CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

May 29, 2003

H.R. 1715

A bill to amend title 38, United States Code, to enhance the authority of the Department of Veterans Affairs to recover from third parties costs of medical care furnished to veterans and other persons by the Department

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

SUMMARY

H.R. 1715 would allow the Department of Veterans Affairs (VA) to seek payment from Medicare when veterans receive health care from a VA facility that would have been covered by Medicare had the veteran received such care in the private sector. The payments from Medicare would be deposited into the Medical Care Collections Fund (MCCF). Subject to annual appropriation, VA can spend the money in the MCCF to provide medical care to veterans. As specified in law, any receipts to that fund are treated as offsets to discretionary spending to the extent that they are made available for expenditure in appropriation acts.

CBO estimates that, under H.R. 1715, direct spending for Medicare would increase by $2.2 billion in 2004, about $27 billion over the 2004-2008 period, and almost $58 billion over the 2004-2013 period. After accounting for the typical lag between collections and spending for the MCCF, CBO estimates that implementing the legislation would result in net discretionary savings of $440 million in 2004 and about $1.5 billion over the 2004-2008 period, assuming appropriation of the estimated collections.

H.R. 1715 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 1715 is shown in Table 1. This legislation would affect spending in budget functions 570 (Medicare) and 700 (veterans benefits and services).

TABLE 1. ESTIMATED BUDGETARY IMPACT OF H.R. 1715

	By Fiscal Year, in Millions of Dollars					
	2003	2004	2005	2006	2007	2008
CHANGES IN DIRECT SPENDING						
Additional Medicare Spending						
Estimated Budget Authority	0	2,210	4,550	7,040	7,260	5,620
Estimated Outlays	0	2,210	4,550	7,040	7,260	5,620
SPENDING SUBJECT TO APPROPRIATION						
Net Baseline Spending for Veterans Medical Care Under Current Law [a]						
Estimated Authorization Level [b]	23,889	24,651	25,382	26,187	27,029	27,907
Estimated Outlays	24,287	24,677	25,178	25,952	26,788	27,726
Proposed Changes:						
Offsetting Receipts (Discretionary)						
Estimated Authorization Level	0	-2,210	-4,550	-7,040	-7,260	-5,620
Estimated Outlays	0	-2,210	-4,550	-7,040	-7,260	-5,620
Spending of Additional Receipts						
Estimated Authorization Level	0	2,210	4,550	7,040	7,260	5,620
Estimated Outlays	0	1,770	3,970	6,430	7,090	5,940
Subtotal - Changes in Discretionary Spending						
Estimated Authorization Level	0	0	0	0	0	0
Estimated Outlays	0	-440	-580	-610	-170	320
Net Discretionary Spending for Veterans Medical Care Under H.R. 1715 [a]						
Estimated Authorization Level [b]	23,889	24,651	25,382	26,187	27,029	27,907
Estimated Outlays	24,287	24,237	24,598	25,342	26,618	28,046

a. Net of receipts to the Medical Care Collections Fund, which total about $1.5 billion per year.

b. 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. 1715 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.

Direct Spending

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. Moreover, current law prohibits VA from billing Medicare for any medical care that VA provides to veterans. H.R. 1715 would allow VA to bill Medicare when veterans receive health care from a VA facility that would have been covered by Medicare had the veteran received such care in the private sector.

According to VA, it will spend about $13 billion or about one-half of its appropriation for medical care in 2003 to treat veterans age 65 and over. Based on information from VA, CBO estimates that about 80 percent of that care will be dispensed to treat nonservice-connected conditions. After accounting for the fact that VA provides some services that Medicare does not cover (e.g., prescription drugs and more generous nursing home benefits), CBO estimates that about 75 percent of VA's expenditures for Medicare-eligible veterans would likely be covered by Medicare. For the purpose of this estimate, CBO assumes that, on average, the cost to VA of providing Medicare-covered services is approximately equal to Medicare's payment rates. After considering that the Medicare program pays about 83 percent of those payment rates (cost-sharing obligations of beneficiaries account for the remaining 17 percent), CBO estimates that VA could collect up to about 25 percent of its annual appropriation from Medicare as payment for medical care it furnishes to veterans age 65 and older.

Because coding medical procedures to bill Medicare is a complex process with which VA has no experience, CBO assumes it would take up to three years before VA would collect the full amount possible under the bill. Thus, CBO estimates that enacting the bill would increase direct spending for Medicare by about $2.2 billion in 2004, about $27 billion over the 2004-2008 period, and almost $58 billion over the 2004-2013 period, as shown in Table 2. Because the authority to bill third-party insurance for the treatment of a nonservice-connected condition when the veteran has a service-connected disability expires at the end of 2007, total collections would decline in 2008. At that point, VA would only be able to bill Medicare for services provided to veterans who do not have service-connected conditions.

TABLE 2. ESTIMATED CHANGES IN DIRECT SPENDING UNDER H.R. 1715

	By Fiscal Year, in Millions of Dollars									
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
CHANGES IN DIRECT SPENDING										
Estimated Budget Authority	2,210	4,550	7,040	7,260	5,620	5,810	6,000	6,210	6,410	6,630
Estimated Outlays	2,210	4,550	7,040	7,260	5,620	5,810	6,000	6,210	6,410	6,630

Spending Subject to Appropriation

All of the payments from Medicare 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, estimated collections and new spending authority would offset each other exactly. Outlays would lag behind collections somewhat, so implementing this provision would result in net discretionary savings over the near term. CBO estimates that net outlays would decline by about $440 million in 2004 and by almost $1.5 billion over the 2004-2008 period—assuming appropriation actions that allow spending of all the additional MCCF collections.

CBO estimates that total collections would decline in 2008 because VA's authority to bill for some care would expire at the end of 2007. This drop in collections would generate a positive outlay effect in 2008.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 1715 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

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:

Robert A. Sunshine
Assistant Director for Budget Analysis