

**COST ESTIMATES FOR H.R. 2116, THE VETERANS'
MILLENNIUM HEALTH CARE ACT**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

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COST ESTIMATES FOR H.R. 2116, THE VETERANS' MILLENNIUM HEALTH CARE ACT

WEDNESDAY, JUNE 30, 1999

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 334, Cannon House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Gutierrez, Doyle, Carson, Snyder, Rodriguez and Shows.

Also Present: Representatives Evans, Buyer and Reyes.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning. The Subcommittee on Health of the Veterans' Affairs Committee will come to order.

After a spirited discussion at our markup last week, the full Committee deferred action on H.R. 2116, the Veterans' Millennium Health Care Act, to permit members to hear testimony on the cost implications of the bill.

By way of background, let me note that Chairman Stump wrote to CBO on May 12 and requested an estimate by June 1. Prior to markup last week, CBO had verbally given committee staff its estimates of the bill's major cost items. I understand that members' staff have been briefed on those estimates. But we did not receive anything in writing, however, until the morning of the markup, and the estimate was still marked "preliminary".

All of us have had somewhat of a frustration with the delay in getting a timely cost estimate. The important point, though, is that we have an opportunity today for members to review cost estimates with CBO and the Veterans' Administration.

The references to the cost of this bill require comment. As CBO acknowledges, the major provisions of H.R. 2116 are subject to the availability of appropriations. Nothing in the bill requires the Appropriations Committee to provide any particular level of funding.

As I understand CBO's testimony, they are essentially saying that, if VA had unlimited money to spend, it could spend up to \$1.4 billion in fiscal year 2004 under this bill. Now, that is a very huge "if". VA has never had unlimited money to spend on medical care, so we should be clear that these are not real costs.

There is, however, a real question about the reliability of these CBO figures. CBO's track record on VA costs is certainly not good. CBO says VA could spend up to one billion by the year fiscal year

2004 on a provision that we believe would require a small fraction of that amount. That provision directs VA to furnish needed long-term care to 50 percent service-connected veterans. But these veterans are already VA's highest priority and VA is providing them care.

To suggest that VA is not already largely meeting the needs of severely disabled service-connected veterans is questionable. We will hear from a VA expert this morning who has estimated that the annual cost of this provision would be less than \$150 million, and that the cost would be largely offset by a new co-payment under the bill.

My colleagues, we may leave this room this morning with different views on whether the potential cost of this provision is closer to CBO's numbers or closer to VA's. But whatever the number, this committee should have no hesitation about a provision aimed at serving 50 percent service-connected veterans. These certainly are America's most deserving.

CBO also assigns a very high cost to another provision of the bill. That provision authorizes but does not require VA payments for emergency care for certain uninsured veterans. Whether or not its cost for that provision is on target, I am troubled that CBO fails to project any offsetting revenues from other copayment provisions of the bill from pharmaceuticals and other high-cost medical items.

How reliable can CBO's cost estimate be when it treats the grant of authority to start a program as a cost, but ignores the grant of authority to offset these costs? Let me repeat that. How reliable can CBO's cost estimate be when it treats the grant of authority to start a program as a cost, but ignores the grant of authority to offset these costs? Clearly, we have many questions to ask.

Before calling our first witnesses, let me acknowledge, with regret, the news that Dr. Ken Kizer yesterday asked the President to withdraw his nomination for a second term as VA Under Secretary for Health. Dr. Kizer has been an exceptional leader and has done a great deal to transform the VA health care system. There is more to be done, obviously, for the VA and our veterans, and I'm sure my colleagues join with me in pledging to work in that effort. Certainly moving our Millennium Health Care Act is an important part of this pledge.

With that, let me invite the ranking member of the full committee, Lane Evans, my colleague, to make an opening statement.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. I appreciate your willingness to hold this hearing today. I'll keep my remarks as brief as possible so that we can have time for all our members to speak.

Last week we began to mark up this Millennium Health Care Act. Unfortunately, the Congressional Budget Office did not have an estimate ready in time for members to fully consider it. I want to reiterate the importance of timely estimates for congressional consideration. I know we have requested estimates on bills that have languished at CBO for a year without an estimate.

CBO will testify that VA is funded by appropriations. So, to the extent that Congress does not appropriate the necessary funds, they will obviously not be spent. CBO also assumes that nothing in Veterans Health Administration operations will change as a result of reprioritization of activities.

We can take two views of CBO estimates for discretionary funds. We can choose to view them as largely "advisory"—that is, they give us some sense of the magnitude of spending required to fully implement the initiative if the organization makes no other changes to accommodate it—or we can accept the "high" CBO estimates as prohibitive of congressional priorities it deems to be too expensive. We can argue about the credibility of these estimates, but when we're talking about appropriated funds, our action or inaction boils down to how we choose to use them.

I choose to view CBO's estimates as advisory. The fact that I do not subscribe to nor fully understand its assumptions based on the report makes them even more so.

CBO estimates are an important information tool that must be reviewed alongside other important information, such as estimates of VA officials, and in light of congressional priorities. In this case, I believe that my priority to mandate comprehensive long-term health care to the highest priority veterans the system treats, and to allow VA to respond to veterans' needs for emergency care services, outweighs the priority I would give a CBO estimate based on unknown methodology. These are important choices we in Congress must make in all of our deliberations.

Mr. Chairman, thank you for holding the hearing, and I look forward to working with you on this issue.

[The prepared statement of Congressman Evans appears at p. 29.]

Mr. STEARNS. I thank my colleague.

In calling up our witnesses, it is my understanding that the VA has no formal statement this morning. But after we hear from the CBO, I would like to ask the VA's long-term care expert, Dan Schoeps, to briefly discuss his cost estimate on section 101, how it differs from the CBO's estimate, and to comment on any major flaws in the CBO long-term care analysis.

Dan, please also explain your work with the VA's Advisory Committee on Long Term Care and your consultations with members of that committee on your estimate.

What we are going to do is allow both the CBO witnesses and the members from the Department of Veterans Affairs each have an opening statement of ten minutes, so that you have a full opportunity to explain your position. We understand you are accompanied by two folks, too. So I will start with Paul Van de Water, the Assistant Director for Budget Analysis, Congressional Budget Office, for your opening statement.

Good morning.

**STATEMENT OF PAUL VANDEWATER, ASSISTANT DIRECTOR
FOR BUDGET ANALYSIS, CONGRESSIONAL BUDGET OFFICE;
ACCOMPANIED BY MICHAEL MILLER, CHIEF, DEFENSE,
INTERNATIONAL AFFAIRS AND VETERANS' AFFAIRS COST
ESTIMATES UNIT, CONGRESSIONAL BUDGET OFFICE**

Mr. VANDEWATER. Thank you, Mr. Chairman. I appreciate the opportunity to appear before your subcommittee to discuss our estimate of H.R. 2116, the Veterans' Millennium Health Care Act.

As you indicated, I am accompanied this morning by Dr. Michael Miller, who is the Chief of our Defense, International Affairs, and Veterans' Affairs Cost Estimates Unit.

My statement will focus on the conceptual issues relating to our estimates in general and how they apply to our estimate for H.R. 2116 in particular. The detailed assumptions underlying our analysis of the bill are set forth in CBO's cost estimate, which is appended to my written statement.

Enactment of H.R. 2116 would affect both discretionary and mandatory spending. Several sections, as you noted, would change veterans' medical care, which is a discretionary program. Notably, the bill would increase access to long-term care for certain veterans and, as you noted, would expand reimbursement for the costs of emergency care—subject, of course, to the appropriation of the necessary amounts. The bill would also give the VA authority to spend, without the need for further appropriations, its share of any amounts that the Federal Government might receive from the tobacco industry for the costs of tobacco-related illnesses.

Let me turn first to the discretionary portions of the bill. By themselves, the legislative changes in H.R. 2116 that authorize long-term and emergency care for veterans do not raise Federal outlays because funding for them is subject to appropriation. However, when CBO estimates the budgetary impact of an authorizing bill—as we are required to do under section 403 of the Budget Act—we estimate the resources that would be required to implement the bill. We assume that the necessary funding is provided and that other activities are not curtailed.

The assumption that appropriations are provided is useful for at least two reasons. First, it gives the Congress a sense of how much more funding it could be asked to provide because of the authorizing bill. Second, it does not require CBO to make any assumptions about which programs would be treated favorably in the appropriation process.

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

CBO's cost estimate provides information that is relevant for both perspectives. It informs the Congress of the likelihood of a

greater demand for health care from veterans and the possible need for more money. It also informs the Congress about the extent to which some veterans could be displaced or denied care if the bill was enacted and appropriations were not increased.

CBO estimates that expanding the provision of long-term care to veterans, as specified in section 101 of the bill, would ultimately increase the VA's resource requirements by about a billion dollars a year. Similarly, expanding the Department's authority to pay for emergency care, as provided in section 102, would increase the VA's resource needs by about \$400 million a year. Again, whether Federal outlays would actually increase as a result of enacting those provisions would depend on the extent to which additional appropriations were provided.

In contrast to those provisions affecting veterans' medical care, the establishment of the Veterans' Tobacco Trust Fund under section 203 of the bill would create direct, or mandatory, spending. If that section of the bill was enacted, no further legislation would be required to allow the VA to spend its share of any proceeds the Government might receive from the tobacco industry. Because the amounts that the Federal Government might receive from the tobacco industry could be substantial, the spending authority created by this bill could be significant.

To develop an estimate of that authority, CBO had to answer three questions. First, what is the likelihood that the Government will win or settle a lawsuit? Second, how much would the Government recover if it did win or settle such a suit? And third, what proportion of the funds recovered would be attributed to the VA?

Clearly, none of those questions can be answered with any precision, and the range of possible outcomes is large. Equally clear, however, is that the provision cannot reduce spending, only increase it. In such a situation, CBO attempts to estimate the expected value of the proposal's budgetary effect—that is, the weighted average of the cost of the proposal under a variety of circumstances, taking account of their respective probabilities.

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

In sum, CBO estimates that H.R. 2116 could have a significant budgetary impact on both spending subject to appropriation and spending that occurs outside the annual appropriation process. Assuming appropriation of the necessary amounts, CBO estimates that the bill would raise discretionary spending by about \$200 million in 2000 and about \$1.4 billion by 2004. Assuming that those amounts are not appropriated, those figures are estimates of the extent to which other activities or beneficiaries would be displaced. In addition, the provision to spend the VA's proceeds from tobacco litigation would create significant authority for direct spending.

That concludes my prepared statement, Mr. Chairman. I am looking forward to answering your questions.

[The prepared statement of Mr. Van de Water, with attachment, appears at p. 31.]

Mr. STEARNS. I thank the gentleman.

Dr. Garthwaite, Deputy Under Secretary for Health, Department of Veterans Affairs. Your opening statement, please.

STATEMENT OF THOMAS L. GARTHWAITE, M.D., DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DANIEL J. SCHOEPS, COMMUNITY BASED CARE SERVICE LINE, GERIATRICS AND EXTENDED CARE STRATEGIC HEALTHCARE GROUP, DEPARTMENT OF VETERANS AFFAIRS; AND WALTER A. HALL, ASSISTANT GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS

Dr. GARTHWAITE. We did not realize or believe we were supposed to prepare one. We have none. But you had asked Mr. Schoeps to review his methodology.

Mr. STEARNS. All right. Daniel Schoeps, Geriatrics and Extended Care Strategic Healthcare Group, Department of Veterans Affairs. Welcome, Daniel. We appreciate your opening comment.

STATEMENT OF DANIEL J. SCHOEPS

Mr. SCHOEPS. Thank you, Mr. Chairman. It's an honor to be here. I would like to review each of the points that you mentioned in your opening remarks and just talk about them briefly.

VA began its planning for long-term care in earnest in 1995, when it brought together a group of VA experts in long-term care and planning, researchers from the University of Michigan, and from the Department of Health and Human Services, to establish a planning model for long-term care, how would we project and plan into the future the long-term care needs of veterans who might come to VA for those services.

That effort was based on a concern that VA had, that we were not planning well for home and community-based care services, that we were underrepresenting the need for those services, and that we needed a model that would help us promote that and bring it to an equal footing with planning for nursing home care, which had been well established and was up and running since 1981.

That model was developed based on the National Medical Expenditure Survey, which looks at utilization of long-term care services, both nursing home and home and community-based care services, and VA adopted that model for its use to project against its own population, sensitive to the fact that need changes with age and need changes with level of disability.

We took that model and brought it to the Federal Advisory Committee on the Future of Long-Term Care in 1997, and asked them to validate whether or not that model was the correct one to use. They had very serious discussions about that model, its strengths and weaknesses. They felt that, since it was reality based, since it was based on projecting need based on people actually using services, as opposed to some theoretical construct of people who might come to use services, that it would a strong model.

The downside of the model was that it was old. It was based on 1987 data and new data was not quite available, although there had been a new survey done in 1996.

So the Federal Advisory Committee validated for our use this long-term care planning model, and we have been using it since that time. That is what we used to develop, at a staff level, projections on the effect of this bill on long-term care and on the service-connected population rated 50 percent or more.

Our findings are, number one, that we serve a large portion of that population already. Two-thirds of the veterans that we estimate need long-term care services, who are service-connected 50 percent or more, are already receiving those services from VA. The model estimates that 15,000 veterans in that group need services on any given day, and we're already serving 10,000 of them.

The second thing the model found when we estimated that 5,000 more veterans would come to VA for care was our cost estimates, again at the staff level, depending on some adjustments in the assumptions that we made, ranged in the first year from \$115 million to \$184 million, and ranged upward in the fifth year from \$148 million to \$237 million, which is again with differing assumptions. The copayments that we estimated were at \$143 million, and remain constant throughout the time.

I could not characterize CBO's work as having serious flaws. I think there might be a question of level of disquietude. On that subject, there would be just two points that I would make—and they differ because CBO used different models for nursing home and for home care. I think we have more serious concerns about the model for nursing home care, which generates this very large number. I feel that there is not enough reality basis, a basis of real experience, in the model that they're using. We are looking at the need for this service based on actual utilization, and I think their approach, quite legitimate, is more theoretical than ours.

On the issue of home care, they do use an experience-based model for their home care projections. It is different than the model that we use. It focuses on a more specific, chronically ill population than the model that we use. I think, if we were to use that model—and we have discussed using that model—we would need some changes. It's a very well respected data set. Dr. Ken Manton at Duke has helped us in our office many times over the years. He is kind of the guru of that data set.

If we were to use that model, I think we would make some modifications, some adjustments to using that approach that they did. But it is experienced based and, for that reason, we could talk about the adjustments.

That would conclude my comments.

Mr. STEARNS. I thank the gentleman.

Let me offer my ranking member, Mr. Gutierrez, an opportunity for an opening statement.

Mr. GUTIERREZ. Mr. Chairman, I would like my opening statement to be included in the record.

Mr. STEARNS. By unanimous consent, so ordered.

[The prepared statement of Congressman Gutierrez appears at p. 26.]

Mr. GUTIERREZ. I thank the chairman for bringing this hearing together, with members of the CBO and Department of Veterans Affairs, and I thank all my colleagues on my side of the aisle and your side for showing up today.

Since we are so well represented with the ranking member, with five other colleagues on this side of the aisle, I'm going to ask to be excused, Mr. Chairman, as I have a very bad cold. But I wasn't sure how many people were going to show up, but it seems to be very well attended.

Mr. STEARNS. You are very well represented.

Mr. GUTIERREZ. Yes, it looks like I'm going to be well represented.

Mr. STEARNS. Mr. Buyer is representing us. (Laughter.)

Mr. GUTIERREZ. Again, thank you. I ask to be excused, Mr. Chairman.

Mr. STEARNS. Thank you for coming.

We will now open up for questions, and I'll start. I think this is one of the rare opportunities I have had to hear CBO estimates and then hear Administration representatives discuss them and perhaps rebut them or agree. I think for members this is a great opportunity for us here on the Veterans' Affairs Committee to understand the assumptions made by CBO and test these assumptions through the experience of those who administer the programs in question.

Mr. Schoeps, you're saying that CBO is incorrect in assuming that most veterans who would qualify for VA nursing home care would seek it, when I guess the reality, the predilection, is that the people themselves would not want to go into a nursing home other than as a last resort. Is that what I hear you saying?

So the difference in the estimate of CBO and the administration, and actually what we see in practice, is that the CBO is assuming that most eligible under this bill would seek complete nursing home care, whereas the reality is that it's not true?

Mr. SCHOEPS. As I read their testimony and analysis, my understanding is that they looked at veterans in this sub-population of service-connected 50 percent or more, and looked at their disability levels in terms of activities of daily living, their ability to dress and bathe and go to the toilet and transfer and walk, and made a determination that if people had three or more or four or more disabilities in ADL's, deficiencies in ADL's, that they would be nursing home eligible and would go into a nursing home.

We were unwilling to make that assumption. That was an assumption that the Federal Advisory Board warned us against. That represents the major difference between our projection at the staff level and CBO's projection.

Mr. STEARNS. You indicated that the long-term copayment would help to offset this estimate that you come up with?

Mr. SCHOEPS. Yes, sir. We estimated at the staff level copayments totalling \$143 million.

Mr. STEARNS. Which would practically offset it.

Mr. SCHOEPS. Depending on, in the first year, the range of costs was \$115 million to \$184 million. So it would offset, or almost offset.

Mr. STEARNS. In looking at this, you refer to the fact that you had some history on this, and looked at different models. I gather you have been working on this question with the advisory committee for, I think, two years. I should point out to my colleagues that CBO has worked on this estimate for a much shorter period of time.

Is that correct, that your experience has been much longer than CBO's?

Mr. SCHOEPS. I don't know the folks that worked on this. I can't speak of their experience. In our office, we have been involved in long-term care planning since VA's first efforts. When I came to extended care in 1980, the first assignment that Dr. Paul Haber, my boss, gave me was to work on a planning model for long-term care. Over that period of time, we have become more sophisticated and have spent a lot of time on this issue, and have called in experts frequently to help us.

Mr. STEARNS. So you're saying, since 1980, you have had experience with developing this modeling for long-term care? You've worked on it for almost 20 years?

Mr. SCHOEPS. Yes, sir.

Mr. STEARNS. Mr. Van de Water, you say that based on age, marital status and functional impairment, 45,000 additional service-connected veterans would get nursing home care under this bill by the year 2010. Perhaps you might want to comment on what Mr. Schoeps said, particularly dealing with the human element. I think your assumption is that most of those eligible under the bill, this 45,000, would go into nursing home care, and his modeling reaches a very different conclusion. So you might want to comment on what he said, and perhaps anything else he has said that you would like to comment on.

Mr. VANDEWATER. Yes, Mr. Chairman. Mr. Schoeps's comments were, I think, very helpful.

I would start by qualifying only one thing that he said: that the VA's approach is experience-based and ours is not. Clearly, in addressing a bill such as this, both of us are trying to project what would happen under circumstances that no one has yet observed. If either of us had experience with the situation, we wouldn't be in this discussion at all. We're trying to guess how people would respond to a change in legislation, so we're both having to extrapolate from past experience.

One of the differences, as Mr. Schoeps indicated, is that they relied on one particular database, the National Medical Expenditure Survey, whereas we have tended to rely on two other databases, the National Survey of Veterans and the National Long-Term Care Survey. That's point number one.

The second point, as you said, is that we have had a limited amount of time to evaluate this particular bill. And I have to say that the estimate that Mr. Schoeps has discussed this morning is one we have only just heard about for the first time. Our previous impression—based on Dr. Kizer's testimony here on the 19th of May, in which he stated that the cost of this provision would be substantial—was that the VA's views were more consistent with ours.

On the 19th, Mr. Backhus from the General Accounting Office also quoted from the Commission on the Future of Long-Term Care, to which Mr. Schoeps referred, indicating their estimate that the VA was now meeting only about 20 percent of the need for nursing home care on the part of veterans with service-connected disabilities.

Given all of the complexities of this issue, and the fact that we've only just heard today of these estimates from Mr. Schoeps, that's about as far as I can go at this point to compare the two estimates. Obviously, we would like very much to work with the VA staff and learn more about the information underlying their estimate and to share with them further details underlying ours.

One final point: our methodology does not assume, as I think you seem to conclude that it did, that everyone who is or might potentially be seriously impaired in the activities of daily living would necessarily go into a nursing home. The databases that we used indicate that obviously people prefer to avoid going into nursing homes, if they can avoid it—particularly people with spouses or other family members who are able to give care. They would much prefer to stay at home and receive care in that setting. That preference is reflected in the databases which we used, which reflect the experiences of real people.

That returns to my initial point: that we're both trying to extrapolate from past behavior, and as always, when you extrapolate, you can get different results. But we're eager to pursue this conversation with the VA.

Mr. STEARNS. Fine.

Just yes or no. Have you heard of the National Database Expenditure Survey?

Mr. VANDEWATER. You mean the National Medical Expenditure Survey?

Mr. STEARNS. Yes.

Mr. VANDEWATER. Oh, yes, indeed.

Mr. STEARNS. Mr. Doyle, my colleague from Pennsylvania.

Mr. DOYLE. Thank you, Mr. Chairman.

First, Mr. Chairman, I would like to ask that my statement be made part of the record.

Mr. STEARNS. By unanimous consent, so ordered.

[The prepared statement of Congressman Doyle appears at p. 28.]

Mr. DOYLE. Mr. Van de Water, I just want to follow up a little bit on what we've been hearing. Mr. Schoeps said that their model was more reality based and yours was more theoretical. You were just speaking to the fact that you used different databases than Mr. Schoeps used in his model, but you're saying the databases that you used are also real-life situations.

Mr. VANDEWATER. Exactly.

Mr. DOYLE. So you don't really concur that you have some theoretical model and he has some reality based model, that you're both using data that's based on actual—

Mr. VANDEWATER. We both have data regarding actual people, and we both have to extrapolate from those data into a situation that none of us has observed.

Mr. DOYLE. And you got two different results when you looked at those two different databases, obviously.

Mr. VANDEWATER. That may be part of it. Again, without going into the details, we can't explain this morning what part of the difference between the estimates may reflect differences in the starting data or in some of the other assumptions that we applied to those data. We will obviously look into that.

Mr. DOYLE. I'm curious. When CBO is putting estimates together, is it common practice for you to be in communication with the Department of Veterans Affairs in this particular case, and did any interaction like that take place prior to your issuing numbers to this committee?

Mr. VANDEWATER. Yes, indeed, it is our practice. We're "hounds" for data. We're always looking for more information from whatever source we can get it, and clearly, any executive branch department (in this case, the VA) is going to have many more resources in a particular area than we do. So we are very eager to make use of any data that we can get. In fact, we have made use of data from the VA. The National Survey of Veterans that we've used extensively is, I believe, a VA database.

Mr. DOYLE. I think I also heard you mention that you thought earlier in the process, when Dr. Kizer testified before the committee, that it was your feeling that VA's estimates of the cost of this legislation were more in line with what your estimates were, but that obviously has changed somewhat?

Mr. VANDEWATER. That appears to be the case.

Mr. DOYLE. What do you think took place between that period of time and today, and where did the lines of communication between CBO and the—when did you first start to realize that veterans had a much different outlook on this bill than what you first thought they had? Was it this morning?

Mr. VANDEWATER. If I may, I would like Dr. Miller to answer that question.

Mr. MILLER. In the process of preparing our estimate, we were aware of Dr. Kizer's testimony, and his statement that it would entail significant costs seemed to coincide with our analysis of the data. At the same time, had conversations with staff at VA that suggested their estimates were considerably lower than that, along the lines of what Mr. Schoeps has described.

One of the things that we wrestled with over a period of several days was how to reconcile Dr. Kizer's statement and our analysis of the data with the kinds of estimates that you heard this morning. In the end, not knowing exactly how to eliminate every difference, we trusted the analysis that we had done and published that. That is the estimate that we appended to Mr. Van de Water's testimony today.

Mr. DOYLE. So you both agreed to disagree in the end?

Mr. MILLER. Yes.

Mr. DOYLE. Mr. Schoeps, am I hearing you correctly, that you're telling us that we can provide this long-term care benefit? This is going to be great news in Pittsburgh if it has any ounce of reality to it. You're saying that we can do this benefit and we're going to save money from the copayment section of this bill, and it's going

to be a wash and life it going to be wonderful for our veterans now; is this what you're telling the committee?

Mr. SCHOEPS. This is what our best estimate is, that it would appear that we're probably on stronger analytical grounds on the cost side than we are on the copayment side. I'm much more comfortable on the cost side than on the copayment side.

Mr. DOYLE. So you feel pretty comfortable about your estimate. This is going to be somewhere in the \$200 million range as far as the cost, but you're less confident that the money brought in from the copayment will wash that out?

Mr. SCHOEPS. That's correct. There is——

Mr. DOYLE. You wouldn't want to stake your reputation on this?

Mr. SCHOEPS. No, I would not.

Mr. DOYLE. And I'm not asking you to.

Mr. SCHOEPS. Our estimate of the copayment is less than CBO's. I'm still not sure that ours may be too high. We had to make some national assumptions, given the time we had and the databases we had access to. To do this correctly, I think you would want to spend a lot of time with the staff at the National Governors Association and look at what medical assistance policies look like in each State. Otherwise, you would tend to create either tremendous windfalls for residents of certain States, and then in other States you would place them in a terrible disadvantage.

You would have to do something quite sensitive and probably State-based so that you weren't upsetting the marketplace, the decision-making processes of people, and really denying access in one State and promoting access in another, which we would find to be quite unfair.

Mr. DOYLE. Thank you, Mr. Schoeps.

I see my time is up, Mr. Chairman. Thank you.

Mr. STEARNS. Just for clarification of Mr. Doyle, you said \$150 million, not \$200 million, is the estimated cost for long-term care.

Mr. SCHOEPS. Our range was between \$115 million to \$184 million in the first year.

Mr. STEARNS. Okay. That's good.

Mr. Reyes, the gentleman from Texas.

OPENING STATEMENT OF HON. SILVESTRE REYES

Mr. REYES. Thank you, Mr. Chairman.

I guess part of the frustration that I feel is the same as expressed to me continuously in the district, and really in other parts of the country as I visit other districts with colleagues, that there is a disconnect between the reality of what's occurring in terms of services for veterans and even, in the opinion of veterans—and I tend to agree with them—the marginal passing interest in the bureaucracy to accommodate their needs, to accommodate their desire for service.

I get frustrated just listening to some of the terms that I have heard here this morning, in terms of the difference in estimates and the difference in the kinds of budgetary language that you apparently now disagree on. That creates a problem for us because we cannot provide good representation to our veterans if we don't have you gentlemen provide us the information on a timely basis.

I think it's a very serious issue when we're unable to mark up legislation because we haven't gotten an estimate out of the CBO. I think it's a very serious issue when there is disagreement. At least from everything I have seen and read, there is enough empirical data within the system of the VA and CBO to come to the table and discuss whatever differences you might have in terms of your estimates and give us one, comprehensive agreed upon estimate so that we can do our jobs.

Part of the frustration that I think we all feel on this committee is the failure on your part, on the part of the Veterans' Administration and also the CBO, in giving us the information so we can make a decision based on the best judgment that you can provide us.

I don't think at this point, Mr. Chairman, I have any questions. I just get frustrated in not being able to do our job because some others don't do theirs.

Thank you.

Mr. STEARNS. I thank my colleague. Dr. Snyder.

OPENING STATEMENT OF HON. VIC SNYDER

Dr. SNYDER. Thank you, Mr. Chairman.

Actually, I have a little different take on this. While I share the frustration in not having the numbers, I hope that people who have divergent views won't feel an obligation to homogenize before they formally release numbers. I kind of like the fact that we've got a difference of views. It gives us a chance to kind of learn more about how you arrived at your numbers and the different approaches.

I wanted to ask, Mr. Van de Water, I'm really interested in the extended care line, the home care and nursing home line. Your total in 2004 is right at a billion dollars, your estimate. Did you come to any conclusions within that number of how much savings there would have been to either the Medicare or Medicaid numbers of veterans and their families who would have chosen to go the VA route, which would have been a savings in the other programs?

Mr. VANDEWATER. Yes, we did, Dr. Snyder.

With regard to Medicare, there is not much of an offset because Medicare basically doesn't provide long-term care—

Dr. SNYDER. It does provide services.

Mr. VANDEWATER. —except under very limited circumstances.

Dr. SNYDER. Yes.

Mr. VANDEWATER. Medicaid is another story because, as you know, Medicaid does pay for a very substantial portion of nursing home services delivered in this country. I think it's in excess of 40 percent.

Now, of course, something close to half of that amount is paid for by the State governments. Medicaid is a joint Federal/State program.

Finally, there is an interesting analogy between Medicaid and the VA health system, in that the demands for medical services under Medicaid tend to be pushing up against the available resources, just as they are in the case of the VA. So it is our experience that if some sort of fiscal relief were provided to the States—as would, in effect, happen if H.R. 2116 were enacted and the VA were to expand substantially its provision of long-term care—the

States would elect to divert a substantial portion of the resources that they might otherwise use for long-term care to other needs, or perhaps provide additional long-term care to low-income people who are not now receiving it.

Taking all of that into account, our staff estimates that the amount of the offset to the Federal Government might be on the order of \$150 million or so annually in the long term in the Medicaid program.

Dr. SNYDER. Once we get to the billion dollar total of that.

Mr. VANDEWATER. Right.

Dr. SNYDER. It's interesting how different States work. In Arkansas, we round up. But about three-fourths of our nursing home beds are paid for by Medicaid, and we have a three to one match. We have a State that has great respect for our veterans hospital system, so we may even have a greater proportion that may want to go to the VA if they had that option.

Dr. Garthwaite, you have this divergence of views. It seems to me that you've got one estimate that kind of took the dark side and said, if everything went wrong, this is what it would be. Then you've got your own in-house estimate. I guess you all have already stated that you could certainly live with this program.

It seems to me that, even if everything went wrong, it still, by the year 2004, would be a manageable program; is that a fair assessment? I mean, even the billion dollar estimate, I had actually expected it to be several billion dollars. I think it's because I didn't realize how much of this care you're already providing.

Dr. GARTHWAITE. My crystal ball is probably not any better than anyone else's, and they have more numbers than I do, probably. But I commend the effort here because we know that there's a massive unmet need for long-term care. We clearly know that it's expensive. This is a very legitimate attempt to try to raise some revenues and clarify prioritization and eligibility and to involve us in what we know is an evolving need of our aging population of World War II veterans.

I think, if Dan's numbers are correct, then it's a relatively minor issue. If it is significantly higher than that, it can call into question the prioritization of whether we deliver basic medical benefits to an expanded population or more comprehensive benefits, including long-term care, to a more confined population of veterans. I think that depends a lot on how it plays out. But ignoring the problem doesn't make it go away.

Dr. SNYDER. Mr. Van de Water's estimate is that by the year 2004 we will have history and experience to go by, and certainly this committee is going to be interested in which estimate turns out to be accurate and what kind of moneys need to be out of the budget.

Thank you for your time.

Mr. STEARNS. I thank my colleague.

Mr. Shows?

Mr. SHOWS. I have no specific comment. I appreciate your having this hearing.

Mr. STEARNS. My colleague, Mr. Buyer from Indiana.

Mr. BUYER. Thank you, Mr. Chairman. I appreciate having the opportunity to appear before your subcommittee.

Mr. STEARNS. We're very glad to have you.

Mr. BUYER. I have some questions for CBO. Under section 104 of the bill, you wrote that you do not have sufficient information to estimate the budgetary impacts.

I could understand that, given the short time frame that you've had. Would you please tell me what additional information you would need, and how much time would you need, to do that estimate?

Mr. VAN DE WATER. Dr. Miller will answer that question.

Mr. MILLER. Mr. Buyer, I think we would need to get a better understanding of which military retirees would be likely to employ this option to use VA health care instead of TRICARE. I think a lot depends on where they live, the availability of VA resources, and their family status. I think single retirees may be more likely to use it than married retirees or retirees with dependents. In addition to those factors, we would need to compare the copayments that the retiree would face in his TRICARE option with those in the VA health system under this bill.

It is hard to say exactly how much time that would take, but it's probably denominated in weeks.

Mr. BUYER. All right. Let's use some thoughts here. In 1998, the VA, utilizing category 7—that would also be the TRICARE standard with copays—the VA treated about 250,000. Is that about right, for category 7?

Dr. GARTHWAITE. That sounds reasonable.

Mr. BUYER. If we went with the provision of the bill as presently written, there is a potential change of venue of category 7 that would shift from the TRICARE standard to the VA system, would it not, because they don't charge copays?

This was a "no brainer" for me. If I'm out there and I have to pay enrollment fees and copays, and I look at that and say, wait a minute, if I'm going to use a military treatment facility, or I get to use the VA, this one is a no brainer for me if I'm worried about my wallet, correct?

Mr. MILLER. Well, you go wherever the copayments are lower.

Mr. BUYER. Thank you. Which means that there would be a shift in population, correct?

Mr. MILLER. Yes.

Mr. BUYER. Have you had conversations with the VA so that you could lay out these types of predicates to help you in your estimates?

Mr. MILLER. No, we haven't.

Mr. BUYER. That would be an enrichment process, would it not, to help you?

Mr. MILLER. Yes.

Mr. BUYER. And hopefully that will happen.

The reason I'm going to ask these questions, and I want these answers, is because I also chair the Military Personnel Subcommittee. Dr. Snyder and I wear some dual hats here today. Our interests are not only in the treatment of the military retirees and our obligations to them, but I also understand what this bill does as to the potential run on DOD dollars.

We worked very hard under the DOD system for a managed care system, as we manage utilization. The VA is a different model.

Now, if we go with the bill as written—and I'm asking for your help here, Doctor—if we go with how the bill is presently written, that we are to do direct reimbursements based on whatever TRICARE contractor is out there, am I correct or incorrect that there would be potential windfalls to the VA because the VA charges and has cost factors for different procedures than DOD, and not only DOD, from a medical treatment facility perspective, but also negotiated rates per region with TRICARE contractors?

Mr. MILLER. As I understand section 104, it would probably take a memorandum of understanding on reimbursement between the two agencies. But the provision also calls for reimbursement to the VA of whatever DOD would pay under TRICARE for that care. If the number of visits doesn't change, one would expect there to be no net cost, simply because DOD would write a check in the same amount, only to a different person. The private physician, let's say, in the case of TRICARE—

Mr. BUYER. Sir, time out. I don't think that's responsive to my question. I agree that's exactly what the bill says. But if you have the VA charging a different rate for a particular procedure, the VA charges differently from how the DOD charges for a particular procedure. These are carefully negotiated contracts that are out there. I'm going to have to go through bid price adjustments and contract, would I not?

Mr. MILLER. It's possible. I expect that DOD wouldn't necessarily entertain what the VA says its costs for the care are, that it would say, "I know that under TRICARE I will pay x amount, and that's the amount I will pay for that service, regardless of what the VA's costs are."

The added cost to DOD from this provision would come from the potential extra visits that a retiree might make to the VA, and that would be based on copayments.

Mr. BUYER. Would the chair be kind enough to yield me additional time?

Mr. STEARNS. We will have a second round of questions, so we'll just continue on, if the gentleman doesn't mind. The gentleman's time has expired.

Let me just continue with what Mr. Buyer was saying. Mr. Hall, of the VA's Office of General Counsel, perhaps you might want to comment on the effect that increases in copayments under H.R. 2116 might have. That's something you might want to comment on, in reference to his question.

Mr. HALL. I don't have anything in particular to add.

Mr. STEARNS. Would the shift in care from TRICARE to VA that Mr. Buyer is talking about necessarily take place given that the bill also calls an increase in VA copayments? Wouldn't an increase in VA copayments under the bill have an effect on what retirees decide about using VA care?

Mr. HALL. If we have authority to adjust the copayments—

Mr. STEARNS. Which you do in this bill.

Mr. HALL. Yes, it would.

Mr. STEARNS. Okay. Let me then pose a question for CBO.

This bill says the VA may pay for emergency care, and it may increase drug copayments. Both are simple authorizations. But you assume the VA will fully implement the one that results in cost,

but you completely fail to take account of the one that generates revenue. I don't understand. It seems inconsistent, why wouldn't you find offsetting savings based on provisions that would generate revenue.

Mr. VANDE WATER. In the case of the copayments, as you indicated, you provide authority or flexibility for VA to implement copayments, but there is not a specific requirement that copayments be imposed in any particular amount or any particular schedule. So we have to make a judgment as to the likelihood of that authority being used.

With respect to prescription drugs in particular, given the lack of popularity of the existing two dollars per prescription copayment, which is currently scheduled to expire——

Mr. STEARNS. But the emergency care provision is also a simple authorization. You assigned that a cost. Your argument is that the copayment is only a simple authorization so you couldn't score it, but in the case of emergency care, also a simple authorization which might or might not be implemented, you did score it. So that seems inconsistent.

Mr. VANDE WATER. As I tried to make clear in my statement, the cost estimate for the provision of emergency care does not assume the extent to which it actually will be implemented. The cost estimate is an estimate of the resources that would be required were the provision to be fully implemented.

Mr. STEARNS. I'm sorry. Say that again. I just didn't follow that.

Mr. VANDE WATER. We have produced an estimate, as we did with the section involving——

Mr. STEARNS. I mean, the language is very simple for the revenue side, as well as for the cost side. But for the revenue side you don't give us any benefit, but on the cost side you take the opposite approach. Tell us again why you're being consistent.

Mr. VANDE WATER. In terms of the spending authority, when we are faced with authorizing provisions such as these, we attempt to provide an estimate of what additional resources would be required to implement the provision if the VA were to carry it out fully.

In the case of the copayments, we have to make a judgment as to whether or not VA would be likely to use the authority. In our estimation, it is not particularly likely.

Mr. STEARNS. How much could be saved through the new pharmacy and prosthetic copayment?

Mr. VANDE WATER. In the limit? I don't know. It depends on how high the VA would be willing to set it. If the VA would indicate that they are, in fact, intending to use this flexibility and would give us some indication of how much, we certainly would change the estimate to reflect that. I don't know if Dr. Garthwaite could give us an indication of that. But, again, we certainly would be happy to take that into account if we've misjudged the situation.

Mr. STEARNS. Dr. Garthwaite, is there anything you would like to comment on in reference to his—Can you help him out at all?

Dr. GARTHWAITE. I think it would be very likely we would continue some copayment. I think a fair amount of discussion would have to be had about the level of copayment. But I think there is a fair amount of wisdom for copayments in certain categories of services.

Mr. STEARNS. I think our concern, and the staff's concern, is that CBO had no trouble coming up with a cost estimate on a speculative item like the tobacco provision, yet when you came to the a revenue generating provision, you couldn't do this. Again, we're just seeing some inconsistency here in assumptions, so it makes it a little frustrating for us.

Mr. Hall, counsel advises me that the only provision of this bill that creates a new spending mandate is the one directing VA to provide extended care to veterans who are 50 percent or more service connected.

Do you agree with that?

Mr. HALL. I wouldn't necessarily call it a mandate. It's limited, of course, by the requirement that we find appropriations to cover those costs.

In addition, it is the same language that's used in 1710 with regard to outpatient and hospital care. We have always concluded that that language, in fact, is more in the nature of a priority for veterans, who the Secretary is required and shall provide care to, as opposed to a mandate that would create an entitlement.

Mr. STEARNS. Thank you.

Dr. Snyder, do you have a second round of questions?

Dr. SNYDER. Yes. I just wanted to ask one question of Dr. Garthwaite and Mr. Schoeps. It's more of a policy question.

Could you give me a background, a couple minutes discussion, about where State veterans' homes fit in this whole challenge of long-term care for veterans today and where you see them five years from now?

Dr. GARTHWAITE. We see them as an important resource for meeting veteran's needs for long-term care. With the State's support we are able to care for veterans at a significantly reduced rate of federal appropriations. Having invested early in the construction of facilities, that must meet our standards, we are able to place veterans in homes that we believe are of high quality and where we have a special relationship in terms of our oversight of the administration of those homes.

Overall we see the State Home Program as a very positive program.

Dr. SNYDER. Now big a part of the need are they currently meeting?

Dr. GARTHWAITE. Do you know the percentage offhand, Dan?

Mr. SCHOEPS. They are meeting between 40 and 45 percent of the long-term—the nursing home care needs of veterans. Of the mix of VA, community and State, they are between 40 and 45 percent. We're the largest single provider of nursing home care on an average daily census basis.

Dr. GARTHWAITE. They're meeting that percentage of our current delivery of services. I think need is a separate discussion.

Dr. SNYDER. How about just the State-owned homes, if you included VA and—

Mr. SCHOEPS. Of the VA, community and State, the States' share is 45 percent, 40 to 45 percent.

Dr. GARTHWAITE. Current patients in nursing home beds, about 44 or 45 percent are in State nursing homes.

Dr. SNYDER. What do you see that role will be as time goes by?

Dr. GARTHWAITE. We have continued to invest in State nursing homes. There is a line in the budget this year for additional funding, so there is some gradual expansion. That would assume that, if the rest stayed constant, their proportion might go up. We continue to believe that it's a good program.

There is a fair amount of discrepancy and variability in the availability of those beds by State. We have tried to maintain a very rigorous selection criteria that involves State contributions to the construction. We have actually—I'm not sure of the exact status of this, but we've been developing a revised methodology for making State Nursing Home Grant requests at the request of many members on the Hill and many of our stakeholders.

Dr. SNYDER. I haven't been on this committee very long. When you talk about the budget line, is that a construction line or—

Dr. GARTHWAITE. Yes. It's separately identified in the VA's Construction Budget.

Dr. SNYDER. Thank you.

Mr. STEARNS. I thank the gentleman.

I understand the gentlewoman, Miss Carson, would like to pass?

Ms. CARSON. Yes.

Mr. STEARNS. Okay.

Let me just conclude with one question here. I thought, since the staff has had the opportunity to look at this a lot more carefully, and it's rare that you have an opportunity like this, I was going to let staff on either side maybe ask questions—if you'll give me forbearance here. This is directed to Mr. Van de Water.

After just the brief hearing we've had this morning, I guess the question is what level of confidence do you have in projecting \$1.4 billion under this bill in fiscal year 2004. Are you extremely confident, are you moderately confident, perhaps uncomfortable, need more information? Would you make a significant personal financial decision based upon the same level of confidence that you have projected?

Mr. VANDEWATER. I think this is a little bit of a trick question. Certainly we want to have some time to learn more about the information that Mr. Schoeps has presented here, because we do take that extremely seriously.

Having said that, I still retain a fairly strong degree of confidence in the estimate that we have presented. I think, as Dr. Garthwaite indicated a few moments ago in answering a question, we all recognize that the needs for long-term care are massive. I think that was the adjective he used. Dr. Snyder himself made the same general point. I think we're all aware of the needs for potential long-term care being faced by many of our own parents.

So the notion, again as Dr. Kizer expressed on the 19th, that the costs of this provision are likely to be substantial still strikes me as being closer to the right answer than the answer that we've heard this morning—that the program would be sufficiently inexpensive and would most likely be paid for by the potential copayments in the bill. That's what my instinct tells me. But I do want to have our staff look very carefully at the information, the data, and the modeling that Mr. Schoeps has presented here this morning.

Yes, I would base a significant financial decision on the estimates with this degree of confidence.

Mr. STEARNS. You know, when we talked—and you've given me an answer twice to that question, about the inconsistency in the cost estimating. I have heard it twice and I still question if—We have two simple authorizations. The VA may pay for emergency care and it may increase drug copayments. But you assume the VA will fully implement the one that results in costs and completely fail to implement the one that generates revenues.

I've heard your answer twice and, for some reason, it doesn't register. I have asked staff and they don't understand, either. So I don't know if a third time will make any difference to us. But somehow, when you make that kind of internally inconsistent assumption and then you make the kind of assumptions that you used for the tobacco provision, I have some real problems. I would certainly think that, when you go back to look at this, you should be consistent.

Your argument is, "well, it's an authorization, but we don't know how much." I think you could give us better answers.

If you don't mind, we're going to go to the staff here, who have a few questions. So we will open it up for staff here for some question.

Mr. IBSON. Mr. Van de Water, there has been considerable discussion back and forth regarding Mr. Schoeps' analysis. I'm somewhat troubled by the implication that Mr. Schoeps' numbers come as a big surprise and that his methodology is unknown to you. It is my understanding that, over the period of weeks that your staff has been working on this, Mr. Schoeps' methodology has been quite clear. If anything, there has been a slight refinement that has permitted him to bring down a number from \$184 million to a number in the range of \$150 million or so. It certainly hasn't been clear to me.

What are the basic flaws in the methodology that Mr. Schoeps shared with your staff at the point in time that it was shared? What's the problem with his estimate?

Mr. MILLER. I don't know that we had any detailed discussion of methodology. In my discussions with Mr. Schoeps, I think I had a better understanding of the results of the analysis than of the method. I think he probably gave as good an explanation this morning of the nature of how the difference comes about as we can have right now.

We had discussions with staff from the VA. It was somewhat general as to methodology but a bit more specific as to results.

Mr. IBSON. Other than to suggest that you looked at a different set of databases than Mr. Schoeps did, do you have a basis to criticize or suggest a fundamental flaw in his analysis?

Mr. MILLER. The one thing that struck me about it was that if he is correct that there are 4,000 to 5,000 additional veterans who would come to the VA for nursing home care, it would cost considerably more than a couple hundred million dollars. My instincts tell me that the cost per person would be higher.

Mr. IBSON. Well, I would just conclude with the thought that it appears to me Mr. Schoeps and his colleagues have been working

on this for two years, analytically, and I'm hearing your final answer being based on instinct. That seems a strange basis for—

Mr. MILLER. The cost estimate is—

Mr. VANDEWATER. I think that's an unfair characterization of Dr. Miller's answer. You yourself have indicated, and the committee has indicated, that we've been under some understandable and entirely reasonable pressure on the part of the committee to provide an estimate for this bill, and in as timely a fashion as possible.

Producing this estimate takes a substantial amount of effort. We have had to look seriously at some very large databases that I mentioned, and we have had to strike a balance between getting out a final estimate and learning more about an estimate that still does not strike us as plausible.

If we had taken more time to work with the VA on this, we would not have been able to have the estimate that you all received on Monday. There is only so much that can be done in a given amount of time.

Mr. IBSON. Mr. Van de Water, I would submit you've had a considerable period of time to work on this. I have difficulty squaring your sense that, had you more time, you could have developed perhaps a different number versus your level of confidence in the result you achieved. But I'll leave it at that.

Mr. VANDEWATER. That's not an accurate characterization either. As I indicated to the chairman, while we do intend to give every consideration to the information that Mr. Schoeps has presented, we still have a strong degree of confidence in the estimate that we have provided to the committee.

Mr. IBSON. Thank you.

Mr. STEARNS. This is the opportunity for counsel for the ranking members. You are recognized.

Ms. EDGERTON. Thank you, Mr. Chairman. I just have one point of clarification that I would like you both to comment on.

I think we can all agree that health care is changing and long-term care is changing. Maybe if you all could speak to how changing patterns of health care impacted your models, I think that would be helpful for the committee.

Mr. SCHOEPS. In the work that we did at the staff level, using the National Medical Expenditures Survey, we were very concerned that the data we were using in the basic model was old, from 1987, and did not recognize the need or the changes in the health care environment in long-term care—namely, a tremendous increase, a dramatic increase, in utilization of home and community based services—and at the same time a reduction in utilization of nursing home care.

What we did, and why we come up with a range of numbers, is to adjust for that at not the level of detail that we would like to. The new National Medical Expenditures Survey, detailed data is not going to be available until this fall. But we do know the national numbers, and we do know that utilization in home care, home and community based care, has increased by almost 20 percent, and we know that utilization in nursing home care is down between 5 and 10 percent.

So in our sensitivity analysis, we took those national numbers and applied it. That is the most up-to-date information that is

available at this point. Again, that information will be refined by age and disability level this fall. We look forward to doing that. In fact, that was one of the key recommendations of the Federal Advisory Committee: keep using the model you're using, but make sure that, at the earliest possible date, you update it so that you include this information.

Dr. Rowe, the chairman of the Advisory Committee, testified on that point before this committee on the 22nd of April.

Ms. EDGERTON. Mr. Van de Water?

Mr. VANDEWATER. I would only add that we share the same concerns and take the same general approach as Mr. Schoeps outlined. But let me note additionally that the National Long-Term Care Survey, which was one of the primary data sources that we used, provides data for 1994. So, to that extent, the data we were using for our analysis were slightly more up to date than those the VA was using. However, I would add finally that I really doubt that the difference of a few years would be the source of a major difference in the estimates.

Ms. EDGERTON. Does the National Long-Term Care Survey include information on both nursing home care and home-based services?

Mr. VANDEWATER. Yes.

Ms. EDGERTON. Is that your understanding, Mr. Schoeps?

Mr. SCHOEPS. There is information in that dataset on institutional care. It's not at the level, or I have not seen the information, displayed at the level of detail that it is for the home care population. We have always dealt with that dataset on the home- and community-based care side.

Ms. EDGERTON. Thank you.

Mr. STEARNS. I just have one last question, and I believe staff wants a follow up.

Mr. Van de Water, if the Justice Department files suit against tobacco companies, and if the Government prevails in this suit, and if any of that hypothetical recovery is based on VA costs, this bill calls for VA to retain that money. The Government has not even filed suit, and it may never do so. Yet you somehow conclude this provision creates \$21 million in direct spending in fiscal year 2003, and \$31 million in the year 2004.

Why doesn't your estimate just say that any direct spending under this provision is too speculative to cost? And what possible basis do you have for projecting a specific amount for a specific year?

Mr. VANDEWATER. As I indicated in my statement, Mr. Chairman, that estimate is indeed subject to a lot more than the usual uncertainties that we face. In fact, one of the major uncertainties, as you indicated, is whether or not the Government will file suit at all.

However, under circumstances such as this, especially when the creation of direct spending authority is involved, we do attempt to give the Congress the best possible information that we can based on our assessment of the relative probabilities.

As I indicated, we know for certain that if the tobacco trust fund provision of this bill was enacted, it could not possibly reduce the Government's cost because it would allow money that might come

in to be spent. Therefore, the only possible effect of this provision is to allow for additional spending.

The sign of the estimate is absolutely clear in this case. Under those circumstances, we try the best we can to assign a specific number to it, since the whole budget process works with specific numbers. The process requires us, to the extent possible, to assign a specific number to a specific year, and that's what we do.

Clearly, the specific years are the least certain part of this particular estimate. If there were recoveries, they might come in sooner or later than the particular years to which we've assigned them in the estimate.

Mr. STEARNS. You see, the problem I have is, I have three hypotheticals before, which I gave you, and yet you make an estimate based upon your best ability, and then you say these are sacrosanct numbers. Yet I have given you three hypotheticals before that even occurs. It seems like the best you could do is say this cost you give as an estimate is speculative, since we have three hypotheticals before this even occurs.

Mr. VANDEWATER. Well, we didn't use the word "speculative," but I think my statement contains some adjective that is close to that and that recognizes the great deal of uncertainty involved. We're trying to be as modest as possible in our claims for the particular numbers we have presented.

Mr. STEARNS. The staff on this side.

Mr. RYAN. Mr. Van de Water, I would like to follow up on a question that Dr. Snyder asked earlier, about the effect of this bill on Medicare and Medicaid.

The Congressional Research Service recently estimated that about 60 percent of this Nation's long-term care expenditures are paid by the Federal and State governments, with Medicare paying for over half of the home and community based care, and Medicaid paying for more than 40 percent of the cost of nursing home care.

Do these numbers appear to be roughly accurate to you?

Mr. VANDEWATER. On the nursing home care figure, yes. I'm not sure about the other one.

Mr. RYAN. I have had an opportunity, as have other members, to read your testimony and the CBO cost estimate, and I fail to find any mention in either the estimate or your testimony of any potential savings to Medicaid or to Medicare if this bill is enacted.

If veterans qualify for these programs at the same rate as other Americans, shouldn't there be about a 50 or 60 percent savings of the total cost of this bill in these other programs?

Mr. VANDEWATER. No. That was, in fact, my answer to the question from Dr. Snyder. If in fact this provision was implemented and fully funded, there would most likely be some savings to the Medicaid program because Medicaid does, as you say, pay for about 40 percent of all nursing home expenditures.

But then I went on in my response to Dr. Snyder's question to observe that Medicaid is a joint State/Federal program, and the Federal share, on average, is 55 percent or so of that amount. Moreover, if the States were to be granted some fiscal relief in the form of having the VA pick up part of the nursing home costs that they are now bearing, based on past behavior, the States would be likely to use a good chunk of that fiscal relief to provide either ad-

ditional long-term care or other medical services under the Medicaid program to people in need.

So the bottom line was that, as a rough estimate, the amount of Federal Medicaid savings would be on the order of \$150 million a year. The savings to Medicare would not be significant, in that Medicare does not, for the most part, provide the institutional, long-term care services of the sort contemplated in this bill.

Mr. RYAN. In your estimate, you did mention that you expected VA costs for home- and community-based care services would exceed \$100 million. Wouldn't there be an identical reduction in Medicare spending if VA were to assume that cost? And is there any mention of that in either the cost estimate or your testimony?

Mr. VANDEWATER. I think we did have—

Mr. MILLER. The estimate for home-based care was based on the out-of-pocket or private insurance benefits that veterans would have. There would be no Medicare impact.

Mr. RYAN. You're saying you're charging the Government with the out-of-pocket costs that veterans now bear?

Mr. MILLER. Not exactly. If a veteran is paying for something out of pocket, there is a chance that he would come to the VA to get the care so he wouldn't have the out-of-pocket expense.

Mr. RYAN. Right. But the Medicare program—

Mr. MILLER. That's his incentive to use the benefit.

Mr. RYAN. The Medicare program spent in excess of \$16 billion last year for home- and community-based care services, and much of that for veterans.

If the VA started paying for those services, wouldn't that produce a savings in Medicare?

Mr. VANDEWATER. I think those are very different benefits. The Medicare home care benefit is severely limited. It is not a continuing long-term care benefit of the sort contemplated in this bill.

Mr. RYAN. I disagree with you, but thank you, Mr. Chairman.

Mr. STEARNS. Dr. Snyder, anything else that you would like to add, or counsel?

Dr. SNYDER. No, Mr. Chairman.

Mr. STEARNS. Well, we appreciate your time. We've had about a hour and a half here of—Yes, counsel.

Mr. IBSON. Mr. Hall, just a couple of last questions.

The emergency care provisions have not gotten as much attention as long-term care, certainly, but this is an area where CBO projects has rather high costs as well. I wonder if you would clarify something.

The bill, as I see it, gives VA very broad discretion regarding limiting the rates that it might pay, assuming that it implemented this provision. Do you see it that way?

Mr. HALL. Yes, that's correct. The Secretary, under the bill, would have the authority to set the amount that would be paid. It says a reasonable amount, but then it gives the Secretary the authority to determine what that amount is. It could be the market rate, or it could be substantially less than that, if for whatever reason he determined that was appropriate.

In addition, he would be the payer of last resort. There would have to be absolutely no other third party payment available to the

veteran to cover his expenses. If any other payment was made, then the VA would be unable to reimburse.

Mr. IBSON. To the extent, then, that CBO's estimate of this particular provision rising to a projected \$400 million in the last fiscal year is based on the experience of private health plans, wouldn't it follow that, to the extent VA has authority to set the rates and limit the rates, that VA's exposure might be considerably less than that amount?

Mr. HALL. If VA set their rates to reimburse at anything less than the market rates, then yes, there would be a significant discount.

Mr. IBSON. Wouldn't that be a prudent step for the VA to take?

Mr. HALL. I would think so, if it met the purposes of ensuring we were the payer of last resort and stretching it as far as possible.

Mr. IBSON. Thank you for that clarification.

Mr. STEARNS. Let me conclude by saying that it seems to me the only provision in this bill that creates a new spending mandate is the one directing VA to provide extended care to veterans who are 50 percent or more service connected.

I just think we have a moral imperative to do this. We have to take care of these veterans. So, by hook or crook, I think we have to go ahead and do it. If members on this subcommittee or members on the full committee somehow have a differing opinion on what we have heard from CBO and the administration, I don't think there's any difference of opinion about the moral imperative to take care of veterans who are 50 percent or more service connected with extended care. So I think we have to keep the big picture in mind, and we have to commit ourselves here, as a subcommittee and the full committee, to do this.

I want to thank all of you for coming here and giving us this very informative presentation, and we will take it forward.

The hearing is concluded.

[Whereupon, at 11:35 a.m., the subcommittee adjourned.]

APPENDIX

**Statement of Representative Luis Gutierrez
House Committee on Veterans' Affairs
Subcommittee on Health
Hearing on Cost Estimates for H.R. 2116
The Veterans Millennium Health Care Act
June 30, 1999**

Thank you, Mr. Chairman. I am eager to hear testimony today from our witnesses, Mr. Paul Van de Water from the Congressional Budget Office and Dr. Thomas Garthwaite, Deputy Under Secretary for Health at the Department of Veterans Affairs.

As we know from our past hearings, H.R. 2116 addresses several concerns that have been raised by our nation's veterans. This bill requires the VA to create a national plan to provide long-term care and expand access to VA health services. It also make improvements to our existing Veterans Health Care system. For example, this legislation extends VA's authority to make grants to assist homeless veterans. It extends the requirement that VA maintain special committees relating to mental illness. This bill requires the VA to establish a policy on the role of chiropractic treatment in the Department's care of veterans. It also requires that the VA report to Congress on proposed closures within a fiscal year of fifty percent or more of the beds in certain bed sections at any VA medical center and notify Congress annually about mission changes in bed sections.

I am pleased that an amendment I introduced during

markup of this bill passed unanimously and has been included in the Millennium Health Care Act. Section 108 of this legislation provides for counseling and medical treatment to veterans who were victims of sexual abuse or harassment during their military training or service. Language in the bill states that this program would be reauthorized until December 31, 2002.

Mr. Chairman, I believe we have before us a bill that helps address the need to improve veterans' health care as we move into the 21st century. While this bill has good intentions, we must ensure that funding is available to achieve our goals. On Monday, President Clinton announced that the surging economy will pump an extra \$1 trillion into the government treasury during the next fifteen years. As we consider this new budget reality, all of us on this committee must re-dedicate ourselves to fighting for a fair and adequate veterans budget. We owe it to the men and women who have honorably served and sacrificed.

We are currently letting them down. A fully-funded Millennium Health Care Act is one vital way for this nation to repay our considerable debt to our veterans.

**STATEMENT OF THE HONORABLE MIKE DOYLE (PA-18)**

Subcommittee on Health of the Veterans' Affairs Committee
Hearing on CBO's Cost Estimate of H.R. 2116

June 30, 1999

Thank you Mr. Chairman. I want to express my thanks to you and other members of the Committee for promptly organizing this hearing in direct response to concerns that were raised during last week's full Committee meeting.

As members of the Health Subcommittee Committee are aware, we have been examining and talking about the substance of the Veterans' Millennium Health Care Act in relationship to potential costs for several weeks now. I feel these have been productive conversations in that we have exchanged ideas in a meaningful and productive manner and have come to resolve many important matters affecting the delivery of health care service to our nation's veterans. That being said about the bill from a policy perspective, we are still left to more closely examine the cost aspect of this initiative.

Like the majority of my colleagues who serve on the Health Subcommittee, I have voiced my concerns about the ability to support many provisions of the bill in terms of adequate funding. And like the majority of my colleagues who serve on the full Committee, I have repeatedly voiced my concerns about the failings to adequately fund current VA health care services. It can not be ignored that our best intentions in this Committee are in certain circumstances only as good as the level of funding provided by the appropriators.

As was demonstrated through last week's comments regarding the importance of having an official CBO cost estimate on H.R. 2116 clearly this is an important aspect in moving forward with the bill. This sentiment was also echoed in the letter that was signed by members of the Committee members that has been sent to the attention of Dan Crippen, the Director of the Congressional Budget Office. Thus, it would appear to be in the Subcommittee's best interest to seriously discuss the cost estimate information that we now have before us this morning.

In the interest of improving VA health care, I would encourage my colleagues to make our discussion this morning a productive one and continue to work together in advancing our mutual goals.

Again, thank you Mr. Chairman.

LANE EVANS
Ranking Democratic Member
Committee on Veterans Affairs
Legislative Hearing on
Cost Estimates for H.R. 2116
“The Veterans’ Millennium Health Care Act”

Thank you, Mr. Chairman. I appreciate your willingness to hold this hearing today. I’ll keep my remarks very brief to accommodate adequate time for Members to question the witnesses.

Last week we began to mark up this Millennium Health Care Act. Many of our Members had real concerns about the costs of this important legislation. Unfortunately, the Congressional Budget Office did not have the estimate ready in time for Members to fully consider. I do not want to belabor this point, but I do want to reiterate the importance of timely estimates for Congressional consideration. I know I have requested estimates on bills that have languished for up to a year without an estimate. For instance, I requested an estimate on the Emergency Care bill I introduced in the 105th Congress a year ago from this past April and never received anything but a preliminary estimate. If CBO had done an analysis of that bill, a predecessor of the emergency care provision in the bill under consideration today, it may not have been so late in arriving at the estimate we now have. I think most of us here today share my frustration.

CBO will testify that VA is funded by appropriations so, to the extent that Congress does not appropriate the necessary funds they will obviously not be spent. CBO also assumes that nothing in Veterans Health Administration operations will change as a result of re-prioritization of activities. We can take two views of CBO estimates for discretionary funds. We can choose to view them as largely “advisory”—that is they give us some sense of the magnitude of spending required to fully implement the initiative if the organization makes no other changes to accommodate it. Or we can accept “high” CBO estimates as prohibitive of Congressional priorities it deems to be too expensive. We can argue about the credibility of the estimates, but our action or inaction boils down to how we choose to use them.

I choose to view CBO's estimates as advisory; the fact that I do not subscribe to nor fully understand its assumptions makes them somewhat more so. Let’s not forget CBO works for us. Too often I think we allow the tail to wag the dog. If Congress chooses to create new priorities within the VA system—priorities that

many officials within the VA itself do not believe are cost prohibitive, I do not believe an unfavorable cost estimate should alter these priorities.

I do not want to belittle the service of the Congressional Budget Office and I appreciate the advice they are able to provide the Committee. It is important information that must be reviewed alongside other important information and in light of priorities. In this case, I believe that my priority to provide comprehensive long-term care to the highest priority veterans the system treats within the \$2 billion VA is already spending on long-term care outweighs the concern I have about the CBO estimate in light of the other information I have available. I believe it is more important to allow VA to respond to veterans' need for emergency care services than to consider CBO's estimate which may not have been based on accurate information. These are important choices we in Congress must make in all of our deliberations.

Thank you for holding this hearing, Mr. Chairman. I have lots of questions I will hold for our witnesses.

Statement of
Paul N. Van de Water
Assistant Director
for Budget Analysis
Congressional Budget Office

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

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

June 30, 1999

NOTICE

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

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

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

DISCRETIONARY COSTS

Veterans' medical care is a discretionary program whose funding is provided annually in the appropriation bill for the Departments of Veterans Affairs and Housing and Urban Development. The appropriation limits how much the VA may actually spend regardless of how much spending is authorized. Table 1 shows the annual appropriations for veterans' medical care for the past 10 years and provides additional data on the program's operations.

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

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

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

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

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

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

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

a. Estimated.

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

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

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

MANDATORY COSTS

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

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

Clearly, none of those questions can be answered with any precision, and the range of possible outcomes is large. Equally clear, however, is that the provision cannot reduce spending but only increase it. In such a situation, CBO attempts to estimate the expected value of a proposal's budgetary effect—that is, the weighted average of the cost of the proposal under a variety of circumstances, taking account of their respective probabilities.

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

CONCLUSION

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

APPENDIX**CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE**

June 28, 1999

**H.R. 2116
Veterans' Millennium Health Care Act***As introduced on June 9, 1999***SUMMARY**

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

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

ESTIMATED COST TO THE FEDERAL GOVERNMENT

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

Spending Subject to Appropriation

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

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

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

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

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

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

CBO's estimate relies on data from VA, the 1992 National Survey of Veterans, and the National Long-Term Care Survey (NLTC). CBO determined the probability of a person being institutionalized as a function of his age, marital status, and number of limitations in activities of daily living—one indicator of an individual's need for long-term care. Applying those probabilities to a distribution of veterans with service-connected disability ratings of 50 percent or higher, CBO estimates that by 2010 about 45,000 additional veterans would receive care in nursing homes for an annual cost of \$1.2 billion. This method of estimation takes into account that spouses often act as caregivers within the home to veterans who might otherwise require a nursing home stay. In the near term, demand for nursing home care through the VA would be lower because some veterans currently rely on Medicaid, private insurance, relatives, and certain Medicare-funded services to provide or finance their care. Initially, those veterans might not want to change their arrangements with providers. CBO assumes that eventually veterans with ratings of 50 percent or higher who enter nursing homes would turn to the VA for their care because, unlike other private or public insurance programs, it would be free to them. CBO expects that most nursing home patients would be placed in community nursing homes for an average stay of 179 days and at a cost of about \$152 a day per patient (in 2000 prices). (Nursing homes owned and operated by VA are almost twice as expensive as privately operated homes.)

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

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

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

Reimbursement for Emergency Care. Section 102 would significantly expand VA's authority to reimburse veterans and institutions for emergency care. It would allow VA to pay for care stemming from life- or health-threatening emergencies involving a veteran who is enrolled with VA for care, has no other coverage for emergencies, and has received care

from VA within the 12 months preceding the emergency. CBO estimates that this provision would increase spending by about \$80 million in 2000 about \$400 million a year by 2004, assuming appropriation of the necessary amounts. Those costs would stem from the costs of emergency room care and any subsequent hospital care

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

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

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

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

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

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

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

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

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

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

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

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

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

Direct Spending

Veterans' Tobacco Trust Fund. Section 203 of the bill would give VA direct spending authority over any amounts the federal government receives on its behalf from the tobacco industry for recovery of costs associated with tobacco-related illnesses. CBO estimates that the additional resources available to VA would total \$80 million over the 2000-2004 period and \$0.8 billion over the 2000-2009 period. Because of normal lags in spending this

provision would increase federal outlays by about \$50 million over the 2000-2004 period and about \$640 million over the 2000-2009 period. These outlays could supplement or supplant discretionary spending for veterans' medical care.

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

To develop an estimate that would fall within the range of possible outcomes, CBO made assumptions about three factors. First, how much would the federal government recover if it won or settled a lawsuit? Second, what proportion would be attributable to the costs of the VA? Finally, what is the likelihood that the federal government will enter into a lawsuit and either win or settle?

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

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

The annual payments under the November 1998 settlement between tobacco companies and the states ultimately rise to about \$9 billion a year before adjustments for inflation and the volume of cigarette sales. The Justice Department contends that the amount of money paid

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

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

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

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

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

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

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

Compensated Work Therapy Program. Section 105 would make veterans eligible for disability compensation benefits for injuries proximately caused by the veteran's receipt of care in the Compensated Work Therapy Program (CWT). CWT is a therapeutic work program for veterans that takes place in various types of workplaces. Under current law, these veterans are not eligible for disability compensation benefits because of injuries suffered while participating in the program. The budgetary impact of this provision would depend on how many veterans are participating in this program and the rate at which they are injured while working. Information from VA indicates that about 15,000 veterans a year participate in this program. Based on data from the Bureau of Labor Statistics on the incidence of occupational illnesses and injuries, CBO estimates that the provision would increase direct spending by less than \$500,000 a year over the 2000-2002 period and by about \$1 million a year thereafter.

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

PAY-AS-YOU-GO CONSIDERATIONS

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

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

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

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

COMPARISON WITH OTHER ESTIMATES

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

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