

CBO TESTIMONY

Statement of
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Future Medical Spending by the Department of Veterans Affairs

before the
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
U.S. House of Representatives

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Note

All years referred to in this testimony are fiscal years, and dollar amounts are nominal unless otherwise noted.

Thank you for inviting me to speak to you today regarding future medical spending by the Department of Veterans Affairs (VA). I would like to make the following key points:

- Under current policy and if trends in enrollment and use continue, the cost of meeting the demand for VA's medical services may grow 3.6 percent annually in real terms, for a total of 88 percent real growth from 2007 through 2025, the Congressional Budget Office (CBO) projects.
- That growth is faster than CBO's assumptions in its baseline and VA's own projections but slower than the recent growth of appropriations for this discretionary program.
- Those projections do not incorporate some costs for recent combat veterans.
- The cost of meeting the demand for VA's medical care could grow faster if more eligible veterans choose to enroll.
- Projections are uncertain and depend on both policies regarding access to care and assumptions about cost growth, enrollment, use of VA's services, and other factors.

The Role of the Veterans Health Administration

The Veterans Health Administration (VHA), within VA, oversees a network of 155 hospitals as well as hundreds of outpatient clinics, nursing homes, and rehabilitation facilities, which provide a wide variety of medical services to veterans of the U.S. military.

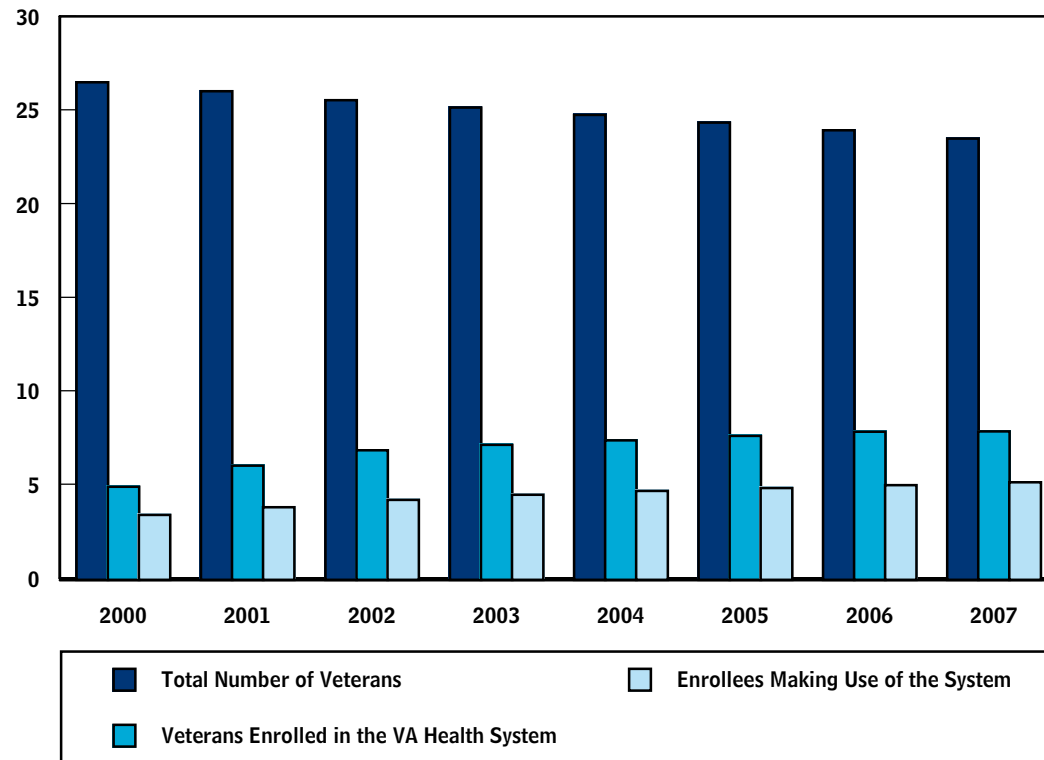
Although VA provides medical care primarily to veterans with service-connected disabilities or low income, the department also serves veterans more broadly. It treats many veterans with chronic illnesses, disabilities unrelated to their service, or conditions that may not be fully covered by private medical insurance. Some veterans have access to other government or private insurance options but nonetheless choose to seek care from VA because it is more convenient to them or because their out-of-pocket costs with VA are lower than their alternatives.

In the mid-1990s, VA began transforming its hospital-based system away from providing inpatient care and toward providing more outpatient services, reflecting changing trends in medical practice nationwide as well as changing demand for VA's care. New VA outpatient clinics have made the department's services more accessible to veterans who do not live near a VA hospital. VA also received statutory authority to reform the rules of eligibility for care, making the full range of its services available to all enrolled veterans, although many in lower-priority groups are required to make copayments for treatment that is not related to service-connected disabilities. In addition, when veterans have certain other types of

Figure 1.

The Population of Veterans, 2000 to 2007

(Millions)



Source: Congressional Budget Office based on data from the Department of Veterans Affairs and *Budget of the United States Government* (Fiscal years 2006 to 2008).

health coverage, their insurance plans may be billed for services that are not related to service-connected disabilities.¹ From 2000 to 2006, the share of veterans seeking medical care from VA rose from 13 percent to 21 percent—perhaps partly reflecting improved geographic access and veterans’ increased awareness of the value of their medical benefit.

Unlike those for the Medicare and Medicaid programs, VHA’s budget is discretionary: Lawmakers appropriate funds for VA medical care on an annual basis. From 2000 to 2006, the Congress increased appropriations by an average of over 8 percent annually. Each year, VA has provided medical care to several hundred thousand additional veterans, as additional older veterans and recent combat veterans have sought care from the department.

1. Revenue from patients and their insurance plans covers only about a quarter of the cost of care for veterans in lower-priority groups and less than that amount for veterans in higher-priority groups.

As directed by the Veterans' Health Care Eligibility Reform Act of 1996, VA created an enrollment system to keep track of veterans who plan to use the department's care. In most cases, a veteran now must enroll in the VA medical system to be eligible for care. (Enrollment is free of charge, although the President's budget request for fiscal year 2008 has proposed enrollment fees for some higher-income veterans who do not have service-connected disabilities.) As part of the enrollment process, applicants must document their status as veterans and are assigned to one of eight priority groups (designated P1 to P8) on the basis of their service-connected disabilities (if any), income, and other factors (see Box 1).

The total number of living veterans in the United States has dropped in recent years, from 26.5 million in 2000 to 23.5 million today (see Figure 1). About 2.6 million of those veterans are eligible for priority access to VA's health care because they have service-connected disabilities rated at least 10 percent disabling. Another 5.7 million veterans may qualify for priority access on the basis of income levels that fall below established thresholds.

The number of veterans enrolled in the VA health system has increased rapidly since the enrollment system was established, from 4.3 million in 1999 to 7.9 million in 2006. However, in any given year, some enrollees do not seek any medical care from VA, either because they do not become ill or because they rely on other sources of care. In 2006, about 5.0 million veterans received services from a VA hospital or clinic, up from 2.9 million in 1995.

VHA's budget has grown along with enrollment and utilization, rising from \$17 billion in 1996 to \$32 billion in 2006. VA is currently operating under a continuing resolution through February 15, 2007. The House has approved and the Senate is considering House Joint Resolution 20, which would provide funding for the full 2007 fiscal year at the level of \$35 billion. The President's budget for fiscal year 2008 requests \$37 billion (see Figure 2).

VHA's current spending reflects only a fraction of the potential costs the agency could incur if all veterans enrolled and sought 100 percent of their medical care from VA. Of the nearly 24 million veterans in the United States, two-thirds, or 16 million, are not currently enrolled. VA estimates that if all veterans were to enroll, 4.4 million additional veterans would fall into priority groups 1 through 6, while another 1.1 million veterans would fall into priority group 7 and 10.5 million into priority group 8 (see Figure 3). Moreover, even among those who are currently enrolled, most receive less than half of their medical care (in dollar terms) from VA. The rest is covered by Medicare, Medicaid, TRICARE (the Department of Defense's health plan for military personnel, retirees, and their families), employment-based insurance, or other insurance or is paid for out of pocket. Thus, resource demands on VHA could grow even higher if, for example, employers required greater cost-sharing by their employees, leading some veterans to seek a greater percentage of their medical care from VA (see Table 1 on page 7).

Box 1.

VA's Health Care Priority Groups

Priority Group 1 (P1)

Veterans with service-connected disabilities (SCDs) rated 50 percent or more disabling.

Priority Group 2 (P2)

Veterans with SCDs rated 30 percent or 40 percent disabling.

Priority Group 3 (P3)

Veterans who are former prisoners of war; were awarded the Purple Heart; were discharged for SCDs; have SCDs rated 10 percent or 20 percent disabling; or were disabled by treatment or vocational rehabilitation.

Priority Group 4 (P4)

Veterans who are receiving aid and attendance benefits or are housebound; and veterans who have been determined by the Department of Veterans Affairs (VA) to be catastrophically disabled.

Priority Group 5 (P5)

Veterans without SCDs or with noncompensable SCDs rated zero percent disabling who are living below VA's means-test thresholds; veterans who are receiving VA pension benefits; and veterans who are eligible for Medicaid benefits.

Priority Group 6 (P6)

Veterans of either World War I or the Mexican Border War; veterans seeking care solely for disorders associated with exposure to chemical, nuclear, or biological agents in the line of duty (including, for example, Agent Orange); and veterans with compensable SCDs rated zero percent disabling.

Priority Group 7 (P7)

Veterans without SCDs or with noncompensable SCDs rated zero percent disabling who have a net worth above VA's means-test thresholds and below a geographic index defined by the Department of Housing and Urban Development (HUD).

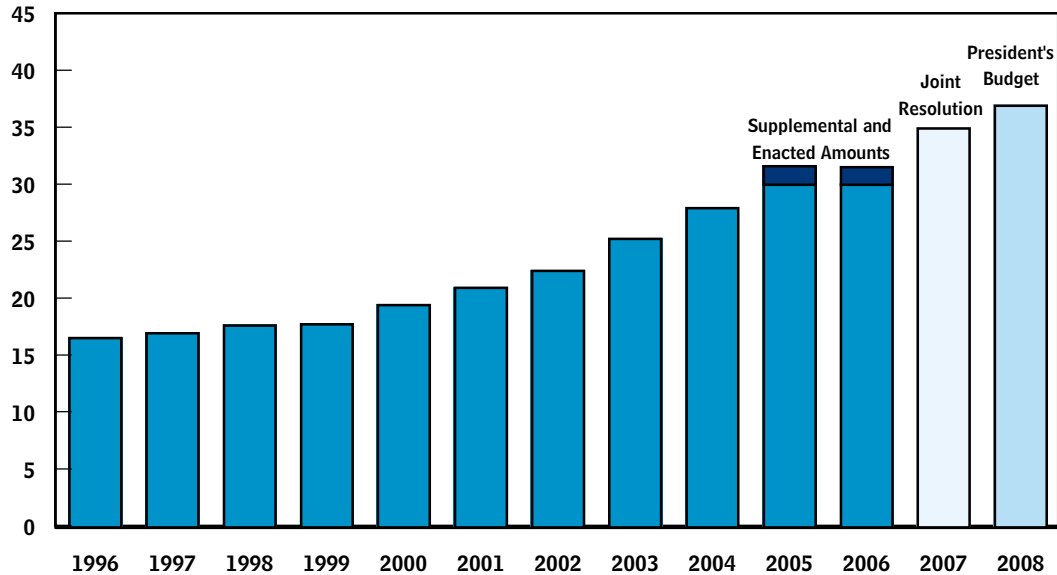
Priority Group 8 (P8)

Veterans without SCDs or with noncompensable SCDs rated zero percent disabling who have a net worth above both VA's means-test thresholds and HUD's geographic index.

Figure 2.

The Department of Veterans Affairs' Funding for Medical Care, 1996 to 2008

(Billions of dollars)



Sources: Congressional Budget Office; Congressional Research Service.

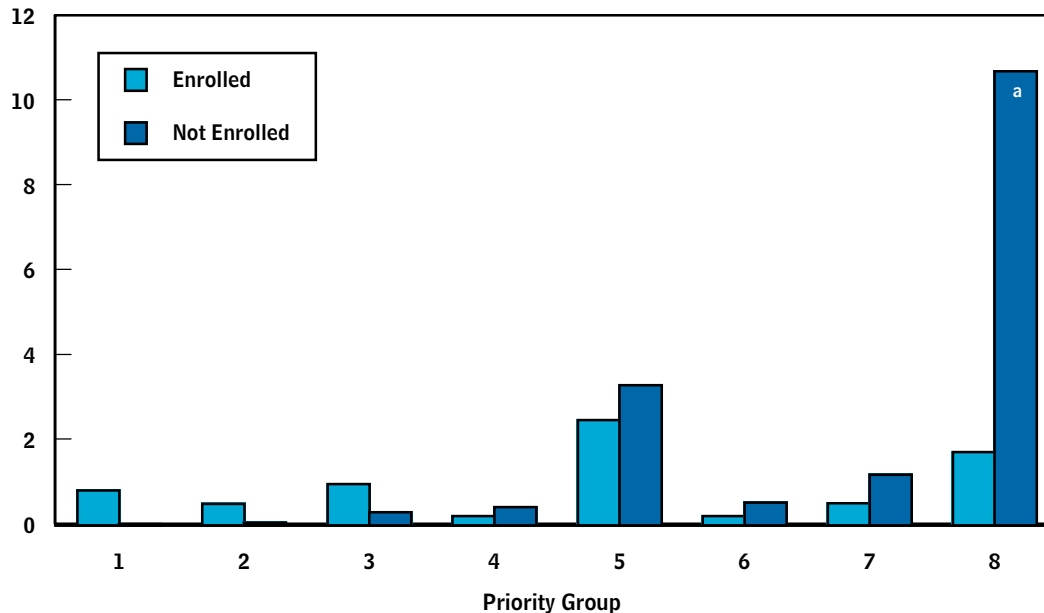
Because veterans in some priority groups are more likely to seek medical care from VA and because some priority groups consist of veterans who have service-connected or other conditions requiring extensive medical care, the spending for each priority group differs from its share of enrollment (see Figure 4 on page 8).

Under the law that established VA's enrollment system—the Veterans' Health Care Eligibility Reform Act of 1996—the Secretary of Veterans Affairs is authorized to determine how many priority groups VA can serve within the funding approved by the Congress each year. Veterans in the lowest-priority groups would be the first to be denied service. VA has applied that authority only once: In January 2003, then-Secretary Anthony Principi froze enrollment for veterans in priority group 8, although veterans in that group who had already enrolled were “grandfathered” and may still receive medical care from VA. The freeze is still in effect. In 2005 and 2006, when budget shortfalls arose that might have necessitated further disenrollments or other cutbacks in services, the Congress approved supplemental

Figure 3.

Veterans Enrolled in VA's Health System and Those Not Enrolled, by Priority Group, 2006

(Millions)



Source: Congressional Budget Office based on data from the Department of Veterans Affairs (VA).

a. Currently, enrollment for this group is frozen.

appropriations totaling \$3 billion over two years.² VA has continued providing a full range of services to previously enrolled veterans in priority groups 1 through 8 as well as new enrollees in priority groups 1 through 7.

Projections

Many factors affect the demand for VA's medical services, including demographic changes in the eligible population, rising health care costs in the economy at large that also affect VA, changes in the number of service members separating from the

2. The Congress included \$1.5 billion in supplemental funding for veterans' medical care in the FY 2006 Department of the Interior, Environment, and Related Agencies Appropriation Act (Public Law 109-54). Subsequently, the Congress included \$1.225 billion in emergency funding in the FY 2006 Military Quality of Life, Military Construction, Veterans Affairs, and Related Agencies Appropriations Act (P.L. 109-114); and a total of \$225 million in the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006 (P.L. 109-234) and the Department of Defense, Emergency Supplemental Appropriations to Address Hurricanes in the Gulf of Mexico, and Pandemic Influenza Act, 2006 (P.L. 109-148).

Table 1.

Health Insurance Coverage Reported by Enrolled Veterans, by Priority Group, 2005

(Percent)

Priority Group	Medicare Part A	Medicare Part B	Medigap	Medicaid	TRICARE and TRICARE For Life	Private Insurance or HMO	Any Non-VA Coverage
1	48	32	12	8	30	23	74
2	35	27	14	5	29	37	80
3	41	32	19	7	23	39	81
4	69	49	19	19	4	10	75
5	58	43	21	14	4	16	71
6	22	17	9	4	16	52	77
7 and 8	69	59	45	8	7	35	89
Total	56	43	26	10	13	28	79

Source: Department of Veterans Affairs, Veterans Health Administration, *2005 Survey of Veteran Enrollees' Health and Reliance Upon VA* (September 2006).

Note: HMO = health maintenance organization.

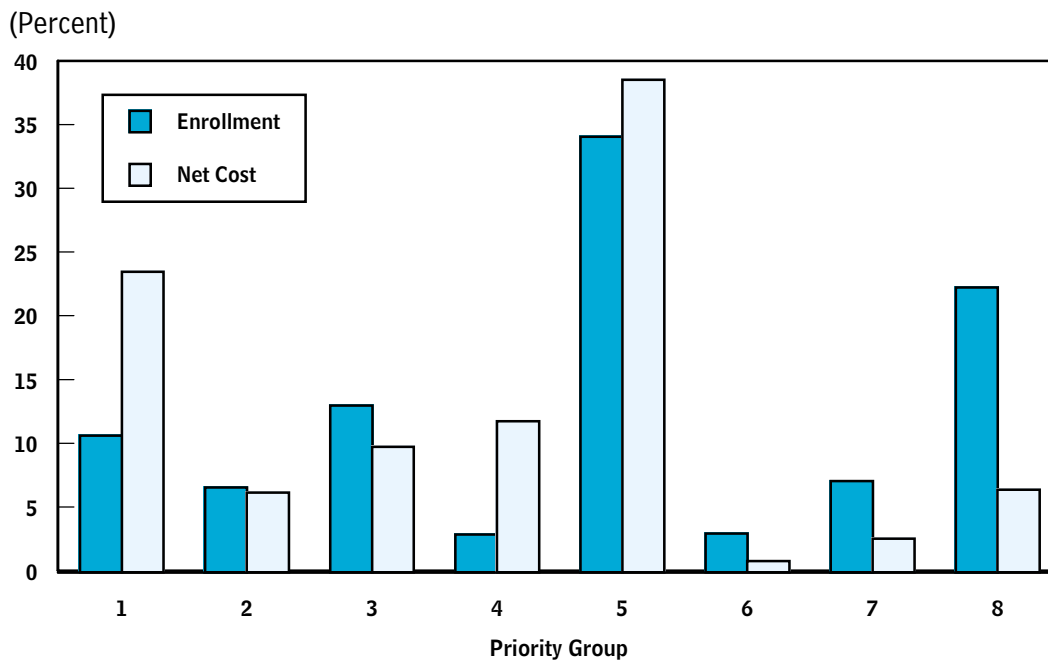
military, changing eligibility and out-of-pocket costs for other types of health coverage, perceptions about the quality of VA services, and changing policies regarding eligibility and out-of-pocket costs within the VA program itself. In March 2005 and again in July 2006, CBO analyzed the changing demand for and cost of VA's medical services and published reports containing projections.³ More recently, CBO has been working on updating those projections but has not yet been able to obtain all of the necessary data from VA. CBO has, however, adjusted its projections with some more recent data, so those updated estimates are the ones presented here.

CBO's analysis assumes that enrollment will remain open and free for veterans in priority groups 1 through 7 and that enrollment for veterans in priority group 8 will remain frozen (veterans in the latter group who are already enrolled will remain so, but veterans in that group who have not yet enrolled will not be able to do so). CBO's projections assume that new enrollment and rates of reliance on VA's health care will follow past trends. Under those assumptions, many eligible veterans in priority groups 1 through 7 will not enroll, and enrolled veterans in all priority groups will continue to seek a substantial portion of their care from other providers outside VA. As the starting point for its projections, CBO used \$35 billion; that sum represents the House-passed appropriation level for 2007 (included in House Joint Resolution 20).

3. Congressional Budget Office, *The Potential Cost of Meeting Demand for Veterans' Health Care* (March 2005) and *Potential Growth Paths for Medical Spending by the Department of Veterans Affairs* (July 2006).

Figure 4.

Shares of Veterans' Enrollment in VA's Health System and Net Costs, by Priority Group, 2007



Source: Congressional Budget Office based on data from the Department of Veterans Affairs (VA).

Note: Net costs take into account revenues from copayments by veterans and third-party bills paid by veterans' insurance plans.

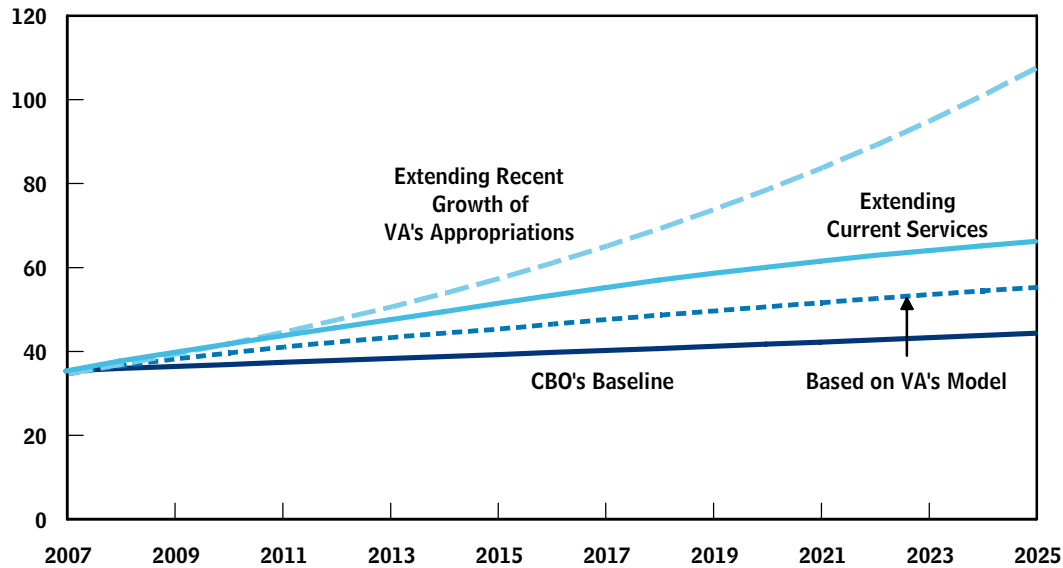
VHA's budget is discretionary—that is, lawmakers appropriate funds for VA's medical care on an annual basis. For this analysis, CBO did not attempt to predict those appropriations; rather, the projections reflect CBO's best estimate of the expenditures that would be required to continue providing the current level of services to the veteran population (as explained, under assumptions that enrollment rates and veterans' reliance on VA's medical care follow current trends). Actual budgetary outcomes are almost certain to differ from CBO's projections, both because of future legislative actions and because of unanticipated changes in economic conditions, health insurance markets, prices for medical products and services, employment, medical technology, and other factors. The projections rely heavily on particular assumptions about enrollment, reliance on VA's health care by veterans who are also eligible for Medicare or other sources of coverage, growth in health care costs, and the average cost of care for veterans in each priority group. CBO based most of those assumptions on VA's own enrollment projections and other data provided by VA, but some of the data are up to three years old because the department has not yet provided the most recent information.

While growth in future costs is uncertain, in making its projections, CBO assumed that VHA's per capita costs would rise at about the same rate as national health

Figure 5.

Four Scenarios for Growth in VA's Medical Spending

(Billions of 2007 dollars)



Source: Congressional Budget Office based on data from the Department of Veterans Affairs (VA).

expenditures in the rest of the economy.⁴ However, because the veteran population is expected to continue to decline through 2025, the growth in total costs is projected to be less rapid than the growth in per capita costs.

Assuming no major changes in policy and no major changes in enrollment trends, CBO estimates that providing the current level of services to enrolled veterans implies that VA's real (inflation-adjusted) medical spending would increase from \$35 billion in 2007 to \$66 billion in 2025, or 88 percent cumulative real growth (see Figure 5). That increase implies annual real growth that averages 3.6 percent over the period (or 5.4 percent in nominal terms, including CBO's projection of general inflation). (See Figure 6 for further detail on how the projection breaks out by priority group.)

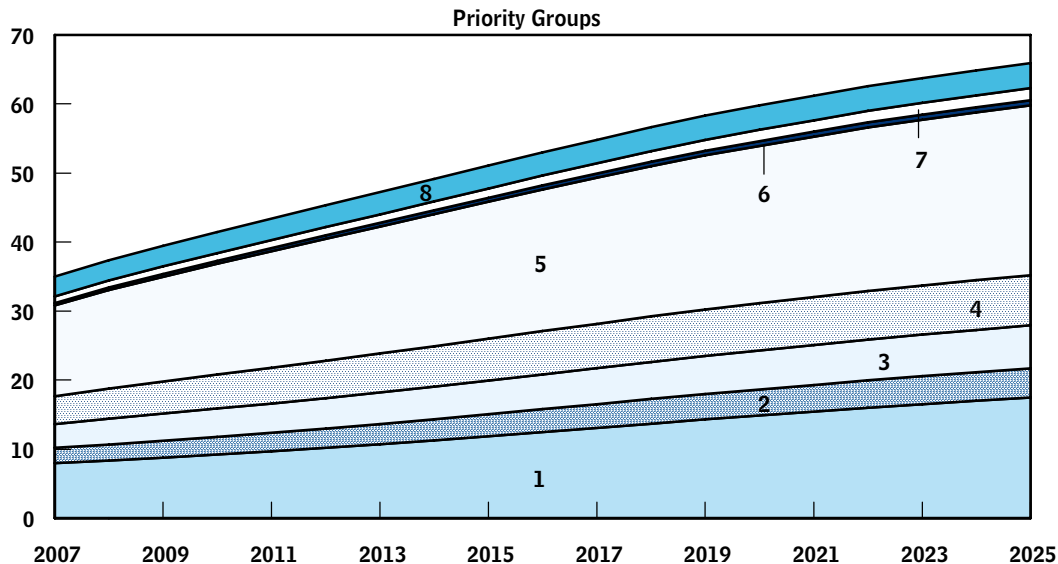
To compare the implications of CBO's and VA's assumptions about cost growth, CBO applied the cost growth rates embedded in VA's enrollment model from last year (the most recent version to which CBO has had access) starting at the 2007

4. Specifically, CBO used projections of national health expenditures on hospital care and physician and clinical services through 2015 made by the Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Expenditures Projections 2005-2015, available at www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2005.pdf. For the years after 2015, CBO assumed that per capita growth in those expenditures would begin to decrease toward an ultimate rate of growth 1 percentage point above the projected growth in per capita gross domestic product.

Figure 6.

CBO's Projections for the Costs of Meeting the Demand for VA's Medical Services, by Priority Group

(Billions of 2007 dollars)



Source: Congressional Budget Office (CBO) based on data from the Department of Veterans Affairs (VA).

budget level of \$35 billion.⁵ Because VA's model implies annual growth in total costs of about 4.4 percent, or 2.6 percent in real terms—lower rates than used in CBO's model—the growth in total spending by 2025 in CBO's projections is 50 percent greater than it is under VA's assumptions (see Figure 5).

The rate of growth in costs used to develop CBO's projections exceeds the rate of growth used for discretionary federal spending in CBO's annual baseline projections of the federal budget, as contained in the agency's January 2007 *Budget and Economic Outlook*. As specified in the Balanced Budget and Emergency Deficit Control Act of 1985, CBO assumes that the most recent year's discretionary budget authority is provided in each future year, adjusted using specific price indexes to offset projected inflation and to allow for factors such as the cost-of-living

5. VA's main enrollment model does not address some services included in that overall funding level of \$35 billion, including long-term care, dental care, care for nonveterans, the Civilian Health and Medical Program of the Department of Veterans Affairs, readjustment counseling, spina bifida care, and the foreign medical program. CBO assumed that spending on those services would grow at the same rate as spending on the medical services included in VA's model. Although that assumption is an oversimplification, CBO does not currently have data to indicate whether spending on those specified programs would grow more or less rapidly than other medical spending.

adjustment for federal workers.⁶ If VHA's spending were restricted to grow at about 3.1 percent per year (or 1.3 percent in real terms), which is the rate of growth CBO assumes for VHA in the most recent baseline, VA would have to begin disenrolling some veterans as early as 2008 (see Figure 5).

All of the projections discussed above imply slower growth in VHA's funding than the actual growth of appropriations has been in recent years. From 2000 through 2006, the average compound growth rate in VHA's budget was 8.4 percent, or 5.7 percent in real terms. If VHA's budget continues to grow at that rate over the next 18 years, VA's medical spending would triple in real terms, reaching \$108 billion in inflation-adjusted dollars by 2025 (see Figure 5).

Because CBO does not have the most recent version of VA's enrollment model, the projections presented here do not incorporate VA's latest estimates of enrollment and costs for veterans returning from Iraq and Afghanistan. Although those veterans will make up only a small portion of the total veteran population served by VA over the next few years, the total cost of care may increase above the estimates shown here—depending in part on how many returning veterans seek care for serious injuries or for stress-related problems arising from deployment to a combat zone.⁷ Separately, CBO has estimated the costs to VA over the next 10 years to provide health care to veterans injured during Operation Iraqi Freedom. Those estimates, based on an assumption that current casualty rates may be extrapolated into the future, range from \$5 billion to \$7 billion through 2016, depending on U.S. troop levels in the region.⁸

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6. The Balanced Budget and Emergency Deficit Control Act of 1985 expired on September 30, 2006, but CBO continues to prepare baseline projections according to the methodology specified in that law. CBO's methodology is described in Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2008 to 2017* (January 2007), pp. 5–9.
 7. Recent combat veterans have special eligibility for VA care for two years after separation from the military or demobilization, during which time they can enroll regardless of income and seek “no questions asked” care for any conditions that might be service-connected. After that two-year period ends, under current policy those veterans will be assigned to a priority group. Those without service-connected conditions and having income above the established thresholds will fall into priority group 8 but will be “grandfathered” and remain eligible for care as if they had enrolled before the January 2003 freeze on enrollments in that group.
 8. See Congressional Budget Office, *Estimated Costs of U.S. Operations in Iraq Under Two Specified Scenarios* (July 2006). CBO has also estimated the 10-year costs of disability compensation at around \$1 billion and the 10-year costs of dependency and indemnity compensation to surviving family members at around \$400 million.

