GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

March 30, 2012

The Honorable Patty Murray
Chairman
The Honorable Richard Burr
Ranking Member
Committee on Veterans' Affairs
United States Senate

The Honorable Jeff Miller
Chairman
The Honorable Bob Filner
Ranking Member
Committee on Veterans' Affairs
House of Representatives

Subject: *VA Health Care: Estimates of Available Budget Resources Compared with Actual Amounts*

The Department of Veterans Affairs (VA) is one of the nation's largest health care providers. In fiscal year 2011, VA spent about $51.4 billion to provide health care to about 6.2 million patients. To provide this care, VA operates more than 150 hospitals, 130 nursing homes, 800 outpatient clinics, and 300 readjustment counseling centers through 21 regional health care networks known as Veterans Integrated Service Networks.[1] VA is required by law to provide health care services to certain veterans and may provide care to other veterans on a discretionary basis.[2] In general, veterans must enroll in the VA health care system to receive VA's medical benefits package, which includes coverage for a full range of hospital and outpatient services, prescription drug coverage, and noninstitutional long-term care

[1]VA is responsible for providing health care services to various populations, including an aging veteran population and a growing number of younger veterans returning from the military operations in Afghanistan and Iraq.

[2]VA is required to provide health care services to specified veterans, such as those with service-connected disabilities, income below a certain level, or other special statuses, such as former prisoners of war. See 38 U.S.C. § 1710(a)(1), (2). VA is authorized to provide care to other veterans not identified in these groups. See 38 U.S.C. § 1710(a)(3). Requirements for VA health care services are effective in any fiscal year only to the extent and in the amount provided in advance in appropriations acts for such purposes. See 38 U.S.C. § 1710(a)(4). To manage the provision of health care services within available resources, VA operates a system of annual patient enrollment, as required by 38 U.S.C. § 1705, in accordance with eight listed priorities.

services provided in veterans' own homes and in other locations in the community.[3] VA also provides some services that are not part of its medical benefits package, such as nursing home care.[4]

The amount of funding VA receives to provide its health care services is determined by Congress in the annual appropriations process. Congress provided new appropriations[5] of about $48.2 billion for fiscal year 2011 and advance appropriations of $50.6 billion for fiscal year 2012 for VA health care.[6] In preparation for the appropriations process, VA must annually develop a budget estimate of the resources that it believes are needed to provide its health care services. This estimate is subsequently used to help inform the President's formal budget request for appropriations for VA health care.[7]

VA's annual budget estimate for a fiscal year includes estimates of the resources available to provide VA health care services.[8] This includes an annual estimate of the amount of resources expected to be available from collections and reimbursements that VA anticipates it will receive in the fiscal year. It also includes an estimated amount of resources VA has not spent—known as an unobligated balance—that VA is authorized to carry over into the following fiscal year from the previous one.[9] VA's collections include third party payments from veterans' private health care insurance for the treatment of nonservice-connected conditions and veterans' copayments for outpatient medications. VA's reimbursements include amounts VA receives for services provided under service agreements with the

[3]VA provides adult day health care, respite care, and other noninstitutional long-term care services as part of the medical benefits package provided to all enrolled veterans. See 38 U.S.C. §§ 1701(6)(E), 1710B; 38 C.F.R. § 17.38.

[4]VA is required by law to provide nursing home care to certain veterans needing such care who also have service-connected disabilities, and VA also makes nursing home care available to other veterans on a discretionary basis as resources permit. See 38 U.S.C. § 1710A.

[5]We use the term "new appropriations" to refer to the appropriations provided during the current annual appropriations process for the upcoming fiscal year and, in the case of "advance appropriations," appropriations provided for the following fiscal year.

[6]Veterans Health Care Budget Reform and Transparency Act of 2009, Pub. L. No. 111-81, § 3, 123 Stat. 2137, 2137–38 (2009), codified at 38 U.S.C. § 117, provided that VA's annual appropriations for health care include advance appropriations that become available 1 fiscal year after the fiscal year for which the appropriations act was enacted.

[7]See GAO, *Veterans' Health Care: VA Uses a Projection Model to Develop Most of Its Health Care Budget Estimate to Inform the President's Budget Request*, GAO-11-205 (Washington, D.C.: Jan. 31, 2011); and GAO, *Veterans' Health Care Budget Estimate: Changes Were Made in Developing the President's Budget for Fiscal Years 2012 and 2013*, GAO-11-622 (Washington, D.C.: June 14, 2011).

[8]VA's annual budget estimate for a fiscal year also includes estimates of the resources needed to meet the expected demand for VA health care services. As we have previously reported, VA uses what is known as the Enrollee Health Care Projection Model (EHCPM) to develop most of its estimate of the resources needed to meet the expected demand for VA health care services, and VA uses other methods to develop the remainder of the estimate. See GAO-11-205.

[9]In addition to new appropriations that VA may receive from Congress as a result of the annual appropriations process, funding may also be available from unobligated balances of multiyear appropriations, which remain available for a fixed period of time in excess of 1 fiscal year. For example, VA's fiscal year 2012 appropriations provided that about $1.75 billion be available for 2 fiscal years. These funds may be carried over from fiscal year 2012 to fiscal year 2013 if they are not obligated by the end of fiscal year 2012. See Pub. L. No. 112-74, § 227(b), 125 Stat. 786, 1159 (2011).

Department of Defense (DOD). As indicated in the President's budget request for VA for fiscal year 2012, VA estimated it would receive $3.4 billion in collections and reimbursements and would carry over an unobligated balance of $1.1 billion from fiscal year 2011. The President's fiscal year 2012 budget request assumed that VA's total spending for health care services would be $54.9 billion to serve an estimated 6.2 million patients.

VA's estimates of collections, reimbursements, and unobligated balances are part of VA's overall formulation of its annual budget estimate. This process is inherently complex, as VA must rely on assumptions and imperfect information. The process begins approximately 18 months in advance of the fiscal year for which the President is requesting funding. As such, VA's budget formulation, including its estimates of collections, reimbursements, and unobligated balances, occurs with significant uncertainty about the future. Our past work has highlighted VA's challenges regarding budget formulation in making realistic assumptions about the budgetary impact of policy changes, making accurate calculations, and obtaining sufficient data for useful budget projections.[10]

Given the importance of VA's collections, reimbursements, and unobligated balances in the formulation of its budget estimate and given VA's budget formulation challenges, you asked us to examine VA's experience estimating these funds in the context of the President's budget request. In this report, we examine how VA:

1. estimates the amount of collections and reimbursements, how the estimated amounts have compared to actual amounts in recent years, and what factors may explain any differences; and
2. estimates the amount of its unobligated balances, how the estimated amounts have compared to actual amounts in recent years, and what factors may explain any differences.

To examine how VA estimates the amount of collections and reimbursements for budget purposes, how VA's estimates have compared to actual amounts collected, and the factors explaining the differences, if any, we reviewed VA documents and interviewed officials from VA's Veterans Health Administration Office of Finance and VA's Chief Business Office. We also examined other information regarding events that took place during the period of our analysis. For example, we examined whether or to what extent changes in the health care services VA is required to provide to certain veterans may impact VA's actual collections amounts. We obtained information on the methods, data, and assumptions VA used to develop the estimates of collections and reimbursements for fiscal years 2005 through 2013. We also compared VA's estimated amounts to the actual amounts VA collected or received for fiscal years 2005 through 2011, as reported in the President's budget request for VA. In instances where we identified differences between VA's estimates and actual amounts, we also examined factors that could help explain these

[10]See GAO, *VA Health Care: Budget Formulation and Reporting on Budget Execution Need Improvement*, GAO-06-958 (Washington, D.C.: Sept. 20, 2006), and *VA Health Care: Challenges in Budget Formulation and Issues Surrounding the Proposal for Advance Appropriations,* GAO-09-664T, (Washington, D.C.: Apr. 29, 2009).

differences. As part of this analysis, we discussed with VA officials the strengths and weaknesses of the data we used and examined the consistency of these data in order to assess the data's reliability. We determined that the data were reliable for our purposes.

To examine how VA estimates the amount of unobligated balances to be carried over from 1 fiscal year to the next, how these estimates have compared with actual amounts, and what factors explain the difference, if any, we reviewed documents, interviewed officials from VA's Veterans Health Administration Office of Finance, and examined other information regarding events that took place during the time frame for our analysis. We obtained information on the methods, data, and assumptions VA used to develop the estimates of its obligations—that is, spending—for fiscal years 2005 through 2013. We also compared VA's estimates of its unobligated balances with the actual balances available to the agency for fiscal years 2005 through 2012 as reported in documents such as the President's budget request for VA. In instances when we identified differences between VA's estimates and actual balances, we also identified the factors that could help explain these differences. As part of this analysis, we discussed with VA officials the strengths and weaknesses of the data we used and examined the consistency of these data in order to assess the data's reliability. We determined that the data were reliable for our purposes.

We conducted our work from July 2011 to March 2012 in accordance with generally accepted government auditing standards. 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.

Results in Brief

VA estimates the amount of collections and reimbursements it expects to receive each year by using a projection model and other methods. These estimates have varied when compared with actual amounts for various reasons. VA used a projection model to estimate its collections for fiscal years 2005 through 2012 based on data reflecting the amount of health care—known as workload—VA has provided in the past and the amounts VA has collected in the past. To estimate its collections in fiscal year 2013, VA began using a second projection model, known as the Integrated Collections Forecasting Model (ICFM) to estimate collections. The ICFM relies on many of the same data sources as VA's previous collections model, but it also incorporates forecasts related to future workload. For fiscal years 2005 through 2011, VA both overestimated and underestimated its collections. For example, for fiscal year 2011, VA overestimated the amount of its collections by about $582 million, or 17 percent. VA officials attribute this difference to several factors, such as overestimating the amount of collections VA would receive when it billed veterans' third-party insurance plans. To estimate the amount of reimbursements it would likely receive in each of the fiscal years, VA used one of two methods depending on the year. For fiscal years 2005 through 2011, VA applied a growth rate to its most recent full year data on actual reimbursement amounts received to reflect anticipated increases in reimbursements, and for fiscal years

2012 and 2013, VA relied on individual reimbursement estimates provided by each of VA's 21 Veterans Integrated Service Networks. While VA's estimates of reimbursements were relatively consistent with actual amounts in fiscal years 2005 through 2007, in fiscal years 2008 through 2011, VA underestimated reimbursements by an average of $74 million, or 26 percent annually.

VA estimates its unobligated balances based on anticipated spending, and these estimates have been generally less than actual amounts for various reasons. Approximately 18 months in advance of the fiscal year for which it is requesting appropriations, VA begins to develop an estimate of the unobligated balance likely to be carried over from the prior year into that year. VA determines this amount based on an estimate of its likely spending—that is, obligations—in that prior fiscal year, relative to available resources. To the extent VA does not obligate all of its available resources in the previous year, it can carry over these resources into the following fiscal year up to the amount authorized by appropriations acts. For fiscal years 2005 through 2011, VA's estimates of its unobligated balances available to be carried over were generally less than the actual amounts available to be carried over. For example, while VA estimated it would have an unobligated balance of $0 to carry over into fiscal year 2011, VA's actual unobligated balance was about $1.4 billion. In contrast, for fiscal year 2012, VA's estimated and actual unobligated balances were nearly equal—$1.1 billion and $1.16 billion, respectively. A change in VA policy helps explain the changing relationship between VA's estimates and its actual unobligated balances. VA officials told us that prior to fiscal year 2012, VA's policy was for its annual budget estimate to assume that VA would not have unobligated balances to carry over that would help lower the request for new appropriations for that fiscal year. In order to implement this policy, VA assumed that it would obligate all of its available resources during the fiscal year for which they were first made available. In contrast, VA officials told us that VA changed this policy so that the agency's annual budget estimate was based on the assumption that VA would have an unobligated balance to carry over into fiscal year 2012 in order to help lower the amount of new appropriations requested for that year.

In commenting on a draft of this report, VA requested that we replace some of the language from our report that described VA's change in policy when estimating the unobligated balance to be carried over into fiscal year 2012. VA requested that we substitute language explaining that three unique events contributed to the unobligated carry over into fiscal year 2012: a federal pay freeze, savings from operational improvements, and updated estimates that reduced program funding requirements. We did not remove the language VA requested concerning the information on the fiscal year 2012 change in policy that VA officials consistently provided us throughout the course of our work. We did, however, revise our draft report to include VA's new information although we also note that VA did not provide documentation to support its assertion.

Background

VA's annual budget estimate for a fiscal year includes estimates of the collections and reimbursements VA expects to receive in the fiscal year and an estimate of the unobligated balance VA will carry over into the fiscal year from prior years. VA has statutory authority to collect amounts from patients and private insurance companies to be obligated for health care services.[11] VA collects first-party payments from patients, such as copayments for outpatient medications, and third-party payments from veterans' private insurance companies for health care services provided to treat health care conditions that are not service connected.[12] For fiscal years 2005 through 2011, about 95 percent of VA's collections were from first-party payments and third-party payments. VA collects the remaining funds for items such as parking fees. VA has the authority to deposit these collections into the Medical Care Collections Fund and may use them to provide health care services and to pay expenses associated with the collections program.[13,14]

To manage veterans' access to services in relation to available resources, VA assigns veterans to one of eight priority groups for purposes of enrollment in VA health care[15] and VA is more likely to collect first- and third-party payments for veterans in lower priority categories. The order of priority for the categories is generally based on service-connected disability, income, or other special status such as having been a prisoner of war. Priority 1—the highest-priority category—consists of veterans with a service-connected disability rated at 50 percent or more, based on the severity of the disability. Priority 8—the lowest-priority category—consists of veterans with no compensable service-connected disability, who have incomes exceeding certain thresholds, and are not catastrophically disabled. VA is more likely to collect first-party or third-party payments for veterans in the lower priority categories who seek medical care at a VA facility, generally because their treatment is more likely to be for nonservice-connected health care conditions and they are more likely to have private insurance. For example, veterans in Priority Group 1 are not required to make copayments for medical care or prescriptions, whereas veterans in Priority Group 8 are generally required to make copayments for both.

[11]See 38 U.S.C. § 1729.

[12]VA is not authorized to collect for service-connected treatments from third-party insurers. VA can bill enrollees' private health insurance policies, including Medicare Supplement Insurance, but cannot bill Medicare.

[13]Amounts in the Medical Care Collections Fund are available without fiscal year limitation for VA health care and expenses of certain activities related to collections subject to provisions of appropriations acts. Appropriations acts have authorized VA to transfer collections to its appropriation for Medical Services, but provide for these amounts to be available without fiscal year limitation. See, e.g., Pub. L. No. 112-74, § 215, 124 Stat. 786, 1156 (2011); Pub. L. No. 111-117, § 215, 123 Stat. 3034, 3305 (2009).

[14]Also, in 2003, 2004, and 2008, we found weaknesses in VA's collections processes that may impair its ability to maximize the amount of dollars VA receives from these sources. See GAO, *VA Health Care: Third-Party Collections Rising as VA Continues to Address Problems in Its Collections Operations*, GAO-03-145 (Washington, D.C.: Jan. 31, 2003); *VA Medical Centers: Further Operational Improvements Could Enhance Third-Party Collections*, GAO-04-739 (Washington, D.C.: July 19, 2004); and *VA Health Care: Ineffective Controls over Medical Center Billings and Collections Limit Revenue from Third-Party Insurance Companies*, GAO-08-675 (Washington, D.C.: June 10, 2008).

[15]See 38 U.S.C. § 1705(a); 38 C.F.R. § 17.36.

VA's ability to collect first-party or third-party payments for veterans also varies depending on the veteran's age, employment status, type of insurance, and geographic location.

- *Veteran age*: VA is less likely to be able to collect third-party payments for services provided to veterans who are 65 years or older than it is for younger veterans because VA is not authorized to collect third-party payments from Medicare.[16]

- *Veteran employment status*: VA is also less likely to collect first-party or third-party payments for veterans who are unemployed. Veterans who are unemployed are less likely to be covered by employer-provided insurance plans, and VA may require fewer payments for veterans who experience financial difficulties.[17]

- *Veteran private insurance type*: Finally, VA cannot collect payments from certain private insurers. For example, VA cannot collect payments from health maintenance organizations (HMO) when VA is not a participating provider unless the HMO covers services provided by nonparticipating providers.[18] Therefore, VA is less likely to collect third-party payments in regions of the country where a large percentage of veterans are enrolled in HMOs.

VA also receives reimbursements for services it provides to other government entities, such as DOD, or to private or nonprofit entities. For example, VA receives reimbursements for services provided under service agreements with DOD and reimbursements from other entities by selling laundry services.[19] These amounts inform funding decisions reflected in the President's budget request for VA. In fiscal year 2011, VA spent about $51.4 billion on health care for veterans and received about $3.2 billion, or about 6 percent, in collections and reimbursements.

In addition to new appropriations that VA may receive from Congress as a result of the annual appropriations process, as well as collections and reimbursements, funding may also be available from unobligated balances from multiyear appropriations, which remain available for a fixed period of time in excess of 1 fiscal year. For example, VA's fiscal year 2011 appropriations provided for some amounts to be available for 2 fiscal years. These amounts may be carried over from fiscal year 2011 to fiscal year 2012 if they are not obligated by the end of fiscal year 2011;

[16]Veterans who are age 65 or older may have private health insurance policies, such as Medicare Supplement Insurance. VA can collect payments from those private health insurers.

[17]Veterans who experience temporary financial difficulties may apply to their local VA facility for hardship waivers to eliminate copayments for a defined period or to have VA waive a specified amount of outstanding debt incurred for prior medical services. See 38 U.S.C. § 1710(a)(2)(G); 38 C.F.R. §§ 17.47, 17.105.

[18]VA has interpreted the third-party payments statute to mean that HMOs must pay only to the extent that they generally cover services provided by health care facilities not affiliated with the HMO and that HMOs that have a point-of-service option are required to pay VA the same amount that would be paid under the plan to nongovernment providers. See 38 U.S.C. § 1729; 75 *Fed. Reg*. 62,348, 62,351 (Oct. 8, 2010).

[19]GAO-06-958.

the remainder expires at the end of 1 fiscal year. VA and the Office of Management and Budget consider anticipated unobligated balances, as well as expected collections and reimbursements, when formulating the President's budget request.

VA Estimates Collections and Reimbursements Using a Projection Model and Other Methods, and These Estimates Have Generally Differed from Actual Amounts

VA uses a projection model each year to estimate most of the amount of collections—first-party payments and third-party payments—the agency expects to receive, and depending on the year, these estimates have varied from the actual amounts to varying degrees. VA estimates the amount of reimbursements it expects to receive by adjusting its most recent full year data on actual reimbursements to reflect anticipated increases due to inflation and other factors. While VA's reimbursement estimates for fiscal years 2005 through 2007 were relatively consistent with actual amounts, in subsequent years, VA's estimates have been less than actual amounts.

Collections Projection Model Estimates

VA uses a projection model to estimate most of the collections—first-party payments and third-party payments—the agency is likely to receive each fiscal year. To estimate its collections for fiscal years 2005 through 2012, VA used a projection model based on data reflecting VA's past workload and the amounts that VA has billed and collected for nonservice-connected health care services in the past. During this period, VA made a number of changes intended to improve the projection model it used to estimate collections. For example,

- In fiscal year 2007, VA began using data on patient demographics in the model, including patient age, gender, and income level. VA officials explained that the agency included these data to more accurately account for differences in VA's ability to collect first-party payments from patients and third-party payments from their health insurance companies. VA officials said that higher income patients are more likely to have health insurance that VA can bill and collect for services provided when compared with lower income patients.

- Beginning in fiscal year 2010, VA incorporated additional data into its projection model to account for regional differences in the rate patients use medical services at each VA medical center and for differences in the average cost of health care across VA medical centers. For VA medical centers where the average cost per service is higher—due to regional differences in cost of health care or to differences in the frequency with which more expensive types of medical services are provided—VA can potentially collect more in third-party payments.

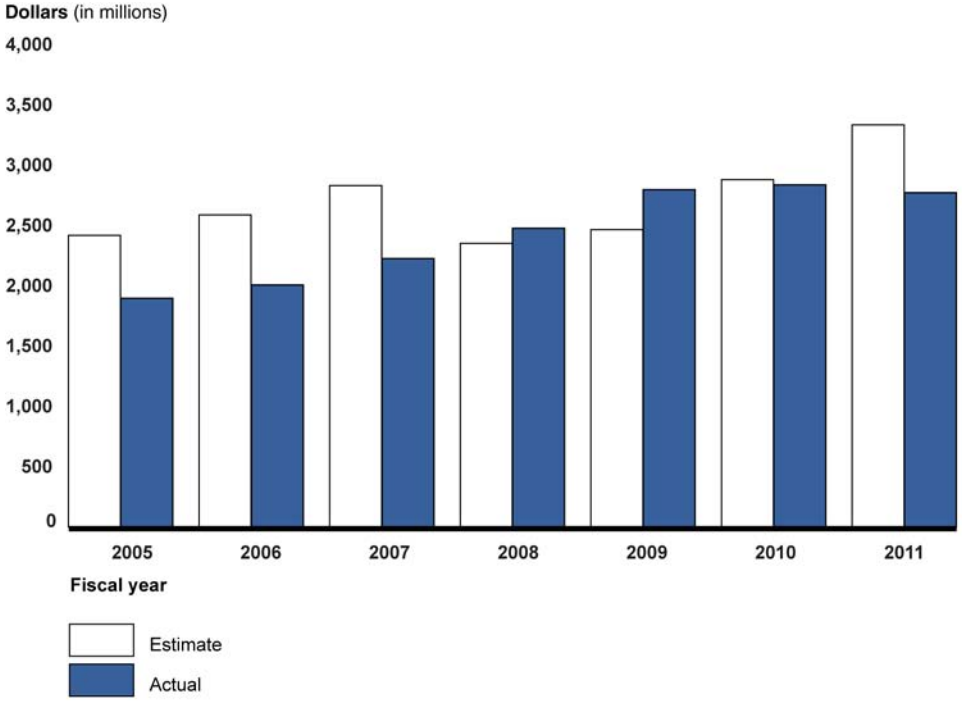
To estimate its collections for fiscal year 2013 and subsequent years, VA developed and began using a second projection model, known as the Integrated Collections Forecasting Model (ICFM). VA officials told us that the agency developed the new model to provide a more transparent and easily understood approach to forecasting

collections. The ICFM relies on many of the same factors from VA's previous projection model, such as patient age, gender, and income level. However, instead of using historical workload data, the new model uses workload projections developed by VA's Enrollee Health Care Projection Model (EHCPM), which VA uses to develop its annual health care budget estimate.[20] The ICFM also incorporates information such as veterans' Priority Group status and insurance coverage; economic and medical care market conditions in the region surrounding each VA medical center; and each medical center's historical performance in billing and collecting for the medical services provided by the medical centers. VA officials told us that this medical center-specific information should improve the new model's ability to forecast collections.

When comparing VA's collection estimates to the amounts it has actually collected, we found that VA has both overestimated and underestimated these collections, depending on the fiscal year. For example, for fiscal years 2005 through 2007, VA overestimated the amount of collections it would receive by an average of about $570 million, or 22 percent. VA overestimated the amount of collections it would receive for fiscal years 2005, 2006, and 2007 by about $522 million, $581 million, and $606 million respectively. For fiscal years 2006 and 2007, VA estimated that it would increase its collections by over $400 million per year based on legislative proposals that, if enacted, would have increased certain pharmacy copayments and implemented an enrollment fee for some veterans. Congress, however, did not pass these proposals. By contrast, for fiscal years 2008 through 2010, VA underestimated the amount of its collections by an average of about 6 percent. (See fig. 1.) For the most recent fiscal year for which data on actual collection amounts are available, fiscal year 2011, VA overestimated the amount of collections by about $582 million or 17 percent.

[20]VA used the EHCPM to estimate the resources needed to meet expected demand for 61 health care services that accounted for 83 percent of VA's health care budget estimate for fiscal year 2011 and similarly for fiscal year 2012.

Figure 1: Comparison of VA's Estimated and Actual Collections, Fiscal Years 2005-2011



Source: GAO analysis of VA data.

For fiscal year 2011, VA officials attributed the difference between VA's estimated and actual collections to the following four factors:

- *Fewer new Priority 8 veterans enrolled in VA health care through fiscal year 2011 than VA projected using its EHCPM*. As a result, VA received less in third-party collections than the collections model projected. On June 15, 2009, VA began enrolling new Priority 8 veterans[21] after a 6-year suspension.[22] VA's fiscal year 2011 estimates for collections assumed that about 270,000 new Priority 8 veterans would enroll for care by the end of fiscal year 2011 and, as a result of this change, VA would receive an additional $144 million in third-party collections attributable to care provided to these new enrollees. However, fewer than 30,000

[21]A committee report accompanying the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 stated that funding had been provided within VA's Medical Services; Medical Support and Compliance; Medical Facilities; Construction, Minor Projects; and Information Technology Systems accounts to support increased enrollment for Priority 8 veterans whose income exceeded the current thresholds by 10 percent or less, including $375 million within VA's Medical Services account. Accordingly, VA raised the income thresholds, effective June 15, 2009. See Pub. L. No. 110-329, 122 Stat. 3574, 3704-08 (2008); House Comm. on Appropriations, 110th Cong., Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, div. E, 750 (Comm. Print 2008); 38 C.F.R. § 17.36; 74 *Fed. Reg.* 22,832 (May 15, 2009).

[22]The Secretary of Veterans Affairs announced on January 17, 2003, that VA would suspend enrolling Priority 8 veterans. Under a statutory provision added by the Veterans Health Care Eligibility Reform Act of 1996 the Secretary is required to make an annual decision concerning enrollment in VA health care in order to ensure that medical services are timely and acceptable in quality. The enrollment system is necessary because VA health care can be provided only to the extent that appropriations are available. In its announcement, VA stated that, in recent months, it had been unable to provide all enrolled veterans with timely access to medical services because of the increase in the number of veterans seeking care from VA. See 38 U.S.C. § 1705; 68 *Fed. Reg.* 2670 (Jan. 17, 2003).

new Priority 8 veterans actually enrolled through fiscal year 2011 and the associated increase in collections was only about $18.5 million. As a result, VA received approximately $122 million less in third-party collections than the collections model estimated. VA officials told us that EHCPM Priority 8 enrollment projections used for the fiscal year 2012 collections estimate and beyond will better reflect the historical experience with the actual number of new Priority 8 enrollees. According to VA officials, VA's EHCPM model developed the fiscal year 2011 Priority 8 enrollment projections using less than 6 months of actual data—from June 15, 2009, when VA began enrolling new Priority 8 veterans to January 2010 when VA's collections estimates for fiscal year 2011 were finalized. For fiscal years 2012 and beyond, the EHCPM's enrollment projections will be developed using 18 months or more of actual Priority 8 enrollment data.

- *The unemployment rate for veterans was likely higher than VA's projections—which were based on economic data for the general population—and thus fewer veterans had employer-provided health insurance than projected*. VA assumed that the average unemployment rate for enrolled veterans for fiscal year 2011 would be about 8.9 percent nationally and consistent with the unemployment projected for the general population that year.[23] However, VA officials said that the actual average national unemployment rate for the general population for fiscal year 2011 was somewhat higher than projected at 9.2 percent, according to Bureau of Labor Statistics data.[24] Further, although data on veteran unemployment are not available for fiscal year 2011, VA officials believe that the actual unemployment rate for enrolled veterans that year was likely higher than the rate for the general population. VA officials said that they base this view, in part, on data from a calendar year 2009 survey, which indicated that the unemployment rate for the enrolled veteran population was approximately 13 percent.[25] VA officials said that they believe a higher actual unemployment rate than projected among enrolled veterans resulted in fewer veterans having employer–provided third-party insurance than the model projected. As a result, VA officials believe that this contributed to VA receiving approximately $114 million less in third-party collections than the model estimated for fiscal year 2011. VA officials said that they have made changes in the collections model projections to better account for the higher unemployment rate for enrolled veterans, and that these changes were implemented in developing the

[23]According to VA officials, VA used unemployment estimates for metropolitan areas that correspond to locations of VA medical facilities—developed by Moody's Analytics (https://www.economy.com/default.asp)—for the fiscal year 2011 collections estimate. The 8.9 percent national unemployment estimate for fiscal year 2011 is an aggregate of these estimates.

[24]Bureau of Labor Statistics, Current Population Survey. Report E-1: Employment status of the civilian noninstitutional population by sex and age, seasonally adjusted. Accessed January 12, 2012, at http://www.bls.gov/web/empsit/cpsee_e01.pdf.

[25]VA officials said that they used data from the U.S. Census Bureau's calendar year 2009 American Community Survey to develop the unemployment rate for the enrolled veteran population. See http://www.census.gov/acs/www/.

collections estimates which will appear in the President's budget request for fiscal year 2013, including the advance appropriations request for 2014.[26]

- *VA received fewer collections when VA billed veterans' third-party insurance plans than VA's collections model projected—using historical billing data*. According to VA officials, this was mainly due to shifts in third-party insurance plan benefits. In recent years, according to VA officials, insurance plans have shifted costs by increasing the out-of-pocket expenses of patients and by decreasing the amount paid to medical providers. VA officials told us that the collections model assumed that VA would be reimbursed for about 41 percent of the total costs VA billed to third-party insurance plans, known as the third-party collections to billing ratio. Instead, during fiscal year 2011, VA's actual third-party collections to billing ratio was approximately 36 percent. This difference resulted in VA receiving about $250 million less in collections than VA's model estimated.

- *VA amended its rules regarding herbicide exposure-related conditions and implemented changes to veterans' eligibility for health care*. VA amended its regulations to classify certain conditions as presumptively service-connected for veterans exposed to certain herbicides, which reduced VA's ability to collect payments because VA cannot collect first- or third-party payments for treatment of service-connected conditions.[27] VA's collections were also estimated to decrease as a result of VA's implementation of changes to veterans' eligibility for VA health care made by the Caregivers and Veterans Omnibus Health Services Act of 2010.[28] According to VA officials, VA received $67 million less in collections than the model estimated because these changes occurred after the collections estimates were made.

Estimates Less than Actual Reimbursements

For fiscal years 2005 through 2013, VA estimated the amount of reimbursements—fees for services provided under service agreements with DOD—it would likely receive in each of the fiscal years using one of two general methods, depending on the year. For fiscal years 2005 through 2011, VA officials told us that the agency estimated the amount of reimbursements it would likely receive each fiscal year by applying a growth rate to its most recent full year data on actual reimbursement amounts received in order to reflect increases due to anticipated rates of inflation

[26]VA officials stated that the agency did not use this new methodology when developing the fiscal year 2013 advance appropriations request which appeared in the President's budget request for fiscal year 2012.

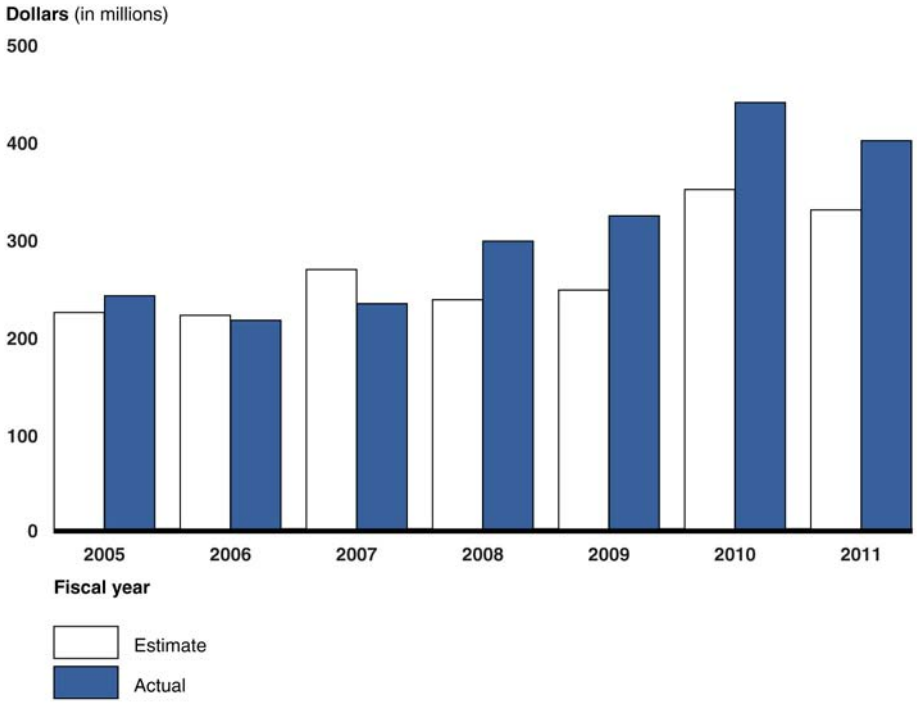
[27]On August 31, 2010, VA amended its regulations to add ischemic heart disease, hairy cell leukemia and other chronic B-cell leukemias, and Parkinson's disease to the list of diseases presumed to be related to exposure to certain herbicides. As a result, VA stopped collecting payments from eligible veterans who were exposed to certain herbicides and subsequently diagnosed with these conditions. See 75 *Fed. Reg.* 53,202 (Aug. 31, 2010) (amending 38 C.F.R. § 3.309).

[28]The law (1) exempted catastrophically disabled veterans from copayments for hospital care and medical services (estimated $6.6 million reduction in collections); (2) classified veterans who received the Medal of Honor into Priority Group 3 (estimated $4,000 reduction in collections); and (3) removed the expiration date for the authority to provide treatment to veterans who were exposed to herbicides in Vietnam and redefined the time period that constitutes the Persian Gulf War (estimated $9.9 million reduction in collections). See Pub. L. No. 111-163, §§ 511-513, 124 Stat. 1130, 1164-65 (2010).

and other factors.[29] To develop its estimates for reimbursements for fiscal years 2012 and 2013, VA relied on individual reimbursement estimates provided by each of VA's 21 Veterans Integrated Service Networks.

While VA's estimates of reimbursements were relatively consistent with actual amounts in fiscal years 2005 through 2007, in subsequent years, VA's estimates have been less than the actual amounts. VA underestimated reimbursements by about $17 million, or 8 percent, in fiscal year 2005, and overestimated reimbursements by $4 million in fiscal year 2006 and $35 million in fiscal year 2007, or by 2 percent and 13 percent respectively. However, in fiscal years 2008 through 2011, VA underestimated reimbursements by an average of $74 million, or 26 percent annually. (See fig. 2.) VA officials attributed the differences between its estimated and actual reimbursements to factors such as an increase in the number of VA's sharing agreements with the Department of Defense, which has led to actual reimbursements exceeding estimates.

Figure 2: Comparison of VA's Estimated and Actual Reimbursements, Fiscal Years 2005-2011



Source: GAO analysis of VA data.

[29]To develop its estimates for reimbursements for fiscal year 2011, VA used the aggregate growth rate the agency uses to develop its overall budget estimates. Agency officials referred to this as the EHCPM aggregate growth rate, and it is the growth rate incorporated into the EHCPM and used to inform the President's annual budget request for VA.

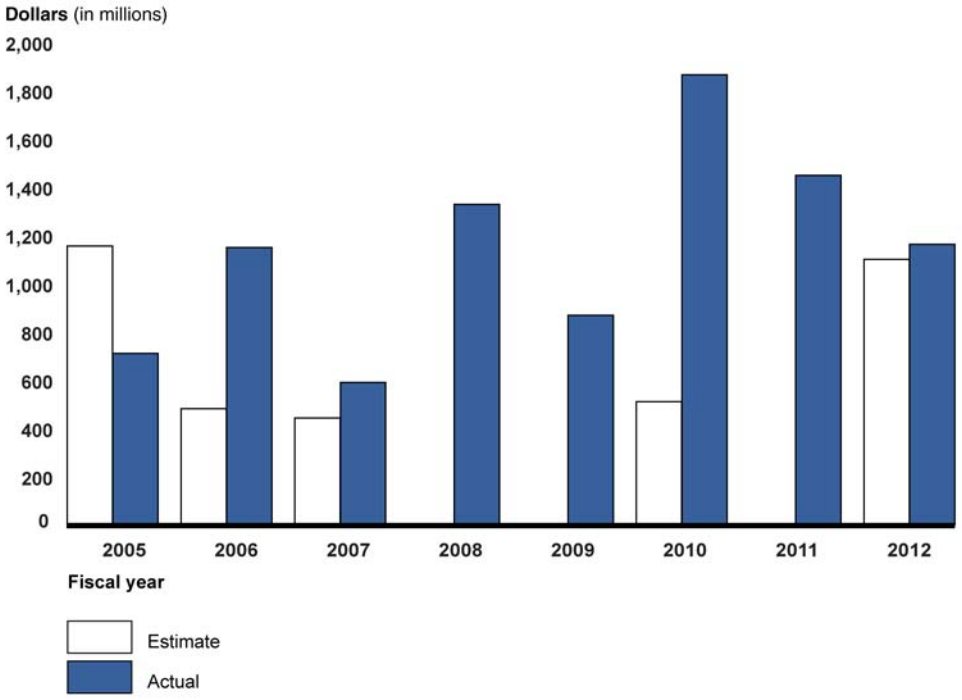
VA Estimates Its Unobligated Balances Based on Anticipated Spending, and These Estimates Have Been Generally Less than Actual Amounts for Various Reasons

VA estimates unobligated balances of appropriations available for more than 1 fiscal year—that is, amounts that may be carried over from one fiscal year to the next—based on an estimate of its anticipated spending—that is, obligations—in the previous fiscal year, relative to those available resources. VA estimates about 83 percent of its obligations for that previous fiscal year using the EHCPM, which incorporates actual data from the most recent fiscal year. This estimate is developed about 10 months before the President's request is made and about 18 months before the fiscal year begins for which the appropriations are requested[30] and for which VA is estimating the availability of an unobligated balance. For example, VA developed its estimates of the unobligated balances available at the beginning of fiscal year 2012 by developing estimates for its likely obligations for fiscal year 2011, which were based on EHCPM output in fiscal year 2009. VA also uses other data for the remaining portion of obligations (17 percent), which includes long-term care, special initiatives, and other services.

Since fiscal year 2005, VA's estimates of its unobligated balances have been less than the actual amounts available to carry over into the next fiscal year, with the exception of amounts carried over from fiscal year 2011 into fiscal year 2012, the most recent year for which data on actual amounts are available. For example, VA initially estimated it would have unobligated balances of $510 million to carry over into fiscal year 2010 and nothing into 2011. However, the actual amounts available to be carried over were $1.9 billion and $1.4 billion, respectively, for those years. In contrast, VA's estimated and actual unobligated balances carried over into fiscal year 2012 were about the same—$1.1 billion and $1.16 billion, respectively. Figure 3 shows the comparison of estimated and actual unobligated balances that were available to be carried over into fiscal years 2005 through 2012.

[30]The President's budget request for VA for fiscal year 2011 also included an advance appropriations request for fiscal year 2012. VA develops estimates for a request for advance appropriations about 30 months prior to the fiscal year for which the request is made. One year later, VA develops estimates again for the same fiscal year. These estimates are made about 18 months prior to the fiscal year and are incorporated into the President's budget request for the fiscal year, including revisions to estimates of unobligated balances to be carried over.

Figure 3: Comparison of Estimated and Actual Unobligated Balances, Fiscal Years 2005-2012



Source: GAO analysis of VA data.

Note: The bars in the figure represent the estimated and actual unobligated balances carried over into each fiscal year. For example, for fiscal year 2005, the bars represent the estimated and actual unobligated balances on October 1, 2004.

VA policy helps explain the relationship between VA's estimates and its actual unobligated balances. VA officials told us that for fiscal year 2012, VA made a policy decision in advance to assume it would carry over an unobligated balance of $1.1 billion from fiscal year 2011 into 2012 to help lower the amount of new appropriations requested for this year. As a result, VA's estimated and actual unobligated balances were about the same in fiscal year 2012. According to VA officials, this assumption was made for fiscal year 2012 in the context of a more challenging fiscal environment. In March 2012, VA officials informed us that the actual $1.16 billion unobligated balance VA carried over into fiscal year 2012 resulted from what the agency identified as three unique events: a federal pay freeze ($237 million), savings from operational improvements ($746 million), and updated estimates of program requirements ($117 million). However, VA officials did not provide documentation to support VA's assertion that these events accounted for the agency's unobligated balance that year. In regard to VA's estimate of $746 million in savings from operational improvements, in particular, we have previously reported our concerns with some of the estimates of savings from operational improvements provided in the request for appropriations for fiscal year 2012 and advance appropriations for fiscal year 2013.[31] It is unclear whether VA used the same methods to estimate this $746 million because VA did not provide documentation.

[31]See GAO, *VA Health Care: Methodology for Estimating and Process for Tracking Savings Need Improvement*, GAO-12-305 (Washington, D.C.: Feb. 27, 2012).

In contrast, VA officials also told us that for fiscal years 2008 through 2011, VA's policy was for its annual budget estimate to assume that VA would not have unobligated balances available that would help reduce the new appropriations requested.[32] In order to implement this policy, VA assumed that it would obligate all of its available resources during this period. However, VA did not obligate all of its available resources as projected, and this largely accounts for the differences between VA's estimates and actual unobligated balances. For example, according to VA officials, in fiscal years 2008-2010, VA was not able to obligate all of its resources due to the following factors:

- *Longer-than-expected award process for planned service contracts*. According to VA officials, when VA is in the process of finalizing its award of a contract for medical services, the agency reserves the full amount of funds associated with that contract; however, if VA receives concurrent bids from competing entities, the award process takes longer. Specifically, if VA is in the process of evaluating bids near the end of the fiscal year, VA may not be able to complete its evaluation and award the contract before the end of the fiscal year. As a result, VA does not incur an obligation and carries over the associated funds into the next fiscal year and awards the contract in the new fiscal year.

- *Delays in planned hiring*. According to VA officials, given that the agency has an average 16 percent turnover rate each year, VA often experiences delays associated with filling these vacancies that range from 90 to 180 days. As a result, VA carries over amounts planned for these positions from one fiscal year to the next when the vacancies are filled.

- *Multiyear appropriations designated for specific initiatives*. For any given fiscal year, VA typically receives multiyear appropriations that allow VA to carry over unobligated amounts beyond that fiscal year. Additionally, in some instances, Congress designates amounts for specific projects or initiatives. If VA does not implement the specific project or initiative during the fiscal year, it can use its multiyear appropriations to fund the project or initiative in the next fiscal year. For example, for fiscal year 2009, Congress appropriated $250 million for the establishment and implementation of a new rural health outreach and delivery initiative, but VA was not able to establish and implement the rural health initiative in fiscal year 2009. Because Congress authorized VA to carry over up to $1.6 billion into fiscal year 2010, VA was able to carry over the designated amount—that is, $250 million—into fiscal year 2010 for the establishment of the rural health initiative.

In addition, differences between VA's estimated and actual amounts of unobligated balances for certain fiscal years can be attributed to unanticipated resources—that is, supplemental appropriations—that VA has received. For example, in May 2007, Congress appropriated over $1.3 billion in supplemental funds to VA, as part of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability

[32]VA officials told us that, for fiscal year 2010, VA included an estimate of the unobligated balance to reflect funds made available through the American Recovery and Reinvestment Act of 2009, which were available for 2 fiscal years—2009 and 2010. See Pub. L. No. 111-5, 123 Stat. 115, 199 (2009).

Appropriations Act, 2007.[33] VA carried over about $830 million of these funds, which were to remain available until expended, into fiscal year 2008. This amount accounted for over 60 percent of the difference between VA's estimated and actual unobligated balances carried over into fiscal year 2008. In addition, in February 2009, Congress appropriated $1 billion in supplemental funds for VA health care, as part of the American Recovery and Reinvestment Act of 2009.[34] VA carried over about $740 million of these funds into fiscal year 2010. This amount accounted for 40 percent of VA's actual unobligated balance carried over into fiscal year 2010. These supplemental appropriations were provided by Congress after the President's budget request was submitted in February; therefore, VA could not have accounted for these additional resources when developing its estimates of the unobligated balances.

Agency Comments and Our Evaluation

We provided a draft of this report to VA for comment. In its written comments, reproduced in enclosure I, VA requested that we replace some of the wording we used to describe and compare VA's estimate and the actual amount of the unobligated balance carried over into fiscal year 2012 with alternative wording VA suggested. VA also provided technical comments, which we incorporated as appropriate.

In its written comments, VA requested that we remove language from our report that stated that according to VA officials, VA changed its policy when estimating a $1.1 billion unobligated balance to be carried over into fiscal year 2012, in order to help lower the amount of new appropriations VA requested for that year. VA also requested that we remove language explaining that this change in policy helped account for the consistency between VA's estimate and the actual amount of the unobligated balance carried over into fiscal year 2012. In place of the language VA suggested removing, VA requested that we insert language explaining that three unique events contributed to the unobligated balance of approximately $1.1 billion carried over into fiscal year 2012. VA said that these events were a federal pay freeze, savings from operational improvements, and updated estimates that reduced program funding requirements.

We did not delete the language VA requested because VA officials consistently told us throughout the course of our work that VA changed its policy for estimating the amount of its unobligated balance to be carried over into fiscal year 2012 and that this change in policy accounted for VA's budget justification showing an estimated amount of $1.1 billion to be carried over into that year. VA officials also told us that in prior years VA's policy was to estimate smaller unobligated balances to be carried over or even a balance of zero for fiscal year 2011, for example, because VA's intent was to obligate all of the agency's available resources. The new policy for fiscal year 2012 resulted in a substantially larger estimate than in recent years and helped

[33]See Pub. L. No. 110-28, 121 Stat. 112, 167-68 (2007). The funds were to remain available until expended.

[34]See Pub. L. No. 111-5, 123 Stat. 115, 199 (2009). These funds, appropriated to VA's Medical Facilities account, remained available until September 30, 2010.

account for the consistency that year between VA's estimate and the actual amount carried over, VA officials told us during our review.

Although we did not remove the language as VA suggested, we revised our report to include VA's assertion that the amount of VA's unobligated balance carried over into fiscal year 2012 resulted from the three unique events VA identified in its written comments. However, we also revised our report to note that VA did not provide documentation to support this statement. During the course of our work, we asked if VA officials could provide us with a breakdown of the unobligated carryover amount by program activity and were told that they could not. Finally, regarding VA's asserted $746 million in savings from operational improvements, we have previously reported our concerns with some of the estimates of savings from operational improvements provided in the request for appropriations for fiscal year 2012 and advance appropriations for fiscal year 2013.[35]

– – – – –

We are sending copies of this report to appropriate congressional committees and the Secretary of Veterans Affairs. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

Should you or your staff have questions concerning this report, please contact me at (206) 287-4860 or WilliamsonR@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in enclosure II.

Randall B. Williamson
Director, Health Care

Enclosures – 2

[35]GAO-12-305.

Enclosure I

Comments from the Department of Veterans Affairs

Note: Page numbers in the draft report may differ from those in this report.

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

March 12, 2012

Mr. Randall B. Williamson
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***"VA Health Care: Estimates of Available Budget Resources Compared with Actual Amounts"*** (GAO-12-383R), and is providing general and technical comments in the enclosure.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

John R. Gingrich
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report:
VA HEALTH CARE: Estimates of Available Budget Resources Compared with Actual Amounts
(GAO-12-383R)

VA comment:

VA recommends replacing the following text on pages 6 and 18 of the draft report:

Page 6:

> *"In contrast, VA officials told us the agencie's annual budget estimate was based on the assumption that VA would have an unobligated balance to carry over into fiscal year 2012 in order to help lower the amount of new appropriations requested for that year."*

Page 18:

> *"VA policy helps explain the relationship between VA's estimates and its actual unobligated balances. VA officials told us that for fiscal year 2012, VA made a policy decision in advance to assume it would carry over an unobligated balance of $1.1 billion from fiscal year 2011 into 2012 to help lower the amount of new appropriations requested for this year.... [T]his assumption was made for fiscal year 2012 in the context of a more challenging fiscal environment."*

The unobligated balance that the Veterans Health Administration (VHA) carried into fiscal year 2012 was not the result of a deliberate effort by VA to reduce the budget request for 2012. Instead, certain unique events gave rise to the unobligated balance at the end of 2011, which VA carried over into 2012. They were: (1) the two-year pay freeze for Federal workers, which freed up $237 million that were not required for personnel compensation; (2) a series of operational improvements that VA implemented in 2011, which produced savings estimated at $746 million; and (3) updated budget estimates, which reduced program funding requirements by $117 million in 2011. As VA has noted many times, any reduction to carryover funds would require a corresponding increase in new appropriations to cover the loss of these funds.

Therefore, we request that GAO replace the above two passages of the draft report to reflect the following language:

> *"Unique events gave rise to the unobligated balance at the end of 2011, which VA carried over into 2012. They were: (1) the two-year pay freeze for Federal workers, which freed up $237 million that were not required for personnel compensation; (2) a series of operational improvements that VA implemented in 2011, which produced savings estimated at $746 million; and (3) updated budget estimates, which reduced program funding requirements by $117 million in 2011."*

1

Enclosure II

GAO Contact and Staff Acknowledgments

GAO Contact

Randall B. Williamson, (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

In addition to the contact named above, James C. Musselwhite, Assistant Director; Melissa Wolf, Assistant Director; Matthew Byer; Krister Friday; Lisa Motley; and Said Sariolghalam made key contributions to this report.

(290960)