CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

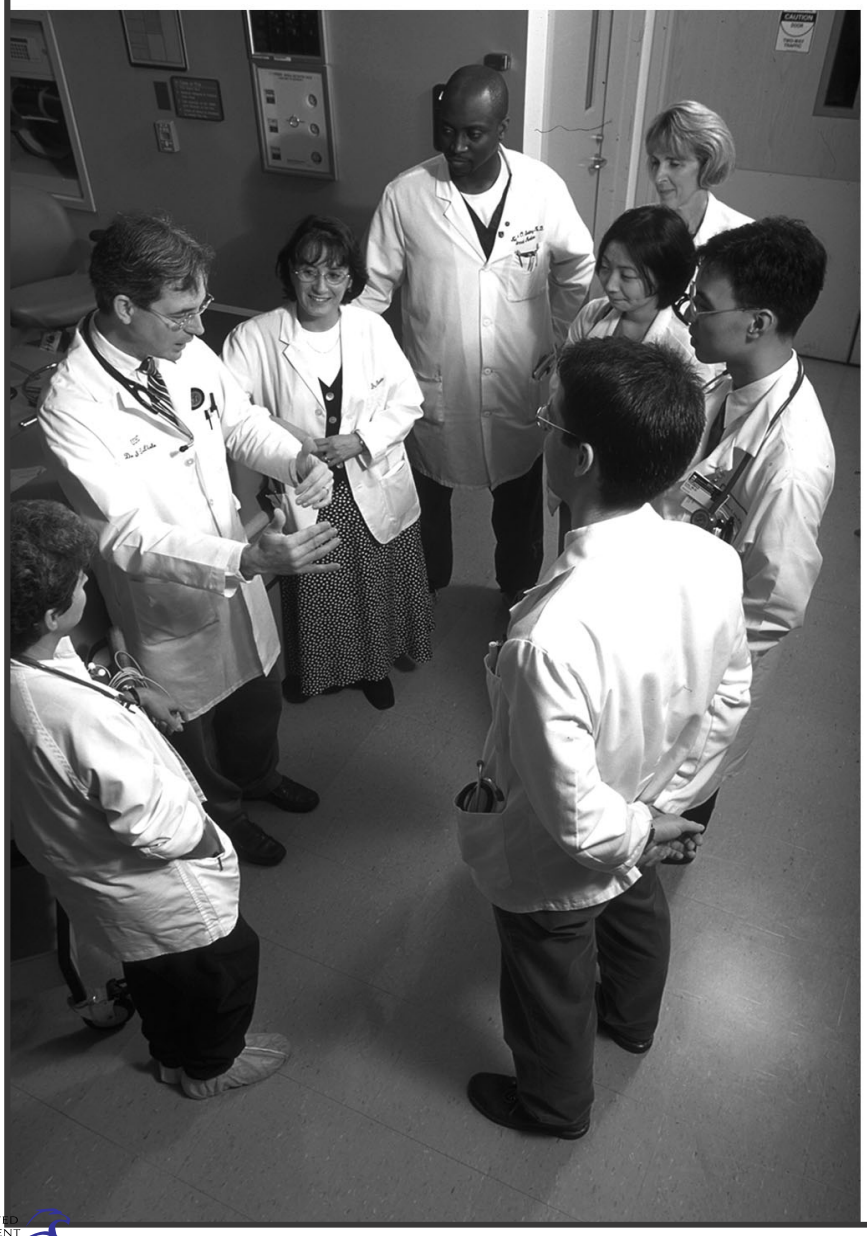
A
CBO
PAPER



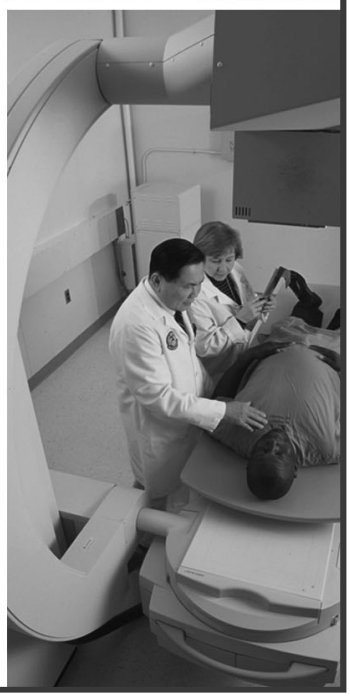
MARCH 2005

The Potential Cost of Meeting Demand for Veterans' Health Care









AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

A

CBO

PAPER

The Potential Cost of Meeting Demand for Veterans' Health Care

March 2005

The Congress of the United States ■ Congressional Budget Office

Notes

Unless otherwise indicated, all years referred to in this paper are fiscal years.

Numbers in the text and tables may not add up to totals because of rounding.

All dollar amounts are expressed in 2005 dollars (having been converted, when necessary, using the GDP price deflator).

All of the cover photographs were provided courtesy of the Department of Veterans Affairs. The photograph in the upper left-hand corner is by Gary Dale. The other photographs are by Ira Wexler.

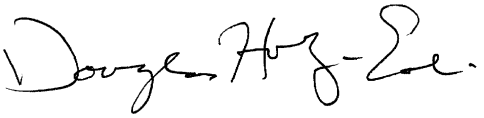
Preface

In recent years, increasing numbers of veterans have turned to the Department of Veterans Affairs (VA) for medical care, responding in part to an easing of eligibility rules in the mid-1990s that opened up the system to veterans who previously had only limited access to VA health care. Although VA medical budgets increased by 40 percent in real (inflation-adjusted) terms from 1999 to 2004, waiting lists and budget constraints led VA in January 2003 to restrict access to the system for higher-income veterans without service-connected disabilities. As the number of veterans seeking care continues to increase each year, it is unclear whether that change alone will relieve the pressures on VA medical facilities.

This Congressional Budget Office (CBO) paper, which was requested by former Senator Don Nickles in his capacity as Chairman of the Senate Budget Committee, examines the potential budgetary implications of meeting veterans' rising demand for medical care. In keeping with CBO's mandate to provide objective, nonpartisan analysis, this paper makes no recommendations.

The paper was prepared by Allison Percy and R. Derek Trunkey of CBO's National Security Division under the supervision of J. Michael Gilmore and Matthew S. Goldberg. David Auerbach and Stuart Hagen helped to develop the analysis in Scenario 3. Thomas Bradley, Arlene Holen, Carla Tighe Murray, Lyle Nelson, Sam Papenfuss, Elizabeth Robinson, and Jo Ann Vines provided thoughtful comments on a draft of the paper, as did external reviewers Gail R. Wilensky of Project Hope and Kent Simonis of Simonis Management Consulting. (The assistance of external reviewers implies no responsibility for the final product, which rests solely with CBO.) The authors wish to thank VA for providing data used in the analysis.

Christine Bogusz edited the paper, and Loretta Lettner proofread it. Cindy Cleveland produced drafts of the manuscript, Daniel Frisk checked the manuscript for factual accuracy, and Maureen Costantino prepared the paper for publication and designed the cover. Lenny Skutnik printed copies of the paper, and Annette Kalicki and Simone Thomas prepared the electronic version for CBO's Web site (www.cbo.gov).



Douglas Holtz-Eakin
Director

March 2005

CONTENTS

Summary *ix*

Introduction *1*

Background *1*
VA's Eligibility Requirements *2*
Recent Trends and Policy Changes *4*
Outpatient Clinics *5*

Methodology of This Analysis *6*

Projection Results *8*
Results for Scenario 1 *8*
Results for Scenario 2 *11*
Results for Scenario 3 *11*

Sensitivity Analysis of Increased Enrollment Rates *13*
Sensitivity Analysis for Scenario 1 *13*
Sensitivity Analysis for Scenario 2 *13*
Sensitivity Analysis for Scenario 3 *14*

Comparing the Scenarios to CBO's Baseline Projections *15*

Conclusion *16*

Tables

1.	VA's Health Care Enrollees, by Priority Group, 1999 to 2004	3
2.	VA's Community-Based Outpatient Clinics	6
3.	Percentage of Veterans with Other Sources of Health Insurance Coverage, by Priority Group	8
4.	Summary of Projection Results Under CBO's Three Scenarios	14
5.	Comparison of Out-of-Pocket Costs for Enrollees in Selected Health Plans in Calendar Year 2005	16
6.	Summary of Sensitivity Analysis with Increased Enrollment Under CBO's Three Scenarios	17
7.	Funds Needed to Meet Projected VA Medical Demand Under the Various Scenarios Presented in This Paper	19

Figures

1.	The Total Population of Veterans, 1990 to 2004	1
2.	VA's Medical Budget, 1990 to 2004	2
3.	Estimated Percentage of Veterans Enrolled for Medical Care from VA, by Priority Group, 2004	7
4.	Veterans' Rates of Reliance on VA Care, by Priority Group, 2002	9
5.	Relative Cost of VA Enrollees, by Priority Group, 2002	11
6.	Veterans' Shares of Total VA Medical Enrollment and Costs, by Priority Group, 2004	12
7.	Estimated Percentage of the Total Population of Veterans in Each Priority Group, 2004	12
8.	Projected Resource Needs Under Different Assumptions of Growth in Heath Care Costs for Scenario 1	15
9.	Projected Demand for VA Medical Resources Under Scenario 1, Allocated by Priority Group, Compared with CBO's Baseline Budget Projections, 2005 to 2025	20
10.	Projected Demand for VA Medical Resources Under CBO's Three Scenarios, 2005 to 2025	21
11.	Summary of the Projections for 2025, by Scenario and Priority Group	22

Boxes

1.	VA's Health Care Priority Groups	4
2.	Interactions Between Sources of Health Care Coverage	10
3	Elements of the Congressional Budget Office's Cost Projection	13
4.	Modeling the Effects of Policy Changes on Enrollment and Costs	18

Summary

The Department of Veterans Affairs (VA) has faced an increase in demand for medical services in recent years that has driven rapid expansion of its budget. Although the number of veterans in the United States has been generally falling (the population of veterans was about 25 million in 2004), VA medical budgets increased by 40 percent in real (inflation-adjusted) terms from 1999 to 2004. In the 1990s, lawmakers expanded eligibility for VA medical services and established an enrollment system, currently consisting of eight priority groups, to identify and prioritize veterans seeking care. Nearly 4.2 million veterans were enrolled in 1999 (the first year in which the enrollment system was fully operational), rising to 7.4 million in 2004 (about 17 percent and 30 percent of the total population of veterans in those two years, respectively).

In this paper, the Congressional Budget Office (CBO) used data from VA and other sources to project the cost from 2005 through 2025 of providing the current level of services to the changing population of veterans under three different scenarios. As a discretionary program, VA medical care relies on annual budget appropriations.[1] This paper does not attempt to predict those appropriations; rather, the projections in this report reflect CBO's best estimate of the funds that would need to be appropriated to continue providing the current level of services to veterans, assuming that enrollment rates and reliance on VA medical care followed current trends (Scenario 1). In addition, this report presents two other scenarios (Scenarios 2 and 3) that examine the effects of policy changes on those projections and shows how the estimates would vary with changes in key assumptions about enrollment and growth in health care costs.

Health care costs have risen faster than overall price inflation in the past few decades. In projecting the cost of meeting the demand for VA medical services from 2005 through 2025, CBO assumed that VA would face the same rate of growth in health care costs as the rest of the economy. Specifically, CBO assumed that per capita health care costs would grow by 6.1 percent in 2006 in nominal terms, falling to 4.2 percent by 2025. To hold down potential future costs, VA could seek to improve efficiency in some areas.

Under Scenario 1, CBO projected the levels of VA medical funding that would be needed to meet the demand for care, assuming that VA proceeds with its plans to expand its number of outpatient clinics but makes no major changes in eligibility rules, cost sharing, or other policies. Under those assumptions, in order to meet the demand, VA medical funding would need to increase by 89 percent in real terms over the projection period, in CBO's estimation, growing from $28.2 billion in 2005 to $53.4 billion in 2025.[2] If VA received appropriations for all of the funds necessary to meet the demand, almost all of the spending (89 percent) in 2025 would be consumed by veterans in the first five priority groups, which include veterans with service-connected disabilities, housebound veterans, and those with low income and few assets. Veterans in priority group 6, most of whom have been exposed to chemical, biological, or radiological agents in the line of duty, make up only 2 percent to 3 percent of enrollees, and their care consumes only about 1 percent of VA's medical budget. Only 10 percent of the costs of the VA health care system would be incurred for veterans in priority groups 7 and 8 (higher-income nondisabled veterans, with veterans in priority group 8 having higher

1. The Veterans Health Administration manages the VA medical centers and clinics, which provide medical and rehabilitation services to veterans, medical research, graduate medical education, and emergency management.

2. The VA medical budget for 2005 used as the starting point for these projections is from the *FY04 VA Health Care Projection Model* (January 2004). It excludes the costs of long-term care and some other VA medical costs and differs somewhat from the final 2005 VA medical budget.

income than those in group 7), in part because under this scenario, enrollment for veterans in priority group 8 would remain frozen, as it has been since January 2003.

Under Scenario 2, CBO assumed that the freeze in enrollment for veterans in priority group 8 would be lifted in 2006 and no further restrictions on enrollment put in place. (All other assumptions were the same as those for Scenario 1.) Under those assumptions, in order to meet the demand for care, VA medical funding would need to increase by 103 percent in real terms over the projection period, CBO estimates, growing from $28.2 billion in 2005 to $57.1 billion in 2025. In particular, spending on veterans in priority group 8 under Scenario 2 would need to triple compared with its level under Scenario 1, rising from $1.9 billion to $5.6 billion.

Under Scenario 3, CBO estimated potential costs if the freeze on enrollment for veterans in priority group 8 was lifted but, at the same time, an annual enrollment fee of $250 and a higher pharmacy copayment of $15 were established for veterans in both priority groups 7 and 8. Those increased out-of-pocket costs for higher-income veterans were among the changes proposed in the President's 2005 budget (although they did not appear in the legislation ultimately passed by the Congress for that year) and again in the President's 2006 budget. CBO assumed that the enrollment fee and higher pharmacy copayments would constrain both enrollment and utilization of care for those two priority groups. Under those assumptions, total VA funding for medical care would need to rise to $52.6 billion in real terms in 2025 in order to meet the demand, CBO estimates, or 1 percent less than its projected level under Scenario 1 and 8 percent less than under Scenario 2.

Projections of VA medical resources under all three scenarios are sensitive to the assumptions made about enrollment rates for each priority group. Only a fraction of eligible veterans are currently enrolled for VA medical care, particularly in the lower priority groups. For example, less than 20 percent of veterans in priority groups 6, 7, and 8 were enrolled in 2004. If just one-quarter of the veterans in each priority group who were eligible but not enrolled turned to VA for care, VA's medical funding would need to rise by 11 percent to 15 percent to meet the demand, in CBO's estimation, compared with the amounts mentioned for each scenario above.

Uncertainty about the accuracy of the assumptions in these projections increases over time, so the projections toward the end of the 20-year time horizon are more uncertain than those toward the beginning. Cost growth, enrollment rates, reliance on other sources of care, and many other factors are more likely to differ from CBO's assumptions as time passes. In addition, legislative and economic changes may have a profound impact on the VA medical system over the next 20 years.

As noted earlier, VA medical care is funded with annual appropriations. To project growth in discretionary programs, CBO uses a methodology specified in the Balanced Budget and Emergency Deficit Control Act of 1985. That formula projects expenditures that rise much more slowly than the anticipated growth in health care costs and VA enrollment. CBO's baseline budget projections show the VA medical budget growing to $35.2 billion in 2025, only two-thirds of the amount projected in the first scenario presented in this paper. If VA medical care was budgeted at that level, and if health care costs and enrollment grew as anticipated under Scenario 1, VA would be able to provide the current level of services only to veterans in priority groups 1 through 4 and less than half of the veterans in priority group 5 likely to seek care from VA.

The Potential Cost of Meeting Demand for Veterans' Health Care

Introduction

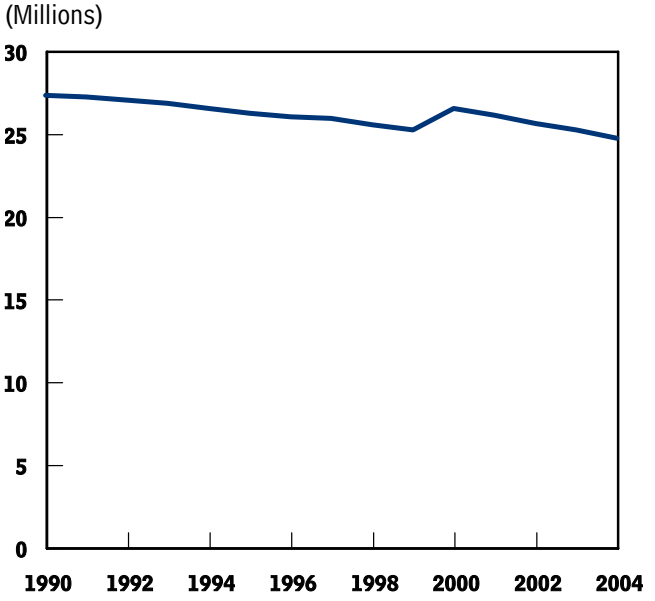
In recent years, the Department of Veterans Affairs (VA) has faced an increase in demand for its medical services that has driven rapid expansion in its budget. VA medical budgets have increased in real (inflation-adjusted) terms from $16 billion in 1990 to nearly $28 billion in 2004, even though the number of veterans in the United States has been falling by 1 percent to 2 percent a year. Since the enrollment system was established in 1999, the number of veterans enrolled in the VA health system has increased rapidly, reaching 7.4 million in 2004 (see Figures 1 and 2 and Table 1).

This paper examines the long-term budgetary implications of continuing to meet the changing demand for VA medical services. Decisions about policies and benefits for the veterans' health care system have long-term consequences for the federal budget and for the performance of VA hospitals and clinics. In this paper, CBO projects the cost from 2005 through 2025 of providing the current level of services to the changing population of veterans under three different scenarios, two of which involve possible policy changes that would affect the growth in VA medical spending during that period.

VA medical care is provided through the Veterans Health Administration (VHA). Because VHA is a discretionary program, it can spend only its appropriated funds. This paper does not attempt to predict those appropriations; rather, the projections in this report reflect CBO's best estimate of the funds that would be required to provide the current level of services to veterans, assuming that enrollment rates and reliance on VA medical care followed current trends. A later section of this report compares those projections to the rate of growth normally anticipated for discretionary spending in the federal budget and discusses the implications for the level of services VA could provide.

Figure 1.

The Total Population of Veterans, 1990 to 2004



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

Note: Estimates were revised after the 2000 census. Previous estimates have not been revised to reflect those newer figures.

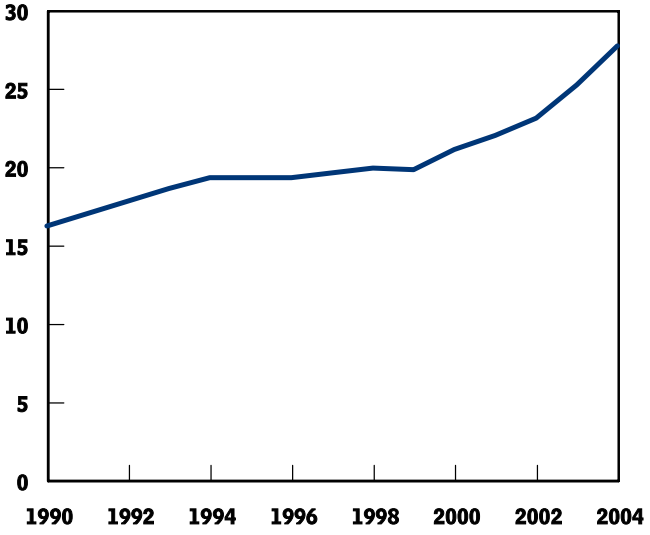
Background

The Department of Veterans Affairs provides veterans with three broad types of services. The Veterans Benefits Administration manages disability compensation, pension, education (such as the Montgomery GI Bill), homeownership, and other programs that benefit veterans through monthly payments, loans, and other forms of financial assistance. The National Cemetery Administration maintains national cemeteries and provides burial benefits for veterans and their eligible family members.

Figure 2.

VA's Medical Budget, 1990 to 2004

(Billions of 2005 dollars)



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

The Veterans Health Administration manages the VA medical centers and clinics.

VHA's mission consists of four major tasks: medical and rehabilitation services for veterans, medical research, graduate medical education, and emergency management. VA medical personnel conduct and publish numerous research studies each year that contribute to medical knowledge about disease and disability. That research program is intended to help improve the medical care provided to veterans and to other patients and to attract quality physicians and other health professionals to VA.

In addition, the department offers training programs as part of its graduate medical education that are "designed to help ensure an adequate supply of clinical care providers for veterans and the Nation."[1] Each year, more than 76,000 medical and associated health students and residents receive part of their clinical training at VA medical facilities because of VA's affiliation with 1,200 educational institutions, including 107 medical schools.[2]

1. Department of Veterans Affairs, *FY 2003 Performance and Accountability Report* (Washington, D.C.: Department of Veterans Affairs, 2003), p. 12.

2. See www.va.gov/oaa/OAA_Mission.asp.

VA also provides contingency support should the military health system need additional medical capacity in case of a major conflict. As part of the National Disaster Medical System, VA provides support for national emergencies or natural disasters. For example, VA health care workers provided assistance after several major hurricanes in 2004.[3]

In the past, VA focused on providing inpatient care in VA hospitals. In recent years, however, VA has expanded its outpatient services, following a national trend toward outpatient medical care. By building outpatient clinics itself (or negotiating contracts with existing clinics), VA has been able to make its services more accessible to veterans who do not live near one of VA's 157 hospitals. During the 1999-2004 period, the share of veterans enrolled for health care with VA rose from 17 percent to 30 percent, and the share of veterans seeking medical care from VA rose from 13 percent to 19 percent.[4] Improved geographic access and increased awareness by veterans of the value of the medical benefit may have contributed to those increases.

For some eligible veterans, VA also provides long-term care in various settings. They include VA nursing homes, state-owned and -operated veterans' homes, contract care at private nursing homes, home health services, and adult day care.

Although VHA provides care primarily to veterans with service-connected disabilities or low income, the department also serves veterans more broadly. Many veterans have chronic illnesses, non-service-connected disabilities, or mental-health and substance-abuse problems that may not be covered by private insurance. Some veterans have access to other government or private insurance options, but they choose to receive care from VA because of its convenience or low out-of-pocket costs.

VA's Eligibility Requirements

Eligibility for health care through the VA system has expanded over time. Before 1924, only veterans with injuries received during their military service were eligible for

3. Department of Veterans Affairs, *FY 2004 Performance and Accountability Report* (Washington, D.C.: Department of Veterans Affairs, 2004), p. 30.

4. Enrollment with VA establishes a veteran's eligibility and priority for health care services. Not all enrolled veterans actually seek care from VA each year.

Table 1.

VA's Health Care Enrollees, by Priority Group, 1999 to 2004

(Thousands)

Priority Group	1999	2000	2001	2002	2003	2004
P1	440	492	561	642	721	a
P2	303	345	400	436	464	a
P3	553	629	790	861	912	a
P4	130	168	200	214	226	a
P5	1,708	1,949	2,203	2,382	2,424	a
P6	70	91	110	124	140	a
P7, P8, and "Unassigned" Veterans	970	1,142	1,748	2,129	2,299	a
Total	4,176	4,816	6,013	6,789	7,187	7,420

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

Notes: Veterans in priority group 7 (P7) have income above a VA-defined means test that is the same throughout the United States. Priority group 8 (P8) was created in October 2002 by dividing priority group 7 veterans into two separate groups on the basis of a higher, geographically adjusted means test. "Unassigned" veterans have not yet completed the process of enrolling and have not been assigned to a priority group.

See Box 1 for definitions of the priority groups.

a. Enrollment for 2004 is not available by priority group. The only available breakdown is 5,112,000 veterans in priority groups 1-6 combined and 2,308,000 veterans in priority groups 7 and 8 combined.

coverage. Eligibility was gradually extended to wartime veterans with low income; by 1973, all low-income veterans, including those without injuries related to their military service, were eligible. The low-income requirement was eliminated in 1986, making all veterans eligible for treatment for service-connected conditions and, in some cases, conditions not related to their military service.[5]

In the mid-1990s, VA began transforming its hospital-based system away from inpatient care toward providing more outpatient services, reflecting changing trends in medical practice nationwide as well as changing demands for VA care. VA also received statutory authority to reform the rules of eligibility for care. VA's then-Undersecretary for Health argued that the eligibility rules were biased toward inpatient care and caused inefficiencies in the VA system. He also asserted that eligibility reform would not increase VA's health care costs, but rather should save money by shifting care from the expensive inpatient setting to the less-expensive outpatient setting.[6]

The change in eligibility rules and creation of more geographically dispersed outpatient clinics brought about a substantial increase in the number of veterans who turned to VA for medical care. The number of veterans using VA's health care system increased from 2.9 million in 1995 to 4.7 million in 2004.[7]

As directed by the Veterans' Health Care Eligibility Reform Act of 1996, VA created an enrollment system to keep track of veterans who planned to use VA care. In most cases, a veteran now must enroll in the VA medical system to be eligible for care. (Enrollment is free of charge.) As part of the enrollment process, applicants must document their status as veterans and are assigned to a priority group (from P1 to P8) on the basis of their service-connected disabilities (if any), income, and other factors (see Box 1 for definitions of VA's priority groups). In any given year, some enrollees do not seek any medical care, either because they do not become ill or because they rely on other sources of care.

5. Statement of Cynthia A. Bascetta, Director, Health Care, Veterans' Health, and Benefits Issues, General Accounting Office, before the Committee on Veterans' Affairs, published as General Accounting Office, *Key Management Challenges in Health Disability Programs*, GAO-03756T (May 8, 2003), p. 4.

6. Kenneth W. Kizer, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation of the Veterans Healthcare System* (Washington, D.C.: Department of Veterans Affairs, 1996), p. 14.

7. Department of Veterans Affairs, *FY 2003 Performance and Accountability Report*, p. 5; and Department of Veterans Affairs, *FY 2006 Budget Submission*, vol. 2, "Medical Programs," p. 2-16.

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 an SCD; 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 living below established VA 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, atmospheric testing, and Project 112/SHAD); and veterans with compensable SCDs rated zero percent disabling

Priority Group 7 (P7)
Veterans with net worth above the VA means test threshold and below a geographic index defined by the Department of Housing and Urban Development (HUD)

Priority Group 8 (P8)
Veterans with net worth above both the VA means test threshold and the HUD geographic index

VA's enrollment system became fully operational in 1999, and enrollment grew from 4.2 million in that year to 7.4 million in 2004. Under the priority system, the Secretary of Veterans Affairs decides each year whether VA's medical budget is adequate to serve veterans in all priority groups who seek care. If not, those in the lowest priority groups (P7 and P8) would be the first to lose access to care.

Recent Trends and Policy Changes

As eligibility for VA medical care has expanded, many moderate-income veterans without service-connected disabilities have sought to fill gaps in their other health insurance by turning to VA for pharmaceuticals and outpatient care. Some of the increased demand for outpatient care stems from VA's policy that it dispenses pharmaceuticals only if they are prescribed during a visit to a VA medical center or clinic.

VA has had difficulties coping with the large influx of new users seeking pharmaceuticals and outpatient care. Although VA has substantial excess inpatient bed capacity in many facilities, the influx of new enrollees seeking pharmaceuticals and outpatient care has exacerbated waiting times for all veterans wanting to see a VA provider. By the end of 2002, about 300,000 enrolled veterans were on waiting lists for VA medical appointments.

Waiting times have been a long-standing problem for the department. In 1993, the General Accounting Office (GAO, now known as the Government Accountability Office) found that veterans frequently waited eight to nine weeks to obtain appointments at some specialty clin-

ics.[8] In 1996, lawmakers enacted legislation requiring VA to serve veterans in a timely manner.[9] In response, the department initiated a number of actions to address waiting times and waiting lists, including better tracking, better scheduling, and use of a primary care model—that is, coordinated health care delivery through interdisciplinary teams.

Accompanying the rise in the number of veterans seeking care at VA facilities were substantial increases in the annual budget for VHA. Although VA medical budgets were relatively flat in real terms in the mid-1990s, they grew by an inflation-adjusted 4 percent to 10 percent each year from 2000 to 2004. Those budget increases were appropriated by the Congress to fund the rapidly increasing demand for VA health care that followed the change in eligibility rules after 1996.[10]

In part because of the long waiting lists and influx of new patients that VHA could not accommodate in a timely manner, in January 2003 then-Secretary of Veterans Affairs Anthony Principi decided to cut off enrollment of new P8 veterans—those without service-connected disabilities who have income above $25,842 per year (for a single veteran) and above a geographically adjusted means test. Veterans in that priority group who had already enrolled in the system were "grandfathered," however, and could continue to seek care from VA. According to the department, "Until the waiting time for medical appointments can be reduced to an acceptable standard, it would not be in the best interest of those most in need of care for VA to enroll additional priority group 8 veterans."[11]

The management initiatives mentioned earlier, along with the freeze on new enrollments for P8 veterans, have reduced waiting times by between 32 percent and 61 percent (from 2000 to 2003) and waiting lists by 78 percent (from 2002 to 2003) in selected clinics.[12]

Outpatient Clinics

Community-based outpatient clinics (CBOCs) operate as physicians' offices and are located in communities close to VA's patients. The number of CBOCs has grown over time; and that growth may have implications for projecting enrollment. Tracking the growth of CBOCs is complicated by two factors, however: the definition of a CBOC has changed, and some clinics were closing while others were opening.[13] VA started expanding the number of CBOCs in 1995 from its initial level of about 175. Around 2000, some VA satellite clinics were renamed as CBOCs, further adding to the increase.[14] The number of new CBOCs changes substantially from year to year but averaged about 30 per year from 2000 to 2004, which is close to the estimated average rate of growth over the next three years (see Table 2).

There is some uncertainty about whether the new CBOCs will primarily serve existing VA enrollees more conveniently or whether they will encourage new veterans to enroll. Roughly 30 percent, or 135,000, of CBOC patients were new to the VA system in 2000, but those new patients represented only about 2 percent of total VA enrollees.[15] Even in the absence of new CBOCs, some of

8. General Accounting Office, *VA Health Care: Restructuring Ambulatory Care System Would Improve Services to Veterans*, GAO/HRD-94-4 (October 1993), p. 3; General Accounting Office, *VA Health Care: More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress*, GAO-01-953 (August 2001), p. 1; statement of Cynthia A. Bascetta, *Key Management Challenges in Health Disability Programs*, p. 8.

9. Section 104(b)(1) of the Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104-262.

10. In recent years, the Congress has authorized and appropriated more for VA health care than was requested in the President's budget.

11. Department of Veterans Affairs, "The Truth About VA Funding" (press release, Washington, D.C., April 23, 2003), available at www.gla.med.va.gov/pages/documents/VAFunding.htm.

12. Data supplied to the Congressional Budget Office by the Department of Veterans Affairs in October 2004.

13. Data sources differ regarding the number of CBOCs in any given year. For example, the reported number in 2000 ranges from 277 to 600; that variation is probably due to different definitions of CBOCs. See Michael K. Chapko and others, "Evaluation of the Department of Veterans Affairs Community-Based Outpatient Clinics," *Medical Care*, vol. 40, no. 7 (2002), pp. 555-560 (reporting 277 CBOCs in 2000); statement of Cynthia A. Bascetta, Director, Health Care, Veterans' Health, and Benefits Issues, General Accounting Office, before the Subcommittee on VA, HUD, and Independent Agencies of the Senate Committee on Appropriations, published as General Accounting Office, *Community-Based Clinics Improve Primary Care Access*, GAO-01-678T (May 2, 2001), p. 1 (reporting about 575 CBOCs in 2000); and data supplied to the Congressional Budget Office by the Department of Veterans Affairs in November 2004 (reporting 600 CBOCs in 2000).

14. Chapko and others, "Evaluation of the Department of Veterans Affairs Community-Based Outpatient Clinics."

15. Statement of Cynthia A. Bascetta, *Community-Based Clinics Improve Primary Care Access*, p. 10.

Table 2.

VA's Community-Based Outpatient Clinics

Year	Existing CBOCs	New CBOCs
2000	600	50
2001	695	95
2002	685	-10
2003	673	-12
2004	696	23
2005	751	55
2006	778	27
2007	798	20
2008	809	11
2009	817	8
2010	827	10
2011	835	8
2012	839	4
2013	844	5
2014	848	4
2015	852	4

Sources: Congressional Budget Office based on data from the Department of Veterans Affairs in November 2004; and Figure 1 in Michael K. Chapko and others, "Evaluation of the Department of Veterans Affairs Community-Based Outpatient Clinics," Medical Care, vol. 40, no. 7 (2002), p. 557 (for data on CBOC growth in 2000 measured as the change in the total number of clinics between July 1999 and July 2000).

Notes: The Department of Veterans Affairs (VA) projected the data for 2005 and beyond.

CBOC = community-based oupatient clinic.

those veterans would probably have enrolled and gone to other, existing VA facilities. Thus, even the figure of 135,000 represents an upper-bound estimate on the amount of new demand generated by the opening of CBOCs. If similar trends continue, new CBOCs opened in the future may add only a small amount to the total number of VA patients.

Methodology of This Analysis

This paper estimates the long-term budgetary implications of providing the current range of VA medical services from 2005 through 2025. The projections include costs for inpatient care, outpatient services, pharmaceuticals, and related costs, but they do not include long-term care and some other costs.[16] The projections take into account trends in the size and composition of the population of veterans as well as trends in health care costs throughout the economy.

The projections in this report are not intended to gauge future resource demands precisely. 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 assumptions about enrollment, reliance on VA 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. A later section of this paper explores the effect of changes in enrollment and other assumptions. The projections represent CBO's best estimate of the funding that would be required in order to meet the demand for veterans' medical care over the next 20 years under the assumptions described for each scenario.

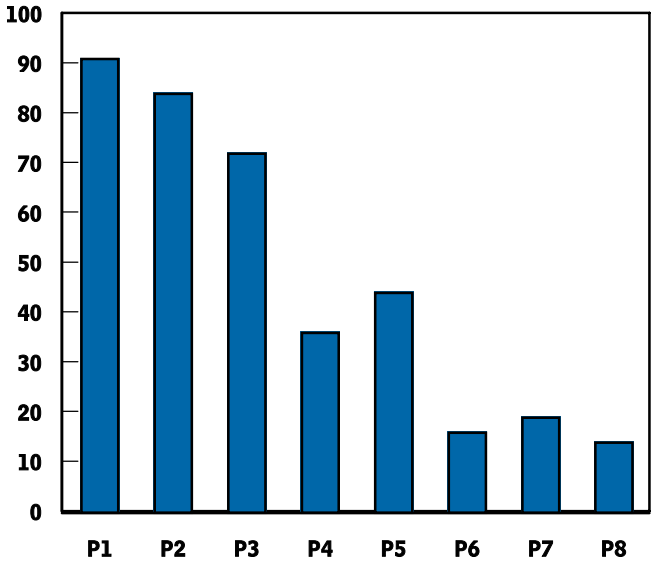
In performing its analysis, CBO relied on projections provided by VA of the size of the total population of veterans. VA distributed those population totals among the priority groups to which they would likely be assigned, on the basis of veterans' income, disability status, and other factors, if the veterans enrolled in VA for health care. The projections do not include the small increase in the size of the population arising from the increase in activation of members of the Reserves and National Guard since September 11, 2001, nor do they include the increase in combat-disabled veterans arising from current conflicts in Iraq and Afghanistan. However, those omissions would probably affect the population projections by only 1 percent to 2 percent and the number of disabled veterans by a similarly small percentage.

VA data indicate that most veterans with service-connected disabilities had enrolled for VA medical care by

16. The excluded programs are 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. See Department of Veterans Affairs, *FY04 VA Enrollee Health Care Projection Model* (January 2004), p. I-3.

Figure 3.

Estimated Percentage of Veterans Enrolled for Medical Care from VA, by Priority Group, 2004



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

Note: See Box 1 for definitions of the priority groups.

2004, but less than half of low-income veterans and less than one-fifth of higher-income veterans without service-connected disabilities had enrolled for care by then (see Figure 3). Enrollment among priority group 8 veterans in that year was further constrained by the freeze that had been imposed in January 2003.

Many veterans rely on other sources of coverage, such as Medicare, Medicaid, private health insurance, the military health system, or public hospitals (see Table 3). Even among enrolled veterans, most receive the majority of their care from sources outside VA (see Figure 4 on page 9). Disabled veterans receive the highest portion of their care from VA. Enrolled veterans in priority groups 1 through 3, with service-connected disabilities, receive between 36 percent and 50 percent of their care, on average, from VA facilities. Enrolled veterans in priority group 4, most of whom are housebound with catastrophic disabilities not related to their military service, receive just over half of their care from VA, on average. Low-income enrolled veterans in priority group 5 receive about 44 percent of their care from VA. By comparison, enrolled veterans in priority group 6 (mostly veterans suffering from exposure to toxic substances) receive about a quarter of their care from VA, and enrolled veterans in priority groups 7 and 8 generally receive about 20 percent of their care from VA. CBO assumed that enrolled veterans would continue to receive the same percentage of their care (as measured in dollars) from VA as they currently do. (See Box 2 for a discussion of that assumption.)

Veterans in some priority groups have higher average costs than others do (see Figure 5 on page 11). VA calculated the relative health care costs for enrolled veterans as part of its health care projection model.[17] Those relative cost weights include the impact of such factors as the age, sex, and morbidity of veterans in each priority group. But the cost weights *exclude* the impact of reliance on other sources of care—that is, these are the relative costs that would be incurred by veterans in each group if they received 100 percent of their care from VA. (Reliance is estimated separately, as noted earlier.) The reference group for those relative cost weights is veterans in priority group 1 (P1 veterans), or those with a 50 percent or higher service-connected disability. Compared with costs for that group, the average cost of services provided to most other groups is substantially less. Veterans in priority groups 2 and 3 cost just 57 percent and 49 percent as much as P1 veterans, while low-income veterans in priority group 5 cost about 59 percent as much as P1 veterans. The most expensive group, however, is veterans in priority group 4 (housebound veterans), who cost 71 percent more than P1 veterans. The least expensive veterans are those in priority groups 6, 7, and 8, who cost between 30 percent and 45 percent as much as P1 veterans.

Those various factors explain the difference between the number of enrolled veterans in each priority group and the costs of caring for veterans in each of those groups (see Figure 6 on page 12). Even though veterans in priority groups 7 and 8 made up 14 percent and 17 percent of enrollment, respectively, in 2004, they consumed just 5

17. Department of Veterans Affairs, *FY04 VA Health Care Projection Model Final Model Run Reports*, vol. I, sec. I, "Executive Summary" (prepared by Milliman USA and CACI, January 2004), available at www.va.gov/vhareorg/enroll02/enrldec.htm.

Table 3.

Percentage of Veterans with Other Sources of Health Insurance Coverage, by Priority Group

	Other Coverage in 2003					Other Coverage in 2002	
Priority Group	Medicare Part A	Medicare Part B	Medigap	Medicaid	Any Insurance	Private HMO	Private Non-HMO
P1	52	43	16	4	74	14	15
P2	40	36	20	4	77	14	15
P3	43	38	23	5	78	14	15
P4	69	59	21	13	75	8	8
P5	57	50	22	9	68	8	8
P6	30	27	17	3	78	8	8
P7 and P8	65	60	45	5	88	16	19
Total	56	50	28	6	77	n.a.	n.a.

Source: Congressional Budget Office based on data from Department of Veterans Affairs, Survey of Veteran Enrollees' Health and Reliance Upon VA (December 2003).

Notes: See Box 1 for definitions of the priority groups.

HMO = health maintenance organization; n.a. = not applicable.

Data for private insurance coverage are available only as averages (for priority groups 1-3, 4-6, and 7-8).

percent and 6 percent, respectively, of VA resources during that year.[18]

Because relatively few veterans in priority groups 7 and 8 are currently enrolled for VA health care, there are a large number of unenrolled veterans who might look to VA for care at some point in the future. VA has estimated the share of the total population of veterans (enrolled and unenrolled) that fell into each of the eight priority groups in 2004 (see Figure 7 on page 12). Those shares must be estimated because priority-group determination for some veterans cannot be made until they enroll. Veterans in priority groups 7 and 8 make up 22 percent and 37 percent, respectively, of the total population. Thus, demand for VA's resources could increase if a larger share of higher-income veterans without service-connected disabilities turned to VA for health care.

Projection Results

The long-range projections in this paper are organized into three main scenarios. The first reflects the cost of meeting the anticipated demand for VA health care without any changes in policy. The second considers the impact of reopening enrollment for higher-income veterans without disabilities. The third examines the impact of increasing cost sharing at the same time that enrollment is reopened for those higher-income veterans.

Results for Scenario 1

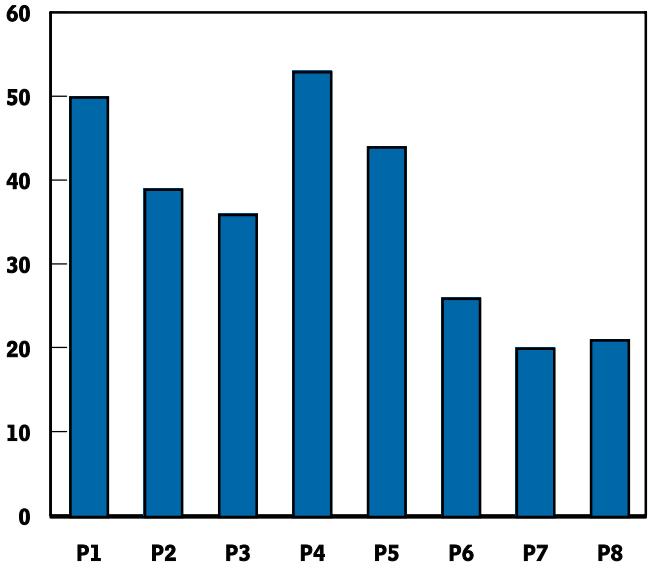
Under the first scenario, CBO projected growth in the cost of meeting the demand for VA medical care assuming no major changes in policy. (This scenario does assume that VA moves forward with its plans to expand the number of CBOCs, as shown in Table 2 on page 6.) CBO assumes that the current priority group structure will remain the same and that new enrollment by veterans in priority group 8 (P8 veterans) will remain frozen. With no new enrollees, the number of enrolled P8 veterans will decrease as a result of mortality. CBO obtained projections of future enrollment under those base-case assumptions from VHA. Underlying those projections is the assumption that a fixed percentage of unenrolled veterans within each priority group (other than P8) will enroll each year—that is, the rate of new enrollment is fixed. That assumption is consistent with the statistical analysis

18. Those shares represent the current situation and are subject to change over time. See a later section of this paper for a sensitivity analysis that examines the impact of changes in enrollment rates on long-term cost projections.

Figure 4.

Veterans' Rates of Reliance on VA Care, by Priority Group, 2002

(Percentage of care from VA)



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

Note: See Box 1 for definitions of the priority groups.

by an actuarial firm with whom VA contracted when developing its health care projection model.[19]

That analysis projected the rates of new enrollment from data collected over a 17-month period, from April 2000 to August 2001. At that time, VA was undergoing a period of geographic expansion, opening 50 new clinics in 2000 and 95 more in 2001. The enrollment rates were probably affected by that expanded geographic access to outpatient services. The 2005-2025 period also includes a substantial planned expansion in the number of outpatient clinics, particularly in underserved areas. Thus, there is a strong case for using the historically estimated enrollment rates to project future enrollment, as this scenario does. If VA adds fewer new clinics in the future or if new enrollment slows down for other reasons, the demand for VA health care will be lower than anticipated in this scenario.

Other key assumptions in CBO's projection involve health care costs and rates of reliance on VA care by enrollees. CBO assumed that health care costs would increase for VA at the same rate as those in the rest of the economy.[20] CBO also began with VA's assumptions about rates of reliance—that is, the percentage of health care that a typical veteran from each priority group receives from VA as opposed to other sources of care—and the relative costs of veterans in each priority group. (See Box 3 on page 13 for a simplified explanation of the elements in CBO's cost projection.) Later sections of this paper will explore the effects of deviating from some of those assumptions.

Under Scenario 1, in order to meet the demand for care, funding for VA medical care would need to increase by 89 percent in real terms over the projection period, CBO estimates, growing from $28.2 billion in 2005 to $53.4 billion in 2025 (see Table 4 on page 14).[21] Most (89 percent) of the costs in 2025 would be to serve the first five priority groups—veterans with service-connected disabilities, housebound veterans, and those with low income or few assets. Only 10 percent of the costs of the VA system would be incurred for veterans in priority groups 7 and 8. That low percentage is due not only to the continued freeze on enrollment for P8 veterans, but also to the assumption that current low rates of enrollment for veterans in priority group 7 (P7) will persist, as well as low rates of reliance by both P7 and P8 veterans.

The projections are sensitive to the assumed rate of growth of health care costs. CBO's projections of the total VA medical budget would change substantially if the

19. Department of Veterans Affairs, *FY04 VA Health Care Projection Model Final Model Run Reports*, vol. II, Appendix C, "Enrollment Rates Analysis Report" (prepared by Milliman USA and CACI, November 2003), available at www.va.gov/vhareorg/enroll02/enrldec.htm. CBO did not attempt to assess the accuracy of VA's base-case enrollment projections.

20. In deriving its estimates, CBO used projections of cost growth for hospital care and physicians' and clinical services through 2013 made by the Office of the Actuary, Centers for Medicare and Medicaid Services, Department of Health and Human Services (see www.cms.hhs.gov/statistics/nhe/projections-2003). For the years after 2013, CBO assumed that per capita growth in those expenditures would begin to decrease toward an ultimate rate of growth that was 1 percentage point above the growth in per capita gross domestic product.

21. The VA medical budget for 2005 used as the starting point for these projections is from the *FY04 VA Health Care Projection Model* (January 2004). It excludes the costs of long-term care and some other VA medical costs and differs somewhat from the final 2005 VA medical budget.

Box 2.

Interactions Between Sources of Health Care Coverage

Veterans' rates of enrollment and reliance on care from the Department of Veterans Affairs (VA) depend heavily on their access to other sources of health insurance and medical care, such as Medicare, Medicaid, and private insurance. Demand for VA medical care in the future will be affected by changes in access to those other sources of coverage, such as cuts or expansions to Medicaid, the introduction of the Medicare drug benefit, and changes in the availability and cost of private insurance through current or past employers, all of which are difficult to predict. Some changes could lead to a reduction in demand for VA care but an increase in spending by another federal or state program. Other changes could substitute federal spending for private-sector spending on health care.

The new Medicare prescription drug benefit could either increase or decrease enrollment and reliance on VA care. Some employers who currently offer drug coverage to their retirees may drop that coverage once Medicare drug plans become available in 2006. If that occurs, some veterans who lose drug coverage through their former employer and are not currently enrolled with VA may decide to turn to VA rather than purchase a Medicare drug plan.[1] Conversely, low-income veterans who have been using VA's services may find that the low-income subsidies available for the Medicare drug benefit make it a preferable option, particularly if they do not live close to a VA hospital or clinic. As a result, the demand for VA medical care may either increase or decrease, with concomitant changes in Medicare spending as well as veterans' out-of-pocket costs. Because the impact of the Medicare drug benefit remains unclear, the Congressional Budget Office (CBO) assumed no specific changes in VA medical funding resulting from its availability.

CBO's projections of future VA resource demands are sensitive to assumptions about enrollment. Changes in the availability or cost of private health insurance or Medicare coverage could lead to higher enrollment at VA. Veterans in priority groups 7 and 8 are the most likely to be affected by changes in alternate sources of coverage. Relatively few veterans in those groups are enrolled in VA, however, and many who are enrolled rely on VA for only a small percentage of their medical care.

1. If those individuals later choose to drop VA coverage and buy a Medicare drug plan, they may face substantially higher premiums. For most seniors, there will be a penalty of at least 1 percent per month for late enrollment in Medicare's drug coverage.

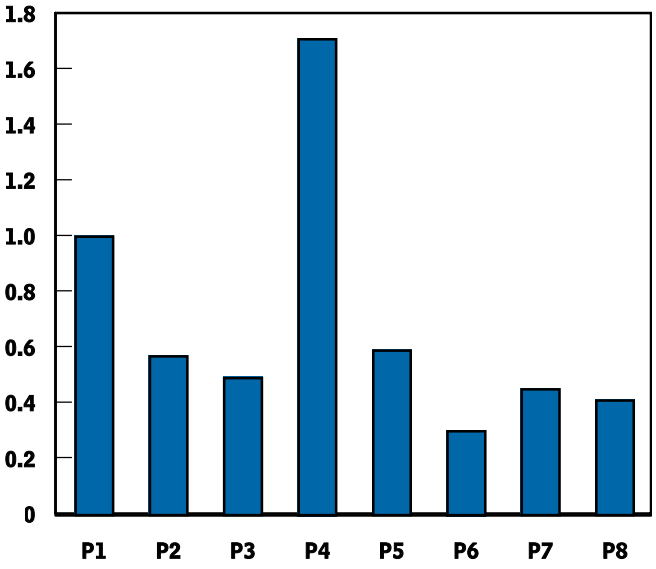
assumed rate of growth of health care costs was 30 percent higher or 30 percent lower than that in Scenario 1 (see Figure 8 on page 15).[22] Under Scenario 1, per capita health care costs begin growing by 6.1 percent per year in nominal terms in 2006, falling to 4.2 percent by 2025. A 30 percent higher rate would imply growth rates of 7.9 percent in 2006 and 5.5 percent in 2025, whereas a 30 percent lower growth rate would equal 4.2 percent in 2006 and 3.0 percent in 2025. The higher-growth assumptions would lead to a projected total level of $71.2 billion in 2025, compared with $53.4 billion in Scenario 1. In contrast, under the lower-growth assumption, VA's budget would need to grow to only $39.8 billion in order to meet the demand for medical care.

Uncertainty about the accuracy of the assumptions in these projections increases over time, so the projections toward the end of the 20-year time horizon are more uncertain than those toward the beginning. Cost growth, enrollment rates, reliance on other sources of care, and many other factors are more likely to differ from CBO's assumptions as time passes. In addition, legislative and economic changes may have a profound impact on the VA medical system in the next 20 years.

22. The choice of rates of growth that are 30 percent higher and lower is within the range of error for projections of health care cost growth over a 10- to 20-year period. For the rationale behind that choice of range, see Congressional Budget Office, *Growth in Medical Spending by the Department of Defense* (September 2003), p. 14.

Figure 5.

Relative Cost of VA Enrollees, by Priority Group, 2002



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

Notes: See Box 1 for definitions of the priority groups.

Veterans in priority group 1 (those with a 50 percent or higher service-connected disability) are the reference group in this figure. Costs for all other priority groups are shown relative to those for P1 veterans. The cost weights exclude the impact of reliance on other sources of care.

Results for Scenario 2

A key assumption in Scenario 1 is that enrollment by veterans in priority group 8 remains frozen—that is, no new P8 veterans are allowed to enroll with VA for medical care. Although medical coverage data that isolate P8 veterans were not available, data for P7 and P8 veterans combined showed that many of those veterans have access to sources of medical coverage outside of VA (see Table 3 on page 8). More than 60 percent are enrolled in Medicare, and nearly 90 percent have some form of medical coverage outside VA. (The P8 veterans—who are more affluent than the P7 veterans—probably have even greater access to private health insurance.) Still, many veterans groups have advocated that the freeze on P8 enrollment be lifted, arguing that those veterans should have equal access to VA medical care.

CBO projected the demand for VA medical care under the assumption that the freeze in enrollment by P8 veterans is lifted in 2006 and no further restrictions on enrollment are put in place. All other assumptions are the same as those in Scenario 1.

Under Scenario 2, the funds needed to meet the demand for VA medical care would increase by 103 percent in real terms over the projection period, in CBO's estimation, growing from $28.2 billion in 2005 to $57.1 billion in 2025 (see Table 4). By 2025, the funds needed to meet the demand under this scenario would be 7 percent higher than under Scenario 1. That increase reflects triple the amount of resources dedicated to P8 veterans—from a projected level of $1.9 billion in Scenario 1 to $5.6 billion in Scenario 2.

Some of that increase in the demand for VA medical resources would be offset by decreases in other federal and nonfederal spending. Medicare spending would decrease as some P8 seniors switched some of their care from Medicare providers to VA facilities, resulting in little net change in federal spending.[23] Some military retirees with TRICARE coverage might turn to VA for some services, reducing spending by the Department of Defense.[24] For veterans with private coverage who drop that coverage or rely on VA for a higher share of their care, the move to VA care would result in a net increase in federal spending. This paper projects only the change in VA resource demands, not the overall change in total federal spending.

Results for Scenario 3

In the President's budget submissions for both 2005 and 2006, the Administration proposed, among other changes, the introduction of a $250 annual enrollment fee for P7 and P8 veterans and an increase in the copayment for pharmaceuticals for those two groups (from $7 to $15 per 30-day prescription). The enrollment fee is similar to the $230 annual fee paid by single military retirees who enroll in TRICARE's managed care plan, TRICARE Prime. The $250 enrollment fee is much lower than the employee's share of health insurance premiums paid by civil servants and annuitants covered by selected plans in the Federal Employees Health Benefits

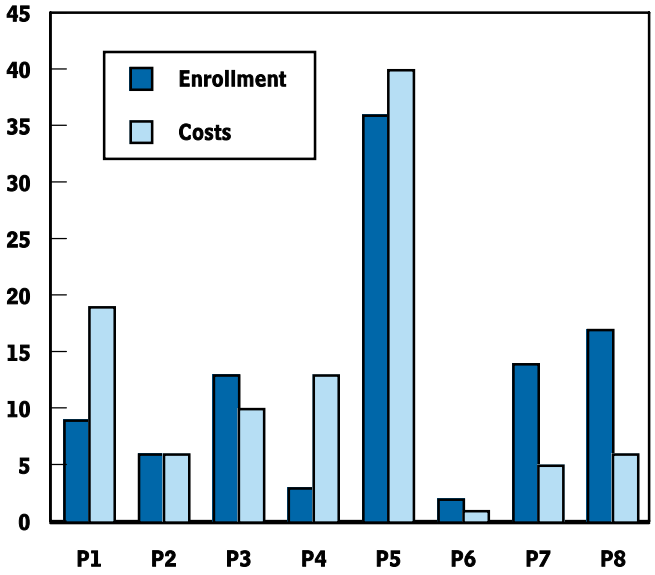
23. There may be an increase or decrease in federal spending if Medicare providers are significantly less expensive or more expensive than VA facilities.

24. TRICARE is the medical coverage provided by the Department of Defense for military service members, those who retire from the military after 20 years of service, and dependents of those two groups.

Figure 6.

Veterans' Shares of Total VA Medical Enrollment and Costs, by Priority Group, 2004

(Percentage of total enrollment and costs)



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

Note: See Box 1 for definitions of the priority groups.

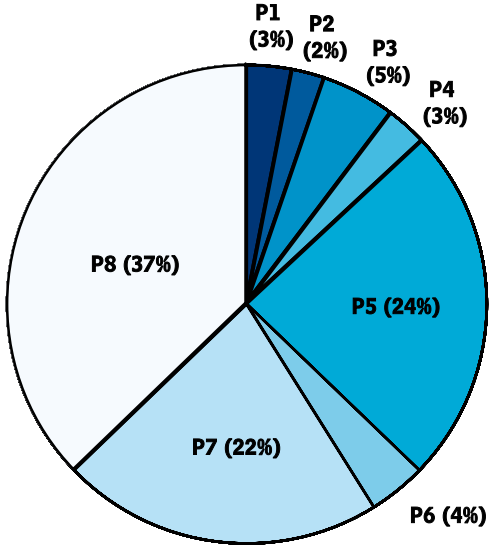
(FEHB) program in the Washington, D.C., area (see Table 5 on page 16). A copayment of $15 for all drugs is at the lower end of the range of copayments for pharmaceuticals paid by enrollees in the FEHB program and not much more than the amount paid by military retirees obtaining pharmaceuticals from an in-network local pharmacy. Examining those proposed fees provides some insight into the effects of modest cost sharing on demand for VA's health services.

CBO examined the impact on costs if those two cost-sharing measures were introduced and, at the same time, the freeze on enrollment for P8 veterans was lifted.[25] CBO assumed that the enrollment fee and increased copayment would be indexed to inflation using the CPI-U (the consumer price index for all urban consumers) and incorporated into its projection the revenues from those two sources and the effect of cost sharing on both enrollment and utilization of services. (See Box 4 on page 18 for a description of CBO's methodology for estimating those effects.)

Under Scenario 3, the cost of meeting the demand for VA medical care would rise to $52.6 billion in 2025, CBO estimates, or 1.4 percent less than the level in Scenario 1 and 7.8 percent less than in Scenario 2 (see Table 4). Even with the enrollment fee, opening up new enrollment to P8 veterans would result in roughly 787,000 additional P8 enrollments by 2025 compared with the level under Scenario 1, in CBO's estimation. In contrast, at least some P7 veterans, who had never been subject to a freeze in enrollment, would be discouraged by the enrollment fee, and about 440,000 fewer of them would sign up by 2025 as compared with their level under Scenario 1. Moreover, the increased copayment would discourage pharmaceutical use by both groups. On net, the cost of meeting the demand for VA medical care would be similar in 2025 under Scenario 3 and under Scenario 1.

Figure 7.

Estimated Percentage of the Total Population of Veterans in Each Priority Group, 2004



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

Notes: The figure includes both enrolled and unenrolled veterans. Shares must be estimated because priority-group determination for some veterans cannot be made until the time of enrollment.

See Box 1 for definitions of the priority groups.

25. The President's budgets for 2005 and 2006 did not propose lifting the enrollment freeze for veterans in priority group 8.

Box 3.

Elements of the Congressional Budget Office's Cost Projection

The long-range spending projections in this paper were determined using the following formula:

spending projection for priority group =
veteran population in priority group x
percentage enrolled x
rate of reliance x
relative cost factor x
base cost.

Rate of reliance represents the dollar share of medical care that the average veteran in a given priority group receives from the Department of Veterans Affairs (VA) as opposed to other sources (Medicare, Medicaid, private insurance, TRICARE, and so forth).

Relative cost factor represents the average demand for all health services (not just VA care) among veterans in that priority group, relative to a veteran in priority group 1.

Base cost is the inflated annual cost of care for a typical full-time priority group 1 veteran.

As mentioned earlier, in the discussion of the previous scenario, there would probably be changes in spending by other federal programs such as Medicare and TRICARE. This paper does not estimate the size of those spending offsets.

Sensitivity Analysis of Increased Enrollment Rates

CBO performed a sensitivity analysis to determine how its projections would be affected by a change in the assumptions about enrollment in the VA system. Currently, only 11.6 percent of total VA medical spending can be attributed to veterans in priority groups 7 and 8. However, that small number is largely due to their low rates of enrollment and reliance as well as the relatively lower average cost of veterans in those priority groups (see Figures 4 through 6). Most P7 and P8 veterans have access to other sources of medical coverage, including private employer-provided health insurance and Medicare.

In recent years, health insurance costs have increased dramatically, rising by an average of 10 percent per year from 1999 to 2004.[26] Some employers have stopped offering health insurance, have increased the share of premiums that must be paid by employees, or have restructured their health plans to offer fewer choices or to require increased deductibles and copayments. If changes in the availability or cost of private health insurance led more veterans to turn to VA for care, enrollment rates and the demand for VA medical care could rise substantially. CBO examined the possible effect of such changes on the long-range projections under each of the three scenarios.

Sensitivity Analysis for Scenario 1

Currently, a substantial number of veterans are not enrolled with VA for care (see Figure 3 on page 7). That pool of unenrolled veterans consists largely of veterans in lower priority groups, but even in high-priority groups a non-negligible minority of veterans has not enrolled for care. If enrollment rates increased among all groups (except P8, whose enrollment would remain frozen) until another 25 percent of each group's unenrolled population had enrolled by the end of the projection period, the annual cost of meeting the demand for VA medical care would grow to $59.3 billion by 2025, an 11 percent increase over the earlier estimate for Scenario 1 (see Table 6 on page 17). Relative to the figures in that earlier Scenario 1, an additional 510,000 P7 veterans would be enrolled by 2025, medical resources for their care would increase by 38.7 percent, and their share of VA medical funding would grow from 6.7 percent to 8.3 percent.

Sensitivity Analysis for Scenario 2

If the freeze on P8 enrollment was lifted and 25 percent of each group's unenrolled population (including veterans in priority group 8) enrolled, the annual cost of meeting the demand for care would grow to $65.2 billion by 2025, or 14 percent more than in the earlier estimate for Scenario 2. In comparison with that Scenario 2, an additional 510,000 P7 veterans and 847,000 P8 veterans

26. See the Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2004 Summary of Findings* (Menlo Park, Calif.: Kaiser Family Foundation, 2004), p. 1.

Table 4.

Summary of Projection Results Under CBO's Three Scenarios

Priority Group	Scenario 1			Scenario 2			Scenario 3		
	2005	2015	2025	2005	2015	2025	2005	2015	2025
	Projected VA Medical Enrollment, by Priority Group (Thousands)								
P1	675	767	801	675	767	801	675	767	801
P2	472	475	447	472	475	447	472	475	447
P3	962	988	912	962	988	912	962	988	912
P4	251	319	298	251	319	298	251	319	298
P5	2,751	2,955	2,551	2,751	2,955	2,551	2,751	2,955	2,551
P6	163	225	223	163	225	223	163	225	223
P7	1,086	1,403	1,317	1,086	1,403	1,317	1,086	849	877
P8	1,198	873	741	1,198	2,333	2,189	1,198	1,500	1,528
Total	**7,559**	**8,005**	**7,291**	**7,559**	**9,465**	**8,739**	**7,559**	**8,078**	**7,638**
	Projected Funds to Meet VA Medical Demand, by Priority Group (Billions of 2005 dollars)								
P1	5.4	9.0	11.9	5.4	9.0	11.9	5.4	9.0	11.9
P2	1.7	2.5	3.0	1.7	2.5	3.0	1.7	2.5	3.0
P3	2.7	4.1	4.8	2.7	4.1	4.8	2.7	4.1	4.8
P4	3.6	6.7	8.0	3.6	6.7	8.0	3.6	6.7	8.0
P5	11.4	17.9	19.6	11.4	17.9	19.6	11.4	17.9	19.6
P6	0.2	0.4	0.5	0.2	0.4	0.5	0.2	0.4	0.5
P7	1.6	3.0	3.6	1.6	3.0	3.6	1.6	1.4	1.8
P8	1.6	1.8	1.9	1.6	4.7	5.6	1.6	2.2	2.9
Total	**28.2**	**45.3**	**53.4**	**28.2**	**48.2**	**57.1**	**28.2**	**44.1**	**52.6**

Source: Congressional Budget Office.

Notes: VA = Department of Veterans Affairs.

See Box 1 for definitions of the priority groups.

Differences in enrollment and cost among scenarios are confined to P7 and P8 veterans.

The VA medical budget for 2005 used as the starting point for these projections is from the *FY04 VA Health Care Projection Model* (January 2004). It excludes the costs of long-term care and some other VA medical costs and differs somewhat from the final 2005 VA medical budget.

would be enrolled by 2025. The level of funding needed to meet the demand by P7 and P8 veterans combined would increase from $9.2 billion to $12.7 billion and would make up 19.5 percent of VA's medical budget.

Sensitivity Analysis for Scenario 3

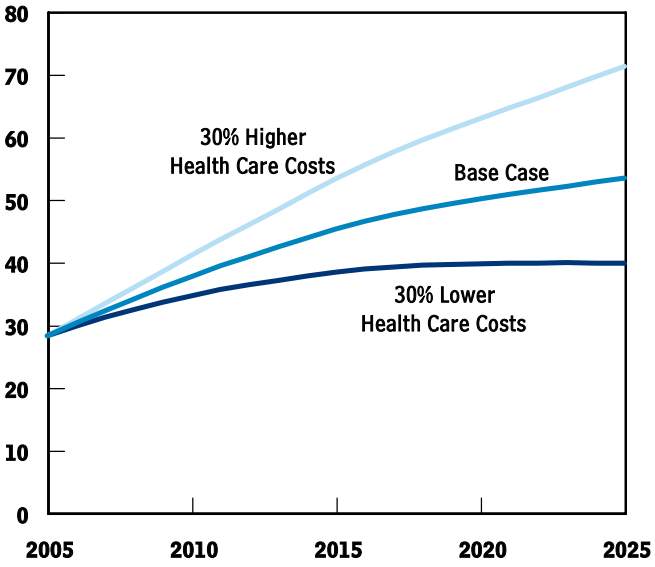
If the freeze on P8 enrollment was lifted but a $250 annual enrollment fee was introduced for P7 and P8 veterans and the copayment for pharmaceuticals for those two groups was increased from $7 to $15 (again indexed to the CPI-U), the annual cost of meeting the demand for VA medical care would reach $60.4 billion by 2025, assuming that enrollment for VA medical care increased as in the previous two sensitivity analyses. Because there is a larger pool of unenrolled veterans in priority groups 7 and 8 who might enroll, the funds needed to meet the demand by those veterans would increase by 68 percent relative to its level in the previous Scenario 3, growing from 9.0 percent to 13.1 percent of the VA medical budget.

As in the earlier comparisons, which used VA's base-case assumptions of enrollment rates, the sensitivity analyses of Scenarios 1 and 3 yield very similar total costs. Opening up new enrollment to P8 veterans, in the face of an

Figure 8.

Projected Resource Needs Under Different Assumptions of Growth in Heath Care Costs for Scenario 1

(Billions of 2005 dollars)



Source: Congressional Budget Office.

enrollment fee but with an assumed 25 percent increase in enrollment relative to VA's base-case projections, results in about 1,013,000 additional P8 enrollments by 2025. Enrollment by P7 veterans would be roughly 620,000 higher than projected under the earlier Scenario 3. The increased copayment again discourages the use of pharmaceuticals by both groups. On net, total resources needed to meet the demand for VA medical care is nearly the same in the sensitivity analyses of Scenarios 1 and 3.

Comparing the Scenarios to CBO's Baseline Projections

The projections in this report use a different methodology than that of CBO's periodic baseline projections for discretionary spending.[27] VA medical care funding must be appropriated by the Congress annually, and VA cannot spend more than the amount appropriated. That type of spending contrasts with mandatory spending, which is automatically obligated each year and requires no annual appropriations. Mandatory programs include Social Security, Medicare, Medicaid, and veterans' disability compensation.

CBO projects discretionary spending (spending controlled by annual appropriation acts) following rules established in the Balanced Budget and Emergency Deficit Control Act of 1985. For its periodic baseline report, CBO projects discretionary spending by assuming that the most recent year's funding is continued in each subsequent year with adjustments for projected inflation. Under that law, the inflation rate CBO uses to project medical budgets for VA is a weighted average of the GDP deflator and the employment cost index for wages and salaries, with the weights reflecting the shares of personnel costs and other costs in that portion of the budget.

That specified inflation rate is applied to the total budget rather than on a per capita basis. As a result, using CBO's baseline rules, the total VA medical budget grows relatively steadily over the 2005-2025 period rather than varying with changes in population, enrollment, and inflation specific to the health care sector. Using the CBO baseline methodology and those inflators for discretionary programs results in slower total budget growth than is seen in the projections in Scenarios 1, 2, and 3, which are based on anticipated growth in per capita health care costs, changes in the population of veterans, and growth in enrollment. The projections in this paper assume that health care costs will continue to grow faster than general economywide inflation, as they have in the past few decades.

Although CBO's latest baseline projections extend out 10 years, to 2015, they can be further extended by assuming that the discretionary inflators from 2016 through 2025 equal the average inflators for the prior three years (2013 through 2015). Under those growth rates, the VA medical budget would climb to $35.2 billion in 2025, only two-thirds the level that CBO projected in Scenario 1 (see Table 7 on page 19). That projected budget is lower than the $39.8 billion that might occur if health care cost growth was 30 percent less than CBO anticipates throughout the next 20 years.

Medical care budgets for VA under CBO's baseline assumptions would be substantially less than in any of the scenarios considered in this report (see Figure 9 on page 20). If health care costs, enrollment, reliance, and other factors evolved as anticipated, it would be difficult

27. See, for example, Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2006 to 2015* (January 2005).

Table 5.

Comparison of Out-of-Pocket Costs for Enrollees in Selected Health Plans in Calendar Year 2005

(Dollars)

		Pharmacy Copayments					
Health Plan	Annual Premium (Single member)	At Government Facility	At Local Pharmacy, for Generic	Mail Order, for Generic	At Local Pharmacy, for Name Brand	Mail Order, for Name Brand	At Local Pharmacy, for Nonformulary
Federal Employees and Annuitants in HMOs							
Aetna Open Access, Basic—Washington, D.C., area	753	n.a.	10	20	25	50	40
Aetna Open Access, High—Washington, D.C., area	1,168	n.a.	10	20	25	50	40
CareFirst BlueChoice—Washington, D.C., metro area	1,315	n.a.	10	20	25	50	40
Kaiser Permanente, Standard—Washington, D.C., area	833	n.a.	15	13	25	25	40
Kaiser Permanente, High—Washington, D.C., area	1,035	n.a.	10	8	20	18	55
Military Retirees							
TRICARE Prime for military retirees	230	0	3	3	9	9	22
Veterans							
Illustrative amounts for Scenario 3	250	15	n.a.	n.a.	n.a.	n.a.	n.a.

Source: Congressional Budget Office based on data from the Office of Personnel Management and TRICARE.

Notes: See the text for a description of the elements of Scenario 3 in CBO's spending projections.

HMO = health maintenance organization; n.a. = not applicable.

TRICARE is the medical plan for military service members, retirees, and their dependents.

for VA to hold spending growth to the rate assumed in CBO's baseline. Under current law, if VA was required to restrain its budgetary growth to the rate assumed in CBO's baseline projections, the Secretary of Veterans Affairs would need to make decisions in the very near future that would freeze enrollment or exclude veterans in several priority groups who are currently receiving care from VA. Priority group 8, as the lowest in the statutory priority list, would be the first to be excluded from receiving services, or "disenrolled." Priority group 7 would face a freeze and disenrollment as early as 2007, as would priority group 6, which includes veterans with exposures to various toxic substances, such as Agent Orange. Even priority group 5, low-income veterans, would eventually face a freeze or other limitations in access if VA was required to restrain its budgetary growth to the rate assumed in CBO's baseline projections.

Conclusion

CBO's projections in this paper show that the resources needed to meet the demand for VA health care are likely to grow substantially through 2025 (see Figure 10 on page 21). Most of the VA medical budget pays for care provided to veterans in the first five priority groups: veterans with service-connected disabilities, housebound veterans, and low-income veterans (see Figure 11 on page 22). Although only a relatively small share of the VA medical budget (11.6 percent) is currently devoted to paying for care provided to P7 and P8 veterans, that share

Table 6.

Summary of Sensitivity Analysis with Increased Enrollment Under CBO's Three Scenarios

Priority Group	Scenario 1			Scenario 2			Scenario 3		
	2005	2015	2025	2005	2015	2025	2005	2015	2025
	Sensitivity Analysis of Projected VA Medical Enrollment, by Priority Group (Thousands)								
P1	675	774	815	675	774	815	675	774	815
P2	472	479	452	472	479	452	472	479	452
P3	962	1,002	931	962	1,002	931	962	1,002	931
P4	251	348	335	251	348	335	251	348	335
P5	2,751	3,201	2,939	2,751	3,201	2,939	2,751	3,201	2,939
P6	163	286	315	163	286	315	163	286	315
P7	1,086	1,756	1,827	1,086	1,756	1,827	1,086	1,271	1,497
P8	1,198	873	741	1,198	2,921	3,036	1,198	2,192	2,541
Total	**7,559**	**8,718**	**8,355**	**7,559**	**10,765**	**10,651**	**7,559**	**9,552**	**9,826**
	Sensitivity Analysis of Funds to Meet Projected VA Medical Demand, by Priority Group (Billions of 2005 dollars)								
P1	5.4	9.0	12.1	5.4	9.0	12.1	5.4	9.0	12.1
P2	1.7	2.5	3.0	1.7	2.5	3.0	1.7	2.5	3.0
P3	2.7	4.2	4.9	2.7	4.2	4.9	2.7	4.2	4.9
P4	3.6	7.3	9.0	3.6	7.3	9.0	3.6	7.3	9.0
P5	11.4	19.3	22.6	11.4	19.3	22.6	11.4	19.3	22.6
P6	0.2	0.5	0.7	0.2	0.5	0.7	0.2	0.5	0.7
P7	1.6	3.7	4.9	1.6	3.7	4.9	1.6	2.0	3.1
P8	1.6	1.8	1.9	1.6	5.9	7.8	1.6	3.2	4.8
Total	**28.2**	**48.4**	**59.3**	**28.2**	**52.5**	**65.2**	**28.2**	**48.1**	**60.4**

Source: Congressional Budget Office.

Notes: VA = Department of Veterans Affairs.

See Box 1 for definitions of the priority groups.

Compared with the earlier Scenarios 1, 2, and 3, the numbers for enrollment under these scenarios are 15 percent, 22 percent, and 29 percent higher, respectively. The numbers for projected spending are 11 percent, 14 percent, and 15 percent higher, respectively, than those in the earlier three scenarios (see Table 4 on page 14).

Differences in enrollment and cost among scenarios are confined to P7 and P8 veterans.

The VA medical budget for 2005 used as the starting point for these projections is from the *FY04 VA Health Care Projection Model* (January 2004). It excludes the costs of long-term care and some other VA medical costs and differs somewhat from the final 2005 VA medical budget.

could increase if veterans in those groups enrolled (or were allowed to enroll) in greater numbers than they do currently. But even under CBO's highest enrollment estimates (shown in the sensitivity analysis for Scenario 2), spending on those two groups would make up less than 20 percent of the VA medical budget.

High anticipated growth in medical costs for the entire economy will play an important role in driving VA's future medical costs regardless of the behavior of lower-priority veterans. But if VA's appropriated budget does not grow at a rate consistent with health care cost growth, or if large numbers of currently unenrolled veterans decide to turn to VA for care, VA could again confront the decision of whether to freeze enrollment or to disenroll veterans who are currently using care within the VA system.

Box 4.

Modeling the Effects of Policy Changes on Enrollment and Costs

The third scenario in the Congressional Budget Office's (CBO's) three scenarios of projected long-range medical funding for the Department of Veterans Affairs (VA) incorporates two cost-sharing measures: a $250 enrollment fee as well as an increased pharmacy copayment of $15 (compared with the current level of $7) for veterans in priority groups 7 and 8. CBO assumed that the enrollment fee would affect veterans' decision about whether to enroll and that the increased copayment for pharmaceuticals would affect both enrollment and utilization.

CBO modeled the enrollment fee as an increase in the "premium" (defined as veterans' expected annual out-of-pocket costs, including copayments and the enrollment fee) for using the VA health care system. In 2004, P7 and P8 veterans faced average annual out-of-pocket costs of $121 for pharmaceuticals and between $37 and $45 for nonpharmacy services if they used VA care.[1] CBO inflated those amounts by the projected rate of health care cost growth from 2004 to 2006 and added in the $250 enrollment fee and expected average increases in pharmacy and other copayments of $218 for P7 veterans and $152 for P8 veterans. As a result, the premium faced by those veterans would increase by 237 percent (P8) to 262 percent (P7) compared with the levels they would have faced without the proposed policy changes.

Previous research on the price responsiveness of individuals choosing employer-sponsored health insurance and nongroup health insurance has found that for a 10 percent increase in health insurance premiums, the percentage of people insured declines by about one-half of one percentage point.[2] CBO assumed the same price response would hold for veterans, so the fraction of P7 and P8 veterans who chose to enroll would decrease by 0.5 percentage points for each 10 percent increase in their "premium."

However, healthier veterans with lower expected medical costs, or veterans with a less expensive alternative source of care, would be more likely to drop VA enrollment once it was no longer free. Thus, the remaining P7 and P8 veterans who chose to enroll despite the $250 fee would probably have higher average costs than would veterans who drop their enrollment, because the former either are sicker or have been relying on VA for a higher percentage of their care. CBO assumed that VA's average cost to treat veterans enrolling after the $250 fee is imposed would be 25 percent greater than for veterans who had enrolled previously.

The higher pharmacy copayment for P7 and P8 veterans would also be expected to affect utilization. CBO assumed that pharmacy utilization would decrease by 22 percent for P7 and P8 veterans as a result of that increase.[3] In addition, because many outpatient visits are prompted by a desire for pharmaceuticals, CBO assumed that outpatient utilization would decrease as well. Specifically, CBO assumed that one-quarter of outpatient visits are prompted largely by a desire for pharmaceuticals and that there would be a 22 percent decrease in utilization for that type of outpatient visit. (Other outpatient and all inpatient utilization would remain unchanged.)

CBO calculated the anticipated revenues from both the enrollment fee and the increased pharmacy copayments and included those amounts in calculating the net cost of VA medical care under Scenario 3.

1. Personal communication to the Congressional Budget Office by staff members of the Department of Veterans Affairs, November 16, 2004 (for collections data) and December 3, 2004 (for enrollment data). VA collected additional revenues from third-party insurance plans covering P7 and P8 veterans, but those revenues were not included in the estimate of the notional "premium" currently faced by those veterans.

2. See, for example, Linda J. Blumberg, Len M. Nichols, and Jessica S. Banthin, "Worker Decisions to Purchase Health Insurance," *International Journal of Health Care Finance and Economics*, vol. 1, no. 3/4 (September/December 2001), pp. 305-325; Jonathan Gruber and Ebonya Washington, *Subsidies to Employee Health Insurance Premiums and the Health Insurance Market*, Working Paper No. 9567 (Cambridge, Mass.: National Bureau of Economic Research, March 2003); and Michael Chernew, Kevin Frick, and Catherine G. McLaughlin, "The Demand for Health Insurance Coverage by Low-income Workers: Can Reduced Premiums Achieve Full Coverage?" *Health Services Research*, vol. 32, no. 4 (October 1997), p. 453.

3. See Bruce Stuart and Christopher Zacker, "Who Bears the Burden of Medicaid Drug Copayment Policies?" *Health Affairs,* vol. 18, no. 2 (March/April 1999), pp. 201-212.

Table 7.

Funds Needed to Meet Projected VA Medical Demand Under the Various Scenarios Presented in This Paper

(Billions of 2005 dollars)

	2005	2010	2015	2020	2025
Scenario 1	28.2	37.7	45.3	50.1	53.4
Scenario 2	28.2	39.8	48.2	53.5	57.1
Scenario 3	28.2	36.1	44.1	49.2	52.6
Scenario 1—Sensitivity Analysis	28.2	39.4	48.4	54.6	59.3
Scenario 2—Sensitivity Analysis	28.2	42.0	52.5	59.7	65.2
Scenario 3—Sensitivity Analysis	28.2	38.2	48.1	55.1	60.4
Scenario 1, 30 Percent Lower Growth Rate for Health Care Costs	28.2	34.6	38.4	39.7	39.8
Scenario 1, 30 Percent Higher Growth Rate for Health Care Costs	28.2	41.1	53.3	62.9	71.2
Memorandum:					
Projected Budgets Under Assumptions Used in CBO's Baseline	28.2	29.9	31.6	33.3	35.2

Source: Congressional Budget Office.

Notes: VA = Department of Veterans Affairs.

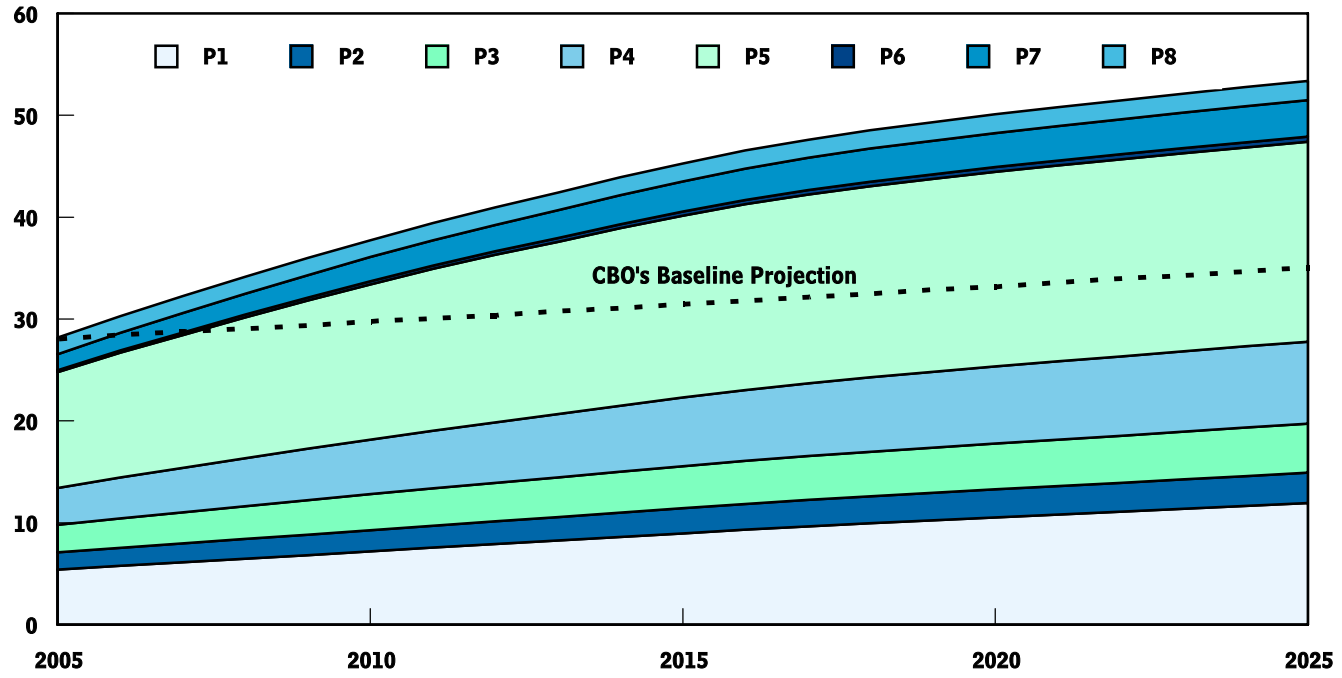
See the text for an explanation of the various scenarios.

The VA medical budget for 2005 used as the starting point for these projections is from the *FY04 VA Health Care Projection Model* (January 2004). It excludes the costs of long-term care and some other VA medical costs and differs somewhat from the final 2005 VA medical budget.

Figure 9.

Projected Demand for VA Medical Resources Under Scenario 1, Allocated by Priority Group, Compared with CBO's Baseline Budget Projections, 2005 to 2025

(Billions of 2005 dollars)



Source: Congressional Budget Office.

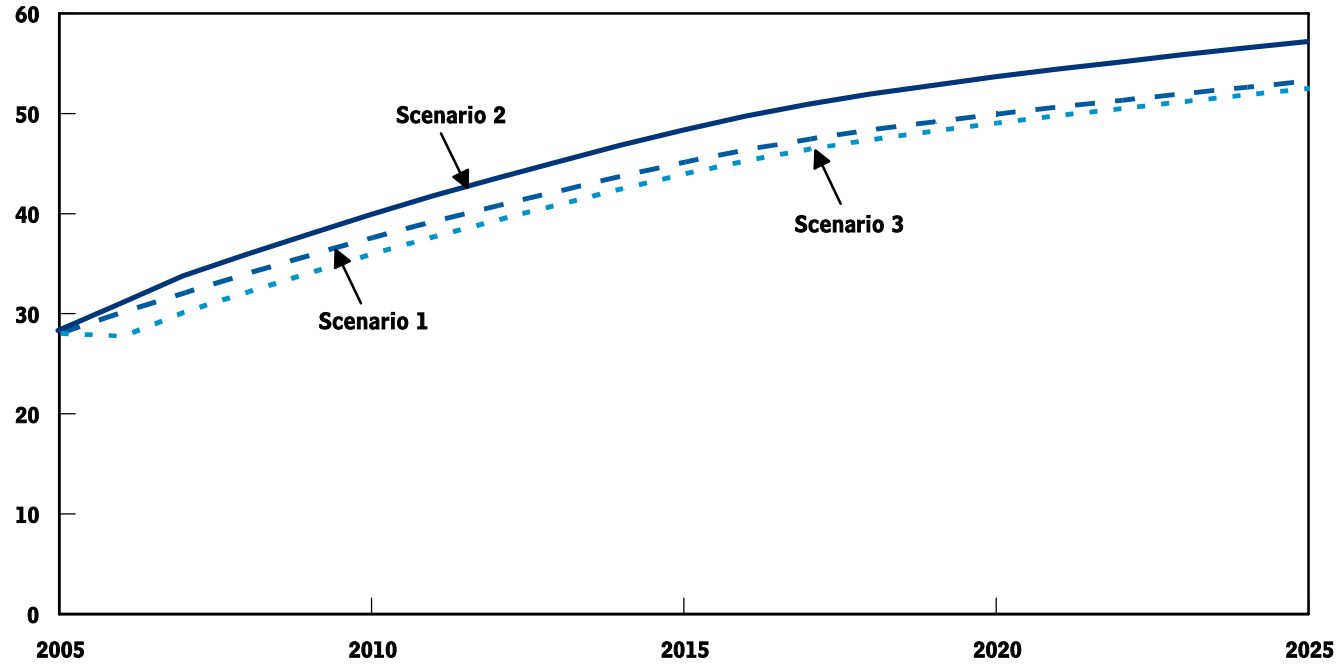
Notes: VA = Department of Veterans Affairs.

See Box 1 for definitions of the priority groups.

Figure 10.

Projected Demand for VA Medical Resources Under CBO's Three Scenarios, 2005 to 2025

(Billions of 2005 dollars)



Source: Congressional Budget Office.

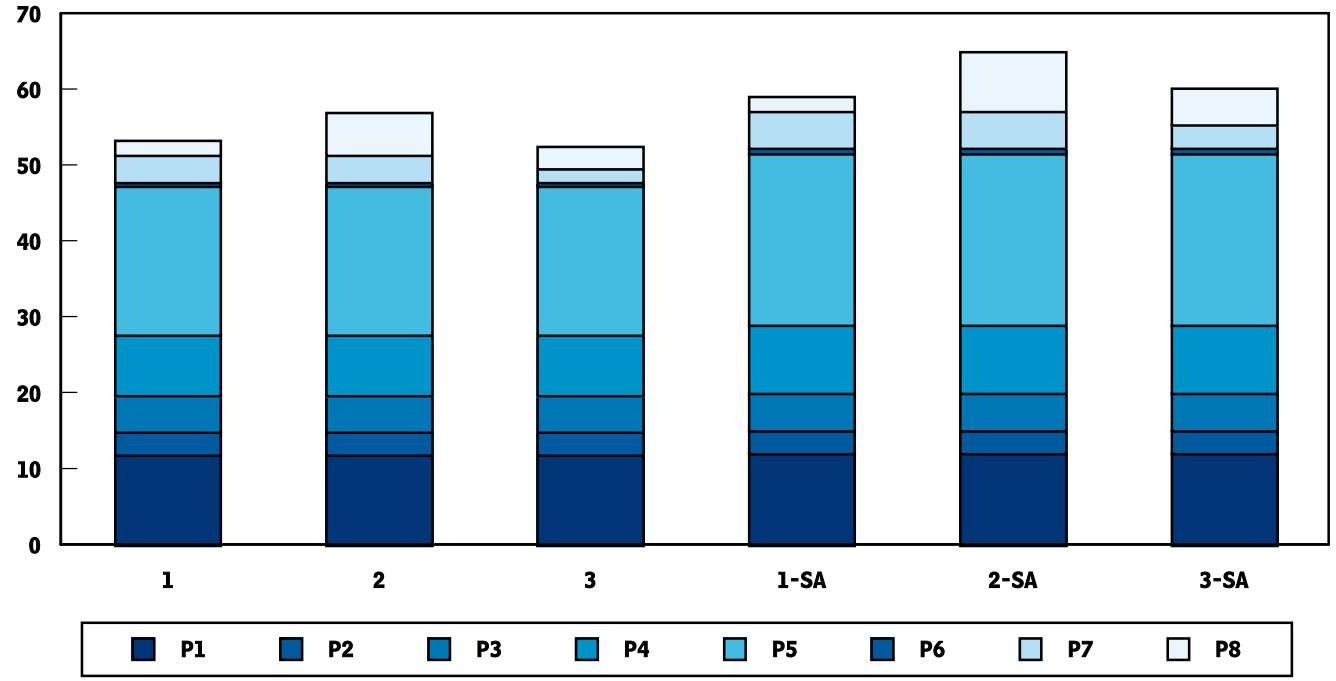
Notes: The reduction in spending from 2005 to 2006 in Scenario 3 reflects the effects of introducing an enrollment fee and increasing pharmacy copayments for veterans in priority groups 7 and 8.

VA = Department of Veterans Affairs.

Figure 11.

Summary of the Projections for 2025, by Scenario and Priority Group

(Billions of 2005 dollars)



Source: Congressional Budget Office.

Notes: SA = sensitivity analysis of higher enrollment rates.

See Box 1 for definitions of the priority groups.

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE
WASHINGTON, DC 20515

INSIDE MAIL