CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 7, 2000

H.R. 1286
Justice for Atomic Veterans Act of 1999

As introduced on March 25, 1999

SUMMARY

H.R. 1286 would add lung, bone, ovarian, skin, colon, and rectal cancer; posterior subcapsular cataracts; nonmalignant thyroid nodular disease; parathyroid adenoma; and tumors of the brain and central nervous system to the current list of diseases presumed to be connected to military service for certain veterans who were exposed to nuclear radiation. CBO estimates that enacting the bill would increase direct spending by $22 million in 2001 and by about $600 million over the 2001-2005 period. Because the bill would affect direct spending, pay-as-you-go procedures would apply. In addition, implementing the bill would cost $2 million in 2001 and $29 million over the five-year period, assuming appropriation of the necessary amounts.

The bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no significant costs on the budgets of state, local, or tribal governments.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 1286 is shown in the following table. The costs of this bill fall within budget function 700 (veterans benefits and services).

BASIS OF ESTIMATE

Direct spending costs would stem from payments for disability compensation and dependency and indemnity compensation (DIC). Discretionary costs would increase because implementing the bill would require the Department of Veterans Affairs (VA) to provide additional medical care services, assuming appropriation of the necessary amounts.

	By Fiscal Year, in Millions of Dollars					
	2000	2001	2002	2003	2004	2005
DIRECT SPENDING						
Spending Under Current Law for Disability Compensation						
Estimated Budget Authority	18,893	19,801	20,577	21,279	21,960	24,447
Estimated Outlays	18,816	19,719	20,505	21,215	21,898	24,377
Proposed Changes						
Estimated Budget Authority	0	24	78	149	173	196
Estimated Outlays	0	22	73	143	171	195
Spending Under H.R. 1286 for Disability Compensation						
Estimated Budget Authority	18,893	19,825	20,655	21,428	22,133	24,643
Estimated Outlays	18,816	19,741	20,578	21,358	22,069	24,573
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law for Veterans' Medical Care						
Estimated Authorization Level [a]	19,493	19,493	19,493	19,493	19,493	19,493
Estimated Outlays	18,791	19,312	19,441	19,415	19,396	19,377
Proposed Changes						
Estimated Authorization Level	0	2	5	7	8	8
Estimated Outlays	0	2	4	7	8	8
Spending Under H.R. 1286 for Veterans' Medical Care						
Estimated Authorization Level [a]	19,493	19,495	19,498	19,500	19,501	19,501
Estimated Outlays	18,791	19,315	19,445	19,422	19,404	19,385

a. The 2000 level is the amount appropriated for that year. The current law amounts for 2001 through 2005 assume that appropriations remain at the 2000 level. If they are adjusted for inflation, the base amounts would rise by about $600 million a year, but the estimated changes would remain as shown under "Proposed Changes."

Direct Spending: Disability Compensation

H.R. 1286 would add 10 conditions to the list of diseases presumed to be connected to participation in atmospheric testing or occupation of Hiroshima and Nagasaki. By requiring a presumption that, for certain veterans, these illnesses are service-connected, the bill would increase the number of radiation-exposed veterans who are eligible for disability

compensation or whose spouses are eligible for DIC benefits. CBO estimates that enacting H.R. 1286 would increase direct spending by $22 million in 2001 and by about $600 million over the 2001-2005 period.

Data from the Defense Special Weapons Agency (formerly the Defense Nuclear Agency) indicate that approximately 210,000 military personnel participated in atmospheric nuclear tests. In addition, approximately 200,000 military personnel participated in the post-war occupation of Hiroshima and Nagasaki, Japan. CBO estimates that about 200,000 of those veterans are alive today, assuming that the average age of participants was 24 years at the time of participation.

To estimate the caseload of veterans having each disease, CBO used disease and age-specific incidence and mortality rates from the National Cancer Institute. (CBO has no basis for estimating different incidence and mortality rates for this particular population.) Because these rates are not available for posterior subcapsular cataracts, nonmalignant thyroid nodular disease, and parathyroid adenoma, data from the 1997 Medicare/Medicaid Statistical Supplement were used to estimate the prevalence of these three diseases. Based on this analysis, CBO estimates that about 17,000 of these veterans and nearly 12,000 spouses of deceased veterans would be eligible for benefits in 2001. The estimate assumes that roughly 28,000 veterans died from these diseases during the 1945-2000 period, that two-thirds of the deceased veterans had spouses, that 20 percent of those spouses remarried, making them ineligible for DIC, and that some spouses died during the same period.

For the 2001-2005 period, CBO estimates benefit payments based on the incidence of the qualifying diseases, expected mortality rates among veterans and survivors, the number of potential beneficiaries at the start of 2001, and assumptions about annual participation. CBO projects that of the 29,000 veterans and survivors who would be eligible for benefits in 2001 about 4,400 would receive benefits in that year. Recognizing that a small number of affected veterans and survivors may draw benefits under current law and that not all potential new beneficiaries would participate, CBO assumes that 50 percent of all eligible survivors at the end of 2000 would apply for benefits and 75 percent of all veterans and post-1998 survivors would participate in the program. We also assume that it would take about three years to reach the full estimated participation rate. CBO anticipates that by 2005 approximately 20,000 veterans and survivors would receive benefits as a result of the bill. About 60 percent of the benefit payments would be related to lung or colon cancer.

CBO used data from the Department of Veterans Affairs that was specific to the 10 diseases to calculate the average compensation payment to veterans. Average annual benefits for veterans with the diseases vary from about $16,000 for brain cancer to about $1,500 for skin cancer, reflecting the differing disability ratings of veterans currently receiving benefits for these illnesses. However, those benefit levels also include payments to veterans for

additional disabilities, and thus incremental benefits under H.R. 1286 would be less than those averages. CBO has no information as to what portions of those averages stem from disabilities other than those covered by the bill. We assume that incremental compensation benefits would fall below those averages by $500 to $2,000. For DIC recipients, the estimated benefit is approximately $11,000 annually for all survivors. This estimate also assumes that beneficiaries would receive annual cost-of-living adjustments.

Discretionary Spending: Medical Care

VA provides medical care to veterans based on priorities established in law. The highest priorities are given to veterans with service-connected disabilities, but VA also has a program under current law to provide health care to veterans with potentially radiogenic diseases, but only for treatment of those diseases. Under H.R. 1286, certain veterans with lung, bone, ovarian, skin, colon, and rectal cancer; posterior subcapsular cataracts; nonmalignant thyroid nodular disease; parathyroid adenoma; and tumors of the brain and central nervous system would receive the highest priorities because their diseases would be presumed to be service-connected. By requiring this presumption of service connection, the bill would probably draw a greater number of veterans to VA for care. It might also lead some veterans who currently receive care from VA to have a greater share of their needs taken care of by VA.

CBO estimates that implementing the bill would raise the costs of veterans' medical care by $2 million in 2001 and by $29 million over the 2001-2005 period, assuming appropriation of the necessary amounts. This estimate depends primarily on assumptions about how many of the affected veterans already receive the highest priorities, how many veterans the bill would attract to the VA health system, and how many current patients would receive a greater range of care. The key assumptions are as follows:

- Roughly one-third of these veterans would already have high-priority access based on other compensable service-connected disabilities or income, as allowed under current law. (This figure is based on CBO's estimate of the proportion of World War II veterans with such status in 1996.)

- About one-tenth of the veterans who gain a higher priority would use VA medical services. CBO estimates that VA’s per capita spending would be about $13,000 annually for most new cancer patients. This cost factor, which is roughly three times VA’s average annual cost per user, is based on a recent study showing a comparable difference between Medicare's average annual cost per beneficiary with certain types of cancer, including lung cancer, and all beneficiaries who receive medical care. CBO estimates that care for the remaining new patients would cost VA the same per capita amount that it spends for current patients.

- One-fourth of the veterans who would use priority care under this bill would already be receiving cancer treatment from VA, based on data from the 1992 Survey of Veterans. CBO estimates that VA would spend an additional $1,300 annually for these veterans.

PAY-AS-YOU-GO CONSIDERATIONS

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 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										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	22	73	143	171	195	188	179	202	208	210
Changes in receipts	Not applicable										

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

The bill contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no significant costs on the budgets of state, local, or tribal governments.

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