Statement of
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before the
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The Veterans Administration (VA) provides free or highly subsidized medical care to eligible veterans. Over the last two decades, the Congress has expanded the categories of veterans eligible for VA care, so that the number of patients served and the size of the system have grown more rapidly than the veteran population. Moreover, VA medical care is rapidly growing as a proportion of the total VA budget. With the aging of the World War II population--most of whom will be eligible for VA care by 1990 when they will have reached age 65--there are concerns about the future growth of the VA medical care budget and the VA's ability to serve all veterans in need of care.

At your request, I will present the Congressional Budget Office's (CBO's) analysis of the Administration's proposals to change the eligibility and payment provisions for VA medical care, concentrating on the following specific issues:

- How the Administration's proposals would change current law and practices;

- The likely effects of enacting the proposals on the current beneficiaries and the federal budget; and

- The sensitivity of these estimates to certain assumptions and data limitations.

THE ADMINISTRATION'S PROPOSALS

The Administration proposes to modify the VA medical and health care system by changing the eligibility rules that apply to veterans without service-connected disabilities, and by collecting from private insurers a portion of the costs of care provided to veterans covered under private policies. Under both current law and the Administration's proposals, the service-connected veteran--any veteran who has a permanent injury or illness contracted during service--would have priority in receiving VA medical services. Since 1970, veterans age 65 and older (and certain other veterans in special categories) have been eligible for most VA medical care without regard to their income, insurance coverage, or other financial status. In contrast, most younger veterans without service-connected disabilities--often called nonservice-connected (NSC) veterans--are eligible for free medical care only if they assert that they are unable to defray the costs of needed care elsewhere.

The proposal would eliminate the categorical eligibility of NSC veterans age 65 and older and would apply to them and to younger NSC veterans a test of their ability to pay. Nonservice-connected veterans would be eligible under the proposal, if they had countable family incomes and assets valued at less than twice the VA pension level, or if they had paid large amounts in medical expenses that reduced their remaining resources

below that level, according to a special formula. 1/ Several groups of veterans would be exempt from the proposal, including pre-World War I and World War I veterans, former prisoners of war, veterans exposed to radiation or Agent Orange during service, and VA pensioners.

Another proposal would require the VA to bill the private insurers of NSC veterans for the costs of their care. Most private insurers currently do not reimburse the federal government for care given to veterans, except in certain cases involving accidental injuries or workmen's compensation benefits. If enacted at the same time as the means test, the VA would recover costs for only those insured veterans who also met the means-test eligibility criteria. Enactment of this reimbursement proposal without the means test would involve a larger portion of the VA patient population.

THE LIKELY EFFECTS OF THE PROPOSALS

To analyze the proposals, several profiles of the VA patient population were obtained from both administrative and survey data. This information was used to derive proportions of the NSC user population that would be affected by the proposals, if enacted. Estimates of the impacts on

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1. Detailed specifications of the Administration's proposals were obtained from the Office of Management and Budget in March 1985. The special formula for computing excessive out-of-pocket expenditures reported in those documents was used in the CBO analysis. Legislation recently submitted by the Administration would, however, leave the specific formula to be defined in regulations prescribed by the VA Administrator.

recipients and costs were derived by applying these proportions to the CBO projections of the numbers and characteristics of VA hospital, clinic, and nursing home patients in 1986 through 1990. 2/ Because detailed specifications on including assets in income were not available, however, only veterans' incomes could be considered when estimating the proposed means test's effects.

The Means Test

Our analysis indicates that the proposed means test would reduce the population eligible for VA medical care, resulting in savings to the VA and the federal budget. Moreover, about 25 percent of veterans who would become ineligible for VA care would incur costs that would be paid under other federally supported medical programs.

The means test would probably deny eligibility to about 20 percent of all individuals who would be VA hospital or clinic patients under current law. In 1987, the first full year of implementation, about 15 percent of the expected users of VA hospital services--about 105,000 veterans, representing 158,000 hospital discharges--would be affected (see Table 1). Most VA system users who would be affected by the proposal are NSC veterans under age 65, who now use VA services by saying that they

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2. See Congressional Budget Office, Veterans Administration Health Care: Planning for Future Years (April 1984) for the methodology and the projections for 1990.

TABLE 1. THE VETERAN POPULATION AND THOSE WHO WOULD BE AFFECTED BY THE PROPOSED MEANS TEST IN 1987 (In thousands and in percent)

Category	Total Veterans	Service-Connected	Nonservice-Connected				
			All	Pensioners a/	Nonpensioners		
					Total	Less Than 65	65 or Older
Number of Veterans	28,200	3,925	24,275	680	23,600	20,670	2,930
Current Law							
Number of Users b/							
Hospital	690	200	490	110	380	260	120
Outpatient	2,980	1,400	1,580	360	1,220	855	365
Users as a Percent of All Veterans							
Hospital	2.4	5.1	2.0	16.2	1.6	1.3	4.1
Outpatient	10.6	35.7	6.5	52.9	5.2	4.1	12.5
Direct Impact of the Means Test's Income Provisions							
Number of Users Made Ineligible b/							
Hospital	105	0	105	0	105	75	30
Outpatient	550	0	550	0	550	425	125
Percent of Users Made Ineligible							
Hospital	15.2	0.0	21.4	0.0	27.6	28.8	25.0
Outpatient	18.5	0.0	34.8	0.0	45.1	49.7	34.2

SOURCE: Congressional Budget Office.

a. Pensioners are recipients of VA pension income. Other groups of nonservice-connected veterans are exempt from the proposal, such as World War I veterans and Vietnam veterans exposed to Agent Orange; to the extent that these groups are not counted as pensioners and service-connected veterans, they are counted as nonservice-connected nonpensioners in the table.

b. The number of veterans using services was estimated by the number of hospital discharges divided by 1.5 and the number of outpatient visits divided by 6. These utilization rates were derived from Veterans Administration staff analyses of the average number of repeat episodes per veteran served.

cannot afford medical care elsewhere, but who would not pass the proposed means test. In all, about 45 percent of the NSC clinic patients--and 28 percent of hospital patients--not exempted from the means test would lose eligibility under the proposal. 3/ Only about 25 percent of veterans losing eligibility for VA care under the means test would be age 65 or older.

If the means test were enacted, direct savings to the VA would amount to about $420 million in 1986, assuming a seven-month phase-in period, but they would be offset by higher administrative costs of almost $30 million, for net savings of about $390 million that year (see Table 2). The net savings would rise, however, to more than $1.4 billion in 1990. These estimates are based on the projected costs of VA medical care under current practices, assuming that the average costs per patient will rise because of inflation in the medical care sector, and that the number of patients will increase in proportion to the expected increases in the elderly veteran population. These projections differ from those used in the Congressional

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3. These estimates reflect the fact that some veterans who would otherwise become ineligible based on income alone would remain eligible because of their high out-of-pocket medical expenses, but it is important to note that the available data describing out-of-pocket expenditures are limited.

TABLE 2. EFFECTS ON OUTLAYS OF THE ADMINISTRATION'S VA MEDICAL-CARE PROPOSALS
(By fiscal year, in millions of dollars)

	1986	1987	1988	1989	1990
Effects on VA Spending					
Means Test	-420	-1,030	-1,245	-1,360	-1,480
Reimbursement	-50	-130	-160	-180	-200
Administrative Costs a/	30	50	55	60	65
Total	-440	-1,110	-1,350	-1,480	-1,615
Effects on Medicare					
HI b/	55	145	180	205	230
SMI c/	25	60	75	90	100
Total	80	205	255	295	330
Net Budgetary Effect					
	-360	-905	-1,095	-1,185	-1,285

SOURCE: Congressional Budget Office.

NOTE: Savings, or reductions in budgetary costs, are in negative numbers. Costs are given in positive numbers. Dollars are rounded to the nearest $5 million. Details may not add to totals because of rounding.

a. Administrative costs for both proposals--the means test and reimbursement from private insurers--are included in these estimates. Only about 5 percent of the estimated increase in administrative costs would be due to the reimbursement proposal.

b. HI represents the Hospital Insurance Program (Part A) under Medicare.

c. SMI represents the Supplementary Medical Insurance program (Part B) under Medicare.

Budget Office's annual report that, to be consistent with projections for other appropriated programs, assume funding to increase only at the rate of inflation. 4/

The Reimbursement Proposal

It appears that only about 18 percent of NSC veteran patients now have sufficient private insurance coverage that the VA could recover all or part of the costs of their hospital care. This estimate is based on survey data and concurs with a recent analysis by the General Accounting Office. 5/ Our estimates also assume that few NSC veterans--roughly 11 percent--would have insurance coverage for acute psychiatric hospitalization. Moreover, because veterans with low incomes are less likely to be insured for medical expenses than those with higher incomes, only about 10 percent of the NSC veterans still served by the VA if the means test were enacted would be likely to have private coverage.

If both the means test and the reimbursement proposals were enacted, the VA could recover an estimated $50 million in 1986 from private insurers for the costs of NSC veteran patients, assuming a phase-in of the proposals. Recoveries might rise to about $200 million in 1990. If enacted without the

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4. See The Economic and Budget Outlook: Fiscal Years 1986-1990 (February 1985).

5. General Accounting Office, Legislation to Authorize VA Recoveries from Private Health Insurance Would Result in Substantantial Savings (February 1985).

means test, VA recovery from private insurers could result in revenues of roughly $160 million in 1986 and $560 million in 1990. In each case, the offset for higher administrative costs would be relatively small.

The Net Budgetary Effect

After full implementation of the proposals, about 20,000 to 30,000 former VA patients would be likely to use medical services paid for by Medicare. Almost all of these veterans would be age 65 or older. Because Medicare outlays would rise by about $200 million in 1987, and $330 million in 1990, the net budgetary effect of the Administration's VA medical-care proposals would be savings of about $360 million in 1986, increasing to $1.3 billion in 1990.

SENSITIVITY OF ESTIMATES TO CERTAIN ASSUMPTIONS

As with any projection, numerous assumptions underlie these estimates. Four are particularly important:

- Strict implementation of the means-test proposal's income provisions;
- No significant substitution of eligible hospital or clinical patients for newly ineligible ones;
- Reductions in total expenditures based on average variable costs per patient; and
- Future changes in the age distribution and economic status of VA patients that reflect historical trends.

The estimates assume strict enforcement of the income provisions under the means test by the VA. Under current law, some groups of veterans are to be served only if they are unable to pay for care elsewhere, but eligibility is determined by their unverified statements of financial ability. If a similar approach were taken to implement the Administration's proposal, the actual effects on veterans and federal outlays could be considerably smaller than estimated. On the other hand, because the Administration's proposal for taking assets into account when applying the means test has not been completely specified, its likely effects could not be reflected in the CBO's estimates. 6/ Including the value of assets in the computation of income would cause more veterans than projected to lose eligibility for VA care, however, thereby increasing federal savings.

The CBO's estimates of budgetary savings reflect different assumptions for hospital and clinical care than for nursing home care about substitution--that is, the extent to which other veterans eligible for care would replace those disqualified by the means test. The available evidence suggests that veterans eligible under current law who seek VA hospital and clinical care do, in fact, receive it; consequently, there is probably little excess demand for such care and patients excluded by the

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6. Even if the details were specified, the lack of data would make it extremely difficult to estimate the likely effects, because they would depend on the types and value of assets held by veterans.

means test would not be replaced by others. Excess capacity and underused acute-care beds are found in almost all VA hospitals today and waiting lists for VA hospital care either do not exist or are very short except at three of the 172 VA hospitals. Moreover, veterans placed on these waiting lists are eventually served. While some recently available data suggest that excess demand for clinical care may have developed in a few local areas, even substantial amounts of substitution would have only a small effect on the likely budgetary savings from the means test. 7/ For example, if the unmet demand for clinical care was 20,000 veterans per month, the CBO's estimate of savings would be reduced by 3 percent in 1987.

In contrast, long waiting lists for beds in VA-operated nursing homes exist in some local areas. Accordingly, the CBO's estimates assume that currently unserved veterans would replace most of the nursing home patients who would lose eligibility under the means test. The net result would be a decline of less than 5 percent in the VA-supported average daily census.

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7. The VA conducted a survey of its facilities in January 1984 to determine unmet demand. Although the type of care requested by veterans during the survey is not known in many cases, apparently there was excess demand for outpatient care in some areas.

To estimate the savings from each patient denied care under the means test, measures of the average variable cost per patient were developed for each of the three types of service. Major construction and educational costs were assumed to be fixed--that is, they would not change in response to a declining patient census--and therefore were not included in the estimates. Costs for VA medical personnel, supplies and equipment, minor construction, and maintenance and repair were assumed to be variable--that is, they could all be reduced in proportion to a fall in the patient load. This variable cost assumption might lead to an overstatement of the savings, especially in the short run as specialized positions or resources might not be eliminated in sufficient numbers. In the longer run, however, the VA might find opportunities for disproportionately larger savings. For example, in response to the smaller patient loads under the means test, either currently underused facilities could be closed or planned construction might be eliminated.

A final set of assumptions was necessary because available administrative data contain insufficient information about veterans' financial status. The VA collects neither income nor insurance information from NSC veterans currently served at its medical centers; the only income-related information is a count of who is receiving a VA pension. As a result, CBO had to combine survey information on the economic situation of users of the

VA health care system with administrative data. 8/ As on any survey, income is likely to be underreported. Such underreporting would also cause our savings estimates to be too low.

In sum, although certain assumptions would cause the estimated budgetary effects of the Administration's proposed means test to be overstated, others would lead to underestimates. For example, incomplete implementation of the means test could substantially reduce savings, but considerably greater savings would accrue if veterans' assets were reflected in the eligibility determination.

CONCLUSION

Although it is difficult to estimate precisely the impacts of the Administration's proposals, they would reduce eligibility for VA medical care and result in budgetary savings. Under the proposed means test, about 20 percent of veterans currently using VA hospitals or clinics would no longer be allowed to do so, and few, if any, other veterans would be substituted for them. In contrast, because of lengthy waiting lists for nursing home care in many localities, the average daily census of VA nursing home patients is estimated to decline by less than 5 percent. By 1990, the

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8. The following surveys were used in this analysis: 1979 Survey of Veterans (Veterans Administration); Survey of Aging Veterans (Veterans Administration; Lou Harris, 1983); and National Medical Care Expenditure Survey (tabulations provided by the National Center for Health Services Research and Health Care Technology Assessment).

proposed means test would save about $1.4 billion in VA spending for health care, and an accompanying private insurance reimbursement proposal would save about $200 million. After accounting for added Medicare outlays, the net budgetary savings from these proposals would be roughly $1.3 billion that year.