CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

August 23, 2007

S. 1233
Veterans Traumatic Brain Injury and Health Programs Improvement Act of 2007

As ordered reported by the Senate Committee on Veterans' Affairs on June 27, 2007

SUMMARY

S. 1233 would create new programs to treat combat veterans with traumatic brain injuries, authorize the construction of hospitals for the Department of Veterans Affairs (VA), and expand health care benefits for veterans. In particular, S. 1233 would allow veterans without disabilities related to military service to enroll in the VA health care system regardless of their income level.

The bill also has two provisions that would modify a VA program that funds hundreds of community agencies that provide services to homeless veterans, potentially allowing those service providers to receive significantly increased funding. CBO cannot determine the costs of those provisions at this time because neither VA nor CBO can predict how the service agencies would alter their requests for VA funding under S. 1233; however, CBO expects the annual cost of those two provisions would probably be in the tens of millions of dollars. CBO estimates that implementing the remainder of S. 1233 would increase discretionary costs for veterans' health care by about $1.4 billion in 2008 and $10.6 billion over the 2008-2012 period, assuming the appropriations of the necessary amounts. In addition, CBO estimates that enacting the bill would increase direct spending by less than $500,000 in 2008 and $3 million over the 2008-2012 period. Enacting the bill would have no effect on federal revenues.

S. 1233 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act; any costs to state, local, or tribal governments would result from complying with conditions of federal assistance.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 1233 is summarized in Table 1. The costs of this legislation fall within budget function 700 (veterans benefits and services).

TABLE 1. ESTIMATED BUDGETARY IMPACT OF S. 1233

	By Fiscal Year, in Millions of Dollars				
	2008	2009	2010	2011	2012
CHANGES IN SPENDING SUBJECT TO APPROPRIATION [a]					
Estimated Authorization Level	2,178	2,122	2,186	2,216	2,251
Estimated Outlays	1,385	2,190	2,355	2,347	2,293
CHANGES IN DIRECT SPENDING [b,c]					
Estimated Budgetary Authority	*	*	*	*	*
Estimated Outlays	*	*	*	*	*

Note: * = less than $500,000.

a. This table does not include the costs for implementing sections 401 and 404 of S. 1233, which CBO cannot estimate.

b. In addition to the direct spending effects shown here, enacting S. 1233 would have additional effects on direct spending after 2012. The estimated increase in direct spending would total $1 million over the 2008-2012 period and $3 million over the 2008-2017 period.

c. Numbers may not add up to totals in text because of rounding.

BASIS OF ESTIMATE

For this estimate, CBO assumes that the legislation will be enacted near the start of fiscal year 2008, that the estimated amounts will be appropriated each year, and that outlays will follow historical spending patterns for the VA medical services and major construction programs.

Spending Subject to Appropriation

S. 1233 would create new programs to treat traumatic brain injury for combat veterans, authorize the construction of hospitals for the Department of Veterans Affairs, and expand

health care benefits for certain veterans, especially for those without disabilities connected to military service. It also would change the rules for funding service agencies which provide assistance to homeless veterans, the cost of which CBO cannot estimate because neither VA nor CBO can predict how the hundreds of service agencies would alter their requests for VA funding. (We expect those costs would probably be in the tens of millions of dollars per year.) CBO estimates that implementing the remainder of S. 1233 would result in discretionary outlays of about $1.4 billion in 2008 and $10.6 billion over the 2008-2012 period (see Table 2).

Enrollment for Priority 8 Veterans. Veterans enrolling in the VA health care system are assigned to one of eight priority care groups, based on such factors as disability rating and income. Each year the Secretary of Veterans Affairs announces which enrollment categories of veterans will be eligible to receive VA health care in the following year. That determination is based on an estimate of health care costs and available resources. Once enrolled, however, veterans are not excluded, regardless of enrollment category.

Since January 2003, VA has not accepted new enrollments of priority 8 veterans—veterans without a service-connected disability and with incomes above certain thresholds—and VA has announced that the ban on enrollment of category 8 veterans will continue through 2008. Section 301 would void that exclusion for 2008. Section 302 would codify the Secretary's responsibility to announce the annual enrollment decision in the Federal Register and require the simultaneous submission of a report on that decision to the Congress. Based on VA's repeated determinations to exclude priority 8 veterans, CBO expects that the effect of these two sections would be the enrollment of priority 8 veterans during 2008 only. (Because the bill's provision to void an exclusion for 2008 applies only to that year, we expect that enrollment of new priority 8 veterans would not continue after 2008 under this bill.)

Based on data from VA about the projected population of potential priority 8 enrollees and the cost of current priority 8 enrollees, CBO estimates that implementing section 301 would allow about 1.3 million new priority 8 veterans to enroll in the VA health care program at an average annual net cost of about $1,400 in 2008. (The net cost equals the cost of care minus copayments and third-party reimbursements.) After adjusting for expected inflation, CBO estimates that implementing this provision would increase VA health care costs by $1.2 billion in 2008 and almost $8.8 billion over the 2008-2012 period, assuming appropriation of the necessary amounts.

Increase in Veterans' Travel Benefits. Section 307 would increase the travel allowance available to certain veterans for medical or vocational rehabilitation appointments. Veterans with a low income and veterans seeking treatment for a service-related disability are currently eligible to receive 11 cents per mile traveled for medical appointments at VA facilities, with

a $3 deductible each way. Those traveling for a disability rating examination receive 17 cents per mile with no deductible. Those travel reimbursements are discretionary costs and are covered in this part of the estimate. (Travel reimbursements for vocational rehabilitation appointments are classified as mandatory spending, and those costs are discussed later in the "Direct Spending" section.)

Current law calls for the $3 deductible to increase proportionately with any increase in the mileage reimbursement rate. Section 307 would freeze the deductible at $3 and link the mileage reimbursement rate to that used by the federal government to reimburse employees for work-related travel in their personal vehicles when government vehicles are available for their use. That rate is currently 28.5 cents per mile. In 2006, VA spent about $55 million to reimburse veterans for travel to medical appointments and about $5 million in travel reimbursements for veterans traveling for disability rating examinations. Based on information from VA, CBO estimates that, in 2008, increasing the mileage rates and freezing the deductible for medical appointments would require the appropriation of $113 million in that year. That cost reflects CBO's expectation that increasing the mileage rate also would increase the number claims for travel reimbursement by 10 percent. Assuming that mileage reimbursement rates would increase by about 2 percent each year, CBO estimates that implementing this section would cost about $750 million over the 2008-2012 period, assuming the appropriation of the necessary amounts.

TABLE 2. COMPONENTS OF DISCRETIONARY SPENDING UNDER S. 1233 [a,b]

	By Fiscal Year, in Millions of Dollars				
	2008	2009	2010	2011	2012
Enrollment for Priority 8 Veterans					
Estimated Authorization Level	1,363	1,866	1,916	1,966	2,015
Estimated Outlays	1,192	1,771	1,884	1,946	1,997
Increase in Veterans' Travel Benefits					
Estimated Authorization Level	113	155	158	162	165
Estimated Outlays	102	153	156	160	164
Major Medical Facility Projects					
Authorization Level	627	0	0	0	0
Estimated Outlays	28	169	204	151	57
Health Professionals Scholarship Program					
Estimated Authorization Level	12	25	27	28	15
Estimated Outlays	11	24	27	28	16

(Continued)

TABLE 2. CONTINUED

	By Fiscal Year, in Millions of Dollars				
	2008	2009	2010	2011	2012
Extending Time for Preferred Health Care					
Estimated Authorization Level	10	20	25	25	25
Estimated Outlays	9	19	24	25	25
Help for Very-Low-Income Veterans					
Authorization Level	16	21	26	0	0
Estimated Outlays	14	20	25	2	*
Traumatic Brain Injury Program					
Authorization Level	10	10	10	10	10
Estimated Outlays	9	10	10	10	10
Assisted Living Pilot Program					
Authorization Level	8	8	8	8	8
Estimated Outlays	7	8	8	8	8
Rural Veterans Transportation					
Authorization Level	6	6	6	6	6
Estimated Outlays	5	6	6	6	6
Copayments for the Catastrophically Disabled					
Estimated Authorization Level	6	6	6	6	6
Estimated Outlays	6	6	6	6	6
Veterans Released from Prison					
Estimated Authorization Level	4	4	4	4	0
Estimated Outlays	1	3	4	4	3
Homeless Demonstration Program					
Authorization Level	2	0	0	0	0
Estimated Outlays	1	*	*	*	0
Total Changes					
Estimated Authorization Level	2,178	2,122	2,186	2,216	2,251
Estimated Outlays	1,385	2,190	2,355	2,347	2,293

Note: * = less than $500,000.

a. This table does not include the costs of implementing sections 401 and 404 of S. 1233, which CBO cannot estimate.

b. Numbers may not add up to totals because of rounding.

Major Medical Facility Projects. Sections 501 through 503 would authorize work on three medical facility projects. CBO estimates that implementing those sections would cost $28 million in 2008 and $609 million over the 2008-2012 period, assuming appropriation of the necessary amounts.

Section 501 would authorize VA to replace the medical center in Denver. The bill would authorize the appropriation of $548 million in 2008 for this project. Section 501 also would authorize VA to spend any unobligated amounts in the major construction account on the Denver medical center. Based on information from VA, CBO does not expect that funding in excess of that which is specifically appropriated for the project will be needed.

Section 502 would authorize the appropriation of $59 million in 2008 for the consolidation of medical centers in Pittsburgh.

Section 503 would authorize the appropriation of $21 million in 2008 for the modernization of inpatient wards at the medical center in Atlanta.

Health Professionals Scholarship Program. Section 601 would revive a health professionals scholarship program that expired in 1998. The provision would give VA the authority to provide funds to cover tuition, fees, the costs of books and laboratory equipment, and a stipend for students in certain medical or nursing school programs, such as general medicine, dentistry, or psychology. The scholarships could be from one to four years, though preference would be given to students in their last year of school. In exchange for financial assistance, recipients would be obligated to work at VA for a specified period of time.

Based on information from VA, CBO estimates that under S. 1233 VA would grant about 250 awards each year with an average award of $46,000 in 2008. Estimating an average scholarship of two years, and taking in to account an estimated 6 percent increase in tuition and other costs each year, CBO estimates that implementing this provision would cost $11 million in 2008 and $106 million over the 2008-2012 period, assuming the availability of appropriated funds.

Extending Time for Preferred Health Care. Under current law, veterans entering the VA health care system who have served in combat zones are automatically placed in priority category 6 until they receive a rating for a service-connected disability or until two years from the date of their discharge from active duty. Those who are determined to have a service-connected disability are reassigned to the highest priority categories—1, 2, or 3. At the end of the two-year period, all others are moved to the lowest priority categories—7 or 8—depending on their level of income. Veterans in those lowest two categories generally

pay higher copayments for treatments and medications than veterans in the higher priority categories.

Section 201 would extend the period during which combat veterans can receive care in priority category 6—from the current two years from their date of discharge to five years. Thus, under this bill, veterans currently in category 6 would be allowed to remain at that priority level for an extra three years. Veterans who had already been reassigned to category 7 or 8, but had been discharged within the last five years, would be returned to category 6 for whatever remained of that five-year period. And combat veterans who had not yet sought care from VA would have up to three additional years to enter the health care system.

CBO estimates that enacting this provision would cause about 4,500 new combat veterans to enroll in the VA health care program in 2008, and 9,000 to enroll in 2009. Thereafter, however, CBO estimates that only a few hundred would enter each year and receive the additional benefit, as the number of combat veterans being discharged from active duty is expected to decline. Based on information from VA, CBO estimates that the cost of treating those additional veterans would be about $12 million in 2008, but that those same veterans would pay VA an additional $2 million that year in copayments. (For injuries or illnesses that are obviously not service-connected, such as those from a recent car accident or a bout with the flu, VA charges copayments.) Over the 2008-2012 period, CBO estimates that treatment of those veterans would increase costs by $120 million. During this same period, CBO estimates VA would receive additional copayments of about $25 million, which reduce the net level of appropriations necessary for health care.

CBO also estimates that, under this provision, VA would lose about $1 million each year in copayments from veterans who would be in priority category 6 rather than priority category 7 or 8. Veterans in the lowest two categories have no service-connected conditions and are charged copayments for all treatments. When veterans in priority category 6 seek treatment, their medical condition is assumed to be related to their military service—unless that is obviously not the case—and as a result, they are not charged copayments for those treatments. Thus, CBO estimates the total net cost of implementing section 201 would be about $10 million in 2008 and about $100 million over the 2008-2012 period, assuming appropriation of the necessary amounts.

Help for Very-Low-Income Veterans. Section 406 would authorize the appropriation of a total of $63 million over three years to provide financial assistance to qualified nonprofit organizations and consumer cooperatives that provide supportive services to very-low-income veterans who live in permanent housing, with preference given to those entities that help veterans make a transition from homelessness to permanent housing. Very-low-income veterans would be defined as those having an income that is less than half of the median

income for the area in which the veteran lives. The authorized funding would support a wide array of services, including outreach, health care, counseling, transportation, assistance with daily living, and assistance in obtaining veterans benefits and other public benefits, among others. It also would support technical assistance from VA to the nonprofit organizations for the planning and provision of services to veterans. CBO estimates that implementing this section would cost $14 million in 2008 and $63 million over the 2008-2012 period.

Traumatic Brain Injury Program. Section 104 would require VA to establish a program to provide neurologic rehabilitation to veterans with severe traumatic brain injury. The program would include research, education, and clinical care and would be done in collaboration with the Defense and Veterans Brain Injury Center—a program funded by the Department of Defense and operated in conjunction with VA and a private neuro-care center in Virginia. Section 104 would authorize the appropriation of $10 million each year from 2008 through 2012 to carry out this program. CBO estimates that implementing this provision would cost $9 million in 2008 and $49 million over the 2008-2012 period.

Assisted Living Pilot Program. Section 105 would require VA to carry out a five-year pilot program in at least four parts of the country to provide assisted living services to enhance the rehabilitation, quality of life, and community integration of veterans with traumatic brain injury. S. 1233 would authorize the appropriation of $8 million each year from 2008 through 2013 to implement and run the pilot program. CBO estimates that section 105 would cost $7 million in 2008 and $39 million over the 2008-2012 period.

Rural Veterans Transportation. Section 304 would authorize the appropriation of $6 million each year from 2008 through 2012 to provide grants to organizations that would assist veterans in rural areas to travel to VA medical facilities. Eligible entities would include state veterans agencies and nonprofit organizations. CBO estimates that implementing this section would cost $5 million in 2008 and $29 million over the 2008-2012 period.

Copayments for the Catastrophically Disabled. Section 303 would prohibit the collection of copayments and other fees from catastrophically disabled veterans who receive medical or nursing home care from VA. Data from VA shows that the department collected about $6 million in medical care and nursing home fees in 2006 from catastrophically disabled veterans, who are priority category 4 veterans because their disabilities are not related to military service. Because those copayments and fees are not linked to any inflation index and the population of those veterans has been relatively stable over the last several years, CBO estimates that implementing this provision would decrease collections by $6 million per year. Such collections are offsets to discretionary appropriations. As part of the annual appropriations process, the Congress gives VA authority to spend those collections.

Therefore, maintaining the same level of health care services for veterans would necessitate additional funding each year to make up for the loss of copayments under this bill. Thus, implementing section 303 would cost $6 million in 2008 and $30 million over the 2008-2012 period.

Veterans Released from Prison. VA is currently working with the Department of Labor (DOL) on a demonstration program to provide counseling and referrals to veterans leaving penal institutions who are at risk of becoming homeless. VA hires case managers to oversee the program while DOL administers the grants to nonprofit organizations that provide the counseling and referrals. Under current law, the program is being conducted at six sites and will expire on September 30, 2007. Section 403 would double the number of program sites and extend the authority through fiscal year 2011. CBO estimates that, in total, implementing this provision would cost about $1 million in 2008 and $15 million over the 2008-2012 period.

Based on information from VA that six case managers would be needed to oversee the 12 sites at an average cost of $80,000 per person, CBO estimates that such additional staff would cost VA less than $500,000 in 2008 and $2 million over the 2008-2012 period.

Under this program, DOL issued grants totaling over $1.6 million in 2007 through nonprofit organizations to provide counseling and referral services to almost 1,000 veterans leaving penal institutions. CBO estimates that increasing the size of the program would increase costs for such grants by less than $500,000 in 2008 and by $13 million over the 2008-2012 period.

Homeless Demonstration Program. Section 402 would require VA to develop and implement a demonstration program to identify active-duty servicemembers who are at risk of becoming homeless after being discharged from the military and to provide referrals, counseling, and other supportive services to help prevent their homelessness. The program would have to be carried out in at least three locations and would expire at the end of September 2011. Section 402 would authorize the appropriation of $2 million for the program. CBO estimates that implementing section 402 would cost $1 million in 2008 and $2 million over the 2008-2012 period.

Hospice Copayments. Section 309 would prohibit VA from collecting copayments from veterans receiving hospice care. This prohibition would apply to care received at both inpatient and outpatient facilities. Depending upon where veterans get hospice care, copayments range from $15 per day to a maximum of $97 per day. Most veterans receiving this type of care from VA are not charged copayments—only veterans whose disabilities are

unrelated to their military service and whose incomes are above a certain level are required to make copayments.

Based on information from VA that fewer than 450 veterans made copayments averaging about $800 last year for hospice care, CBO estimates that implementing this provision would decrease collections by less than $500,000 each year and by about $2 million over the 2008-2012 period. Those collections are funding offsets to discretionary appropriations. As part of the annual appropriations process, the Congress gives VA authority to spend those collections. Therefore, maintaining the same level of health care services for veterans would necessitate additional funding each year to make up for the loss of copayments under this bill. Therefore, implementing section 309 would cost less than $500,000 in 2008 and about $2 million over the 2008-2012 period.

Homeless Providers Grant and Per Diem Program (GPD). VA's Homeless Providers Grant and Per Diem Program funds community-based agencies providing services to homeless veterans. The GPD provides two levels of funding—capital grants and per diem payments. Capital grants can provide up to 65 percent of the cost of establishing or expanding a community program offering transitional housing assistance, meals, vocational counseling and training, and other related services to homeless veterans. Capital grants may not be used for salaries or other operational costs. GPD provided about $5 million in capital grants in 2006.

Community agencies are also eligible for per diem payments, which fund operational costs. Per diem payment rates reflect the daily cost of services furnished to eligible veterans, but are reduced by the amounts of payments for similar purposes from other governmental agencies or private organizations. GPD distributed about $59 million in per diem payments to about 300 agencies in 2006. The program has received funding of $92 million for grants and payments in 2007.

Section 404 would allow capital grants to be used to pay staff salaries, thus potentially increasing the dollar amount of the grants community agencies would be eligible to receive. In addition, section 401 would require that per diem payments not be reduced by the amounts of payments from other organizations. Based on the current usage of the grant and per diem program, CBO expects that implementing sections 401 and 404 would probably increase discretionary outlays for capital grants and per diem payments by tens of millions of dollars a year. CBO cannot provide a more specific estimate because neither VA nor CBO can predict how the many community agencies would alter their requests for VA funding under these provisions.

Other Provisions. There are several sections in S. 1233 that would have an insignificant impact on discretionary spending. These provisions would require reports or plans or would authorize VA to do something it is already doing or planning to do, such as providing age-appropriate nursing home care or conducting research on traumatic brain injuries. Other sections that would have an insignificant impact on discretionary spending include:

- Section 203 would require VA to aggregate information from various sources on the quality of its medical centers and provide this information to the public on the Internet or through promotional literature.

- Section 204 would require VA to provide a mental health evaluation for certain war veterans within 30 days of receiving a request.

- Section 305 would require VA to establish a demonstration project to examine alternatives for expanding care for veterans in rural areas.

- Section 505 would designate a medical center in Augusta, Georgia, the "Charlie Norwood Department of Veterans Affairs Medical Center."

Direct Spending

Section 307 would increase the mileage rate used to reimburse certain veterans for travel to and from some appointments at VA facilities. (For more details on the travel benefits program and an estimate of the discretionary costs for implementing this provision, see the discussion under "Spending Subject to Appropriation.") Veterans who travel to a required appointment to receive counseling and evaluation before beginning vocational rehabilitation are reimbursed at 17 cents per mile. This section would link the veterans' mileage payment rate to the rate used by the federal government when reimbursing employees who travel in their personal vehicles for business when government vehicles are available for their use. That rate is currently 28.5 cents per mile and is increased at intervals to account for inflation.

VA reports that it spends about $400,000 per year to reimburse veterans for traveling to appointments for vocational rehabilitation, which is a mandatory program. Increasing the mileage rate under this provision would increase spending by $1 million over the 2008-2012 period and $3 million over the 2008-2017 period.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

S. 1233 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act. State, local, and tribal governments that participate in programs to assist disabled or homeless veterans would benefit from research and new programs authorized in the bill. Any costs they might incur would result from complying with conditions of federal assistance.

PREVIOUS CBO ESTIMATES

On May 21, 2007, CBO transmitted a cost estimate for H.R. 612, the Returning Servicemember VA Healthcare Insurance Act of 2007, as ordered reported by the House Committee on Veterans' Affairs on May 15, 2007. Section 201 of S. 1233 is similar to H.R. 612, though it would not extend the benefit to those whose period of priority health care has already expired. Therefore, the estimated cost for section 201 is less than the cost for H.R. 612.

On July 24, 2007, CBO transmitted a cost estimate for H.R. 2623, a bill to amend title 38, United States Code, to prohibit the collection of copayments for all hospice care furnished by the Department of Veterans Affairs, as ordered reported by the House Committee on Veterans' Affairs on July 17, 2007. That bill would prohibit the collection of copayments for hospice care furnished by VA. Section 309 of S. 1233 is similar to H.R. 2623 and the estimated costs are the same.

On July 27, 2007, CBO transmitted a cost estimate for H.R. 2874, the Veterans' Health Care Improvement Act of 2007, as ordered reported by the House Committee on Veterans' Affairs on July 17, 2007. Sections 304, 403, and 406 of S. 1233 are similar to provisions found in H.R. 2874. Section 406 of S. 1233 and section 9 of H.R. 2874 would provide funding to organizations that help very-low income veterans, though each bill would authorize appropriations of different amounts each year for the new program. Section 304 of S. 1233 and section 3 of H.R. 2874 would establish grants for organizations that provide transportation to veterans in rural areas in need of medical care, though S. 1233 would authorize a higher amount of funding. Section 403 of S. 1233 and section 7 of H.R. 2874 would expand a program to help veterans leaving penal institutions. Differences in the estimated costs for these provisions reflect differences in the bills.

On August 21, 2007, CBO transmitted a revised cost estimate for H.R. 760, the Filipino Veterans Equity Act of 2007, as ordered reported by the House Committee on Veterans' Affairs on July 18, 2007. Both section 5 of H.R. 760 and section 307 of S. 1233 would increase the milage rate of the travel benefit for veterans receiving certain kinds of care. However, the increase under H.R. 760 would be more generous than under S. 1233. The provision in H.R. 760 would eliminate the deductible while the one in S. 1233 would only freeze the deductible. The estimated costs of the two provisions differ for those reasons.

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