CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

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Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Congressional Budget Office (CBO) has prepared a preliminary analysis of sections 2 and 3 of the House amendment to the Senate amendment to H.R. 3230, the Veteran Access to Care Act of 2014, as posted on the House Rules Committee's website on June 16, 2014 (referred to hereinafter as "the House bill"). For two years after the date of enactment, the House bill would substantially expand the current authority of the Department of Veterans Affairs (VA) to provide medical services to veterans through agreements with non-VA health care providers, and would require VA to use that authority to ensure that all eligible veterans receive requested health care in a timely fashion. The effects of providing such broad new authority to VA are highly uncertain, and CBO has been able to make only a preliminary and partial assessment of the legislation.

Based on that preliminary assessment, CBO estimates that implementing sections 2 and 3 of the House bill for that two-year period would have a net cost of about $44 billion over the 2014-2019 period, assuming appropriation of the necessary amounts.[1] That net amount comprises increased costs of about $51 billion for VA, less a reduction of $7 billion in federal spending for Medicare and Medicaid.

Because funding for the VA's health care program is discretionary—that is, subject to the annual appropriation process—almost all of the added costs would be discretionary. But to cover some of the costs of the bill, section 3 would allow the use of funds that have already been appropriated but would

1. Most nondefense discretionary appropriations are subject to a statutory cap, which is currently set at $492 billion for 2015 and estimated to remain at that level for 2016.

otherwise not be used; by CBO's estimate, that provision would increase direct spending by $620 million over the 2014-2016 period. CBO has not yet estimated the budgetary effects of the other sections of the bill.

Estimated Costs of Sections 2 and 3

Sections 2 and 3 of the House bill would require VA, subject to the availability of appropriations, to use existing contracts, new contracts, and fee-for-service arrangements with non-VA doctors and hospitals to provide care to veterans who cannot be served by the VA health care system within 14 days of their requested appointment time. Although the bill does not specify that veterans must seek pre-authorization from VA before obtaining such care, CBO expects that VA would probably establish such a requirement in its implementing regulations. Care required under the House bill could be provided in medical offices and hospitals located anywhere in the country.

Health care provided by VA requires no premiums, imposes no deductibles, and assesses low, or for many veterans, no, copayments. CBO expects that the combination of convenient location and streamlined access to inexpensive care would make VA-funded care more attractive to all veterans. However, because the requirements and authorities in sections 2 and 3 would last for only two years, CBO expects that most veterans who are not currently enrolled would not change their health care arrangements for that short period of time.

VA currently has about 8.4 million veterans enrolled in its health care program. Of the remaining roughly 13 million living veterans, CBO estimates that about 8 million qualify to enroll in VA's health care program but have not done so. VA currently spends a total of about $44 billion to provide health care services to veterans, or about $5,200 per enrollee. (That amount does not include spending on programs that CBO expects would not be increased under this legislation, such as long-term care, caregivers, and ending veterans' homelessness.) Based on information from VA on veterans' reliance on VA, CBO estimates that this cost represents about 30 percent of the total amount of health care received by those veterans.

CBO estimates that, under sections 2 and 3, enrolled veterans would ultimately seek to increase the amount of care they receive from VA by about 75 percent. In addition, CBO expects that about one-fourth of the veterans who are eligible to enroll but have not yet enrolled would choose to enroll because of the improved access to low-cost health care financed

through VA. Most of the costs incurred to provide that care would be for care that would otherwise be financed by other payers, including Medicare and Medicaid. Thus, to the extent that appropriations were provided to increase spending for VA health care, a portion of that additional spending would result in savings to the Medicare and Medicaid programs.

All told, CBO expects that if the bill was fully implemented, some veterans would ultimately seek additional care that would cost the federal government about $54 billion a year, after accounting for savings to other federal programs.

However, CBO expects that VA would have difficulty in quickly setting up a program to contract for health care nationwide and in establishing administrative processes to authorize care by private health care providers. Moreover, the amount of care that veterans sought through VA might increase gradually over time. Thus, CBO expects that, of the amount of additional care sought by veterans, VA would provide only about 30 percent in 2015 and about 60 percent in 2016. VA also would spend a comparatively small amount in 2014 on administration and new hiring. Thus, CBO estimates that implementing sections 2 and 3 of the House bill would cost roughly $500 million in 2014, $16 billion in 2015, and $28 billion in 2016.

The magnitude of those budgetary effects is highly uncertain. A significant number of veterans could receive new and expanded health care benefits under the House bill. How many would ultimately receive those benefits and the resulting costs will depend on a number of factors that are very difficult to predict. Further, the specific parameters of the new program would depend on regulations that would need to be developed. Because the behavioral changes that would result from enacting those provisions are so uncertain, this estimate should be viewed as falling in the middle of a wide range of possible outcomes.

Because the bill would increase enrollment in VA health care in 2015 and 2016, the demand for VA health care services would probably increase in 2017 and subsequent years. If lawmakers wanted to accommodate that increase in demand, additional appropriations would be necessary after 2016. This estimate does not include the costs of providing such additional services after 2016.

Comparison of House and Senate Bills

On June 11, 2014, CBO published a preliminary analysis of Title III of S. 2450, the Veterans' Access to Care Through Choice, Accountability, and Transparency Act of 2014, as introduced on June 10, 2014. That title is similar to sections 2 and 3 of the House bill in that both bills would provide VA with expanded authority to provide medical services to veterans through agreements with non-VA health care providers, and would require VA to use that authority to ensure that all eligible veterans receive requested health care in a timely fashion. Several differences between the two bills affect CBO's estimate of costs. Although both pieces of legislation would authorize VA to contract with the private sector to provide care if the department cannot provide it within a certain time, the wait period identified in the House bill is 14 days, whereas the Senate bill would direct the VA to identify an acceptable wait-time goal; in its estimate for the Senate bill, CBO assumed that goal would be 30 days.

In addition, the rates paid by VA to some private providers would probably be different under the two bills. To the extent VA has not implemented contracts to provide sufficient outside care, the House bill would allow veterans to elect to receive care in the private sector and would direct the department to reimburse any non-VA facility for such care at the greater of the Medicare rate, the Tricare rate, or a rate established by the VA; CBO expects that VA would use the Medicare rate for those non-contractual payments. The Senate bill would require that all privately provided care be implemented through contracts. CBO expects the costs of contracted care to be closer to commercial rates, which are generally higher than Medicare rates. Although such contracts would probably be used under the House bill to cover some care, CBO estimates that the average payment rate under the House bill, including both contractual and non-contractual payments, would be lower than that under the Senate bill.

CBO believes that the shorter wait time identified in the House bill would allow veterans who would be enrolled under current law to use more privately provided health care services than would be the case under the Senate bill, and, by making the VA program more accessible, would increase the number of new enrollees more than the Senate bill would. In addition, CBO expects that having the authority to reimburse facilities directly without having to negotiate contracts would speed implementation of the House bill. Thus, CBO anticipates that, of the amount of additional care sought by veterans, VA would provide about 30 percent and 60 percent in 2015 and 2016, respectively, under the House bill, compared

with 20 percent and 50 percent under the Senate bill. Moreover, because less contracting would be required, CBO anticipates that VA payments to private providers resulting from the legislation would commence sooner under the House bill than under the Senate bill. The increases in usage by existing enrollees, in the number of new enrollees, and in the rate of implementation all combine to increase the estimated cost of the House bill relative to the Senate legislation. However, to the extent that VA would reimburse facilities at Medicare's rates, its cost per unit of additional care provided under the House bill would be lower.

The House bill would expire two years after enactment, but would allow ongoing treatment to be continued for up to 60 days. CBO assumes an enactment date of July 31, 2014. The authorities, requirements, and appropriations provided in the Senate bill would expire on September 30, 2016. That difference reduces the estimated cost of the House bill by less than 10 percent relative to the Senate bill.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Ann Futrell.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

cc: Honorable Mike Michaud
Ranking Member