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Veterans' Medical Care Funding: FY1995-FY2004

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Summary

The Department of Veterans Affairs (VA) provides services and benefits such as hospital and medical care, rehabilitation services, and pensions, among other things, to veterans who meet certain eligibility criteria. VA provides these benefits and services through four administrative units: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), the National Cemetery Administration (NCA), and the Board of Veterans' Appeals. VHA is primarily a direct service provider of primary care, specialized care, and related medical and social support services to veterans through an integrated health care system.

Funding for VHA is an issue of perennial interest to Congress, especially with the increasing demand for VA medical services and with some veterans increasingly having to wait more than six months for a primary care or speciality care appointment. VHA is funded through multiple appropriation accounts, which are supplemented by other sources of revenue. Over the past decade, the composition of VHA's funding has changed. Not only has VA's appropriation account structure been modified, but also VA's ability to retain nonappropriated funds has increased. These changes present challenges in comparing VHA funding over a period of time.

Between FY1995 and FY2004, appropriations for VA medical care grew by 63%. For the first four years of this time period, from FY1995 through FY1999, appropriations for VA medical care grew by 6.7%, from $16.2 billion in FY1995 to $17.3 billion in FY1999. In comparison, during the last five years of this time period, from FY1999 through FY2004, VA medical care appropriations grew by 52.7%, from $17.3 billion in FY1999 to $26.4 billion in FY2004. These amounts do not include appropriations for medical research, medical administration and miscellaneous operating expenses (MAMOE), and funds from nonappropriated funding sources.

The total number of veteran enrollees has grown by 76.9% from FY1999, the first year VHA instituted an enrollment system, to FY2004. During this same period the number of veterans receiving medical care has grown by almost 50%, from 3.2 million veterans in FY1999 to an estimated 4.7 million veterans in FY2004.

This report will not be updated.

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The Department of Veterans Affairs (VA) provides services and benefits such as hospital and medical care, rehabilitation services, and pensions, among other things, to veterans who meet certain eligibility criteria. VA provides these benefits and services through four administrative units: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), the National Cemetery Administration (NCA), and the Board of Veterans' Appeals.

Funding for the VHA in particular has been an issue of perennial interest to Congress, especially in the context of increasing demand for its services. Enrollment in VHA increased from 4.9 million to 7.6 million between FY1999 and FY2004. VA has stated that it has been unable to provide services in a timely manner to all enrolled veterans who are seeking care.[1] In January 2003, VA announced suspension of enrollment of veterans with high incomes and without military-related disabilities.[2] VA estimated that as of January 2003, 212,000 enrolled veterans were on waiting lists, sometimes for six months or more for a nonemergency clinic visit. VA estimates that since December 2004, almost 31,000 enrolled veterans were on waiting lists for six months or more for a nonemergency clinic visit.

This report provides information on trends in VHA appropriations. To provide some context, it is important to understand the difference between *appropriations* and *spending*. When Congress appropriates money, it provides *budget authority*, that is, authority for an agency to enter into obligations. Obligations occur when agencies enter into contracts, employ personnel, and so forth. *Outlays* or spending occur when obligations are liquidated, primarily through issuance of checks, transfer of funds, and so forth. It should be noted that not all budget authority in a given year becomes outlays in the year for which it is provided; a portion of each year's outlays derives from "carryover" budget authority provided in prior years. The total new budget authority in a year typically exceeds total outlays for a fiscal year. Particularly for programs with long lead times, such as construction, it may take years for the funds provided by Congress to be spent. Furthermore, in certain instances, Congress explicitly establishes multiyear appropriation accounts, which are budget authorities that can be expended over several years. This report will specifically provide an overview of trends in appropriations or budget authority for VA health care, as well

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[1] U.S. Department of Veterans Affairs, "Medication Prescribed by Non-VA Physicians," 68 *Federal Register* 43927-43930 (July 25, 2003).

[2] U.S. Department of Veterans Affairs, "Annual Enrollment Level Decision," 68 *Federal Register* 2669-2673 (Jan. 17, 2003). "High-income veterans" are those whose incomes are above a statutory threshold, for example, a veteran with no dependents with an income of $25,163 or more for 2004. Income thresholds are higher for veterans with dependents.

as data on the number of veterans, veteran enrollees, and unique veteran patients from FY1995 through FY2004.[3] The report will use the terms "appropriations" and "funding" interchangeably.

VHA is funded through multiple appropriation accounts that are supplemented by other sources of revenue. Over the past two decades, Congress has passed legislation to increase VHA's ability to supplement its appropriations. The composition of these supplemental revenues, as well as their use by VA has been modified periodically. Historically, the House and Senate Appropriations Committees and the Office of Management and Budget (OMB) have used the following appropriation accounts for VA (the larger entity) to describe funding for VHA: medical care, medical and prosthetic research, and medical administration and miscellaneous operating expenses (MAMOE). These accounts have constituted the majority of VHA's appropriations. However, over the past decade VA's account structure has changed. In recent years in its budget submissions to Congress, VA proposed different account structures to fund VHA, and Congress adopted a different account structure during enactment of appropriations. Also Congress appropriates funds for constructing, altering, extending, and improving all VA facilities, and a significant and changing portion of these sums are expended on VA medical facilities. These changes present challenges in comparing VHA funding over a period of time.

Legislation to Supplement Appropriations

Beginning in 1986 Congress enacted several major pieces of legislation to increase VA's ability to supplement its appropriations.

In 1986 Congress passed the Veterans' Health-Care Amendments of 1986 (P.L. 99-272) and gave VA the authority to seek reimbursement from third-party health insurers for the cost of medical care furnished to insured nonservice-connected (NSC) veterans. This law also authorized VA to assess a means test copayment to certain NSC veterans based on the veteran's income and assets. The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) expanded VA's cost recovery program by providing VA the authority to seek reimbursement from third-party payers for the cost of medical care provided to insured service-connected veterans treated for NSC conditions.[4]

However, VA was not initially allowed to use these funds to supplement its medical care appropriations; instead, the collections were returned to the Treasury. With the passage of the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33),

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[3] For a detailed description of funding for VA medical care for FY2004 and FY2005, see CRS Report RL32548, *Veterans' Medical Care Appropriations and Funding Process*, by Sidath V. Panangala. For details on funding for other VA programs, see CRS Report RL32304, *Appropriations for FY2005: VA, HUD, and Independent Agencies,* by Richard Bourdon and Paul Graney.

[4] A "service-connected" disability is one that results from an injury or disease or other physical or mental impairment incurred or aggravated in the line of duty in the active military, naval, or air service.

Congress provided VA the authority to retain funds from third-party collections in the Medical Care Collections Fund (MCCF). VA has the authority to collect inpatient, outpatient, medication, and nursing home copayments from veterans and authority to recover third-party payments from veterans' insurers. By statute, subject to appropriations, MCCF funds must be spent on providing VA medical care and services and on VA's expenses associated with MCCF program operations.[5] Since FY1998, VA has used these funds to supplement its medical care appropriations. Unlike appropriations for VHA, which must be expended in a given fiscal year(s), MCCF funds are available indefinitely and may be spent without **any** fiscal year limitation.

In 1999 Congress once again enacted legislation to improve VA's ability to enhance its nonappropriated revenues. The Veterans Millennium Health Care and Benefits Act of 1999 (P.L. 106-117) authorized VA to increase the medication copayment amount and to establish annual caps on the medication copayment amount. This act also established the Health Services Improvement Fund (HSIF) to reduce waiting times for receiving care and to reduce the burden of cost sharing for drugs and prosthetics on veterans.[6] Monies in this fund were available without fiscal year limitation. Revenues for the fund came from increases in medication copayments from $2 to $7,[7] revenue from enhanced-use lease agreements,[8] and reimbursement from Department of Defense (DoD) for TRICARE-eligible military retirees.[9] The Consolidated Appropriation Resolution, FY2003 (P.L. 108-7), consolidated this account with MCCF and granted VA permanent authority to collect prescription copayments.[10]

More recently in 2004, Congress authorized consolidating several revenue accounts into MCCF to augment these revenues. The FY2004 Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act (FY2004 VA-HUD Appropriations Act, P.L. 108-199) authorized consolidating the following accounts into MCCF: long-term care copayments, Compensated Work Therapy Program revenues, Compensation and Pension Living Expenses Program collections, and Parking Program fees (formerly known as the Parking Revolving Fund), and collections from sale of assets that had

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[5] These are expenses incurred in the identification, billing, auditing, and collecting of amounts owed to VA by reason of furnishing medical care services.

[6] H.Rept. 106-470, *Veterans Millennium Health Care and Benefits Act of 1999*,Conference Report to accompany H.R. 2116, 106th Cong., 1st sess., p. 68.

[7] On Feb. 4, 2002, the medication copayment was increased from $2 to $7 for veterans with nonservice-connected conditions and higher incomes. The $5 difference was deposited into the account. U.S. Department of Veterans Affairs "Copayments for Medications," 66 *Federal Register* 234 (Dec. 6, 2001).

[8] Enhanced-use leases allow VA to enter into long-term agreements under which VA real property may be leased and improved for use that is not inconsistent with VA's mission.

[9] This legislation contains other important provisions affecting VA health care. This description summarizes changes that affect VA's collection authority and revenues.

[10] H.Rept. 108-10, Conference Report to accompany H.J.Res 2, Making Further Continuing Appropriations for FY2003 and for Other Purposes, 108th Cong., 1st sess., p. 475.

been deposited in the Nursing Home Revolving Fund. This consolidation was valid only for FY2004, and not for successive fiscal years. The Consolidated Appropriations Act, 2005 (P.L. 108-447) authorized consolidating these accounts in future fiscal years as well. According to the VA, funds in the above-mentioned accounts have not yet been deposited into MCCF. VA plans to transfer all the funds in these accounts into MCCF during the course of FY2005.[11] A detailed listing of revenue accounts that constitute MCCF for FY2004 is given in **Appendix 1.**

It should be noted that MCCF collections are estimated by VA when developing a budget proposal for the forthcoming fiscal year. These VA estimates incorporate the changes associated with the implementation of the Administration's legislative proposals, such as an increase in cost-sharing charges. However, the House and Senate Appropriations Committees may reject these legislative proposals and include a more conservative estimate for MCCF collections. For example, in its FY2004 budget request to Congress, VA projected MCCF collections for FY2004 at $1.8 billion, an amount that included revenue from increased cost-sharing charges. The House and Senate Appropriations Committees rejected these cost-sharing proposals and used a lower MCCF estimate of $1.6 billion in deciding that year's VA appropriation recommendation.

Changes in Account Structure

Another challenge in comparing funding from one year to the next is the changes in appropriation accounts that constitute funding for VHA. The following examples illustrate the inherent complexities when trying to compare funding. Historically, the House and Senate Appropriations Committees have funded VHA using the following accounts: medical care, medical and prosthetic research, and MAMOE accounts. However, in some years VA as well as the Committees on Appropriations have restructured appropriation accounts that constitute funding for VHA.

For instance, the FY1991 VA-HUD Appropriations Act (P.L. 101-501) established the Health Professional Scholarship Program as a separate appropriation account.[12] From FY1991 through FY1995, VA included the Health Professional Scholarship Program under the VHA budget.[13] About $10 million was appropriated for this program in each fiscal year during this period. Beginning in FY1996 the account received no appropriation from Congress and was not included as a separate appropriation account under the VHA budget. VA made its last award under this program at the end of FY1995. Although the Health Professional Scholarship program was funded as a separate account, VA funded several programs for training of health professionals through the medical care account. In FY1995 VA spent approximately $408 million for education and training of health professionals; in FY2003 VA spent $841 million.

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[11] Personal communication with VA budget staff, Oct. 13, 2004.

[12] The Health Professional Scholarship Program was initially authorized by the Veterans' Administration Health Care Amendments of 1980, P.L. 96-330.

[13] The administrative cost of this program was supported from the MAMOE account.

Similarly, the FY1991 VA-HUD Appropriations Act (P. L. 101-507), authorized an annual appropriation to replace and upgrade equipment and to rehabilitate the plant and facilities of the Veterans Memorial Medical Center [VMMC] in Manila, Philippines as a separate account under the VHA budget. Beginning in FY1996, Congress discontinued providing U.S. funds to maintain and upgrade the physical plant at this facility. This was due to the suspension of U.S. veteran admissions to the VMMC. About $500,000 was provided for each of the fiscal years from FY1991 through FY1995.

More recently in FY2004, VA submitted its budget request for VHA using an account structure based on "business lines." The new medical care business line, in addition to the medical care appropriation, included the following appropriation accounts that were previously funded separately: MAMOE, which funds headquarters VHA staff; the VHA portion of the major projects construction appropriation; VHA portion of the minor projects construction appropriation; and grants for construction of state extended care facilities. Medical care cost recovery collections (MCCF) were also included in this business line. Historically considered a VHA funding account, the medical and prosthetic research account was excluded from this business line and was proposed as a separate business line.

However, during the FY2004 congressional appropriation process, both the House and Senate Appropriations Committees chose not to use the Administration's new budget account structure and funded VHA under four accounts: medical services, medical administration, medical facilities, and medical and prosthetic research (a description of these accounts is given in **Appendix 2**).[14] The Conferees also included MCCF in calculating the total amount available for VHA.

Changes in Appropriations for Capital Investments

VA holds a substantial inventory of real property and facilities throughout the country. A majority of these buildings and property supports VHA's mission. Therefore, funding for capital investments should also be examined when trying to understand VHA's funding trends. VHA uses various sources to fund capital investments. Prior to the restructuring of accounts in FY2004, most of VHA's capital investments were funded from three major appropriation accounts: medical care, major construction, and minor construction. VHA also had several smaller funding sources for capital investments, including the parking revolving fund, the nursing home revolving fund, and grants for the construction of state extended-care facilities.

Aside from costs associated with providing direct medical services to veterans such as spending on salaries and benefits of VHA physicians and nurses, the medical care appropriations account also covers VHA expenses on equipment purchases and spending on land and structures. Equipment purchases include those for durable property such as medical diagnostic equipment, data processing and telecommunications equipment, software, furniture, and vehicles. Spending on land

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[14] H.Rept. 108-401, Conference Report to accompany H.R. 2673, Consolidated Appropriations Act, 2004 (P.L. 108-199), p. 1036.

and structures includes nonrecurring maintenance expenses and leasing of building space. Nonrecurring maintenance involves repairs or modifications to existing buildings, including upgrades or replacements of major building systems or minor improvements to add space or to make other minor structural changes. As an added complication, although these amounts were included in the total appropriations for VHA, major construction and minor construction appropriations as well as grants to states for construction of state extended-care facilities were not included under the VHA budget, although these amounts were expended on medical facilities.

At present, VHA's capital investment initiatives are funded by the following accounts: medical administration, medical facilities, major construction, minor construction, and grants for the construction of state extended care facilities. The medical administration and medical facilities accounts are included under the VHA budget. The major construction and minor construction accounts, as well as grants to states for the construction of state extended-care facilities, are funded under separate construction appropriations accounts for VA as a whole. **Appendix 3** provides details on these accounts.

Maintaining VA's vast capital infrastructure has substantial costs. GAO found in 1999 that one in four medical care dollars is spent on maintaining and operating its buildings and land. GAO also estimated that VA has over 5 million square feet of vacant space, which can cost as much as $35 million a year to maintain.[15] Since this finding, VA has taken steps to reduce the funds used to operate and maintain its capital infrastructure, through the implementation of its Capital Asset and Realignment and Enhanced Services (CARES).[16] This process is still in progress.

The Consolidated Appropriations Act, 2004 (P.L. 108-199) provided funding for VHA based on a new account structure: medical services, medical administration, medical facilities, and medical prosthetic research. According to the Conference Committee, this action was taken to provide better oversight and a more accurate accounting of funds. **Table 1** and **Table 2** provide amounts requested by the Administration and finally enacted by Congress. Please note that to ease comparison between years, for FY2004 the medical services, medical administration, and medical facilities accounts have been combined into the medical care account to reflect the historic account structure, and not the account structure ultimately passed by Congress.

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[15] U.S. General Accounting Office, *VA Health Care: Capital Asset Planning and Budgeting Need Improvement*, GAO/T-HEHS-99-83, Mar. 10,1999, pp. 1 and 6.

[16] The Capital Asset Realignment for Enhanced Services (CARES) is VA's attempt to create a strategic framework to upgrade the health care delivery capital infrastructure, and ensure that scarce resources are placed in the types of facilities and locations that would best serve the needs of the veteran population. See U.S. General Accounting Office, *High-Risk Series: Federal Real Property*, GAO-03-122, Jan. 2003, p. 37.

Trends in Funding and Enrollment.

Trends in Funding for Medical Care. Between FY1995 and FY2004 appropriations for VA medical care grew by 63%. As shown in the subtotal for medical care in **Table 1**, in FY1995 appropriations for VA medical care was $16.2 billion. As indicated in **Table 2,** by FY2004 this amount was $26.4 billion.[17] For the first four years of this time period, from FY1995 through FY1999, appropriations for medical care grew by 6.7% — from $16.2 billion in FY1995 to $17.3 billion in 1999. In comparison, during the last five years of this time period, VA medical care appropriations grew by 52.7% — from $17.3 billion in FY1999 to $26.4 billion in FY2004. It should be also noted that appropriations for medical care excluds funds for medical research, MAMOE, and MCCF, as well as funds appropriated by Congress for capital investment concerning VHA facilities under separate major and minor construction appropriations. If the effect of medical research and MAMOE are considered, between FY1999 and FY2004 appropriations for total medical programs grew by 52% — from $17.7 billion in FY1999 to $26.8 billion in FY2004. It should be emphasized that these trend data should be viewed with care, especially in light of changes in VHA's account structure in FY1996 and FY2004. The effect of MCCF collections as well as appropriations for capital investment on funding for medical care is discussed below.

[17] For ease of presentation **Table 1** provides enacted appropriations from FY1995 through FY1999, and **Table 2** provides enacted appropriations from FY2000 through FY2004.

Table 1. Appropriations for Veterans' Health Care, FY1995-FY1999

(dollars in thousands)

	FY1995		FY1996		FY1997		FY1998		FY1999	
	Request	**Enacted**	**Request**	**Enacted**	**Request**	**Enacted**	**Request**	**Enacted**	**Request**	**Enacted**
Medical care	$16,121,756	$16,214,684	$16,961,487	$15,775,000	$16,438,447	$16,313,447	$16,958,846	$16,487,396	$16,392,975	$16,528,000
Delayed equipment obligation	—	—	—	789,000	570,000	700,000	—	570,000	635,000	778,000
Subtotal medical care	**16,121,756**	**16,214,684**	**16,961,487**	**16,564,000**	**17,008,447**	**17,013,447**	**16,958,846**	**17,057,396**	**17,027,975**	**17,306,000**
Medical and prosthetic research	211,000	251,743	257,000	257,000	257,000	262,000	234,374	272,000	300,000	316,000
Medical Administration and Miscellaneous Operating Expenses (MAMOE)	69,258	69,789	72,262	63,602	62,207	61,207	60,160	59,860	60,000	63,000
Health Professional Scholarship Program	10,386	10,386	10,386	—	—	—	—	—	—	—
Grants to the Republic of Philippines	500	500	—	—	—	—	—	—	—	—
Total medical programs (VHA)	**$16,412,900**	**$16,547,102**	**$17,301,135**	**$16,884,602**	**$17,327,654**	**$17,336,654**	**$17,253,380**	**$17,389,256**	**$17,387,975**	**$17,685,000**
Medical Care Collections Fund (MCCF)	—	—	—	—	—	—	604,000	543,000	558,000	583,000
Total medical programs with MCCF (VHA)	**—**	**—**	**—**	**—**	**—**	**—**	***$17,857,380***	***$17,932,256***	***$17,945,975***	***$18,268,000***

Source: Table prepared by CRS, based on funding figures from the House Appropriations Committee Reports to accompany the VA-HUD and Independent Agencies Appropriations Bills from FY1995-FY2005. H.Rept. 103-555; H.Rept. 104-201; H.Rept. 104-628; H.Rept. 105-175; H.Rept. 105-610; H.Rept. 106-286; H.Rept. 106-674; H.Rept. 107-159; H.Rept. 107-740;108-235; H.Rept. 108-674.

Table 2. Appropriations for Veterans' Health Care, FY2000-FY2004

(dollars in thousands)

	FY2000		FY2001		FY2002		FY2003		FY2004	
	Request	**Enacted**	**Request**	**Enacted**	**Request**	**Enacted**	**Request**	**Enacted**	**Request**	**Enacted**
Medical care	$16,671,000	$18,106,000	$19,381,587	$19,381,587	$20,304,742	$20,656,164	$22,243,761	$23,889,304	$25,218,080	$26,708,954[b]
Delayed equipment obligation	635,000	900,000	900,000	900,000	675,000	675,000	500,000	—	—	—
Rescission	—	-79,519[a]	—	—	—	—	—	—	—	-270,000[c]
2002 Supplemental (P.L.107-206)	—	—	—	—	—	142,000	—	—	—	—
Subtotal medical care	**17,306,000**	**18,926,481**	**20,281,587**	**20,281,587**	**20,979,742**	**21,473,164**	**22,743,761**	**23,889,304**	**25,218,080**	**26,438,954**
Medical and prosthetic research	316,000	321,000	321,000	351,000	360,237	371,000	394,373	397,400	408,000	405,593
Medical Administration and Miscellaneous Operating Expenses (MAMOE)	61,200	59,703	64,884	62,000	67,628	66,731	69,716	74,230	79,140	—
Total medical programs (VHA)	**17,683,200**	**19,307,184**	**20,667,471**	**20,694,587**	**21,407,607**	**21,910,895**	**23,207,850**	**24,360,934**	**25,705,220**	**26,844,547**
Medical Care Collection Fund (MCCF)	608,000	608,000	639,000	639,000	691,000	691,000	752,000	1,386,000	1,800,000	1,554,772
Total medical programs with MCCF (VHA)	***$18,291,200***	***$19,915,184***	***$21,306,471***	***$21,333,587***	***$22,098,607***	***$22,601,895***	***$23,959,850***	***$25,746,934***	***$27,505,220***	***$28,399,319***

Source: Table prepared by CRS, based on funding figures from the House Appropriations Committee Reports to accompany the VA-HUD and Independent Agencies Appropriations Bills from FY1995-FY2005. H.Rept. 103-555; H.Rept. 104-201; H.Rept. 104-628; H.Rept. 105-175; H.Rept. 105-610; H.Rept. 106-286; H.Rept. 106-674; H.Rept. 107-159; H.Rept. 107-740; H.Rept. 108-235; H.Rept. 108-674.

a. This represents an across-the-board rescission of 0.38%

b. To ease comparison between years, for FY2004 the medical services, medical administration, and medical facilities accounts have been combined into the medical care account to reflect the historic account structure, and not the account structure ultimately used to fund VHA.

c. The Senate Committee on Appropriations included bill language that cancelled budget authority of $270 million, representing prior year recoveries from medical care.

MCCF Collections. Aside from direct appropriations for medical care, VA has been able to supplement its appropriations through MCCF collections. Since FY1998 (the first year VA started retaining these collections) VA has utilized these collections to provide medical services to veterans. In FY1998, approximately 3% of the VA medical care budget comprised MCCF collections; by FY2004, this amount had increased to nearly 5.5% of the VA medical care appropriation (**Table 3**).

MCCF collections increased substantially from FY2002 and FY2003 and then significantly from FY2003 to FY2004. From FY2002 through FY2003, the increase was due to the passage of the Veterans Millennium Health Care and Benefits Act of 1999 (P.L. 106-117), which, among other things, authorized VA to increase the medication copayment amount; as discussed earlier, the Consolidated Appropriations Resolution, 2003 (P.L. 108-7) granted VA authority to consolidate HSIF with MCCF. Between FY2003 and FY2004 VA was able to increase its MCCF funds by $170 million, from approximately $1.4 billion in FY2003 to almost $1.6 billion in FY2004. This was due to the enactment of the FY2004 VA-HUD Appropriations Act, which, among other things, authorized consolidating the several other revenue accounts into MCCF.[18] This growth reflects the consolidation that has not yet occurred (see previous discussion under **Legislation to Supplement Appropriations**).

Table 3. Medical Care Collections Fund (MCCF) as a Percent of VHA Appropriations

(dollars in thousands)

	VHA appropriation	MCCF	MCCF as a % of VHA appropriations
FY1995	$16,547,102		
FY1996	16,884,602		
FY1997	17,336,654		
FY1998	17,932,256	$543,000	3.03
FY1999	18,268,000	583,000	3.19
FY2000	19,915,184	608,000	3.05
FY2001	21,333,587	639,000	3.00
FY2002	22,601,895	691,000	3.06
FY2003	25,746,934	1,386,000	5.38
FY2004	$28,399,319	$1,554,772	5.47

Source: Table prepared by CRS, based on funding figures from the House Appropriations Committee Reports to accompany the VA-HUD and Independent Agencies Appropriations Bills from FY1995-FY2005

[18] Starting in FY2004 other revenue accounts have been consolidated into MCCF including long-term care co-payments, compensated work therapy program funds, compensation and pension living expenses program funds, and parking program fees. See **Appendix 1** for further details on these accounts.

Appropriations for Construction and Capital Improvement. Although not included in the VA medical care appropriation, a large proportion of VA's construction and capital improvement dollars are spent in support of the health care delivery system. In FY1995, 92% of VA's construction appropriation went toward capital improvement of VA's medical infrastructure. In FY2004, 89% of VA's construction budget was for VA's medical facilities (**Table 4**). During the past 10-year period (FY1995 through FY2004), VHA's construction budget averaged about $335 million. This figure excludes funds from the medical care appropriation, which funds nonrecurring maintenance projects, equipment and leases, and grants to states for the construction of state extended care facilities. Furthermore, during this same period, appropriations for VHA construction grew by approximately 75% — from $468 million in FY1995 to $817 million in FY2004.

Table 4. Appropriations for Construction of VHA Facilities FY1995-FY2004

(dollars in thousands)

	Major construction appropriation for VHA	Minor construction appropriation for VHA	Total major and minor construction appropriation for VHA	Total major and minor VA construction appropriation	Total VHA construction as a % of VA construction
FY1995	$341,379	$126,934	$468,313	$507,228	92.3
FY1996	125,775	169,800	295,575	325,969	90.6
FY1997	200,658	142,800	343,458	393,758	87.2
FY1998	174,133	146,200	320,333	385,000	83.2
FY1999	122,387	157,000	279,387	317,287	88.0
FY2000	52,610	137,670	190,280	225,140	84.5
FY2001	18,330	129,255	147,585	232,119	63.5
FY2002	111,450	161,560	273,010	394,331	69.2
FY2003	43,941	176,444	220,385	323,909	68.0
FY2004	$612,738	$205,082	$817,820	$921,737	88.7

Source: Table prepared by CRS based on unpublished data provided by VA.
Note: Total VA construction excludes Grants for Construction of State Extended Care Facilities, and funds for nonrecurring maintenance projects, equipment, and leases, which are funded under medical care appropriations.

Veteran Enrollment. Before discussing trends in veteran enrollment, it is important to understand VA's enrollment process. The Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262) required that VA establish a national enrollment system to manage the delivery of inpatient hospital care and outpatient medical care, within the available appropriated resources. The law provided that starting in FY1999 most veterans had to enroll in the VA health care system as a condition of receiving VA hospital and outpatient care. Enrollment is in effect a registration system for veterans who want to receive care. The law established seven priority groups, with Priority Group 1 being the highest level of need, and Priority Group 7 being the lowest. Subsequently, Congress enacted the Department of Veterans Affairs Health Care Program Enhancement Act of 2001 (P.L. 107-135) further amending the law governing enrollment. It altered the enrollment system by

establishing effective FY2003 an additional Priority Group 8. Therefore, at present Priority Group 1 is the highest and Priority Group 8 is the lowest. Currently, VA has suspended enrolling veterans in Priority Group 8.[19]

Priority Group 1 includes those veterans with the most severe service-connected disabilities; Priority Group 8 includes veterans whose incomes and assets exceed a specified level and who do not qualify for VA payments for a service-connected disability. Priority Group 8 veterans must agree to make copayments for health services (see **Appendix 4** for a detailed list of priority enrollment groups).[20]

Not all veterans are enrolled in VA's health care system. Some veterans are exempt from the enrollment requirement. Veterans who do not have to enroll include veterans who: (1) have a service-connected compensation rating of 50% or greater;[21] (2) have been discharged in the past year for a compensable disability that VA has not yet rated; or (3) want care for a service-connected disability. This means that although VA generally requires all veterans to enroll in the VA health care system in order to receive health care, veterans who meet the above-mentioned special eligibility criteria are exempt from the enrollment requirement. However, it should be noted that for planning and budgeting purposes VA encourages all veterans who wish to receive health care from VA to enroll.

Trends in Enrollment. From FY1995 through FY2004 the total number of individual "unique" veterans receiving medical care has grown by 88.2%. The total number of veteran enrollees has grown by 76.9% from FY1999, the first year of enrollment, to FY2004 (**Table 5**). During this same period the number of unique veterans receiving medical care has grown by 49.2% — from 3.2 million veterans in FY1999 to an estimated 4.7 million veterans in FY2004. This number excludes Readjustment Counseling, the State Home, Civilian Health and Medical Program of VA (CHAMPVA),[22] Spina Bifida, Foreign Medical Program, and nonveterans. In FY2003, VA provided care to around 417,000 nonveterans. There was a large surge in enrollment between FY2000 and FY2001. During this time period VA saw a 23% increase in enrollment (**Table 5**).

Veterans may be attracted to VA because many older veterans may lack or have limited prescription drug coverage from other sources. A study done by VA in 2003 on uninsured veterans, found that among all the priority enrollment groups, Priority

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[19] U.S. Department of Veterans Affairs, "Annual Enrollment Level Decision," 68 *Federal Register* 2669-2673 (Jan. 17, 2003).

[20] For a detailed description of VA health care enrollment, see CRS Report RL32548 *Veterans' Medical Care Appropriations and Funding Process*, by Sidath V. Panangala.

[21] Percentage ratings represent the average impairment in earning capacity resulting from diseases and injuries encountered as a result of or incident attributed to military service; those with a rating of 50% or more are placed in Priority Group 1.

[22] Under CHAMPVA, VA is authorized to furnish medical care to the spouse or the child of a veteran who has a total and permanent service connected disability and the widowed spouse or child of a veteran who (a) died as a result of a service-connected disability or (b) at the time of death had a total disability permanent in nature, resulting from a service-connected disability.

Group 7 veterans have shown the largest increase in enrollment (29% of all enrolled veterans), and many may be coming to VA to bridge gaps in their insurance coverage or to reduce their out-of-pocket costs.[23] The General Accounting Office (renamed the Government Accountability Office in 2004) found that between FY1999 and FY2001, Priority Group 7 users age 65 and over as a proportion of total users in this age group grew from 52% to 65%.[24] According to GAO, older veterans might be attracted to VA because many in this age group lack or have limited prescription drug coverage from other sources.[25] Furthermore, GAO reported that VA's outpatient pharmacy expenditures for Priority Group 7 veterans have increased from $178 million in FY1999 to $418 million in FY2001, a growth rate four times that of other veterans[26]

There has been considerable interest in understanding the impact of the recently passed Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173) on future demand for VA medical services. VA contracted an outside consultant to estimate the impact of this legislation on VA enrollment. The study estimated that approximately 2 million retirees with employment-based prescription drug coverage will lose that coverage. Applying these results to the veteran population, approximately 35,000 additional new veterans will enroll in VA; nearly half of these enrollees will be in Priority Group 7. Thus a majority of the new enrollees would not use VA's health care system beyond its prescription drug benefit.[27]

It should be emphasized that not all enrolled veterans seek care during any given year. In FY1999 74% of enrolled veterans received care from VA; in FY2003 about 63% of all enrolled veterans received care from VA (**Table 5**).

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[23] Donald Stockford, Mary Martindale, and Gregg Pane, *Uninsured Veterans and the Veterans Health Administration Enrollment System, 2003*, U.S. Department of Veterans Affairs.

[24] U.S. General Accounting Office, *VA Health Care: Expanded Eligibility Has Increased Outpatient Pharmacy Use and Expenditures*, GAO-03-161, Nov. 2002, p. 5. This study was done before Congress established a new Priority Group 8.

[25] Ibid, p. 5.

[26] According to GAO, Priority Group 7 veterans now constitute 14% of VA pharmacy benefit spending. See U.S. General Accounting Office, *Major Management Challenges and Program Risks: Department of Veterans Affairs*, GAO-03-110, Jan. 2003, pp. 14-15.

[27] U.S. Congress, House Committee on Appropriations, Subcommittee on VA, HUD, and Independent Agencies, *Hearings on the Department of Veterans Affairs (VA) and Housing and Urban Development (HUD), and Independent Agencies Appropriations for FY2005*. 108th Cong., 2nd sess., Mar. 31, 2004, pp. 24-34.

Table 5. Veteran Population, Veteran Enrollees, and Veterans Receiving Care FY1995-FY2004

	FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004 Estimate
Total number of veterans	27,901,000	27,661,000	27,404,000	27,122,000	26,830,000	26,475,000	26,053,000	25,618,000	25,179,000	24,737,000
Total number of veteran enrollees	Not available	Not available	Not available	Not available	4,314,528	4,936,259	6,073,264	6,882,488	7,186,643	7,632,416
Total number of unique veterans receiving medical care	2,519,892	2,562,345	2,692,862	2,945,837	3,177,216	3,427,925	3,843,832	4,246,084	4,544,430	4,741,611

Source: Table Prepared by CRS. Data provided by the Office of the Actuary, Department of Veterans Affairs (VA) using the following databases: FY1991-FY1998 — VSSC (PTF/OPC files); FY1999-FY2003 — VHA ADUSH annual enrollment files; FY2003 and FY2004 unique veteran patient data and FY2004 enrollment data from FY2005 Congressional Budget Submission.

Vet Pop2001 modified for smoothness at 2000; Vetpop2001 adjusted to Census 2000. Data adjustments done by VA.

Methodology and Data Limitations

Total appropriations for VA medical care was obtained from the House Appropriations Committee reports to accompany the Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Bills for FY1995-FY2005.[28] For example, to obtain the FY2004 enacted amount we used the FY2005 House Appropriations Committee report to accompany the FY2005 VA-HUD Appropriations Bill (H.R. 5041). We believe that using the appropriation figures as reported after one year provides a more accurate estimates because any necessary adjustments will have been made. Budget request estimates for a given fiscal year were obtained from the House Appropriations Committee report for that year. For example, to obtain the FY2004 request we used the FY2004 House Appropriations Committee report to accompany the FY2004 VA-HUD Appropriations Bill (H.R. 2861). It should be again emphasized that we have provided appropriations for VHA and not spending or outlays for VHA programs. It should be noted that not all budget authority becomes outlays in the year for which is provided, and a portion of each year's outlays derives from "carryover" budget authority provided in prior years.

Data on the total number of veterans and the number of enrolled veterans were obtained from VA, except for FY2003 and FY2004, where data were obtained from the VA's FY2005 budget submission to Congress. However, as mentioned earlier VA did not implement its enrollment system until FY1999; therefore, enrollment data are only available from FY1999 onwards. Although VA enrolls only veterans, its employees, as well as those in CHAMPVA, also use the VA health system.

Concluding Observations

Due to the overwhelming demand of new veterans seeking VA medical services, some veterans waiting more than six months for a primary care or speciality care appointment, and the suspension of enrolling new Priority Group 8 veterans in January 2003 by VA, Congress has been particularly interested in funding for VHA, in general, and trends in funding over time.

As described earlier, between FY1995 and FY2004 appropriations for VA medical care grew by 63%. For the first four years of this period, from FY1995 through FY1999, appropriations for VA medical care grew by 6.7% — from $16.2 billion in FY1995 to $17.3 billion in FY1999. Whereas, for the last five years of this period, from FY1999 through FY2004, VA medical care appropriations grew by 52.7% — from $17.3 billion in FY1991 to $26.4 billion in FY2004. However, the number of veterans receiving health care also grew during this time period — from 2.5 million in FY1995 to an estimated 4.7 million in FY2004 — and the total number of veteran enrollees grew by 76.9% from FY1999, the first year of enrollment, to FY2004. Although these trend data indicate a growth in appropriations during the past decade, these data need to be viewed with care, particularly as a result of

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[28] H.Rept. 103-555; H.Rept. 104-201; H.Rept. 104-628; H.Rept. 105-175; H.Rept. 105-610; H.Rept. 106-286; H.Rept. 106-674; H.Rept. 107-159; H.Rept. 107-740; H.Rept. 108-235; H.Rept. 108-674.

changes to VHA's account structure, VA's increased access to nonappropriated funding sources, and appropriations for construction and capital improvement spent in support of the health care delivery system that are not included when describing funding for VHA. These factors make it challenging to compare appropriations from one year to the next.

Appendix 1. Revenue Accounts That Constitute the Medical Care Collections Fund (MCCF) for FY2004

Pharmacy Co-payments (formerly collected in the Health Services Improvement Fund — HSIF). In FY2002, Congress created a new fund (Health Services Improvement Fund) to collect increases in pharmacy copayments (from $2 to $7 for a 30-day supply of outpatient medication) that went into effect on February 4, 2002. The Consolidated Appropriations Resolution, 2003 (P.L.108-7) granted VA the authority to consolidate the HSIF with MCCF and granted permanent authority to recover copayments for outpatient medications.

Long-Term Care Co-payment Account (formerly the Veterans' Extended Care Revolving Fund). The Millennium Health Care and Benefits Act (P.L.106-117) provided VA authority to collect long-term care copayments. These out-of- pocket payments include per diem amounts and copayments from certain veteran patients receiving extended care services. These funds are used to provide extended care services, which according to the Administration's budget documents, are defined as geriatric evaluation, nursing home care, domiciliary services, respite care, adult day health care, and other noninstitutional alternatives to nursing home care.[29]

Compensated Work Therapy Program (formerly the Special Therapeutic and Rehabilitation Activities Fund). The program was created by the Veterans' Omnibus Health Care Act of 1976 (P.L. 94-581) to provide rehabilitative services to certain veteran beneficiaries receiving medical care and treatment from VA. Funds collected in this program are derived from goods and services produced and sold by patients and members in VA health care facilities.

Compensation and Pension Living Expenses Program (formerly the Medical Facilities Revolving Fund). The program was established by the Veterans' Benefits Act of 1992 (P.L.102-568). Under this program, veterans who do not have either a spouse or child may have their monthly pension reduced to $90 after the third month a veteran is admitted for nursing home care. The difference between the veteran's pension and the $90 is used for the operation of the VA medical facility.

Parking Program (formerly the Parking Revolving Fund). The program provides funds for construction and acquisition of parking garages at VA medical facilities. VA collects fees for use of these parking facilities. The Consolidated Appropriations Act, 2004 authorized collections from the Parking Program to be deposited in MCCF and be used for medical services. Funds for construction or alterations of parking facilities will now be included under the construction major projects and construction minor projects accounts.[30]

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[29] U.S. Department of Veterans Affairs, *FY2005 Budget Submissions, Medical Programs*, vol. 2 of 4, pp. 2A-32.

[30] H.Rept. 108-401, Conference Report to accompany H.R. 2673, Consolidated Appropriations Act, 2004 (P.L. 108-199).

Sale of Assets (formerly the Nursing Home Revolving Fund). This fund provides for construction, alteration, and acquisition (including site acquisition) of nursing home facilities as provided for in appropriation acts. Collections to this revolving fund are realized from the transfer on any interest in real property that is owned by VA and has an estimated value in excess of $50,000. No budget authority is required for this revolving fund, and funds are available without fiscal year limitation.

Appendix 2. VHA's New Account Structure

Medical Services. Provides funds for treatment of veterans and eligible beneficiaries in VA medical centers, nursing homes, outpatient clinic facilities, and contract hospitals. Hospital and outpatient care is also provided by the private sector for certain dependents and survivors of veterans under the Civilian Health and Medical Program of VA (CHAMPVA). Funds are also used to train medical residents, interns, and other professional, paramedical and administrative personnel in health science fields to support VA's medical programs. Overhead costs associated with medical and prosthetic research is also funded by this account.

Medical Administration. Provides funds for the management and administration of VA's health care system. Funds are used for the costs associated with the operation of VA medical centers, other facilities, VHA headquarters, costs of Veterans Integrated Service Network (VISN) offices, billing and coding activities, and procurement.[31]

Medical Facilities. Provides funds for the operation and maintenance of VHA's infrastructure. Funds are used for costs associated with utilities, engineering, capital planning, leases, laundry, food services, groundskeeping, garbage disposal, facility repair, and selling and buying of property.

Medical and Prosthetic Research. Provides funds for medical, rehabilitative, and health services research. The medical and prosthetic research program is an intermural program. In addition to funds from this appropriation, reimbursements from the Department of Defense (DOD), grants from the National Institutes of Health (NIH), and private sources supports VA researches. Medical research supports basic and clinical studies that advances knowledge so that efficient, and rational interventions can be made to prevent, care for, or alleviate disease. The prosthetic research program is involved in the development of prosthetic, orthopedic and sensory aids to improve the lives of disabled veterans. The health services research program focuses on improving the outcome effectiveness and cost-efficiency of health care delivery for the population of veterans. Overhead costs associated with medical and prosthetic research are also funded by the medical services account.

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[31] VHA has divided its health care delivery locations into 21 geographic regions. Each region is known as a Veterans Integrated Service Network (VISN) and has director and small staff, who perform a wide range of activities, including asset planning and budgeting.

Appendix 3. VHA's Appropriation for Capital Investments

Medical Administration. Provides funds for costs associated with operation of medical centers, other facilities and VHA headquarters as well as VISN offices. It also funds all the medical information technology, including patient records, computer equipment and software development, which are considered capital assets by VA.

Medical Facilities. Provides funds for the operation and maintenance of VHA's infrastructure. Funds are used for costs associated with utilities, engineering, capital planning, leases, laundry, food services, groundskeeping, garbage disposal, facility repair, and selling and buying of property.

Construction Major. Provides funds for capital projects costing $7 million or more that are intended to design, build, alter, extend or improve a VHA facility. As part of VA's budget process, Congress reviews, approves, and funds major construction on a project by project basis. Typical major construction projects are replacements of hospital buildings, addition of large ambulatory care centers, and new hospitals or nursing homes.

Construction Minor Projects. Provides funds for capital projects costing $500,000 or more and less than $7 million that are intended to design, build, alter, extend or improve a VHA facility. Minor construction projects are approved at the Veterans Integrated Service Network (VISN) level.

Grants for Construction of State Extended Care Facilities. Provides grants to states for construction or acquisition of state home facilities, including funds to remodel, modify or alter existing buildings used for furnishing domiciliary, nursing home or hospital care to veterans. A grant may not exceed 65% of the total cost of the project.

Appendix 4. Priority Groups and Their Eligibility Criteria

Priority Group 1
Veterans with service-connected disabilities rated 50% or more disabling

Priority Group 2
Veterans with service-connected disabilities rated 30% or 40% disabling

Priority Group 3
Veterans who are former POWs
Veterans awarded the Purple Heart
Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
Veterans with service-connected disabilities rated 10% or 20% disabling
Veterans awarded special eligibility classification under 38 U.S. C. § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation

Priority Group 4
Veterans who are receiving aid and attendance or housebound benefits
Veterans who have been determined by VA to be catastrophically disabled

Priority Group 5
Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds
Veterans receiving VA pension benefits
Veterans eligible for Medicaid benefits

Priority Group 6
Compensable 0% service-connected veterans
World War I veterans
Mexican Border War veterans
Veterans solely seeking care for disorders associated with
— exposure to herbicides while serving in Vietnam; or
— ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
— for disorders associated with service in the Gulf War; or
— for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.

Priority Group 7
Veterans who agree to pay specified copayments with income and/or net worth *above* the VA Means Test threshold and income *below* the HUD geographic index
Subpriority a: Noncompensable 0% service-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
Subpriority c: Nonservice-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date.
Subpriority e: Noncompensable 0% service-connected veterans not included in Subpriority a above
Subpriority g: Nonservice-connected veterans not included in Subpriority c above

Priority Group 8
Veterans who agree to pay specified copayments with income and/or net worth *above* the VA Means Test threshold and the HUD geographic index
Subpriority a: Noncompensable 0% service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
Subpriority e: Noncompensable 0% service-connected veterans applying for enrollment after January 16, 2003
Subpriority g: Nonservice-connected veterans applying for enrollment after January 16, 2003.