Congressional CBO Budget Office
Summary

Potential Costs of Veterans' Health Care

The Department of Veterans Affairs (VA) provides health care at little or no charge to more than 5 million veterans annually. Medical services are provided through the inpatient and outpatient facilities run by the Veterans Health Administration. Those services include routine health assessments, readjustment counseling, surgery, hospitalization, and nursing home care.

The Congressional Budget Office (CBO) projects that the future costs for VA to treat enrolled veterans will be substantially higher (in inflation-adjusted dollars) than recent appropriations for that purpose, partly because more veterans are likely to seek care in the VA system but mostly because health care costs per enrolled veteran are projected to increase faster than the overall price level. Under two scenarios that CBO examined, the total real resources (in 2010 dollars) necessary to provide health care services to all veterans who seek treatment at VA would range from $69 billion to $85 billion in 2020, representing cumulative increases of roughly 45 percent to 75 percent since 2010.

Although veterans from recent conflicts will represent a fast-growing share of enrollments in VA health care over the next decade, the share of VA's resources devoted to the care of those veterans is projected to remain small through 2020, in part because they are younger and healthier than other veterans served by VA.

Background

To provide health care services, VA depends on discretionary funding that the Congress provides in annual appropriation acts. Although eligibility for VA health care is based primarily on veterans' military service, VA may, and does, adjust enrollment according to the resources available to it.

The Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262, 110 Stat. 3177) mandated that VA deliver services to veterans who have service-connected conditions, to veterans unable to pay for necessary medical care, and to specific groups of veterans, such as former prisoners of war. The legislation permitted VA to offer services to all other veterans to the extent that resources and facilities were available; it also required VA to develop and implement an enrollment system to facilitate the management and delivery of health care services.

VA's enrollment system includes eight categories that determine veterans' eligibility and priority for access to health care. The highest priority is given to veterans who have service-connected disabilities (priority groups 1 through 3, or P1 through P3); the lowest priority is given to higher-income veterans who have no compensable service-connected disabilities, that is, no conditions that are disabling to the degree that VA provides compensation (P8).

The number of veterans treated by VA climbed rapidly following the enactment of the 1996 law, increasing from 2.9 million in fiscal year 1995 to 4.5 million in 2003.[1] By 2003, VA no longer had the capacity to adequately serve all current enrollees, prompting the Secretary of Veterans Affairs to suspend further enrollment of some higher-income veterans (those in P8); VA eased that restriction in 2009 to allow some of those veterans to enroll. (Enrolled veterans typically have more than one source of health care available to them and choose to use VA for only a small portion of their health care, relying on other sources such as Medicare, employer-sponsored insurance, or the Department of Defense's TRICARE program.)

1. Some enrolled veterans do not seek treatment from VA each year and consequently are not included in the counts of patients in a given year.

Current Resources

A total of $44 billion was appropriated to VA for 2009 to provide medical services to veterans and to conduct medical research.[2] That amount was increased by 8 percent, to $48 billion, for 2010. VA has requested an appropriation of $52 billion, an additional 8 percent, for 2011.[3] The average annual increase was more than 9 percent from 2004 through 2009.

One group of veterans—those who have deployed or will deploy to overseas contingency operations (OCO), which include Operation Iraqi Freedom, Operation New Dawn, and Operation Enduring Freedom in Afghanistan and related activities—are of particular interest as policymakers and others attempt to determine the extent of the war-related medical conditions of those veterans and the resources required to treat them. Those veterans accounted for only about 6 percent of all patients in 2009 and 3 percent of the total dollars obligated for veterans' health care in that year. Of the $43 billion obligated in 2009, VA estimates that it obligated $1.5 billion to care for OCO veterans. VA further estimates that those obligations will rise to $2.0 billion in 2010, $2.6 billion in 2011, and $3.3 billion in 2012.

Projecting Future Costs

This CBO report examines prospective demands on VA and projects the resources the agency would need to provide medical care to all enrolled veterans during the next 10 years, 2011–2020. (The report does not attempt to predict appropriations for VA.) Although the focus of this report is on the resources VA would need to treat all enrolled veterans, CBO has also separately projected the portion of those resources that would be needed to treat the veterans of the ongoing overseas contingency operations.

The recent increases in VA's medical budget have reflected factors that will probably affect future resource requirements. First, as is true for all U.S. health care, VA's medical expenditures per enrollee have grown more rapidly than has the overall price level. Second, the ongoing deployments to combat operations in Iraq and Afghanistan have increased the number of veterans seeking care from VA. Third, VA has been easing restrictions on enrolling higher-income veterans (those in P8), in part because of concerns expressed by policymakers and others who believe that restrictions on enrollment have caused some veterans to be denied benefits that they deserve.

To account for some possible policy changes and for uncertainty about the number of veterans who will be enrolled and the growth of medical expenditures per enrollee, CBO presents two scenarios to capture some of the range of possible outcomes. The scenarios differ in their assumptions about the number of enrollees in the VA health care system and the costs of providing medical services (see Summary Table 1). CBO also assumes that there will be no major changes in VA's policies (except for a possible change in eligibility criteria) and that the enrollment of non-OCO veterans (except for higher-income veterans) and the percentage of total health care that veterans receive from VA as opposed to other sources, referred to as their "reliance on VA," follow current trends.

Scenario 1. The first scenario was crafted using assumptions about enrollment and medical expenditures per

2. All dollar amounts in this and the following paragraph are reported in nominal terms.

   VA's budget for medical care and research includes funding from all of VA's health care accounts, including all collections (that is, reimbursements to VA from third parties for medical care), but excludes funding for construction of medical facilities. In 2009, appropriations for construction totaled more than $1.5 billion. Funding for medical care and research for 2009 includes $1 billion appropriated in the American Recovery and Reinvestment Act of 2009 (Public Law 111-5).

3. The Veterans Health Care Budget Reform and Transparency Act of 2009 (P.L. 111-81) authorized advance appropriations for VA's medical services, medical support and compliance, and medical facilities accounts; it also requires that VA's annual budget submission include estimates of appropriations for those accounts for the fiscal year following the budget year. An advance appropriation is an appropriation that first becomes available for the government to obligate (that is, legally commit to pay for goods and services ordered or received) in a fiscal year after the budget year. For example, the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2010—Division E of the Consolidated Appropriations Act, 2010 (P.L. 111-117)—provided an advance appropriation of $48 billion for the three health care accounts (excluding the authority to spend collections) to be first available for obligation in fiscal year 2011. The President's budget for fiscal year 2011(submitted in February 2010) contains the amounts that were appropriated in advance in P.L. 111-117 for the three VA health care accounts and requests additional amounts for medical and prosthetic research and for the spending of collections. Accordingly, the total amount available for VA medical care and research in 2011 will include the advance appropriations made in 2010 modified by funding provided in the appropriation act for 2011.

Summary Table 1.

Assumptions Underlying the Scenarios Used to Project Enrollment of Veterans and the Potential Costs for VA to Provide Health Care Services to Them

	Baseline	Scenario 1	Scenario 2
		Assumptions Underlying the Scenarios	
Eligibility to Enroll for VA Health Care			
Veterans of overseas contingency operations	n.a.	Deployed troop strength for those operations drops to 30,000 by 2013	Deployed troop strength for those operations drops more slowly, to 60,000 by 2015
All other veterans	n.a.	Policies in place at the beginning of 2010 remain in effect	Enrollment allowed for veterans whose income exceeds thresholds by 30 percent or less; all other VA policies in place at the beginning of 2010 remain in effect
Per Capita Growth in Medical Expenditures	n.a.	About the same rate as in the general population[a]	30 percent faster than in Scenario 1
		Projections for All Enrolled Veterans	
Number of Enrollees (Millions)			
2011	n.a.	8.5	8.7
2020	n.a.	8.7	9.3
Potential VA Health Care Costs (Billions of 2010 dollars)			
2011	51	50	52
2016	54	62	70
2020	56	69	85
2011–2020	535	602	682
		Projections for Enrolled Veterans of Overseas Contingency Operations	
Number of Enrollees			
In millions			
2011	n.a.	0.8	0.8
2020	n.a.	1.4	1.7
As a percentage of all enrolled veterans			
2011	n.a.	9	9
2020	n.a.	16	18
Potential VA Health Care Costs			
In billions of 2010 dollars			
2011	n.a.	2	3
2016	n.a.	4	6
2020	n.a.	5	8
2011–2020	n.a.	40	54
As a percentage of the potential costs for all enrolled veterans			
2011	n.a.	5	5
2016	n.a.	7	8
2020	n.a.	8	10
2011–2020	n.a.	7	8

Source: Congressional Budget Office.

Notes: The starting point for the cost projections in the two scenarios is the Department of Veterans Affairs' (VA's) appropriation for medical care and research in 2010. CBO's baseline budget projection, following Congressional rules, is based on VA's enacted advance appropriations for 2011 for medical services, medical support and compliance, and medical facilities and on VA's enacted appropriations for 2010 for all other medical accounts. Under those rules, CBO projects baseline spending in subsequent years by adjusting those appropriations by a forecast of future inflation—a weighted average of the gross domestic product (GDP) price index and the employment cost index for wages and salaries. For comparison with the two scenarios, those projections are converted to 2010 dollars by applying the GDP price index. Because CBO projects that wages and salaries will rise more rapidly than the GDP price index, the baseline projection increases slightly (in 2010 dollars) during the 2011–2020 period.

Overseas contingency operations include current military operations in Iraq and Afghanistan and related activities.

n.a. = not applicable.

a. Projections of growth in medical expenditures for the general population are based on data from the Centers for Medicare and Medicaid Services and others.

enrollee that generate lower resource requirements than Scenario 2. The assumptions about factors affecting enrollment include the following:

- VA's eligibility, cost-sharing, and other policies are those in effect at the beginning of 2010. Those policies include the easing of enrollment restrictions that began in 2009 for veterans in priority group 8 who have no compensable service-connected disabilities and whose income is 10 percent or less above VA's income thresholds.
- The number of troops deployed to overseas contingency operations, which currently include the military operations in Iraq and Afghanistan and related activities, drops to 30,000 by 2013 and remains at that number throughout the decade.
- VA's medical expenditures per enrollee for each priority group grow in nominal terms at slightly more than 5 percent per year, about the same rate as that anticipated in the general population over the decade.

Scenario 2. CBO crafted the second scenario to illustrate potential policy changes and other outcomes that may result in higher resource needs for VA's health care services. The assumptions for that scenario are as follows:

- VA changes its eligibility rules to allow veterans who have no compensable service-connected disabilities and whose income is 30 percent or less above VA's income thresholds to enroll. Other than that change, all policies relating to eligibility, cost sharing, and other factors are those in effect at the beginning of 2010.
- The number of troops deployed to overseas contingency operations declines more slowly than in Scenario 1, dropping to 60,000 by 2015 and remaining at that number through the rest of the decade.
- VA's medical expenditures per enrollee for each priority group grow initially at the rate VA assumed in preparing the Administration's 2011 budget request that was transmitted in February 2010 and, in subsequent years, at an annual rate that is about 30 percent higher than that anticipated in the general population—a rate that exceeds the average rate experienced by VA from 2003 through 2007, before significant numbers of veterans from the ongoing conflicts had enrolled.

Potential Costs to Treat All VA Enrollees

Under Scenario 1, CBO estimates that total enrollment would grow from 8.0 million in 2009 to more than 8.8 million by 2016—an increase of about 10 percent—but would edge down to 8.7 million in 2020 (see Summary Table 1 and Summary Figure 1). The resources required to treat all enrolled veterans would be about $69 billion in 2020, nearly 45 percent higher than the $48 billion that has been provided for 2010.

Under Scenario 2, enrollment would be 620,000 higher in 2020 than in Scenario 1, with 340,000 new enrollees resulting from VA's further relaxation of the restrictions on enrollment and 280,000 from the higher troop deployments. The resources required to treat all enrolled veterans would reach nearly $85 billion in 2020, or 22 percent more than under Scenario 1 and about 75 percent more than the amount provided for 2010.

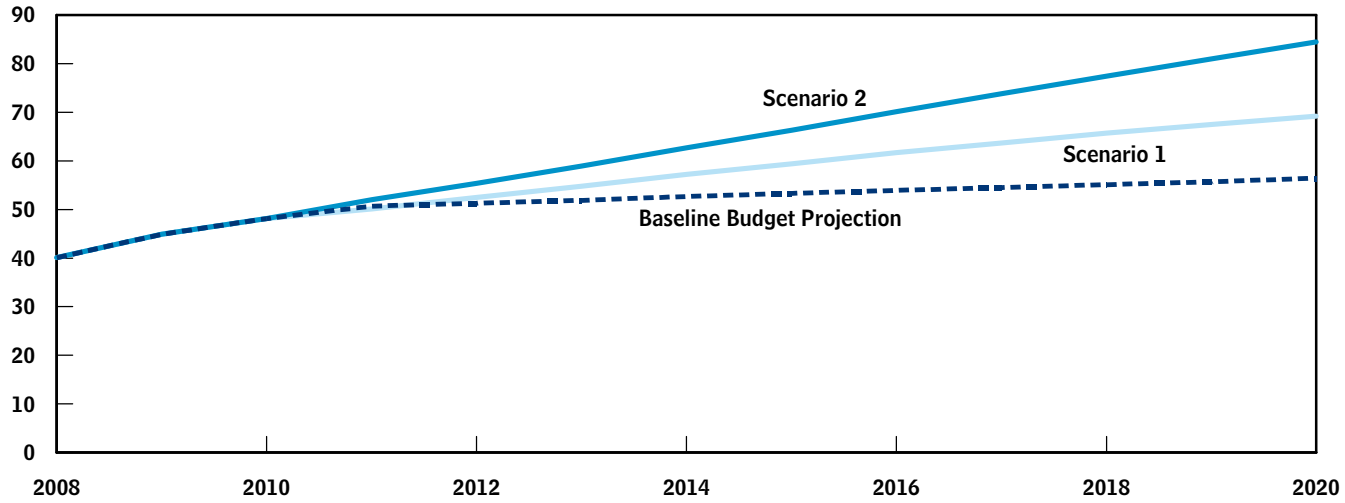
What factors explain the difference of roughly $15 billion in the potential costs of the two scenarios in 2020? The disparity between the growth rates of medical expenditures per enrollee in the two scenarios accounts for the lion's share of the difference—$13 billion. Extending eligibility to additional higher-income veterans who have no compensable service-connected disabilities would add just $1 billion to the costs under Scenario 1; because those new enrollees are drawn from a group that historically has cost less to treat than most other veterans, the additional resources VA would require would be relatively small. The higher troop levels for contingency operations under Scenario 2 would also add $1 billion; the increase in the number of enrollees would be small—only about 3 percent—and they too would use fewer resources than the average enrollee.

The projections for both scenarios exceed the baseline projections that CBO constructs in accordance with the provisions set forth in the (now expired) Balanced Budget and Emergency Deficit Control Act of 1985. The baseline projections reflect the assumption that appropriations increase at the same rate as the employment cost index for the wage and salary component of VA's budget

Summary Figure 1.

Potential Costs for VA to Provide Health Care Services to Enrolled Veterans

(Billions of 2010 dollars)



Source: Congressional Budget Office.

Notes: The starting point for the projections in the two scenarios is the Department of Veterans Affairs' (VA's) appropriation for medical care and research in 2010. CBO's baseline budget projection, following Congressional rules, is based on VA's enacted advance appropriations for 2011 for medical services, medical support and compliance, and medical facilities and on VA's enacted appropriations for 2010 for all other medical accounts. Under those rules, CBO projects baseline spending in subsequent years by adjusting those appropriations by a forecast of future inflation—a weighted average of the gross domestic product (GDP) price index and the employment cost index for wages and salaries. For comparison with the two scenarios, those projections are converted to 2010 dollars by applying the GDP price index. Because CBO projects that wages and salaries will rise more rapidly than the GDP price index, the baseline projection increases slightly (in 2010 dollars) during the 2011–2020 period.

Compared with Scenario 1, under Scenario 2 CBO assumes higher enrollment of veterans of overseas contingency operations (currently including military operations in Iraq and Afghanistan and related activities), further easing of the restrictions on enrollment of higher-income veterans, and faster growth in medical expenditures per enrollee. See the text for a detailed explanation of the scenarios.

and at the same rate as the gross domestic product price index for all other components.[4]

In making its projections, CBO did not explicitly account for recently enacted health care legislation—in particular, the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Although there is considerable uncertainty regarding how the new legislation will be implemented, CBO conducted a preliminary analysis of how it might affect VA's resource requirements. That analysis indicates that the new laws may either increase or decrease the number of enrollees—and therefore VA's resource requirements—but in either case probably by only a small amount. On the one hand, the costs of obtaining health insurance will be lower for some veterans in the latter part of the coming decade, leading some of them to seek less care from VA than they would have without the recent legislation. On the other hand, to avoid financial penalties that may be assessed on people who do not have a required level of health insurance, some veterans who would otherwise neither enroll in VA's program nor obtain other insurance might choose to enroll with VA. Neither of those effects is likely to be large enough to significantly affect the projections in this report.

4. The projections shown in this report are from CBO's January 2010 report *The Budget and Economic Outlook: Fiscal Years 2010 to 2020*. CBO recently released *The Budget and Economic Outlook: An Update* (August 2010), which updates CBO's baseline budget and economic projections. Those economic projections, however, are not sufficiently different from the ones in the January volume to affect the projections for VA presented in this report.

Potential Costs to Treat Veterans of Overseas Contingency Operations

As part of its projections for the resources needed to treat all enrolled veterans, CBO separately estimated the portion of resources that would be required to treat veterans of overseas contingency operations. CBO estimates that between the time hostilities began and the end of 2020, VA would enroll a total of 1.4 million or 1.7 million OCO veterans under Scenarios 1 and 2, respectively.[5] The annual resources (in 2010 dollars) required to treat OCO veterans would increase from an estimated $2.0 billion in 2010 to $5.4 billion in 2020 under Scenario 1 and to $8.3 billion under Scenario 2. Because OCO veterans are typically younger and healthier than the average VA enrollee, they are less expensive to treat. Accordingly, the resources devoted to OCO veterans would be a small share of outlays, consuming 8 percent and 10 percent of VA's resources for health care services in 2020 under Scenario 1 and Scenario 2, respectively. As the OCO veterans age, however, CBO expects that their costs will be similar to those of other older veterans who use VA's health care services.

5. Operations in Afghanistan and Iraq began in October 2001 and March 2003, respectively.