CBO TESTIMONY

Statement of
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on the
Budgetary Impact of H.R. 2116,
the Veterans' Millennium Health Care Act

before the
Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives

June 30, 1999

NOTICE

This statement is not available for public release until it is delivered at 10:00 a.m. (EDT) on Wednesday, June 30, 1999.

CONGRESSIONAL BUDGET OFFICE
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I appreciate the opportunity, Mr. Chairman, to appear before this Subcommittee to discuss the budgetary impact of H.R. 2116, the Veterans' Millennium Health Care Act. My statement will focus on conceptual issues related to Congressional Budget Office (CBO) estimates in general and how they apply to H.R. 2116 in particular. The detailed assumptions underlying our analysis of that bill are set out in CBO's cost estimate, which is appended to my statement.

Enactment of H.R. 2116 would affect both discretionary and mandatory (or direct) spending. Several sections would change veterans' medical care—a discretionary program. Notably, the bill would increase access to long-term care for certain veterans and would expand reimbursement for the costs of emergency care, subject to appropriation of the necessary amounts. The bill would also give the Department of Veterans Affairs (VA) the authority to spend, without further need for appropriations, its share of any amounts that the federal government might receive from the tobacco industry for the costs of tobacco-related illnesses.

DISCRETIONARY COSTS

Veterans' medical care is a discretionary program whose funding is provided annually in the appropriation bill for the Departments of Veterans Affairs and Housing and Urban Development. The appropriation limits how much the VA may actually spend regardless of how much spending is authorized. Table 1 shows the annual

TABLE 1. VETERANS' MEDICAL CARE, 1990-2000 (By fiscal year)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999[a]	2000[a]
Budget Authority (Millions of dollars)											
Appropriation	11,436	12,335	13,626	14,646	15,640	16,148	16,551	17,012	17,724	17,904	18,055[b]
Obligations (Millions of dollars)											
Outpatient Care	2,912	3,202	3,707	4,085	4,372	4,857	5,505	6,361	7,263	8,437	9,023
Nursing Home Care	1,020	1,140	1,266	1,416	1,534	1,635	1,646	1,751	1,780	1,979	2,118
Hospital Care	6,776	7,208	7,778	8,156	8,442	8,603	n.a.	n.a.	n.a.	n.a.	n.a.
Acute Hospital Care	n.a.	n.a.	n.a.	n.a.	n.a.	5,884	5,584	5,482	5,040	4,757	4,234
Workload											
Outpatient Care (Thousands of visits)	n.a.	23	24	24	25	28	30	33	36	38	40
Nursing Home Care (Thousands of patients treated)	71	72	71	75	78	79	82	89	97	107	112
Hospital Care (Thousands of patients treated)	1,016	974	956	942	963	899	853	n.a.	n.a.	n.a.	n.a.
Acute Hospital Care (Thousands of patients treated)	n.a.	n.a.	n.a.	n.a.	n.a.	680	621	498	442	389	339
Installations											
VA Hospitals	172	172	171	171	172	173	173	172	172	172	172
VA Nursing Homes	126	127	128	128	128	131	133	131	132	132	132
VA Domiciliaries	32	35	35	37	37	39	40	40	40	40	40
Outpatient Clinics	n.a.	169	192	183	366	392	399	439	551	722	811

SOURCES: Office of Management and Budget; Department of Veterans Affairs.

NOTES: n.a. = not available; VA = Department of Veterans Affairs.

a. Estimated.
b. Requested in the President's budget for fiscal year 2000.

appropriations for veterans' medical care for the past 10 years and provides additional data on the program's operations.

By themselves, legislative changes such as those in H.R. 2116 authorizing long-term and emergency care for veterans do not raise federal outlays, because funding for them is subject to appropriation. However, when CBO estimates the budgetary impact of an authorizing bill as required under section 403 of the Congressional Budget Act, it estimates the resources that would be required to implement the bill. In doing so, CBO assumes that the necessary funding is provided and that other activities are not curtailed in order to provide the services authorized by the bill.

The assumption that appropriations conform to authorizations is useful for at least two reasons. First, it gives the Congress a sense of how much more funding it could be asked to provide because of the authorizing bill. Second, the assumption means that CBO does not have to predict which programs will be treated favorably by the appropriation process. Instead, all programs of all committees are treated alike. If CBO did not assume changes in appropriations, no authorizing legislation—even one that eliminated every restriction on providing veterans' medical care—would ever be shown to increase costs.

When we receive a bill for costing, we must determine what changes it would make in the law and what consequences it would have for participation in a program such as veterans' medical care. For example, expanding access to care in nursing homes could increase participation by eligible veterans—in this case, those with service-connected disabilities rated at 50 percent or more. On the one hand, the Congress could increase funding to accommodate the greater participation and leave the rest of the program to be funded as under current law. On the other hand, if no additional funding was provided, the VA might be forced to curtail enrollment by or certain services to some veterans who would otherwise have been served under current law.

CBO's cost estimate provides relevant information for both perspectives. It informs the Congress and the appropriations committees of the likelihood of a greater demand for health care from veterans and the possible need for more money. It also informs the Congress about the extent to which some veterans could be displaced or denied care if the bill was enacted and appropriations were not increased.

CBO estimates that expanding the provision of long-term care to veterans, as specified in section 101 of H.R. 2116, would ultimately increase the VA's resource requirements by about $1.0 billion a year. Similarly, expanding the department's authority to pay for emergency care, provided in section 102, would increase the VA's resource needs by about $400 million a year. Whether federal outlays would

increase as a result of enacting those provisions, however, would depend on the extent to which additional appropriations were provided.

MANDATORY COSTS

In contrast to the provisions affecting veterans' medical care, the establishment of the veterans' tobacco trust fund under section 203 of the bill would create direct spending. If that section of the bill was enacted, no further legislation would be required to allow the VA to spend its proportional share of any funds recovered by the federal government from the tobacco industry. Because the amounts that the federal government might collect from the tobacco industry could be substantial, the spending authority created by this provision could also be significant.

To develop an estimate of that authority, CBO had to answer three questions. First, what is the likelihood that the federal government will win or settle a lawsuit? Second, how much would the federal government recover if it won or settled a lawsuit? Third, what proportion of the amounts recovered would be allocated to the VA?

Clearly, none of those questions can be answered with any precision, and the range of possible outcomes is large. Equally clear, however, is that the provision

cannot reduce spending but only increase it. In such a situation, CBO attempts to estimate the expected value of a proposal's budgetary effect—that is, the weighted average of the cost of the proposal under a variety of circumstances, taking account of their respective probabilities.

For this estimate, CBO has assumed that there is a 10 percent chance that the federal government will win or settle a lawsuit with the tobacco companies. All things considered, CBO estimates that section 203 could be expected to increase mandatory outlays by about $600 million over the 2000-2009 period. Those outlays could supplement or supplant discretionary spending for veterans' medical care.

CONCLUSION

In sum, CBO estimates that H.R. 2116 would have a significant budgetary impact on both spending subject to appropriation and spending that occurs outside the annual appropriation process. Assuming appropriation of the necessary amounts, CBO estimates that the bill would raise discretionary spending by about $0.2 billion in 2000 and about $1.4 billion annually by 2004. Assuming that those amounts are not appropriated, those figures are estimates of the extent to which other activities or beneficiaries would be displaced. In addition, the provision to spend the VA's proceeds from tobacco litigation would create significant authority for direct spending.

APPENDIX

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 28, 1999

H.R. 2116
Veterans' Millennium Health Care Act

As introduced on June 9, 1999

SUMMARY

The bill contains several provisions that would have a significant budgetary impact, including provisions to increase access to long-term care for certain veterans, allow the Department of Veterans Affairs (VA) to reimburse veterans or providers for the cost of emergency care, extend medical benefits to combat-injured veterans, and permit VA to spend some of the money that the United States might receive from litigation with tobacco companies. Assuming appropriation of the necessary amounts, CBO estimates that the bill would entail discretionary costs of about $138 million in 2000 and about $1.4 billion in 2004. In addition, the provisions to spend proceeds from tobacco litigation would raise direct spending by about $20 million in 2003, $30 million in 2004, and $170 million in 2009. Because the bill would affect direct spending, pay-as-you-go procedures would apply.

H.R. 2116 contains intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). The costs to state, local, and tribal governments as a result of the mandates would not exceed the threshold specified in the act ($50 million, adjusted annually for inflation). Similarly, costs of the private-sector mandate are unlikely to exceed the corresponding threshold specified in UMRA ($100 million, adjusted annually).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 2116 is shown in the following table. The costs of this legislation fall within budget function 700 (veterans' affairs).

	By Fiscal Year, in Millions of Dollars					
	1999	2000	2001	2002	2003	2004
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law for Veterans' Medical Care						
Estimated Authorization Level[a]	17,862	17,862	17,862	17,862	17,862	17,862
Estimated Outlays	17,609	17,958	17,975	17,782	17,751	17,751
Proposed Changes						
Extended Care Services						
Estimated Authorization Level	0	50	250	600	800	1,000
Estimated Outlays	0	40	230	560	780	980
Reimbursement for Emergency Care						
Estimated Authorization Level	0	90	270	380	390	400
Estimated Outlays	0	80	250	360	380	400
Care for Combat-Injured Veterans						
Estimated Authorization Level	0	5	15	21	22	23
Estimated Outlays	0	5	14	21	22	23
Extension and Revision of Authorities						
Estimated Authorization Level	0	15	18	21	10	10
Estimated Outlays	0	14	18	21	11	10
Other Provisions						
Estimated Authorization Level	0	b	b	b	b	b
Estimated Outlays	0	b	b	b	b	b
Total - Proposed Changes						
Estimated Authorization Level	0	160	553	1,022	1,222	1,433
Estimated Outlays	0	138	512	961	1,193	1,413
Spending Under the Bill for Veterans' Medical Care						
Estimated Authorization Level	17,862	18,022	18,415	18,884	19,084	19,295
Estimated Outlays	17,609	18,096	18,487	18,743	18,944	19,164
CHANGE IN DIRECT SPENDING						
Estimated Budget Authority	0	c	c	c	31	51
Estimated Outlays	0	c	c	c	21	31

a. The figure shown for 1999 is the amount appropriated for that year.
b. CBO does not have enough information to estimate the costs of some provisions.
c. Less than $500,000.

Spending Subject to Appropriation

Extended Care Services. Spending for veterans' medical care is limited by discretionary appropriations. An enrollment system ensures that care is provided to veterans with the highest priority. These priorities established in law require VA to treat veterans with service-connected disabilities before other beneficiaries. The law states that VA shall provide medical services such as hospital and outpatient care and may provide nursing home care. Thus, VA has discretion whether to provide nursing home care to high-priority beneficiaries or to use its resources to provide additional hospital or outpatient care to other veterans.

VA currently provides nursing home care to about 34,000 veterans each day. In total, it provides nursing home or other long-term care to approximately 65,800 veterans a day at an annual cost of about $2.6 billion. Of the veterans who receive long-term care from VA on any given day, about 11,000 have service-connected disabilities of 50 percent or greater even though about 535,000 veterans in total are disabled to that degree.

The need for long-term care by veterans is very large because many veterans are disabled or elderly. According to the Federal Advisory Commission on the Future of VA Long-Term Care about 610,000 veterans a day needed some form of long-term care in 1997. Among the veterans with higher priority for medical care from VA, so-called Category A veterans, the daily need totaled an estimated 295,000. (Category A veterans are those with service-connected disabilities, those who fall into special categories (such as former prisoners of war), and those with incomes below a certain threshold. Most Category A veterans have relatively low incomes, and low-income veterans comprise most of the roughly 3 million veterans who enroll with VA for health care).

Section 101 of H.R. 2116 would limit the discretion allowed to VA under current law by requiring that extended care be available for veterans whose service-connected disabilities are rated 50 percent or greater or who require long-term care because of a service-connected disability. The program of care would include geriatric evaluations, nursing home care (in VA and community-based facilities), domiciliary services, respite care, and adult day health care. CBO estimates that this section would take three to four years to implement and would eventually cost about $1.0 billion a year in fiscal year 2000 dollars.

CBO's estimate relies on data from VA, the 1992 National Survey of Veterans, and the National Long-Term Care Survey (NLTCS). CBO determined the probability of a person being institutionalized as a function of his age, marital status, and number of limitations in activities of daily living—one indicator of an individual's need for long-term care. Applying those probabilities to a distribution of veterans with service-connected disability ratings of 50 percent or higher, CBO estimates that by 2010 about 45,000 additional veterans would receive care in nursing homes for an annual cost of $1.2 billion. This method of estimation

takes into account that spouses often act as caregivers within the home to veterans who might otherwise require a nursing home stay. In the near term, demand for nursing home care through the VA would be lower because some veterans currently rely on Medicaid, private insurance, relatives, and certain Medicare-funded services to provide or finance their care. Initially, those veterans might not want to change their arrangements with providers. CBO assumes that eventually veterans with ratings of 50 percent or higher who enter nursing homes would turn to the VA for their care because, unlike other private or public insurance programs, it would be free to them. CBO expects that most nursing home patients would be placed in community nursing homes for an average stay of 179 days and at a cost of about $152 a day per patient (in 2000 prices). (Nursing homes owned and operated by VA are almost twice as expensive as privately operated homes.)

In addition, veterans who have disability ratings of 50 percent or more may need long-term, personal care short of that provided in a nursing home, often in their own home. CBO estimates that 62,000 such veterans would require home-based care at an annual cost of $0.1 billion (an average of 2-1/2 hours of care per week at an hourly cost of $18).

The bill would require copayments from veterans receiving long-term care if the veteran does not have a service-connected disability rated at 50 percent or greater. VA would be allowed, without further appropriation, to spend these amounts on providing long-term care. VA would be required to base the copayment on the assets and income of the veteran and spouse. The maximum monthly copayment would allow for protecting the spouse from financial hardship and for the veteran to retain a monthly personal allowance.

CBO estimates that collections from copayments would amount to $0.3 billion in 2010. The estimate assumes that veterans with no service-connected disability or with a disability rating less than 50 percent would be charged copayments on about 69,000 stays at VA nursing homes, community nursing homes, and VA domiciliaries if that stay were longer than 21 days. CBO also assumes that single veterans would keep a minimum personal allowance of $1,000 per year, while those with a living spouse would retain at least $13,000 per year. Based on VA's Patient Treatment Files, the vast majority of the 69,000 stays would be low-income veterans who would be unable to defray the full cost of their care. If VA were to require veterans to draw down their personal assets or if it pursued estate recoveries, copayment revenues might be higher.

Reimbursement for Emergency Care. Section 102 would significantly expand VA's authority to reimburse veterans and institutions for emergency care. It would allow VA to pay for care stemming from life- or health-threatening emergencies involving a veteran who is enrolled with VA for care, has no other coverage for emergencies, and has received care from VA within the 12 months preceding the emergency. CBO estimates that this provision would increase spending by about $80 million in 2000 about $400 million a year by 2004,

assuming appropriation of the necessary amounts. Those costs would stem from the costs of emergency room care and any subsequent hospital care.

Of the 3 million veterans enrolled with VA, CBO estimates that about 750,000 are uninsured and would be eligible for benefits under the bill. Emergency room care represents about 3 percent of the costs of private health plans. Emergency room costs would be two to three times greater for veterans covered by the bill, however, based on their generally poorer health. Thus, CBO estimates that the immediate costs of emergencies would amount to about $155 million annually (in 2000 dollars).

CBO estimates that two-thirds of all visits to the emergency room would be urgent and that 16 percent of those visits would lead to admitting the veteran for an inpatient stay. For veterans under 65 years of age, the average hospital stay would cost about $7,000. For veterans 65 years old or older, Medicare would cover the hospital costs, but VA would pay physicians' costs for those veterans without Part B coverage; CBO estimates that those costs would average about $1,000 for the small fraction of veterans who lack Part B coverage. The costs of the subsequent hospital stay would raise the annual bill to VA under this provision by about $195 million (also in 2000 dollars).

Care for Combat-Injured Veterans. VA currently accords highest priority to veterans with service-connected disabilities that are rated at least 50 percent disabling. The lowest priority is given to veterans without such disabilities and with incomes over a certain threshold. Section 103 would raise the priority status for medical care of combat-injured veterans. Because medical care is a discretionary program, available appropriations limit the number of veterans who receive care, and this bill would make it more likely that VA would provide care to a combat-injured veteran who does not receive a high priority under current law. CBO estimates that this provision would raise the costs of veterans' medical care by about $20 million a year, assuming that additional appropriations would allow VA to treat the new beneficiaries as well as veterans who would receive care under current law.

For this estimate, CBO assumes that the population of combat-injured veterans is about as large as the number of individuals who have been awarded a Purple Heart. According to data from the Military Order of the Purple Heart, about 550,000 veterans with the award were still living in 1995. Roughly half of those veterans already qualify for priority-level care based on service-connected disabilities or income, according to data from VA.

Although the remaining veterans—roughly 250,000—would be eligible for priority care, it is likely that only a small portion would seek VA services—only about 2 percent of all veterans in the lowest priority category used VA's medical services in 1996. We assume that the same percentage of such veterans who were injured in combat currently seek care from VA and would use VA's medical services a bit more intensively under this bill. We also

assume that another 2 percent of those veterans would become new users of VA care under the bill. CBO assumes the average cost of care for combat-injured veterans would be the same as that of other veterans in the same priority grouping.

Extension and Revision of Authorities. Section 205(a) would extend the eligibility of Vietnam-era veterans for readjustment counseling from January 1, 2000, through January 1, 2003. Vietnam-era veterans currently account for 19 percent of the patients in this program and an estimated 15 percent of the program's total costs—about $70 million in 1999. CBO estimates that this provision would cost about $8 million in 2000 and $34 million over the 2000-2004 period.

Section 205(d) would amend the Homeless Veterans Comprehensive Service Programs Act and would extend the program's ability to make grants through fiscal year 2002, from its current deadline at the end of fiscal year 1999. Based on recent experience in this program, CBO expects annual grants to construct shelters for homeless veterans in the amount of $6 million over the 2000-2002 period. These grants would lead to a stream of payments to operate the shelters in subsequent years. The construction and operating expenses would total $37 million through 2004.

Section 205(e) would allow the Homeless Veterans Program to subsidize the purchase of vans for the purpose of outreach to homeless veterans. Based on the number of vans purchased in earlier years, CBO estimates annual expenditure of $520,000 to assist in the purchase of 20 vans a year for four years.

Other Provisions. CBO does not have enough information to estimate the budgetary impacts of some provisions in the bill. Section 104 would allow VA to provide medical care to certain military retirees on a priority basis and be reimbursed by the Department of Defense (DoD) at the rate that DoD would have paid to a contractor under TRICARE. For the most part, the payments by DoD to VA would not add to the costs of TRICARE, but the provision could lead to somewhat greater use of medical benefits and thus higher overall payments by DoD. DoD would incur extra expenses to the extent that retirees increase their use of medical care because VA's copayments are less than under TRICARE.

Section 106 would authorize VA to conduct a three-year pilot program to provide medical care for certain dependents of enrolled veterans. The provision would require payment of a reasonable charge by the dependent or the dependent's parent or guardian. CBO estimates that this provision would probably raise costs to VA but by a small amount. Most enrolled veterans have low incomes, and although ability to pay would be a criterion for care, it is likely that some of the dependents would be unable to make the payment.

Section 107 would require VA to establish a program designed to improve access to and utilization of medical centers. Under current law, the Secretary already has broad powers to allocate resources to facilities and to lease, renovate, and close facilities. CBO estimates this provision would have little or no budgetary impact.

Section 108 would extend by one year a counseling and treatment program for veterans who have experienced sexual trauma. The program would be extended from December 31, 2001, to December 31, 2002, and would probably cost a few million dollars.

Section 207 would expand VA's program of enhanced-use leases. Such leases provide VA with cash or other items of value in exchange for the right to use assets of the department. Under current law, these arrangements usually result in barter instead of cash payments to VA because cash proceeds must be returned to the Treasury. The bill would allow VA to spend any proceeds from enhanced-use leases; thus, VA would be more likely to accept cash payment. Although the increase in receipts would equal the increase in spending, using the proceeds from the leases could offset an equal amount of discretionary appropriations.

Direct Spending

Veterans' Tobacco Trust Fund. Section 203 of the bill would give VA direct spending authority over any amounts the federal government receives on its behalf from the tobacco industry for recovery of costs associated with tobacco-related illnesses. CBO estimates that the additional resources available to VA would total $80 million over the 2000-2004 period and $0.8 billion over the 2000-2009 period. Because of normal lags in spending this provision would increase federal outlays by about $50 million over the 2000-2004 period and about $640 million over the 2000-2009 period. These outlays could supplement or supplant discretionary spending for veterans' medical care.

There is substantial uncertainty about whether the federal government will file a lawsuit against the tobacco industry, whether it would win or settle, and if so, for what amounts. Earlier this year the Justice Department announced its intent to file a suit, and it is currently assessing the legal theories and strategies it will use. The President's budget request includes $20 million for preparing the lawsuit, but the report accompanying the Senate-reported appropriation bill for the Department of Justice states that no funds are provided for tobacco litigation.

To develop an estimate that would fall within the range of possible outcomes, CBO made assumptions about three factors. First, how much would the federal government recover if it won or settled a lawsuit? Second, what proportion would be attributable to the costs of the

VA? Finally, what is the likelihood that the federal government will enter into a lawsuit and either win or settle?

Amount of Potential Recoveries. To estimate the amount that the federal government could recover in any lawsuit against the tobacco industry, CBO examined available research on the cost of smoking and considered the arguments made by the states in their recent lawsuits. Many studies have examined the medical and other costs associated with smoking and have arrived at different conclusions. Smoking probably increases the net costs of some federal programs but decreases the costs of others. Two methods typically used by researchers to estimate the costs of smoking are the prevalence-based method, which estimates the costs of smoking by calculating the average difference in costs over a given period between smokers and nonsmokers, and the life-cycle method, which makes a similar comparison over the lifetimes of smokers and nonsmokers. In general, the two methods reach different conclusions because smokers, on average, have shorter life spans than nonsmokers. By comparing the costs of only living smokers and nonsmokers, the prevalence-based method does not include either the avoided costs or lost tax revenue from smokers in years in which they are no longer alive. In contrast, the life-cycle method accounts for the shorter life spans of smokers relative to nonsmokers.

CBO's review of the research finds that estimates of the cost to the federal government of cigarette smoking (for programs other than Medicaid) range from negligible under some of the life-cycle estimates to as high as $30 billion to $40 billion a year under some of the prevalence-based estimates. The states based their lawsuits, at least partly, on a prevalence-based analysis that showed the costs of smoking to Medicaid in fiscal year 1993 was $13 billion.[1] This figure could correspond to as much as $40 billion in current dollars for other federal programs. In another study, the Centers for Disease Control estimated the total costs of smoking in 1993 to be $50 billion, with federal programs other than Medicaid paying for 30 percent and state programs (including Medicaid) paying for about 13 percent.[2] This finding would suggest total federal costs of about $20 billion this year and total state costs of about $9 billion.

The annual payments under the November 1998 settlement between tobacco companies and the states ultimately rise to about $9 billion a year before adjustments for inflation and the volume of cigarette sales. The Justice Department contends that the amount of money paid out by the federal government for smoking related illnesses is even larger than that paid out

1. Leonard S. Miller and others, "State Estimates of Medicaid Expenditures Attributable to Cigarette Smoking, Fiscal Year 1993," *Public Health Reports*, vol. 113 (March/April 1998).

2. Centers for Disease Control and Prevention, "Medical-Care Expenditures Attributable to Cigarette Smoking – United States, 1993," *Morbidity and Mortality Weekly Report*, vol. 43, no 26 (1994).

by the states through the Medicaid program.[3] For the purpose of this estimate, CBO assumes that if the federal government wins a lawsuit or settles with tobacco companies, it will receive slightly over twice the amounts the states are slated to receive under their settlement. CBO further assumes that these amounts will be adjusted for inflation and cigarette sales in the same manner as in the state settlement, resulting in payments of between $16 billion and $25 billion a year over the 2000-2009 period.

Proportion Attributable to Veterans' Programs. In 1998 the federal government spent about $18 billion on health care for veterans through VA. That figure represents 7 percent of spending on all federal non-Medicaid health care benefits (including Medicare, the Federal Employee Health Benefits Program, the Department of Defense health care programs, and the Indian Health Service). For this estimate CBO assumes that 7 percent of the amounts recovered under a federal lawsuit would be attributable to the VA.

Probability of Recovery of Amounts. CBO assumes that there is ultimately a 10 percent probability that the federal government will enter into a lawsuit and win or settle for recoveries in these amounts. Because the timing is unclear, CBO assumes no recoveries until 2003 and a lower but growing probability of recoveries over the 2003-2006 period.

Other Copayments and Collections. The bill contains several other provisions that would allow VA to collect and spend funds. The bill would allow VA to charge higher copayments for prescriptions and outpatient visits of certain veterans and to set copayments for certain costly items of equipment other than wheelchairs and artificial limbs. The proceeds from these charges would be either used for medical care or deposited in the Treasury.

The budgetary effects of using these authorities would be felt in mandatory and appropriated accounts. The provisions would have an impact on direct spending because the receipts and subsequent spending would not be subject to appropriation, but the net effect would be negligible in a typical year because the extra spending would roughly equal the corresponding receipts. The extra spending could reduce the need for appropriated funds if VA would otherwise request funding for the expenses met through the use of the receipts. CBO does not expect, however, that VA would make much use of these authorities.

Compensated Work Therapy Program. Section 105 would make veterans eligible for disability compensation benefits for injuries proximately caused by the veteran's receipt of care in the Compensated Work Therapy Program (CWT). CWT is a therapeutic work program for veterans that takes place in various types of workplaces. Under current law, these veterans are not eligible for disability compensation benefits because of injuries

3. U.S. Department of Justice, "Developing a Plan to Take the Tobacco Industry to Court" (Department of Justice Fact Sheet, Washington D.C., January 1999).

suffered while participating in the program. The budgetary impact of this provision would depend on how many veterans are participating in this program and the rate at which they are injured while working. Information from VA indicates that about 15,000 veterans a year participate in this program. Based on data from the Bureau of Labor Statistics on the incidence of occupational illnesses and injuries, CBO estimates that the provision would increase direct spending by less than $500,000 a year over the 2000-2002 period and by about $1 million a year thereafter.

PAY-AS-YOU-GO CONSIDERATIONS

Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars										
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Changes in outlays	0	0	0	0	21	31	61	91	121	151	171
Changes in receipts	Not Applicable										

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

Section 102 of the bill would authorize the Department of Veterans Affairs to reimburse providers for the reasonable cost of emergency treatment furnished to certain veterans. The provision would impose a private-sector and intergovernmental mandate on providers (including public hospitals) because, in the event of a dispute over reasonable cost, it would extinguish any liability on the part of the veteran for that treatment unless the provider rejects and refunds the department's payment within 30 days. It is not clear whether the provision would lead to a net financial loss or gain for providers. All providers would face costs if the department's payment were lower than the amount billed. But some providers might experience a net gain under this provision if reimbursements from the department more than offset liabilities that otherwise would not be collected and any associated collection costs. In any event, costs of the provision are unlikely to exceed the thresholds specified in UMRA for intergovernmental costs ($50 million, adjusted annually for inflation) or private-sector costs ($100 million, adjusted annually).

COMPARISON WITH OTHER ESTIMATES

The Administration's budget request for fiscal year 2000 contains a proposal for veterans' out-of-network emergency care that is similar to section 102 of H.R. 2116. The Administration's proposal, however, would cover fewer than half as many veterans. The budget request includes about $244 million in 2000 to cover the out-of-network emergency care for uninsured, enrolled veterans with compensable disabilities related to military service. H.R. 2116 would cover that kind of care for all uninsured, enrolled veterans, including veterans whose eligibility is based on income.

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