CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

May 19, 2003

H.R. 1562
Veterans Health Care Cost Recovery Act of 2003

As ordered reported by the House Committee on Veterans' Affairs on May 15, 2003

SUMMARY

H.R. 1562 would increase the ability of the Department of Veterans Affairs (VA) to collect reimbursements from third-party insurers for medical care provided to veterans at VA facilities. Specifically, the bill would not allow any person or preferred provider organization (PPO) to deny or reduce reimbursement to VA solely because VA does not have a participation agreement with that person or PPO. The bill also would grant specific authority for VA to recover the cost of providing medical care to nonveterans from any private health plan or government health program, including Medicare and Medicaid. These collections would be deposited into the Medical Care Collections Fund (MCCF) which, under current law, are treated as offsets to discretionary spending. Subject to annual appropriation, VA can spend the money in the MCCF to provide medical care to veterans. H.R. 1562 also would change the name of two VA health care facilities.

CBO estimates that, under H.R. 1562, direct spending for Medicare and Medicaid would increase by $8 million in 2004, $55 million over the 2004-2008 period, and $125 million over the 2004-2013 period. CBO also estimates that, under the bill, collections from nonfederal sources would increase by $111 million in 2004, and $737 million over the 2004-2008 period. When added to the payments from Medicare and Medicaid, total collections deposited into the MCCF under the bill would amount to $119 million in 2004 and $792 million over the 2004-2008 period. After accounting for the typical lag between collections and spending, CBO estimates that implementing the legislation would result in net discretionary savings of $24 million in 2004, and $38 million over the 2004-2008 period, assuming appropriation of the estimated collections.

H.R. 1562 contains both intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that in fiscal year 2004, additional VA collections from private third parties would not exceed the annual threshold for private-sector mandates established in UMRA ($120 million in 2004, adjusted annually for inflation). CBO estimates that the cost of the private-sector mandates would exceed the

thresholds for fiscal years 2005 through 2007, but would drop below the threshold for fiscal year 2008. CBO estimates that collections from state and local governments would not exceed the annual thresholds for intergovernmental mandates ($60 million in 2004, adjusted annually for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 1562 is shown in Table 1. The costs of this legislation fall within budget functions 550 (health), 570 (Medicare), and 700 (veterans benefits and services).

TABLE 1. ESTIMATED BUDGETARY IMPACT OF H.R. 1562

	By Fiscal Year, in Millions of Dollars					
	2003	2004	2005	2006	2007	2008
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law for Veterans Medical Care						
Estimated Authorization Level [a]	25,279	26,153	26,987	27,890	28,824	29,452
Estimated Outlays	25,677	26,179	26,783	27,655	28,583	29,271
Proposed Changes						
Estimated Authorization Level	0	0	0	0	0	0
Estimated Outlays	0	-24	-16	-4	-2	8
Spending Under H.R. 1562						
Estimated Authorization Level [a]	25,279	26,153	26,987	27,890	28,824	29,452
Estimated Outlays	25,677	26,155	26,767	27,651	28,581	29,279
CHANGES IN DIRECT SPENDING						
Estimated Budget Authority	0	8	11	12	12	12
Estimated Outlays	0	8	11	12	12	12

a. The 2003 level is the estimated net amount appropriated for that year. No full-year appropriation has yet been provided for fiscal year 2004. The current-law amounts for the 2004-2008 period assume that appropriations remain at the 2003 level with adjustments for anticipated inflation.

BASIS OF ESTIMATE

This estimate assumes that H.R. 1562 will be enacted by the end of fiscal year 2003 and that all amounts deposited into the MCCF will be appropriated as part of VA's annual appropriation each year.

Spending Subject to Appropriation

Under current law, VA can seek reimbursements from third-party insurers for medical care that VA provides to veterans if the medical care is for a nonservice-connected condition. VA has permanent authority under current law to bill third-party insurers when VA provides medical care to a veteran who does not have a service-connected condition. If the veteran has a service-connected condition, however, VA may bill third-party insurers for nonservice-connected treatment only through 2007. According to VA, it collected $690 million from those third-party insurers in 2002.

VA indicates that it collects almost two-thirds of the amount that it bills private health plans including PPOs. Under current law, private health plans must pay VA when it seeks reimbursement, but according to VA some health plans reduce their payments because VA is not a recognized or preferred provider. Under the bill, PPOs and other health plans would not be allowed to reduce the amount they reimburse VA, based solely on the fact that they do not recognize VA as a preferred provider.

Using data from VA, CBO estimates that implementing this provision could increase collections by about 15 percent. If VA were to recover the full amount that it billed private companies, collections would increase by 50 percent. However, CBO does not expect VA would recover 100 percent of billed charges under the legislation, as insurance companies seldom pay the full amount of reasonable charges even to preferred providers. CBO estimates that VA could increase its collections to about 75 percent of billed charges, which would be about a 15 percent increase in total collections. Assuming a one-year phase-in period for VA and insurance companies to adapt to this change, CBO estimates that under H.R. 1562, collections would increase by $90 million in 2004 and $591 million over the 2004-2008 period.

H.R. 1562 also would authorize VA to bill third-party insurers for the medical treatment that nonveterans receive at VA facilities. (This would include Medicare and Medicaid.) VA does not have this authority under current law. Using data provided by VA, CBO estimates that in 2002 VA provided about $140 million of health care to nonveterans and collected about $7 million from those nonveterans for that care. CBO estimates that under the bill VA would

be able to collect an additional $29 million in 2004 from third-party insurers, including Medicare and Medicaid, and $201 million over the 2004-2008 period. (Collections from nonfederal sources would total $21 million in 2004 and $146 million over the 2004-2008 period, CBO estimates.)

All of these collections would be deposited into the MCCF. Subject to annual appropriation, VA can spend the money in the MCCF to provide medical care for veterans. Assuming that appropriations of the new collections are provided, VA would spend those collections so that estimated collections and new spending authority would offset each other exactly. Outlays would lag behind collections slightly, so implementing this provision would result in net discretionary savings over the near term. CBO estimates that net outlays would decline by $24 million in 2004, and by $38 million over the 2004-2008 period—assuming appropriation actions that allow spending of all the additional MCCF collections.

Under current law, CBO estimates that total collections will decline in 2008 because VA's authority to bill for some care expires at the end of 2007. This drop in collections would affect collections under the bill and generate a positive outlay effect in 2008.

H.R. 1562 also contains two provisions that would change the names of health care facilities operated by VA. One provision would name the health care facility of the Department of Veterans Affairs located at 820 South Damen Avenue in Chicago, Illinois, as the "Jesse Brown Department of Veterans Affairs Medical Center." The other would name the Department of Veterans Affairs outpatient clinic in New London, Connecticut, as the "John J. McGuirk Department of Veterans Affairs Outpatient Clinic." Both provisions would require that any reference to such medical center or outpatient clinic in any law, regulation, map, document, record, or other paper of the United States be considered to be a reference to the medical center or clinic by the new name. CBO estimates that implementing those provisions would have a negligible cost, subject to the availability of appropriated funds.

Direct Spending

As stated above, H.R. 1562 would authorize VA to bill third-party insurers for the treatment of nonveterans at VA facilities, including Medicare and Medicaid. Thus enacting H.R. 1563 would increase direct spending for those programs because they would have to pay for medical care that they currently do not pay for. For this estimate, CBO assumes that the percentage of care given to nonveterans who are covered under Medicare and Medicaid by VA is proportional to the number of people covered in the general population under those two programs. Using that assumption, CBO estimates that enacting the bill would increase direct spending for Medicare and Medicaid by $8 million in 2004, by $55 million over the

2004-2008 period, and by $125 million over the 2004-2013 period (see Table 2). Over the 10-year period, spending for Medicare would increase by $91 million and spending for Medicaid would increase by $34 million, CBO estimates.

TABLE 2. ESTIMATED CHANGES IN DIRECT SPENDING UNDER H.R. 1562

	By Fiscal Year, in Millions of Dollars										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
CHANGES IN DIRECT SPENDING											
Estimated Budget Authority	0	8	11	12	12	12	13	14	14	14	15
Estimated Outlays	0	8	11	12	12	12	13	14	14	14	15

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 1562 contains both intergovernmental and private-sector mandates as defined in UMRA. First, the bill would amend existing law by stipulating that the absence of an agreement between VA and a third party, including a preferred provider organization or health maintenance organization, would not reduce the amount VA can recover from a third party when insured veterans receive care at a VA facility. Third parties would not be able to reimburse VA at an out-of-network or other reduced rate. State and local governments that employ veterans and provide self-insured health coverage also would be subject to these requirements.

Second, the bill would permit VA to seek reimbursement from third parties, including workers' compensation plans, when nonveterans receive health care at a VA facility. At present, VA does not have the authority to seek reimbursement in those instances. This provision is also both an intergovernmental and private-sector mandate as defined in UMRA.

CBO estimates that both provisions for VA collections from private third parties, taken together, would total $93 million in fiscal year 2004 and would not exceed the annual threshold for private-sector mandates established in UMRA ($120 million in 2004, adjusted annually for inflation). CBO estimates that the cost of the private-sector mandates would rise to $133 million in fiscal year 2005, exceeding the threshold in that year and continuing above the thresholds for fiscal years 2006 and 2007. CBO then estimates that the cost of the private-sector mandate would drop below the threshold for fiscal year 2008.

Because the number of state and local employees that use VA facilities is relatively small, CBO estimates that the provisions' cost for state and local governments would total about $16 million in fiscal year 2004. This amount does not exceed the annual threshold for intergovernmental mandates as established in UMRA ($60 million in 2004, adjusted annually for inflation) and would remain below the threshold every year through fiscal year 2008.

The nonveteran care provision would increase state Medicaid costs by $27 million over the fiscal year 2004 through 2013 period.

PREVIOUS CBO ESTIMATES

On May 13, 2003, CBO transmitted an estimate of H.R. 1832, a bill to name the Department of Veterans Affairs outpatient clinic located in New London, Connecticut, as the "John P. McGuirk Department of Veterans Affairs Outpatient Clinic," as introduced on April 12, 2003. On May 13, 2003, CBO also transmitted an estimate of H.R. 1908, a bill to name the health care facility of the Department of Veterans Affairs located at 820 South Damen Avenue in Chicago, Illinois, as the "Jesse Brown Department of Veterans Affairs Medical Center," as introduced on May 1, 2003. The provisions of those bills are essentially the same as the ones now contained in section 4 and section 5 of H.R. 1562.

ESTIMATE PREPARED BY:

Federal Costs: Sam Papenfuss
Impact on State, Local, and Tribal Governments: Gregory Waring
Impact on the Private Sector: Allison Percy

ESTIMATE APPROVED BY:

Peter H. Fontaine
Deputy Assistant Director for Budget Analysis