CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 29, 1999

H.R. 2116
Veterans' Millennium Health Care Act

As reported by the House Committee on Veterans' Affairs on July 16, 1999

SUMMARY

The bill contains several provisions that would have a significant budgetary impact, including provisions to increase access to long-term care for certain veterans, allow the Department of Veterans Affairs (VA) to reimburse veterans or providers for the cost of emergency care, extend medical benefits to combat-injured veterans, and permit VA to spend some of the money that the United States might receive from litigation with tobacco companies. Assuming appropriation of the necessary amounts, CBO estimates that the bill would raise discretionary costs to VA by about $141 million in 2000 and about $1.4 billion in 2004; however, in that event the costs to the federal government under the Medicaid program would be lower by about $150 million in 2004. In addition, the bill would raise direct spending by about $2 million over the 2000-2004 period and about $647 million over the next 10 years. Annual direct spending would reach an estimated $171 million in 2009 almost entirely due to provisions that would allow VA to spend proceeds from litigation with tobacco companies. Because the bill would affect direct spending, pay-as-you-go procedures would apply.

H.R. 2116 contains intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). The costs to state, local, and tribal governments as a result of the mandates would not exceed the threshold specified in the act ($50 million, adjusted annually for inflation). Similarly, costs of the private-sector mandate are unlikely to exceed the corresponding threshold specified in UMRA ($100 million, adjusted annually).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 2116 is shown in the following table. The costs of this legislation fall within budget function 700 (veterans' affairs).

	By Fiscal Year, in Millions of Dollars					
	1999	2000	2001	2002	2003	2004
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law for Veterans' Health Care						
Estimated Authorization Level[a]	18,004	17,862	17,862	17,862	17,862	17,862
Estimated Outlays	17,864	18,202	18,169	17,913	17,831	17,803
Proposed Changes						
Extended Care Services						
Estimated Authorization Level	0	50	250	600	800	1,000
Estimated Outlays	0	40	230	560	780	980
Reimbursement for Emergency Care						
Estimated Authorization Level	0	90	270	380	390	400
Estimated Outlays	0	80	250	360	380	400
Care for Combat-Injured Veterans						
Estimated Authorization Level	0	5	15	21	22	23
Estimated Outlays	0	5	14	21	22	23
Extension and Revision of Authorities						
Estimated Authorization Level	0	15	18	21	10	10
Estimated Outlays	0	14	18	21	11	10
Major Construction and Leases						
Estimated Authorization Level	0	15	15	0	0	0
Estimated Outlays	0	3	6	7	7	4
Other Provisions						
Estimated Authorization Level	0	b	b	b	b	b
Estimated Outlays	0	b	b	b	b	b
Total - Proposed Changes						
Estimated Authorization Level	0	175	568	1,022	1,222	1,433
Estimated Outlays	0	141	517	969	1,200	1,417
Spending Under the Bill for Veterans' Health Care						
Estimated Authorization Level	18,004	18,037	18,430	18,884	19,084	19,295
Estimated Outlays	17,864	18,343	18,686	18,882	19,031	19,220
Memorandum:						
Estimated Impact on Medicaid	0	-10	-40	-90	-120	-150

Continued

	By Fiscal Year, in Millions of Dollars					
	1999	2000	2001	2002	2003	2004
CHANGE IN DIRECT SPENDING						
Compensated Work Therapy Program						
Estimated Budget Authority	0	c	c	c	1	1
Estimated Outlays	0	c	c	c	1	1
Tobacco Trust Fund						
Estimated Budget Authority[d]	0	0	0	0	0	0
Estimated Outlays[d]	0	0	0	0	0	0
Total - Proposed Changes						
Estimated Budget Authority	0	c	c	c	1	1
Estimated Outlays	0	c	c	c	1	1

a. The figure shown for 1999 is the amount appropriated for that year for major construction and medical care. Because major construction is subject to annual authorization, the amounts shown for 2000-2004 correspond to 1999 funding, without adjustment for inflation, for only medical care. If funding over that period is adjusted for inflation, the base amounts would increase by about $600 million a year, but the proposed changes would remain as shown.

b. CBO does not have enough information to estimate the costs of some provisions.

c. Less than $500,000.

d. Starting in 2005, the bill would allow VA to spend some of the proceeds from litigation with tobacco companies. The direct spending from that provision would cost about $640 million over the 2005-2009 period.

Spending Subject to Appropriation

Extended Care Services. Spending for veterans' medical care is limited by discretionary appropriations. An enrollment system ensures that care is provided to veterans with the highest priority. These priorities established in law require VA to treat veterans with service-connected disabilities before other beneficiaries. The law states that VA shall provide medical services such as hospital and outpatient care and may provide nursing home care. Thus, VA has discretion whether to provide nursing home care to high-priority beneficiaries or to use its resources to provide additional hospital or outpatient care to other veterans.

VA currently provides nursing home care to about 34,000 veterans each day. In total, it provides nursing home or other long-term care to approximately 65,800 veterans a day at an annual cost of about $2.6 billion. Of the veterans who receive long-term care from VA on any given day, about 11,000 have service-connected disabilities of 50 percent or greater even though about 535,000 veterans in total are disabled to that degree.

The need for long-term care by veterans is very large because many veterans are disabled or elderly. According to the Federal Advisory Commission on the Future of VA Long-Term Care about 610,000 veterans a day needed some form of long-term care in 1997. Among the veterans with higher priority for medical care from VA, so-called Category A veterans, the daily need totaled an estimated 295,000. (Category A veterans are those with service-connected disabilities, those who fall into special categories (such as former prisoners of war), and those with incomes below a certain threshold. Most Category A veterans have relatively low incomes, and low-income veterans comprise most of the roughly 3 million veterans who enroll with VA for health care.)

Section 101 of H.R. 2116 would limit the discretion allowed to VA under current law by requiring that extended care be available for veterans whose service-connected disabilities are rated 50 percent or greater or who require long-term care because of a service-connected disability. The program of care would include geriatric evaluations, nursing home care (in VA and community-based facilities), domiciliary services, respite care, and adult day health care. CBO estimates that this section would take three to four years to implement and would eventually cost about $1.0 billion a year in fiscal year 2000 dollars.

CBO's estimate relies on data from VA, the 1992 National Survey of Veterans, and the National Long-Term Care Survey (NLTCS). CBO determined the probability of a person being institutionalized as a function of his age, marital status, and number of limitations in activities of daily living—one indicator of an individual's need for long-term care. Applying those probabilities to a distribution of veterans with service-connected disability ratings of 50 percent or higher, CBO estimates that by 2010 about 45,000 additional veterans would receive care in nursing homes for an annual cost of $1.2 billion. This method of estimation takes into account that spouses often act as caregivers within the home to veterans who might otherwise require a nursing home stay. In the near term, demand for nursing home care through the VA would be lower because some veterans currently rely on Medicaid, private insurance, relatives, and certain Medicare-funded services to provide or finance their care. Initially, those veterans might not want to change their arrangements with providers. CBO assumes that eventually veterans with ratings of 50 percent or higher who enter nursing homes would turn to the VA for their care because, unlike other private or public insurance programs, it would be free to them. CBO expects that most nursing home patients would be placed in community nursing homes for an average stay of 179 days and at a cost of about $152 a day per patient (in 2000 prices). (Nursing homes owned and operated by VA are almost twice as expensive as privately operated homes.)

In addition, veterans who have disability ratings of 50 percent or more may need long-term, personal care short of that provided in a nursing home, often in their own home. CBO estimates that 62,000 such veterans would require home-based care at an annual cost of $0.1 billion (an average of 2-1/2 hours of care per week at an hourly cost of $18).

The bill would require copayments from veterans receiving long-term care for a nonservice-connected disability or if the veteran does not have a service-connected disability rated at 50 percent or greater. VA would be allowed, without further appropriation, to spend these amounts on providing long-term care. VA would be required to base the copayment on the assets and income of the veteran and spouse. The maximum monthly copayment would allow for protecting the spouse from financial hardship and for the veteran to retain a monthly personal allowance.

CBO estimates that collections from copayments would amount to $0.3 billion in 2010. The estimate assumes that veterans with no service-connected disability or with a disability rating less than 50 percent (and not receiving long-term care for their service-connected disability) would be charged copayments on about 69,000 stays at VA nursing homes, community nursing homes, and VA domiciliaries if that stay were longer than 21 days. CBO also assumes that single veterans would keep a minimum personal allowance of $1,000 per year, while those with a living spouse would retain at least $13,000 per year. Based on VA's Patient Treatment Files, the vast majority of the 69,000 stays would be low-income veterans who would be unable to defray the full cost of their care. If VA were to require veterans to draw down their personal assets or if it pursued estate recoveries, copayment revenues might be higher.

Although section 101 would cost VA about $1.0 billion for long-term care, implementing that section would also lead to some savings in Medicaid. Today, Medicaid finances about 42 percent of all nursing home expenditures; over half of Medicaid's cost is paid for by the federal government and the remainder is paid by the states. However, to become eligible for Medicaid, an individual must first draw down most of their personal assets and turn over any income beyond a small monthly allowance for personal needs. Since this bill would not require any copayments or liquidation of assets by veterans receiving long-term care for a service-connected disability or those with service-connected disability ratings of 50 percent or higher, VA-financed care would be preferable to them over Medicaid.

As veterans begin to turn to VA-financed nursing home care, the Medicaid program might experience some savings. But those amounts would be limited to the savings from the federal share of the Medicaid program and would also be tempered significantly if the states used their freed resources for other types of Medicaid-financed services. CBO estimates that eventual federal savings in Medicaid could be about $150 million annually as a result of the additional nursing home costs that VA could bear under this bill. Medicaid home-based care would not be materially affected by the bill because Medicaid's expenditures are low for this type of care.

CBO estimates that H.R. 2116 would not displace Medicare spending for either nursing home care or home health care. Although Medicare offers a skilled nursing facility benefit, it is targeted toward patients who need care after an acute hospitalization rather than the long-term custodial care that would be provided under H.R. 2116. In addition, because Medicare's home health care benefit is at least as generous (unlimited coverage with no coinsurance requirement) as that proposed in the bill, CBO's estimate assumes that VA spending would not displace Medicare (or Medicaid) home health care expenditures and would only replace spending for care paid for by private insurance or the individual veteran. To the extent that VA spending replaced spending under Medicare, CBO's estimate of the costs to VA of section 101 for home-based care would increase by a similar amount.

Reimbursement for Emergency Care. Section 102 would significantly expand VA's authority to reimburse veterans and institutions for emergency care. It would allow VA to pay for care stemming from life- or health-threatening emergencies involving a veteran who is enrolled with VA for care, has no other coverage for emergencies, and has received care from VA within the 12 months preceding the emergency. CBO estimates that this provision would increase spending by about $80 million in 2000 and about $400 million a year by 2004, assuming appropriation of the necessary amounts. Those costs would stem from the costs of emergency room care and any subsequent hospital care.

Of the 3 million veterans enrolled with VA, CBO estimates that about 750,000 are uninsured and would be eligible for benefits under the bill. Emergency room care represents about 3 percent of the costs of private health plans. Emergency room costs would be two to three times greater for veterans covered by the bill, however, based on their generally poorer health. Thus, CBO estimates that the immediate costs of emergencies would amount to about $155 million annually (in 2000 dollars).

CBO estimates that two-thirds of all visits to the emergency room would be urgent and that 16 percent of those visits would lead to admitting the veteran for an inpatient stay. For veterans under 65 years of age, the average hospital stay would cost about $7,000. For veterans 65 years old or older, Medicare would cover the hospital costs, but VA would pay physicians' costs for those veterans without Part B coverage; CBO estimates that those costs would average about $1,000 for the small fraction of veterans who lack Part B coverage. The costs of the subsequent hospital stay would raise the annual bill to VA under this provision by about $195 million (also in 2000 dollars).

Care for Combat-Injured Veterans. VA currently accords highest priority to veterans with service-connected disabilities that are rated at least 50 percent disabling. The lowest priority is given to veterans without such disabilities and with incomes over a certain threshold. Section 103 would raise the priority status for medical care of combat-injured veterans. Because medical care is a discretionary program, available appropriations limit the number

of veterans who receive care, and this bill would make it more likely that VA would provide care to a combat-injured veteran who does not receive a high priority under current law. CBO estimates that this provision would raise the costs of veterans' medical care by about $20 million a year, assuming that additional appropriations would allow VA to treat the new beneficiaries as well as veterans who would receive care under current law.

For this estimate, CBO assumes that the population of combat-injured veterans is about as large as the number of individuals who have been awarded a Purple Heart. According to data from the Military Order of the Purple Heart, about 550,000 veterans with the award were still living in 1995. Roughly half of those veterans already qualify for priority-level care based on service-connected disabilities or income, according to data from VA.

Although the remaining veterans—roughly 250,000—would be eligible for priority care, it is likely that only a small portion would seek VA services—only about 2 percent of all veterans in the lowest priority category used VA's medical services in 1996. We assume that the same percentage of such veterans who were injured in combat currently seek care from VA and would use VA's medical services a bit more intensively under this bill. We also assume that another 2 percent of those veterans would become new users of VA care under the bill. CBO assumes the average cost of care for combat-injured veterans would be the same as that of other veterans in the same priority grouping.

Extension and Revision of Authorities. Section 205(a) would extend the eligibility of Vietnam-era veterans for readjustment counseling from January 1, 2000, through January 1, 2003. Vietnam-era veterans currently account for 19 percent of the patients in this program and an estimated 15 percent of the program's total costs—about $70 million in 1999. CBO estimates that this provision would cost about $8 million in 2000 and $34 million over the 2000-2004 period.

Section 205(d) would amend the Homeless Veterans Comprehensive Service Programs Act and would extend the program's ability to make grants through fiscal year 2002, from its current deadline at the end of fiscal year 1999. Based on recent experience in this program, CBO expects annual grants to construct shelters for homeless veterans in the amount of $6 million over the 2000-2002 period. These grants would lead to a stream of payments to operate the shelters in subsequent years. The construction and operating expenses would total $37 million through 2004.

Section 205(e) would allow the Homeless Veterans Program to subsidize the purchase of vans for the purpose of outreach to homeless veterans. Based on the number of vans purchased in earlier years, CBO estimates an annual expenditure of $520,000 to assist in the purchase of 20 vans a year for four years.

Major Construction and Leases. Title IV of the bill would authorize $13 million each year in 2000 and 2001for the construction of new medical facilities in Florida and Missouri. The bill would also authorize $2 million a year in 2000 and 2001 for VA to lease medical facilities in Texas and California. CBO estimates these provisions would raise spending by $3 million in 2000 and by $27 million through 2004.

Other Provisions. CBO does not have enough information to estimate the budgetary impacts of some provisions in the bill. Section 104 would allow VA to provide medical care to certain military retirees on a priority basis and be reimbursed by the Department of Defense. The rate of reimbursement and other terms and conditions would be determined in an interagency agreement. The provision would apply to areas covered by TRICARE contracts entered into after the date of enactment of the provision; thus, the budgetary impact would be phased in. Section 104 could lead to somewhat greater use of medical benefits and consequently higher costs for retirees' medical care. The extra expenses would occur to the extent that retirees increase their use of medical care because VA's copayments are less than under TRICARE.

Section 106 would authorize VA to conduct a three-year pilot program to provide medical care for certain dependents of enrolled veterans. The provision would require payment of a reasonable charge by the dependent or the dependent's parent or guardian. CBO estimates that this provision would probably raise costs to VA but by a small amount. Most enrolled veterans have low incomes, and although ability to pay would be a criterion for care, it is likely that some of the dependents would be unable to make the payment.

Section 107 would require VA to establish a program designed to improve access to and utilization of medical centers. Under current law, the Secretary already has broad powers to allocate resources to facilities and to lease, renovate, and close facilities. CBO estimates this provision would have little or no budgetary impact.

Section 108 would extend by one year a counseling and treatment program for veterans who have experienced sexual trauma. The program would be extended from December 31, 2001, to December 31, 2002, and would probably cost a few million dollars.

Section 207 would expand VA's program of enhanced-use leases. Such leases provide VA with cash or other items of value in exchange for the right to use assets of the department. Under current law, these arrangements usually result in barter instead of cash payments to VA because cash proceeds must be returned to the Treasury. The bill would allow VA to spend any proceeds from enhanced-use leases; thus, VA would be more likely to accept cash payment. Although the increase in receipts would equal the increase in spending, using the proceeds from the leases could offset an equal amount of discretionary appropriations.

Direct Spending

Veterans' Tobacco Trust Fund. Section 203 of the bill would give VA direct spending authority starting in 2005 over any amounts the federal government receives on its behalf from the tobacco industry for recovery of costs associated with tobacco-related illnesses. CBO estimates that the additional resources available to VA would total $160 million in 2005 and $760 million over the 2000-2009 period. Because of normal lags in spending, this provision would increase federal outlays by about $80 million in 2005 and about $640 million over the 2000-2009 period. These outlays could supplement or supplant discretionary spending for veterans' medical care.

There is substantial uncertainty about whether the federal government will file a lawsuit against the tobacco industry, whether it would win or settle, and if so, for what amounts. Earlier this year the Justice Department announced its intent to file a suit, and it is currently assessing the legal theories and strategies it will use. The President's budget request includes $20 million for preparing the lawsuit, but the report accompanying the Senate-reported appropriation bill for the Department of Justice states that no funds are provided for tobacco litigation.

To develop an estimate that would fall within the range of possible outcomes, CBO made assumptions about three factors. First, how much would the federal government recover if it won or settled a lawsuit? Second, what proportion would be attributable to the costs of the VA? Finally, what is the likelihood that the federal government will enter into a lawsuit and either win or settle?

Amount of Potential Recoveries. To estimate the amount that the federal government could recover in any lawsuit against the tobacco industry, CBO examined available research on the cost of smoking and considered the arguments made by the states in their recent lawsuits. Many studies have examined the medical and other costs associated with smoking and have arrived at different conclusions. Smoking probably increases the net costs of some federal programs but decreases the costs of others. Two methods typically used by researchers to estimate the costs of smoking are the prevalence-based method, which estimates the costs of smoking by calculating the average difference in costs over a given period between smokers and nonsmokers, and the life-cycle method, which makes a similar comparison over the lifetimes of smokers and nonsmokers. In general, the two methods reach different conclusions because smokers, on average, have shorter life spans than nonsmokers. By comparing the costs of only living smokers and nonsmokers, the prevalence-based method does not include either the avoided costs or lost-tax revenue from smokers in years in which they are no longer alive. In contrast, the life-cycle method accounts for the shorter life spans of smokers relative to nonsmokers.

CBO's review of the research finds that estimates of the cost to the federal government of cigarette smoking (for programs other than Medicaid) range from negligible under some of the life-cycle estimates to as high as $30 billion to $40 billion a year under some of the prevalence-based estimates. The states based their lawsuits, at least partly, on a prevalence-based analysis that showed the costs of smoking to Medicaid in fiscal year 1993 was $13 billion.[1] This figure could correspond to as much as $40 billion in current dollars for other federal programs. In another study, the Centers for Disease Control estimated the total costs of smoking in 1993 to be $50 billion, with federal programs other than Medicaid paying for 30 percent and state programs (including Medicaid) paying for about 13 percent.[2] This finding would suggest total federal costs of about $20 billion this year and total state costs of about $9 billion.

The annual payments under the November 1998 settlement between tobacco companies and the states ultimately rise to about $9 billion a year before adjustments for inflation and the volume of cigarette sales. The Justice Department contends that the amount of money paid out by the federal government for smoking related illnesses is even larger than that paid out by the states through the Medicaid program.[3] For the purpose of this estimate, CBO assumes that if the federal government wins a lawsuit or settles with tobacco companies, it will receive slightly over twice the amounts the states are slated to receive under their settlement. CBO further assumes that these amounts will be adjusted for inflation and cigarette sales in the same manner as in the state settlement, resulting in payments of between $16 billion and $25 billion a year over the 2000-2009 period.

Proportion Attributable to Veterans' Programs. In 1998 the federal government spent about $18 billion on health care for veterans through VA. That figure represents 7 percent of spending on all federal non-Medicaid health care benefits (including Medicare, the Federal Employee Health Benefits Program, the Department of Defense health care programs, and the Indian Health Service). For this estimate CBO assumes that 7 percent of the amounts recovered under a federal lawsuit would be attributable to the VA.

Probability of Recovery of Amounts. CBO assumes that there is ultimately a 10 percent probability that the federal government will enter into a lawsuit and win or settle for recoveries in these amounts. Because the timing is unclear, CBO assumes no recoveries until 2003 and a lower but growing probability of recoveries over the 2003-2006 period.

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1. Leonard S. Miller and others, "State Estimates of Medicaid Expenditures Attributable to Cigarette Smoking, Fiscal Year 1993," *Public Health Reports*, vol. 113 (March/April 1998).

2. Centers for Disease Control and Prevention, "Medical-Care Expenditures Attributable to Cigarette Smoking – United States, 1993," *Morbidity and Mortality Weekly Report*, vol. 43, no 26 (1994).

3. U.S. Department of Justice, "Developing a Plan to Take the Tobacco Industry to Court" (Department of Justice Fact Sheet, Washington D.C., January 1999).

Other Copayments and Collections. The bill contains several other provisions that would allow VA to collect and spend funds. The bill would allow VA to charge higher copayments for prescriptions and outpatient visits of certain veterans and to set copayments for certain costly items of equipment other than wheelchairs and artificial limbs. The proceeds from these charges would be either used for medical care or deposited in the Treasury.

The budgetary effects of using these authorities would be felt in mandatory and appropriated accounts. The provisions would have an impact on direct spending because the receipts and subsequent spending would not be subject to appropriation, but the net effect would be negligible in a typical year because the extra spending would roughly equal the corresponding receipts. The extra spending could reduce the need for appropriated funds if VA would otherwise request funding for the expenses met through the use of the receipts. CBO does not expect, however, that VA would make much use of these authorities.

Compensated Work Therapy Program. Section 105 would make veterans eligible for disability compensation benefits for injuries proximately caused by the veteran's receipt of care in the Compensated Work Therapy Program (CWT). CWT is a therapeutic work program for veterans that takes place in various types of workplaces. Under current law, these veterans are not eligible for disability compensation benefits because of injuries suffered while participating in the program. The budgetary impact of this provision would depend on how many veterans are participating in this program and the rate at which they are injured while working. Information from VA indicates that about 15,000 veterans a year participate in this program. Based on data from the Bureau of Labor Statistics on the incidence of occupational illnesses and injuries, CBO estimates that the provision would increase direct spending by less than $500,000 a year over the 2000-2002 period and by about $1 million a year thereafter.

PAY-AS-YOU-GO CONSIDERATIONS

Section 252 of 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 and governmental receipts 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										
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Changes in outlays	0	0	0	0	1	1	81	101	141	151	171
Changes in receipts	Not Applicable										

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

Section 102 of the bill would authorize the Department of Veterans Affairs to reimburse providers for the reasonable cost of emergency treatment furnished to certain veterans. The provision would impose a private-sector and intergovernmental mandate on providers (including public hospitals) because, in the event of a dispute over reasonable cost, it would extinguish any liability on the part of the veteran for that treatment unless the provider rejects and refunds the department's payment within 30 days. It is not clear whether the provision would lead to a net financial loss or gain for providers. All providers would face costs if the department's payment were lower than the amount billed. But some providers might experience a net gain under this provision if reimbursements from the department more than offset liabilities that otherwise would not be collected and any associated collection costs. In any event, costs of the provision are unlikely to exceed the thresholds specified in UMRA for intergovernmental costs ($50 million, adjusted annually for inflation) or private-sector costs ($100 million, adjusted annually).

COMPARISON WITH OTHER ESTIMATES

Extended Care Services

On June 30, 1999, in a hearing before the Subcommittee on Health of the House Committee on Veterans' Affairs, a representative of VA testified that the gross costs of section 101 would be around $200 million annually, in contrast to CBO's estimate of $1.2 billion per year. The estimates were closer for the proceeds from new copayments on long-term care that would be authorized under the bill—VA estimated that they would be about $140 million annually, while CBO estimated that the proceeds would be about $0.3 billion a year.

Subsequent to that hearing, staff from CBO met with VA staff to compare methods and assumptions behind the estimates. Both estimates depend on assumptions about the degree to which veterans suffer from difficulties with activities of daily living (ADLs). VA assumed that on average veterans with disabilities rated 50 percent or greater had difficulties with ADLs to the same extent as all veterans. VA arrived at its estimate by observing the average rates at which individuals use long-term care from the 1987 National Medical Expenditure Survey (NMES), adjusted for age. For example, NMES rates would predict that only about half of one percent of veterans ages 21 through 64 would require nursing home care, but about 13 percent of those age 85 and older would need it. VA staff multiplied average use rates by the number of veterans rated 50 percent or more disabled in various age cohorts and found that an average of about 15,000 such veterans would require long-term care each day (of whom about 10,000 would need stays in nursing homes).

However, VA did not examine whether average rates of usage were reasonable ones to apply to highly disabled veterans. In contrast, CBO's estimate is based on data from the 1992 National Survey of Veterans (NSOV). The NSOV shows that less than 5 percent of all veterans suffer from difficulties with three or more activities of daily living (ADLs), but that among those with service-connected disabilities rated 50 percent or greater, about 27 percent have trouble with three or more ADLs. Thus, veterans with higher disability ratings are nearly six times more likely than all veterans to need long-term care. CBO applied average probabilities of using nursing home care from the National Long-Term Care Survey (NLTCS), while controlling for a person's age, marital status, and number of difficulties with ADLs. CBO relied on the NLTCS rather than the NMES because it provides a more recent snapshot of how frequently individuals turn to nursing homes for care.

In order to formulate a more direct comparison with VA's estimate, CBO obtained data from the NMES on the average use of nursing home care after adjusting for an individual's age and number of difficulties with ADLs. Among people who have difficulty with three ADLs, for example, NMES rates would predict that about 5 percent of veterans ages 21 through 64 would require care in a nursing home, while about 24 percent of those age 85 and older would need it. Applying those data to the number of disabled veterans rated 50 percent or higher leads to an estimate of new demand for nursing home care over nine times greater than the estimate VA presented to the Subcommittee. Thus, CBO believes that its estimate is much closer to the mark.

Reimbursement for Emergency Care

The Administration's budget request for fiscal year 2000 contains a proposal for veterans' out-of-network emergency care that is similar to section 102 of H.R. 2116. The Administration's proposal, however, would cover fewer than half as many veterans. The budget request includes about $244 million in 2000 to cover the out-of-network emergency care for uninsured, enrolled veterans with compensable disabilities related to military service. H.R. 2116 would cover that kind of care for all uninsured, enrolled veterans, including veterans whose eligibility is based on income.

PREVIOUS CBO ESTIMATE

On June 28, 1999, CBO prepared a cost estimate for H.R. 2116 as introduced. The CBO cost estimates for the common provisions are identical, but the reported bill contains three amendments that change the cost estimate. Unlike the first bill the reported version would

authorize funding for certain construction projects and leases. The Committee's bill would delay until 2005 the availability of proceeds from tobacco litigation, but it would not change the overall costs of the provision. The reported version also modified section 104, which would set up a program for treating certain military retirees in VA medical facilities.

ESTIMATE PREPARED BY:

Federal Costs:

Extended Care Services: Sunita D'Monte, Stuart Hagen, and Rachel Schmidt
Construction of Medical Facilities: Matthew A. Martin
Reimbursement for Emergency Care: Michael A. Miller
Care for Combat-Injured Veterans: Michael A. Miller
Extension and Revision of Authorities: Sarah T. Jennings
Veterans' Tobacco Trust Fund: Dorothy A. Rosenbaum
Compensated Work Therapy Program: Michael A. Miller
Other Provisions: Sunita D'Monte

Impact on State, Local, and Tribal Governments: Susan Sieg
Impact on the Private Sector: Rachel Schmidt

ESTIMATE APPROVED BY:

Paul N. Van de Water
Assistant Director for Budget Analysis