) health care programs. These programs form one of the largest health care delivery systems in the nation and provide, for eligible veterans, a range of services, including preventive and primary health care, outpatient and inpatient services, long-term care, and prescription drugs. VA estimated that in fiscal year 2009, its health care programs would serve 5.8 million patients with appropriations of about \$41 billion.

VA health care programs are funded through the annual appropriations process along with other areas of critical importance and high priority to the nation, including national defense, homeland security, transportation, energy and natural resources, education, and public health. VA formulates its health care budget by developing annual estimates of its likely spending for all of its health care programs and services. This is by its very nature challenging, as it is based on assumptions and imperfect information on the health care services VA expects to provide. For example, VA is responsible for anticipating the service needs of two very different populations—an aging veteran population and a growing number of veterans returning from the military operations in Afghanistan and Iraq—calculating the future costs associated with providing VA services, and using these factors to develop the department’s budget request submitted to the Office of Management and Budget (OMB).¹ VA provides its annual congressional budget justification to the appropriations subcommittees, providing additional explanation for the President’s budget request.²

VA uses an actuarial model to develop its annual budget estimates for most of its health care programs, including inpatient acute surgery, outpatient care, and prescription drugs. This model estimates future VA health care costs by using projections of veterans’ demand for VA’s health care services as well as cost estimates associated with particular health

¹VA begins to formulate its own budget request at least 18 months before the start of the fiscal year to which the request relates and about 10 months before transmission of the President’s budget request, which usually occurs in early February.

²The President’s budget request for VA is developed by the Office of Management and Budget.

care services.³ In fiscal year 2006, VA used the actuarial model to estimate about 86 percent of its projected health care spending for that year. VA uses a separate approach to project long-term care demands and costs, which accounted for about 10 percent of VA's estimated health care spending for fiscal year 2006. VA used other approaches to project demand and costs for the remaining 4 percent of the medical programs budget request for fiscal year 2006.

In 2006 and 2009, we issued reports that examined some of the challenges VA faces in budget formulation; these reports pertained to VA's overall health care budget as well as portions of its budget that pertain to long-term care.⁴ We also testified in March 2009 before the House Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, about challenges VA faces in formulating and executing its budget.⁵ You asked us to discuss budgeting for VA health care. As agreed, today we will discuss (1) challenges VA faces in formulating its health care budget and (2) some issues surrounding the possibility of providing advance appropriations for VA health care.⁶

For our 2006 report on VA's overall health care budget for fiscal years 2005 and 2006, we analyzed and reviewed budget documents, including VA's budget justifications for health care programs for fiscal years 2005 and 2006, and interviewed VA officials responsible for VA health care budget issues and for developing budget projections. In addition, from August to September 2008, we reviewed VA documents to determine whether VA had

³The actuarial model reflects factors such as the age, sex, and morbidity of the veteran population as well as the extent to which veterans are expected to seek care from VA rather than health care providers reimbursed by other payers such as Medicare and Medicaid.

⁴See GAO, *VA Health Care: Budget Formulation and Reporting on Budget Execution Need Improvement*, [GAO-06-958](#) (Washington, D.C.: Sept. 20, 2006); GAO, *VA Health Care: Long-Term Care Strategic Planning and Budgeting Need Improvement*, [GAO-09-145](#) (Washington, D.C.: Jan. 23, 2009).

⁵See GAO, *VA Health Care: Challenges in Budget Formulation and Execution*, [GAO-09-459T](#) (Washington, D.C.: Mar. 12, 2009).

⁶The Veterans Health Care Budget Reform and Transparency Act of 2009 would provide for the VA Medical Services, Medical Support and Compliance, and Medical Facilities appropriations accounts to receive advance appropriations beginning with fiscal year 2011. H.R. 1016 and S. 423, 111th Cong. (2009). Advance appropriations represent budget authority that becomes available 1 or more fiscal years after the fiscal year covered by the appropriations act in which they are made.

implemented the recommendations we made in our 2006 report. For our 2009 report on VA's long-term care budget, we reviewed VA's fiscal year 2009 congressional budget justification and related documents. We also interviewed VA officials. VA did not initially comment on the recommendations in our 2009 report, but said it would provide an action plan. VA provided this action plan in a March 23, 2009, letter to GAO. For this statement we reviewed VA's letter and action plan. For the discussion of appropriations and budgeting we reviewed previous GAO work, budgets, budget resolutions, and related legislative documents.⁷

We conducted our work for these performance audits in accordance with generally accepted government auditing standards.⁸ Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We discussed the contents of this statement with VA officials.

VA Faces Challenges in Formulating Its Health Care Budget

Our prior work highlights some of the challenges VA faces in formulating its budget: obtaining sufficient data for useful budget projections, making accurate calculations, and making realistic assumptions. Our 2006 report on VA's overall health care budget found that VA underestimated the cost of serving veterans returning from military operations in Afghanistan and Iraq, in part because estimates for fiscal year 2005 were based on data that largely predated the Iraq conflict.⁹ In fiscal year 2006, according to VA, the agency again underestimated the cost of serving these veterans because it

⁷See GAO, *Budget Process: Issues in Biennial Budget Proposals*, [GAO/T-AIMD-96-136](#) (Washington, D.C.: July 24, 1996); GAO, *Budget Process: Comments on S.261-Biennial Budgeting and Appropriations Act*, [GAO/T-AIMD-97-84](#) (Washington, D.C.: Apr. 23, 1997); GAO, *Budget Issues: Cap Structure and Guaranteed Funding*, [GAO/T-AIMD-99-210](#) (Washington, D.C.: July 21, 1999); GAO, *Congressional Directives: Selected Agencies' Processes for Responding to Funding Instructions*, [GAO-08-209](#) (Washington, D.C.: Jan. 31, 2008).

⁸We conducted our work on VA's overall health care budget from October 2005 through September 2006, our work on VA's long-term care budget from November 2007 through January 2009, and our work for this statement in April 2009. The discussion of advance appropriations draws on work and analysis conducted on an ongoing basis for over a decade.

⁹See [GAO-06-958](#).

did not have sufficient data due to challenges obtaining data needed to identify these veterans from the Department of Defense (DOD). According to VA officials, the agency subsequently began receiving the DOD data needed to identify these veterans on a monthly basis rather than quarterly.

We also reported challenges VA faces in making accurate calculations during budget formulation. VA made computation errors when estimating the effect of its proposed fiscal year 2006 nursing home policy, and this also contributed to requests for supplemental funding. We found that VA underestimated workload—that is, the amount of care VA provides—and the costs of providing care in all three of its nursing home settings.¹⁰ VA officials said that the errors resulted from calculations being made in haste during the OMB appeal process,¹¹ and that a more standardized approach to long-term care calculations could provide stronger quality assurance to help prevent future mistakes. In 2006, we recommended that VA strengthen its internal controls to better ensure the accuracy of calculations it uses in preparing budget requests. VA agreed with and implemented this recommendation for its fiscal year 2009 budget justification by having an independent actuarial firm validate the savings estimates from proposals to increase fees for certain types of health care coverage.

Our 2006 report on VA's overall health care budget also illustrated that VA faces challenges making realistic assumptions about the budgetary impact of its proposed policies. VA made unrealistic assumptions about how quickly the department would realize savings from proposed changes in its nursing home policy. We reported the President's requests for additional funding for VA's medical programs for fiscal years 2005 and 2006 were in part due to these unrealistic assumptions.¹² We recommended that VA improve its budget formulation processes by explaining in its budget justifications the relationship between the implementation of proposed policy changes and the expected timing of cost savings to be achieved. VA

¹⁰VA provides nursing home care in VA-operated nursing homes, in state veterans' nursing homes, and in community nursing homes under local or national contract to VA.

¹¹In late November, OMB "passes back" budget decisions to the agencies on the President's budget requests for their programs, a process known as "passback." These decisions may involve, among other things, funding levels, program policy changes, and personnel ceilings. The agencies may appeal decisions with which they disagree.

¹²In June 2005, the President requested a \$975 million supplemental appropriation for fiscal year 2005, and in July 2005, the President submitted a \$1.977 billion budget amendment for the fiscal year 2006 appropriation.

agreed and acted on this recommendation in its fiscal year 2009 budget justification.

In January 2009, we found that VA's spending estimate in its fiscal year 2009 budget justification for noninstitutional long-term care services appeared unreliable, in part because this spending estimate was based on a workload projection that appeared to be unrealistically high in relation to recent VA experience.¹³ VA projected that its workload for noninstitutional long-term care would increase 38 percent from fiscal year 2008 to fiscal year 2009. VA made this projection even though from fiscal year 2006 to fiscal year 2007—the most recent year for which workload data are available—actual workload for these services decreased about 5 percent. In its fiscal year 2009 budget justification, VA did not provide information regarding its plans for how it would increase noninstitutional workload 38 percent from fiscal year 2008 to fiscal year 2009. We recommended that VA use workload projections in future budget justifications that are consistent with VA's recent experience with noninstitutional long-term care spending or report the rationale for using alternative projections. In its March 23, 2009, letter to GAO, VA stated it concurs with this recommendation and will implement our recommendation in future budget submissions.

In January 2009, we also reported that VA may have underestimated its nursing home spending and noninstitutional long-term care spending for fiscal year 2009 because it used a cost assumption that appeared unrealistically low, given recent VA experience and economic forecasts of health care cost increases. For example, VA based its nursing home spending estimate on an assumption that the cost of providing a day of nursing home care would increase 2.5 percent from fiscal year 2008 to fiscal year 2009. However, from fiscal year 2006 to fiscal year 2007—the most recent year for which actual cost data are available—these costs increased approximately 5.5 percent. VA's 2.5 percent cost-increase estimate is also less than the 3.8 percent inflation rate for medical services that OMB provided in guidance to VA to help with its budget estimates. We recommended that in future budget justifications, VA use cost assumptions for estimating both nursing home and noninstitutional long-term care spending that are consistent with VA's recent experience or

¹³VA provides two types of long-term care: institutional long-term care, which is provided almost exclusively in nursing homes, and noninstitutional long-term care, which is provided in veterans' own homes and in other locations in the community.

report the rationale for alternative cost assumptions. In its March 23, 2009, letter to GAO, VA stated it concurs with our recommendations and will implement these recommendations in future budget submissions.

Issues in Changing the Appropriations for VA Health Care

Consideration of any proposal to change the availability of the appropriations VA receives for health care should take into account the current structure of the federal budget, the congressional budget process—including budget enforcement—and the nature of the nation’s fiscal challenge. The impact of any change on congressional flexibility and oversight also should be considered.

In the federal budget, spending is divided into two main categories: (1) direct spending, or spending that flows directly from authorizing legislation—this spending is often referred to as “mandatory spending”—and (2) discretionary spending, defined as spending that is provided in appropriations acts.

It is in the annual appropriations process that the Congress considers, debates, and makes decisions about the competing claims for federal resources. Citizens look to the federal government for action in a wide range of areas. Congress is confronted every year with claims that have merit but which in total exceed the amount the Congress believes appropriate to spend. It is not an easy process—but it is an important exercise of its Constitutional power of the purse.

Special treatment for spending in one area—either through separate spending caps or guaranteed minimums or exemption from budget enforcement rules—may serve to protect that area from competition with other areas for finite resources. The allocation of funds across federal activities is not the only thing Congress determines as part of the annual appropriations process. It also specifies the purposes for which funds may be used and the length of time for which funds are available. Further, annually enacted appropriations have long been a basic means of exerting and enforcing congressional policy.

The review of agency funding requests often provides the context for the conduct of oversight. For example, in the annual review of the VA health care budget, increasing costs may prompt discussion about causes and possible responses—and lead to changes in the programs or in funding levels. VA health care offers illustrations of and insights into growing health care costs. This takes on special significance since—as we and

others have reported—the nation’s long-term fiscal challenge is driven largely by the rapid growth in health care costs.

Both the Congress and the agencies have expressed frustration with the budget and appropriations process. Some members of Congress have said the process is too lengthy. The public often finds the debate confusing. Agencies find it burdensome and time consuming. And the frequent need for continuing resolutions¹⁴ (CR) has been a source of frustration both in the Congress and in agencies. Although there is frustration with the current process, changes should be considered carefully. The current process is, in part, the cumulative result of many changes made to address previous problems. This argues for spending time both defining what the problem(s) to be solved are and analyzing the impact of any proposed change(s).

In considering issues surrounding the possibility of providing advance appropriations for VA health care—or any other program—it is important to recognize that not all funds provided through the existing appropriations process expire at the end of a single fiscal year. Congress routinely provides multi-year appropriations for accounts or projects within accounts when it deems it makes sense to do so. Multi-year funds are funds provided in one year that are available for obligation beyond the end of that fiscal year. So, for example, multi-year funds provided in the fiscal year 2010 appropriations act would be available in fiscal year 2010 and remain available for some specified number of future years.¹⁵ Unobligated balances from such multi-year funds may be carried over by the agency into the next fiscal year—regardless of whether the agency is operating under a continuing resolution or a new appropriations act. For example, in fiscal year 2009 about \$3 billion of approximately \$41 billion for VA health care programs was made available for two years. Congress also provides agencies—including VA—some authority to move funds between appropriations accounts. This transfer authority provides flexibility to respond to changing circumstances.

¹⁴When Congress and the President do not reach final decisions about one or more regular appropriations acts by the beginning of the federal fiscal year, October 1, they often enact a continuing resolution (CR). A CR provides agencies with funding for a period of time until final appropriations decisions are made or until enactment of another CR.

¹⁵Some of these funds are available for two years; some are available for a longer specified time; some are available “until expended.”

Advance appropriations are different from multi-year appropriations. Whereas multi-year appropriations are available in the year in which they are provided, advance appropriations represent budget authority that becomes available one or more fiscal years after the fiscal year covered by the appropriations act in which they are provided. So, for example, advance appropriations provided in the fiscal year 2010 appropriations act would consist of funds that would first be available for obligation in fiscal year 2011 or later.

In considering the proposal to provide advance appropriations, one issue is the impact on congressional flexibility and its ability to consider competing demands for limited federal funds. Although appropriations are made on an annual cycle, both the President and the Congress look beyond a single year in setting spending targets. The current administration's budget presents spending totals for ten fiscal years.¹⁶ The concurrent Budget Resolution—which represents Congress's overall fiscal plan—includes discretionary spending totals for the budget year and each of the four future years.¹⁷ The provision of advance appropriations would “use up” discretionary budget authority for the next year. In doing so it limits Congress's flexibility to respond to changing priorities and needs and reduces the amount available for other purposes in the next year.

Another issue would be how and when the limits on such advance appropriations would be set. Currently the concurrent Budget Resolution both caps the total amount that can be provided through advance appropriations and identifies the agencies or programs which may be provided such funding.¹⁸ It does not specify how the total should be allocated among those agencies.

A related question is what share of VA health care funding would be provided in advance appropriations. Is the intent to provide a full appropriation for both years in the single appropriations act? This would

¹⁶These are usually provided by budget category, by budget function, and by agency as well as for the total budget. The President's budget for fiscal year 2010 includes summary budget totals for the ten years spanning fiscal year 2010 through fiscal year 2019.

¹⁷The FY 2010 budget resolution specifies discretionary spending amounts—both budget authority and outlays—in total and for each budget function for each of fiscal years 2010-2014. (It also specifies the amount of new appropriations and outlays for FY 2009).

¹⁸A point of order can be raised against advance appropriations provided for those entities not identified by the Resolution.

in effect enact the entire appropriation for both the budget year and the following fiscal year at the same time. If appropriations for VA health care were enacted in two-year increments, under what conditions would there be changes in funding in the second year? Would the presumption be that there would be no action in that second year except under unusual circumstances? Or is the presumption that there would be additional funds provided? These questions become critical if Congress decides to provide all or most of VA health care's funding in advance. Even if only a portion of VA health care funding is to be provided in advance appropriations, Congress will need to determine what that share should be and how it should be allocated across VA's medical accounts.

While providing funds for 2 years in a single appropriations act provides certainty about some funds, the longer projection period increases the uncertainty of the data and projections used. Under the current annual appropriations cycle, agencies begin budget formulation at least 18 months before the relevant fiscal year begins. If VA is expected to submit its budget proposal for health care for both years at once, the lead time for the second year would be 30 months. This additional lead time increases the uncertainty of the estimates and could worsen the challenges VA faces when formulating its health care budget.

Concluding Observations

Given the challenges VA faces in formulating its health care budget and the changing nature of health care, proposals to change the availability of the appropriations it receives deserve careful scrutiny. Providing advance appropriations will not mitigate or solve the problems noted above regarding data, calculations, or assumptions in developing VA's health care budget. Nor will it address any link between cost growth and program design. Congressional oversight will continue to be critical.

No one would suggest that the current budget and appropriations process is perfect. However, it is important to recognize that no process will make the difficult choices and tradeoffs Congress faces easy. If VA is to receive advance appropriations for health care, the amount of discretionary spending available for Congress to allocate to other federal activities in that year will be reduced. In addition, providing advance appropriations for VA health care will not resolve the problems we have identified in VA's budget formulation.

Mr. Chairman, this concludes our prepared remarks. We would be happy to answer any questions you or other members of the Committee may have.

GAO Contacts and Staff Acknowledgments

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