CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

August 26, 2003

H.R. 2318
Assured Funding for Veterans Health Care Act of 2003

As introduced on June 4, 2003

SUMMARY

H.R. 2318 would require the Secretary of the Treasury to make available to the Veterans Health Administration (VHA) each fiscal year, beginning in 2005, an amount determined under the bill, to be available without fiscal year limitation for VHA's programs, functions, and activities. Under H.R. 2318, the amount in 2005 would be equal to 130 percent of the total obligations made by the VHA in 2003. The amounts in succeeding years would be adjusted for medical inflation and growth in the number of veterans enrolled in VHA's health care system and other nonveterans eligible for care from VHA.

Although the bill would primarily affect funding for health care services provided by VHA—replacing annually appropriated discretionary funding with direct spending, it also would result in some savings in direct spending for other government programs, primarily Medicare and Medicaid.

CBO estimates that enacting H.R. 2318 would result in a net increase in direct spending totaling about $30 billion in 2005, $165 billion over the 2005-2008 period, and $473 billion over the 2005-2013 period. Under the bill, funding for VHA would be considered direct spending, so CBO estimates that discretionary outlays for VHA and other government programs would decline—relative to baseline projections—by $7 million in 2004, about $23 billion in 2005, and $262 billion over the 2004-2013 period. That potential discretionary savings assumes that appropriations are reduced from baseline levels underlying the current Congressional budget resolution by the estimated amounts.

H.R. 2318 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). Lower Medicaid spending for veterans who would now receive health services through the Veterans Health Administration would result in savings to states totaling about $640 million over the 2006-2008 period, and $2.2 billion over the 2006-2013 period.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 2318 is shown in Table 1. The costs of this legislation fall within budget functions 050 (national defense), 550 (health), 570 (Medicare), and 700 (veterans benefits and services).

TABLE 1. ESTIMATED BUDGETARY IMPACT OF H.R. 2318

	By Fiscal Year, in Millions of Dollars				
	2004	2005	2006	2007	2008
CHANGES IN DIRECT SPENDING					
Estimated Budget Authority	0	33,508	41,631	46,865	51,247
Estimated Outlays	0	30,157	33,537	46,415	54,552
CHANGES IN SPENDING SUBJECT TO APPROPRIATION					
Estimated Authorization Level	0	-25,884	-26,752	-27,623	-28,531
Estimated Outlays	-7	-23,296	-26,347	-27,390	-28,312

BASIS OF ESTIMATE

This estimate assumes that the bill is enacted before the end of calendar year 2003 and that future appropriations are reduced by the estimated amounts.

Direct Spending

Under H.R. 2318, direct spending for VHA would increase significantly but would be offset in part by lower direct spending for other government programs, including Medicare and Medicaid. On balance, CBO estimates that enacting H.R. 2318 would result in a net increase in direct spending totaling $165 billion over the 2005-2008 period and $473 billion over the 2005-2013 period (see Table 2).

TABLE 2. ESTIMATED CHANGES IN DIRECT SPENDING UNDER H.R. 2318

	By Fiscal Year, in Millions of Dollars									
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
CHANGES IN DIRECT SPENDING										
Veterans Health Administration										
Estimated Budget Authority	0	33,508	43,100	48,819	53,637	58,149	62,255	65,732	68,594	72,106
Estimated Outlays	0	30,157	35,006	48,369	56,942	58,736	61,706	64,989	68,230	71,380
Medicare										
Estimated Budget Authority	0	0	-1,333	-1,758	-2,127	-2,439	-2,714	-2,929	-3,121	-3,302
Estimated Outlays	0	0	-1,333	-1,758	-2,127	-2,439	-2,714	-2,929	-3,121	-3,302
Medicaid										
Estimated Budget Authority	0	0	-227	-282	-345	-364	-382	-402	-425	-445
Estimated Outlays	0	0	-227	-282	-345	-364	-382	-402	-425	-445
Veterans Benefits Administration										
Estimated Budget Authority	0	0	108	108	108	107	107	107	0	0
Estimated Outlays	0	0	108	108	108	107	107	107	0	0
Federal Employees Health Benefits Program										
Estimated Budget Authority	0	0	-17	-22	-26	-30	-33	–35	-37	-40
Estimated Outlays	0	0	-17	-22	-26	-30	-33	-35	-37	-40
Total Changes										
Estimated Budget Authority	0	33,508	41,631	46,865	51,247	55,423	59,233	62,473	65,371	68,319
Estimated Outlays	0	30,157	33,537	46,415	54,552	56,010	58,684	61,730	64,647	67,593

Veterans Health Administration. Under current law, funding for VHA is provided in an annual appropriation. That appropriation typically includes funds for medical care for veterans (the bulk of the appropriation); funds for construction or renovation of hospitals, nursing homes, and clinics; and funds to pay operating expenses. Under H.R. 2318 beginning in fiscal year 2005, the funding for all of VHA's programs, functions, and activities would be provided through a permanent, indefinite appropriation directly by the Treasury, except for construction projects and a program that provides grants to states to build long-term care facilities. CBO estimates that, under H.R. 2318, direct spending for veterans health care would increase by about $30 billion in 2005, $170 billion over the 2005-2008 period, and $496 billion over the 2005-2013 period.

Under H.R. 2318, the Treasury would be required to make available in 2005 to VHA an amount that is specified in the bill as 130 percent of the total obligations made by VHA in fiscal year 2003. According to VHA, obligations in 2003 are expected to total almost $26 billion. Thus, CBO estimates that under H.R. 2318 the Treasury would make

$33.5 billion available to VHA in 2005, resulting in direct spending outlays of about $30 billion. (The corresponding reduction in discretionary spending under the bill is discussed below under the heading of "Spending Subject to Appropriation.")

For each year after 2005, H.R. 2318 would establish a baseline per capita cost equal to the amount that would be provided by the Treasury in fiscal year 2005 divided by the number of veterans enrolled to receive medical care from VHA at the end of fiscal year 2003. CBO estimates that this per capita cost would be about $4,760 in 2005. This baseline amount would then be increased each year at the rate for medical inflation published by the Bureau of Labor Statistics (BLS). For each year after 2005, the Treasury would be required to make available to VHA an amount equal to the inflated per capita amount for that fiscal year times the number of veterans enrolled to receive medical care from VHA as of July 1 of the previous fiscal year. Under current law, most veterans have to enroll with VHA before they can receive care from VHA. Many enrolled veterans, though, do not actually receive any care from VHA.

Some nonveterans are eligible to receive care from VHA without being enrolled with VHA. Under the bill, the number of those nonenrolled individuals who received care from the VHA in the previous fiscal year also would be counted with the number of enrolled veterans for the purposes of determining funding for VHA. Nonenrolled individuals who are eligible to receive health care from VHA include dependents of veterans who are either 100 percent disabled or who have a total and complete disability.

Estimate of the Number of Enrolled and Nonenrolled Individuals. According to VHA, almost 7 million veterans are enrolled in VHA's health care system for 2003. CBO estimates that number will grow to about 7.5 million by 2013 under current law and VA policy to stop accepting new enrollments from priority 8 veterans, who are veterans without a service-connected disability and with income above certain thresholds. VHA projects enrollment would total almost 9 million veterans in 2013 if it were to once again allow all new priority 8 veterans to enroll. VHA has stopped enrolling new priority 8 veterans and now gives veterans with service-connected disabilities higher priority when providing health care because it indicates that its appropriation is not sufficient to meet the health care demands of all currently enrolled veterans. Thus, CBO believes that VHA would once again enroll priority 8 veterans under the bill.

In addition, under H.R. 2318, CBO estimates that by 2013 total enrollment would increase by about 20 percent above VHA's projection of almost 9 million veterans because VHA would have a guaranteed source of funding for all newly enrolled veterans. Accordingly, CBO estimates that under H.R. 2318, about 10.5 million veterans or about half of all living veterans would be enrolled to receive health care from VHA in 2013. (That amount is about

1.8 million more veterans than VHA projects for 2013 if it were to allow priority 8 veterans to enroll.)

While this may seem a large percentage increase, VHA's projection of almost 9 million veterans enrolled to receive health care if it were to accept new priority 8 enrollments would comprise more than 40 percent of all living veterans by 2013. Said another way, CBO estimates that only one out of six veterans not yet enrolled would enroll under H.R. 2318 by 2013. While this is CBO's best estimate, there is some risk that enrollment could be higher than our estimate of 10.5 million veterans by 2013 which would lead to higher costs than we currently estimate.

Under H.R. 2318, CBO believes enrollment would be higher than VHA's open enrollment projections because veterans would have a greater incentive to enroll and VHA would be increasingly motivated to enroll them. That greater incentive stems from the fact that there would be a guaranteed funding source for medical benefits under the bill. VHA provides generous health care benefits that many veterans already receive today. Data and projections from VHA indicate that enrollment has been and continues to increase even though VHA is unable to provide all of the health care that veterans are seeking. With a significant increase in funding to provide those benefits, CBO expects even more veterans would enroll in order to use the benefits provided by VHA. Using the increased and guaranteed funding that would be made available under H.R. 2318, VHA would be able to provide health care to more veterans and provide that health care in a more timely manner; thus increasing the likelihood of more veterans enrolling.

In addition, under H.R. 2318, VHA's budget authority would be directly linked to the number of veterans it is able to enroll, not the number of veterans who actually receive care at VHA. As mentioned above, many enrolled veterans do not actually receive any health care from VHA. Thus, the more veterans VHA enrolls the more effectively it would be able to fulfill its mission to provide health care to all veterans that seek that care from VHA. Accordingly, CBO estimates that the total number of enrolled veterans would increase significantly above current projections.

In addition to providing care to enrolled veterans, VHA also provides health care to many individuals who are not veterans. Dependents and survivors of certain veterans, primarily those who are either 100 percent disabled or have a total and complete disability, can participate in a program called CHAMPVA that acts as a third-party insurance provider for those individuals. Using information from VHA, CBO estimates that in 2005 there would be about 280,000 individuals in the CHAMPVA program who would be counted in the formula to determine VHA's annual budget authority under H.R. 2318.

Estimate of VHA Spending. Using the formulas specified in H.R. 2318 and the above estimates of population and per capita costs, CBO estimates that under H.R. 2318 direct spending by VHA would increase by about $30 billion in 2005, $170 billion over the 2005-2008 period, and $496 billion over the 2005-2013 period.

Under the bill, the amount VHA would receive for medical care in 2006 would be significantly more than what it would receive in 2005. That difference would occur because the budget authority for the two years would be calculated differently. For 2005, budget authority would be equal to 130 percent of obligations in 2003. For 2006, budget authority would be equal to the inflated per capita amount multiplied by the number of veterans enrolled to receive health care from VHA as of July 1, 2005, plus the number of individuals in the CHAMPVA program who received care from VHA in fiscal year 2005. The baseline per capita amount is derived by dividing the 2005 budget authority ($33.5 billion) by the number of enrolled veterans in 2003 (7 million) which is then inflated at the medical inflation rate published by the BLS. CBO estimates that the number of veterans and other individuals enrolled in VHA's health care system in 2005 would be 1.7 million people more than in 2003—generating the large increase in budget authority for 2006. About 600,000 of the 1.7 million person increase would result from CBO's assumption that VHA lifts the current ban on enrolling new priority 8 veterans. Another 800,000 would result from CBO's projected increase in enrollment above VHA's open enrollment projection. The remaining increase comes from the 280,000 CHAMPVA beneficiaries who are not counted when determining the per capita amounts. That increase in the population accounts for most of the increase in budget authority.

Under the bill, the first significant increase in budget authority would occur in 2006. Because it would take some time before VHA could adjust its spending of the larger budget authority, CBO estimates that increases in outlays would lag the increases in budget authority for two years. By 2008, CBO expects that VHA would be able to obligate and spend the increased amounts in a normal manner (close to historical rates of spending). Estimated outlays would exceed budget authority in 2008 because a significant amount of lagged outlays from prior years' budget authority would be combined with the normal, first-year spending of the new 2008 budget authority. CBO expects that the adjustment back to historical outlay rates would take only two years because VHA has extensive authority to contract with nonVHA health care facilities—especially to provide long-term care needs such as nursing home care, home health care, adult day care, and respite care to veterans that they cannot provide for in their own facilities. Additionally, VHA would have almost two years to prepare plans to make use of that first significant increase.

Medicare. About half of all enrolled veterans are also eligible for Medicare benefits. While benefits provided by VHA include many benefits provided by Medicare, VHA also provides

a prescription drug benefit and a long-term care benefit that is not currently provided by Medicare. As mentioned above, under H.R. 2318, VHA would be able to provide health care to more veterans and increase its spending per veteran. Thus, CBO expects that veterans treated by VHA would use Medicare somewhat less than they currently do. While the increased spending on health care would not result in dollar-for-dollar savings in Medicare, CBO estimates that Medicare spending on veterans who use VHA for health care would decline.

Using population and budget data from VHA, CBO estimates that under current law, per capita spending by VHA on veterans receiving care would be about $5,550 in 2006. Under H.R. 2318, CBO estimates that spending would increase by about $2,200 for veterans who currently use VHA to receive health care services. Thus, for veterans who would begin to use VHA for the first time under H.R. 2318, per capita spending would be about $7,750. Because VHA provides substantial health care benefits that Medicare does not currently provide, CBO believes that veterans would disproportionately demand those services (prescription drugs and long-term care) when seeking care from the Veterans Health Administration. In other words, less than half of all new spending on veterans' health care would replace Medicare-covered services.

CBO estimates that for veterans age 65 and older Medicare pays for about 50 percent of their total health care expenditures, and that under H.R. 2318 VHA would pay for about half of the expenditures now paid for by Medicare. Thus, for those veterans who currently receive health care from VHA, CBO assumes that Medicare spending would be reduced by about 25 percent of the estimated increase in average spending by VHA. For those veterans who would begin to receive health care from VHA for the first time, CBO assumes that Medicare spending would decrease by about 25 percent of the total per capita amount that VHA would spend on Medicare-eligible veterans under H.R. 2318. Thus, the reduction in spending by Medicare would only partially offset the increased spending by VHA.

Because the large increase in VHA's budget would not occur until 2006, CBO estimates that these savings also would not occur until 2006. CBO estimates that under H.R. 2318 Medicare spending would decline by about $1.3 billion in 2006, $5 billion over the 2006-2008 period, and $20 billion over the 2006-2013 period.

Medicaid. Using data from the Current Population Survey (CPS) and VHA, CBO estimates that under H.R. 2318 about 21,000 veterans who would have used Medicaid would now use VHA for health care in 2006, with that number growing to almost 43,000 by 2013. CBO believes that more than 9,000 of the veterans that would initially use VHA for health care would be those veterans who are eligible for a pension from the Veterans Benefits Administration (VBA) and are in Medicaid-approved nursing homes. Under current law,

veterans who are in Medicaid-approved nursing homes and are also eligible for a pension from VBA must forfeit the majority of their pension; these veterans may keep only about $90 a month. If, however, veterans are in a VHA-sponsored nursing home, the veterans forfeit a much smaller percentage of their pension. Because VHA would have more money to spend on nursing home care under H.R. 2318, CBO expects that many veterans would choose to use VHA for nursing home care instead of Medicaid.

CBO estimates that in 2006, almost 19,000 veterans who are eligible for a pension would be in nursing homes paid for by Medicaid with that number declining to about 16,000 by 2013. Based on programmatic experience, CBO assumes that about half of those veterans would switch to receive their nursing home care from VHA with federal savings for Medicaid averaging about $19,200 in 2006. CBO estimates that the number of Medicaid-eligible veterans who are not in nursing homes that would begin to use VHA for some health care would total about 12,000 in 2006, and grow to about 35,000 veterans by 2013. The federal savings associated with those veterans, CBO estimates, would be much less—at about $4,000 per veteran in 2006—because they do not receive institutional care. Accordingly, CBO estimates that federal savings in the Medicaid program would be $227 million in 2006, $854 million over the 2006-2008 period, and $2.9 billion over the 2006-2013 period.

Veterans Benefits Administration. As mentioned above, veterans who are eligible for a pension from VBA and are in Medicaid-approved nursing homes must forfeit the majority of that pension. Thus, under H.R. 2318, CBO estimates that VBA would have to pay significantly more each year in pension payments for each veteran that is eligible for a pension and who would now receive nursing home care from VHA instead of Medicaid. CBO estimates that the additional pension payments would be about $11,500 per veteran in 2006. Using the above assumption that 50 percent of those veterans in Medicaid-approved nursing homes (9,000 in 2006) would choose to receive nursing home care from VHA, CBO estimates that the costs to VBA would be $108 million in 2006, $324 million over the 2006-2008 period, and $645 million over the 2006-2011 period. There would be no costs in 2012 and 2013 because VBA's authority to reduce pensions for veterans in Medicaid-approved nursing homes expires at the end of 2011.

Federal Employees Health Benefit (FEHB) Program. Using data from the CPS and VHA, CBO estimates that in 2006 about 100,000 civilian retirees of the federal government also would receive health care from VHA with that number remaining fairly constant through 2013. Most civil service retirees age 65 and over also are eligible for Medicare and thus would have little incentive to use VHA services except for benefits not covered by Medicare and FEHB, primarily long-term care. Thus, CBO estimates that the per capita savings to the FEHB program would be somewhat smaller than the savings for those

veterans enrolled in Medicare. In addition, CBO estimates that about 150,000 federal workers would use VHA for some health care services in 2006 with that number also remaining fairly constant through 2013. CBO estimates that the savings for active workers would be much lower on a per capita basis than for FEHB annuitants because medical costs are highly correlated with age.

Using this information, CBO estimates that the total savings to the FEHB program under H.R. 2318 would be about $58 million in 2006, $225 million over the 2006-2008 period, and $829 million over the 2006-2013 period. However, that pool of savings would be shared by the federal government (72 percent) and participants in the FEHB program (28 percent). About 40 percent of the federal savings would be realized through lower contributions to premiums for annuitants—those contributions are considered direct spending. (The remaining savings would be for active workers, which is considered discretionary spending and is discussed below under the heading "Spending Subject to Appropriation," and for postal workers and annuitants, which is off-budget.) Thus, CBO estimates that under H.R. 2318 direct spending by the FEHB program for annuitants would decline by $17 million in 2006, $65 million over the 2006-2008 period, and $240 million over the 2006-2013 period.

TRICARE-For-Life. The Department of Defense (DoD) operates a program called TRICARE For Life (TFL) that pays all copayments and deductibles for Medicare-covered services and provides a generous prescription drug benefit for all retirees of the uniformed services who are eligible for Medicare. Those retirees also would be eligible to receive health care from VHA, but given the extent of their current insurance, CBO does not expect many retirees to use VHA for health care except for long-term care needs, which are not covered by Medicare or TFL. Thus, CBO does not estimate any significant savings in the TFL program from enacting H.R. 2318.

Spending Subject to Appropriation

H.R. 2318 also would affect discretionary spending by reducing VHA's need for future appropriations and increasing the amount of offsetting collections deposited to the Medical Care Collections Fund (MCCF). CBO estimates that implementing H.R. 2318 would lower discretionary outlays by $7 million in 2004, $105 billion over the 2004-2008 period (see Table 3), and $262 billion over the 2004-2013 period, assuming appropriations are reduced by the estimated amounts.

TABLE 3. ESTIMATED CHANGES IN SPENDING SUBJECT TO APPROPRIATION FOR H.R. 2318
(By fiscal year, in millions of dollars)

	2003	2004	2005	2006	2007	2008
VETERANS HEALTH ADMINISTRATION						
Baseline Spending Under Current Law						
Estimated Authorization Level [a]	24,784	25,569	26,323	27,154	28,021	28,928
Estimated Outlays	25,168	25,602	26,123	26,909	27,762	28,723
Proposed Changes						
Veterans Medical Care						
Estimated Authorization Level	0	0	-25,844	-26,706	-27,564	-28,460
Estimated Outlays	0	0	-23,283	-26,284	-27,307	-28,227
Offsetting Collections						
Estimated Authorization Level	0	0	0	0	0	0
Estimated Outlays	0	-7	-13	-23	-27	-16
Subtotal						
Estimated Authorization Level	0	0	-25,844	-26,706	-27,564	-28,460
Estimated Outlays	0	-7	-23,296	-26,307	-27,334	-28,243
Spending Under H.R. 2318						
Estimated Authorization Level	24,784	25,569	439	448	457	468
Estimated Outlays	25,168	25,595	2,827	602	428	480
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM						
Baseline Spending Under Current Law						
Estimated Authorization Level [a]	7,104	7,604	8,060	8,574	9,131	9,760
Estimated Outlays	7,104	7,604	8,060	8,574	9,131	9,760
Proposed Changes						
Estimated Authorization Level	0	0	0	-14	-18	-22
Estimated Outlays	0	0	0	-14	-18	-22
Spending Under H.R. 2318						
Estimated Authorization Level	7,104	7,604	8,060	8,560	9,113	9,738
Estimated Outlays	7,104	7,604	8,060	8,560	9,113	9,738
DEFENSE HEALTH PROGRAMS						
Baseline Spending Under Current Law						
Estimated Authorization Level [a]	14,888	15,199	15,540	15,914	16,296	16,706
Estimated Outlays	15,488	15,651	15,814	15,989	16,206	16,504
Proposed Changes						
Estimated Authorization Level	0	0	0	-32	-41	-49
Estimated Outlays	0	0	0	-26	-38	-47
Spending Under H.R. 2318						
Estimated Authorization Level	14,888	15,199	15,540	15,882	16,255	16,657
Estimated Outlays	15,488	15,651	15,814	15,963	16,168	16,457
SUMMARY OF CHANGES IN SPENDING SUBJECT TO APPROPRIATION						
Estimated Authorization Level	0	0	-25,884	-26,752	-27,623	-28,531
Estimated Outlays	0	-7	-23,296	-26,347	-27,390	-28,312

a. The 2003 level is the estimated net amount appropriated for that year. No full-year appropriation has yet been provided for fiscal year 2003. The current-law amounts for the 2004-2008 period assumes that appropriations remain at the 2003 level with adjustments for anticipated inflation.

Reduced Appropriations for VHA. Under H.R. 2318, VHA would no longer need most of its annual appropriation. The only remaining appropriated spending for VHA would be for construction, the spending of offsetting collections, and grants that are made to states to construct long-term care facilities. CBO estimates that funding VHA directly from the Treasury would save about $23 billion in 2005, $105 billion over the 2005-2008 period, and $261 billion over the 2005-2013 period, assuming appropriations are reduced by the estimated amounts. Those are the amounts underlying the current Congressional budget resolution. The baseline is derived by inflating the most recent full-year appropriation for a program. Future appropriation levels may be either higher or lower than such baseline projections.

Offsetting Collections. Under current law, certain veterans must make copayments when receiving health care from VHA. In addition, VHA can bill a veteran's third-party insurance when the veteran is treated for nonservice-connected conditions. These payments are deposited into the MCCF and, under current law, are treated as offsets to discretionary spending. Spending from the MCCF is subject to appropriation.

As mentioned earlier, CBO estimates that under H.R. 2318 total enrollment in VHA's health care system would increase by about 20 percent above VHA's projection of 9 million if it were to allow new priority 8 veterans to enroll. Although direct funding from the Treasury would not begin under the bill until 2005, CBO expects that enrollment would begin to increase in 2004 in anticipation of guaranteed funding in 2005, assuming VHA stops barring priority 8 veterans from enrolling to receive health care. CBO estimates that the increase in the number of veterans who actually receive care from VHA would increase more slowly with about 100,000 new users in 2004, growing to more than 1 million by 2013.

Based on that estimated increase, CBO estimates that collections would increase by $34 million in 2004, $975 million over the 2004-2008 period, and about $3 billion over the 2004-2013 period. When the amounts in the MCCF are appropriated, the budget authority for collections and spending of the collections offset each other exactly in each year, but there is a lag in outlays. CBO estimates that the lag in outlays would decrease spending by $7 million in 2004, by $86 million over the 2004-2008 period, and $107 million over the 2004-2013 period, assuming the appropriation of the amounts in the MCCF.

Federal Employees Health Benefits Program. As discussed above, enacting H.R. 2318 would lower FEHB costs by about $58 million in 2006, $225 million over the 2006-2008 period, and $829 million over the 2006-2013 period. CBO estimates that spending on active workers who do not work for the Postal Service represents about one-third of total FEHB spending. After accounting for the 72 percent of costs that the federal government is responsible for, CBO estimates that implementing H.R. 2318 would reduce expenditures for

FEHB by $14 million in 2006, $54 million over the 2006-2008 period, and $196 million over the 2006-2013 period, assuming appropriations are reduced by the estimated amounts.

DoD Retiree Health Care. All military retirees are, by definition, veterans. DoD provides third-party health care insurance as well as direct care in military hospitals and clinics to retirees. Spending on health care for military retirees who are under age 65 and not eligible for Medicare is subject to appropriation. While exact numbers are not available, CBO estimates that about 80,000 retirees would receive some health care from VHA in 2006 with that number remaining fairly constant through 2013. Assuming slightly lower per capita savings as with federal retirees, CBO estimates that implementing H.R. 2318 would save $32 million in 2006, $122 million over the 2006-2008 period, and $454 million over the 2006-2013 period, assuming appropriations are reduced by the estimated amounts.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 2318 contains no intergovernmental or private-sector mandates as defined in UMRA. Lower Medicaid spending for veterans that would now receive health services through the Veterans Health Administration would result in savings to states totaling about $640 million over the 2006-2008 period, and $2.2 billion over the 2006-2013 period.

ESTIMATE PREPARED BY:

Federal Costs:
Veterans Programs: Sam Papenfuss
Other Federal Health Care Programs: Thomas Bradley

Impact on State, Local, and Tribal Governments: Melissa Merrell

Impact on the Private Sector: Allison Percy

ESTIMATE APPROVED BY:

Peter H. Fontaine
Deputy Assistant Director for Budget Analysis