Cato Handbook *for* Policymakers

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14. Veterans Benefits

Congress should

- direct federal actuaries to develop annual present-value estimates of the long-term cost of all accrued veterans-benefits obligations;
- increase military pay such that all active-duty military personnel can purchase, at actuarially fair rates, a standard package of private life, disability, and health insurance benefits comparable to benefits provided by the Department of Veterans Affairs;
- privatize Veterans Health Administration facilities and physical capital, such as by transferring ownership to veterans; and
- issue risk-adjusted payments, "premium support," or vouchers to VHA-eligible veterans who are not eligible for the new system of veterans benefits.

The Department of Veterans Affairs (VA) is never more than a few months away from scandal for the poor service it provides veterans. Yet the reality of how the VA disserves veterans is far worse than any headlines suggest.

Overview

The VA spends $178 billion per year to provide various benefits to veterans, survivors, and dependents who meet various criteria. Benefits include life, disability, and health insurance. Veterans benefits are a form of compensation the U.S. government provides to employees of the U.S. Armed Forces.

The VA provides health care directly to beneficiaries through the Veterans Health Administration (VHA). The VHA is an integrated health care

delivery system: the U.S. government owns (or increasingly, leases) the facilities and employs the clinicians and other employees. At the same time that the government intervenes in countless ways to suppress private integrated health systems (see Chapters 35, 36, and 38), the federal government itself operates the nation's largest integrated delivery system.

Congress determines overall funding for veterans benefits and the allocation of VHA resources. In 2016, the VHA will spend a projected $68 billion and employ the equivalent of more than 311,000 full-time employees. In 2014, it had 9.1 million veteran-enrollees, out of a total population of 21.6 million veterans, and treated 6.6 million patients, 89 percent (5.9 million) of whom were veterans. The remaining 11 percent (708,921) of VHA patients were spouses, dependents, and others (e.g., VHA employees who received vaccinations).

Quality

The VHA appears to outperform private providers on some quality measures. Studies generally find the VHA does better on process measures of quality (such as providing evidence-based care) but no better on outcomes (such as risk-adjusted mortality).

Researchers and journalists too often fail to appreciate that such studies are comparing two types of government-run systems, rather than comparing a government-run system to a market system. The federal government created the VHA, its integrated delivery system, and its "capitated" payment system, whereby providers receive a fixed budget to care for a population of patients. The federal government also protects the VHA from competition. Government does just as much to shape the delivery of care at "private" hospitals through Medicare's payment systems and other interventions that encourage fee-for-service payment and fragmented delivery. It likewise shields those hospitals from competition from other delivery systems. These studies thus fail to consider whether a market system could improve quality in both delivery systems by forcing each to compete on the dimensions of care where they are weak.

Coverage cannot be high quality if it is not secure. Veterans can lose access to VHA coverage at the whim of politicians and bureaucrats. If Congress adopts one Congressional Budget Office proposal, 2.3 million VHA enrollees would lose eligibility (and have to pay more for coverage through Medicare, the Affordable Care Act's exchanges, or elsewhere). If

and when Congress ever gets serious about reducing federal spending, it could terminate eligibility or particular benefits for even more veterans.

An Unresponsive Bureaucracy

The most obvious example of poor quality at the VHA is long waits for care. Wait times for care are longer in some areas and tend to persist because the VHA does not have a price mechanism to move resources from low- to high-value uses. Congress and the VA use a combination of politics and bureaucratic rationing to decide when and where to open and close VHA facilities, or how many clinicians to hire in each region of the country. The result is inevitable and persistent mismatches between demand and supply: shortages in some areas and gluts in others.

In 2014, whistleblowers and watchdogs discovered that 60 percent of VHA facilities were falsifying official records to make wait times appear shorter. Veterans at one facility in Phoenix were waiting 115 days for appointments. Congress responded with $5 billion to hire additional clinicians and expand VHA capacity, and $10 billion to pay for veterans to see private-sector doctors at taxpayers' expense. The additional bureaucracy associated with this option left many veterans waiting even longer than before.

Even after a media firestorm, congressional oversight hearings, and numerous VA officials losing their jobs, the Government Accountability Office (GAO) reported, "we continue to find scheduling errors that affect the reliability of wait-time data used for oversight, which make it difficult to effectively oversee newly enrolled veterans' access to primary care." According to the official data, 526,277 veterans were waiting more than 30 days for an appointment and 35,329 were waiting more than 120 days as of July 2016. And the problem of slow service extends beyond health benefits. In 2013, more than 600,000 veterans were waiting more than 120 days for disability-benefits determinations.

The flip side of shortages is gluts. Political and bureaucratic constraints make it difficult for the VHA to shut down, sell, or repurpose unneeded facilities. The VHA has increasingly turned to leasing properties, a process that makes it easier to open, close, and repurpose VHA facilities. Yet the VHA's secrecy makes it difficult even to know whether this process is more or less efficient. According to the GAO, the "VA does not . . . assess and provide information to decision makers on how it has benefited from this flexibility. Without transparency on these benefits, VA and

congressional decision makers may lack information to understand the need for these leases."

Costs

Idle capital is just one of the costs of the VHA. Supporters claim that for all its faults, the VHA provides care of comparable quality at a lower cost than Medicare or private insurance. The VHA's secrecy makes it difficult to make these comparisons. The Congressional Budget Office has testified to Congress:

> [W]ith few exceptions, VHA does not make either existing administrative data or clinical records (even with personal identifying information removed) available to researchers in other government agencies, universities, or elsewhere. . . . [I]t would be useful to know the average salaries, performance pay, and other elements of compensation that VHA provides for its physicians in various specialties and for its other clinicians; the number of patients its clinicians treat per unit of time (for example, in a typical week) and the length and intensity of those encounters; and the average prices it pays for pharmaceutical products—but VHA does not report that information publicly.

Even so, it would not be particularly surprising if a health care system subject to bureaucratic rationing and tolerant of long waits for care had lower per-unit costs, given the excessive prices government intervention allows to persist in the private sector (see Chapter 35) and Medicare (see Chapter 38).

The Real Veterans Scandal

The greatest harms the VA inflicts on veterans stem not from the services it provides, but from how it helps Congress and the president start wars. Veterans' benefits are some of the most expensive financial costs of war. The Treasury Department reports that the accrued cost of veterans' compensation and burial benefits alone had reached more than $2 trillion by 2015. That figure does not include the accrued liabilities of health care, long-term care, or life insurance benefits.

Congress does not fund veterans' benefits until they come due, often decades after sending troops off to war. Disability payments typically do not peak until 40 or 50 years after the end of a military conflict. Thus, when Congress and the president are deciding whether to commit U.S.

armed forces to battle, the VA system enables them to pretend those costs don't exist.

In an alternate universe, where Congress funded those obligations as it accrued them, Congress would have to raise money every year for future veterans benefits. It would have to raise even more in years when it was sending troops into battle, because future claims would be higher. Having to budget for the cost of additional veterans benefits, and weigh that additional cost against other priorities (e.g., entitlements, education, infrastructure), might make Congress more cautious about committing Americans to battle. When the decision to authorize military force is a close call, it could even prevent unnecessary wars.

Instead, the VA system allows Congress to ignore these costs and therefore eliminates a constraint that could prevent unnecessary wars. The very agency that exists to care for sick and disabled veterans perversely makes it more likely that veterans will end up sick, disabled, or dead.

Reporting the Cost of Accrued Veterans Benefits

Requiring transparency about the cost of future veterans benefits would be an important step toward improving veterans benefits. Congress should immediately direct federal actuaries, at the VA or other agencies, to project and report regularly on the cost of accrued veterans-benefits obligations, just as the Social Security and Medicare trustees report on those programs' accrued obligations. Simply having better information would improve debates over veterans benefits, the U.S. military, and foreign policy.

Prefunding Veterans Benefits

Congress must do more than make the current VA system transparent. Protecting veterans, active-duty personnel, and civilians requires a complete overhaul of veterans benefits. One reform would deliver better, more reliable benefits for veterans and force Congress and the president to make more careful decisions affecting the lives of active-duty personnel: Congress should fund veterans benefits in advance by increasing pay for all active-duty personnel. Each individual service member would receive a pay raise sufficient to allow her to purchase, from private insurers at actuarially fair rates, a statutorily defined package of life, disability, and health care benefits comparable to what the VA offers. Benefits would cover losses related to an enlistment or commission, beginning when she leaves active duty. Military personnel would be free to purchase more or less coverage than

the standard benefits package. Veterans could receive benefits from the insurance carriers and health care providers of their choice, rather than be limited to a single, government-run health system.

Congress should peg pay raises for each job type to the actual premiums (e.g., the second-lowest, median, or average premium) that competing insurers charge to cover personnel in each position. Insurers would be free to set actuarially fair premiums. Premiums—and the corresponding pay raises—would be higher for paratroopers than desk jockeys, so all personnel could afford the same package of benefits. The differences in premiums would allow military personnel to compare the relative risks of different military jobs and careers.

This veteran-centered system would provide veterans with better benefits. Rather than benefits that can disappear at the whim of a government bureaucrat, veterans would have benefits backed up by a legally enforceable contract. If you lose your benefits under the current system, the government works against you. If you lost them under a veteran-centered system, the government would work with you to restore those benefits—if things ever got that far. Private insurers and providers would be more responsive to veterans' needs; if not, veterans could fire them (see Chapter 36). Insurers who developed a VA-level reputation for mistreating veterans would have a difficult time enrolling new active-duty personnel. And if Congress privatized the VHA system by transferring ownership to veterans themselves (see below), then veterans would have the option of using an integrated health system run by veterans, for veterans.

Most important, this new system would make Congress and the president more cautious about using military force. Military action would cause insurers to increase premiums for life, disability, and health benefits to cover the increased risk, which would trigger mandatory pay increases for military personnel that Congress would have to fund. In addition to being a more honest and transparent way of providing veterans benefits, prefunding them in this manner could make Congress and the president more cautious about engaging in military action, because they would have to give up even more to get it. Revealing the costs of war to policymakers would lead to better decisions about when to begin and end wars.

Putting those funds directly in the hands of military personnel so they could purchase private life, disability, and health insurance benefits would be an indispensable component of a prefunded system. Creating yet another government trust fund would merely allow Congress to pretend it has solved problems that it has not.

A prefunded system of veterans benefits could also aid recruiting, because it would give military personnel more information about various jobs and more peace of mind about their veterans benefits. Competition among insurers and providers for cost-conscious active-duty personnel and veterans would help drive inflated private prices downward.

Privatizing VHA Facilities

In addition, to enable even greater competition in the provision of medical care, Congress should privatize VHA facilities. One approach would transfer ownership of the VHA to veterans themselves. Congress could incorporate the VHA and give ownership shares to VHA-eligible veterans on the basis of length of service or similar criteria. Shareholders would then select a management team—perhaps from current VHA personnel, veterans groups, private health systems, and/or insurers or other financial institutions with a record of serving military personnel. Privatization would increase competition in every local market where the VHA has facilities and would be a large wealth transfer to veterans.

The exact manner in which Congress transfers ownership of the VHA system to private hands is less important than that it do so as soon as possible.

Choice for Current VHA Enrollees

To maintain benefits for current veterans after privatization, Congress should provide risk-adjusted payments, "premium support," or vouchers to enable VHA-eligible veterans who cannot obtain benefits under the new system to purchase a comparable level of health care benefits from private providers. This approach could be similar to the Medicare reforms discussed in Chapter 38. With risk adjustment, veterans could afford to purchase health benefits at actuarially fair premiums.

Liberalizing and privatizing veterans benefits will result in better, more affordable, and more secure health care for veterans—and perhaps even discourage military conflicts.

Suggested Readings

Bilmes, Linda J., and Joseph E. Stiglitz. "The True Cost of the War." Testimony before the Committee on Veterans' Affairs, U.S. House of Representatives, September 30, 2010.

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Frist, William, Michael Kussman, Jim Marshall, and Avik Roy. "Fixing Veterans Health Care: A Bipartisan Policy Taskforce." Concerned Veterans for America, January 2016.

Nuti, Sudhakar V., et al. "Association of Admission to Veterans Affairs Hospitals vs. Non–Veterans Affairs Hospitals with Mortality and Readmission Rates among Older Men Hospitalized with Acute Myocardial Infarction, Heart Failure, or Pneumonia." *JAMA* 315, no. 6 (February 9, 2016): 582–92.

Trivedi, Amal N., et al. "Systematic Review: Comparison of the Quality of Medical Care in VA and Non-VA Settings." *Medical Care* 49, no. 1 (January 2011): 76–88.

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