CBO TESTIMONY

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on
Estimating the Budgetary Impact of Changing Eligibility
for Veterans' Health Care

before the
Committee on Veterans' Affairs
United States Senate

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NOTICE

This statement is not available for public release until it is delivered at 10:00 a.m. (EDT) on Wednesday, May 8, 1996.

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I appreciate the opportunity, Mr. Chairman, to appear before this Committee to discuss methods and assumptions for estimating the budgetary impact of changing eligibility for veterans' health care. My testimony will begin with some brief comments on eligibility for medical care and on its budgetary status. Most of my testimony will address the Congressional Budget Office's (CBO's) methods and assumptions for cost estimates in general and how they apply to our estimates for eligibility reform.

BACKGROUND

Under current law, a veteran's eligibility for medical care depends on several factors, including:

- Whether the veteran has a service-connected disability;
- The extent of any disability;
- Whether the medical ailment is related to the disability;
- Whether it requires admission to a hospital or an outpatient visit; and
- The veteran's income.

For most veterans, hospital care is easier to obtain than outpatient care because of the more restrictive criteria governing eligibility for outpatient treatment.

According to the General Accounting Office (GAO), the criteria for eligibility under current law confuse veterans who are unsure of their health care benefits as well as staff of the Department of Veterans Affairs (VA) who deliver and administer medical care. Moreover, veterans' medical care is not an open-ended entitlement like Social Security or Medicare. Rather, it is subject to annual appropriations that could--and apparently do--require the VA to ration care based on available resources. Indeed, expanding eligibility without increasing funding would increase rationing and create dissatisfaction among veterans. In testimony last July, GAO stated that reforming the criteria for eligibility "would likely generate significant new workload and could cost billions of dollars. While retaining the discretionary nature of VA health care funding would theoretically give the Congress more control over VA spending, it would, in our opinion, be extremely difficult for the Congress to control growth in VA appropriations if other changes increased workload."

During its last session, the House of Representatives passed legislation (H.R. 2491) that would remove certain restrictions on outpatient care. It would allow about 11 million veterans to receive a broad range of outpatient care. Under current law, their eligibility for outpatient care is limited to visits preventing the need for inpatient care or to pre- or post-hospitalization visits.

Last October, the Congressional Budget Office estimated that the House bill would increase the cost of veterans' medical care by $3 billion or more annually,

assuming appropriation of the necessary amounts. In contrast, the VA believed the provision would incur no cost and could even lead to savings. Because of that wide difference in budgetary assessments, it is good to have this opportunity to clarify CBO's assumptions and methods as we reexamine our estimates for past proposals and prepare fresh estimates for new legislation.

GENERAL ASSUMPTIONS FOR CBO COST ESTIMATES

To start, we recognize that veterans' medical care is a discretionary program. By themselves, changes in the criteria for eligibility do not raise the government's spending because funding for medical care is subject to annual appropriations. In contrast, some programs, such as veterans' disability benefits, are entitlement programs with permanent and indefinite appropriations in current law. Nevertheless, CBO assumes that funding will be provided to cover costs when it estimates the budgetary impact of authorizing legislation under the Congressional Budget and Impoundment Control Act of 1974.

The assumption that appropriations conform to authorizations is useful for at least two reasons. First, it gives the Congress and the appropriations committees a sense of how much more or less funding it could be asked to provide because of the authorizing bill. Second, the assumption means that CBO does not have to predict

which programs will be treated favorably by the appropriation process and which programs will suffer. All programs of all committees are treated alike. Were we not to assume changes in appropriations, no authorizing legislation--even one that eliminated every restriction on medical care--would ever be shown as increasing or reducing costs.

When we receive a bill for costing, we must determine what changes it would make in the law and what consequences it would have for participation in a program such as veterans' medical care. For example, expanding access to outpatient care could lead the VA to treat some veterans on an outpatient basis instead of as inpatients, thereby lowering costs. However, expanding access might also allow the VA to provide outpatient care to those veterans who would not otherwise have come to the VA, thereby increasing costs. A fair representation of the potential impact of the proposal needs to encompass both effects.

At this point, CBO's assumption about appropriation action comes into play. Although under current appropriation levels a shift from inpatient to outpatient treatment may occur, our estimates must also inform the Congress and the appropriations committees of the likelihood of a greater demand for health care from veterans who would not otherwise have come to the VA. Moreover, the veterans who come to the VA for outpatient care because of the bill may also raise the VA's

inpatient costs if outpatient visits lead to even more hospital admissions. Those costs would also appear in our estimate.

Perhaps the main reason that CBO and the VA had such different estimates of the cost of the House's bill was that CBO assumed full availability of appropriations and the VA did not. Assuming that appropriations would be available for a higher workload was essential to our estimate that the bill would cost $3 billion or more each year. In contrast, the VA wrote to the House Committee on Veterans' Affairs, "The operating premise for [VA's cost estimate] and the VA proposal is that eligibility reform will be budget neutral." We take that statement to mean that the VA assumed that any reform in the criteria for eligibility would not affect appropriations. Nevertheless, the VA went on to say that reforming the criteria for eligibility would allow it to shift some of its workload from hospital admissions to outpatient visits, thereby saving $268 million a year that could be spent on "new outpatient workload (and concomitant inpatient workload), noninstitutional care, and greater access to primary care."

ASSUMPTIONS AND METHODS REGARDING CRITERIA FOR ELIGIBILITY

Clearly, estimating the net budgetary impact of eligibility reform requires assumptions about how much additional care might be demanded under the bill. When CBO

estimates the costs of proposals during this session of the Congress, we will turn to the 1992 Survey of Veterans--a source that may provide key insights. CBO's current hypothesis is that a proposal like the House's bill would lead those veterans who now come to the VA for only inpatient care and related outpatient care to come to the VA for all outpatient needs. It is reasonable to expect that individuals who now find it possible, convenient, and desirable to seek medical care from the VA for hospital stays will feel the same way about all of their outpatient visits. The survey may help us to estimate the number of those veterans, as well as the number of other veterans who now receive no care from the VA but who would turn to it under expanded eligibility.

Once we have an idea of the number of veterans whose behavior would change, we will need to quantify the extent of the change. We will search for answers to such questions as:

- How often would the veteran visit an outpatient facility?

- How often would the extra outpatient visit lead to an additional hospital admission?

- How long or costly would the outpatient visit or hospital admission be?

Of course, the nature and scope of the budgetary impact will depend on the legislation itself. Clearly, the more easily a veteran can obtain medical care, the more costly the program will become. Similarly, expanding eligibility for prosthetics could add significantly to costs.

USING MANAGED CARE IN THE VETERANS ADMINISTRATION'S MEDICAL SYSTEM

Managed care methods have been proposed as a way of controlling the VA's costs under eligibility reform. In a sense, however, the Veterans Administration already practices a form of managed care in that it is both the provider and bill payer. Like private-sector health maintenance organizations (HMOs), the VA has a fixed amount of money--its appropriation--to spend on care that it provides to people with certain legal rights to care. HMOs provide care within their means and so does the VA--a big difference is that the VA can ration care by legally turning people away.

One proposal to reduce the cost increase of eligibility reform would require veterans to enroll annually with the VA to receive medical care and would define a system of priorities for the VA to follow in enrolling veterans so that it could stay within available resources. An enrollment system could help to hold down costs if its

effect was to limit the demand for care. However, that outcome is by no means certain. For example, if veterans had to pay premiums in order to enroll with the VA, or if they faced some cost-sharing requirements in order to receive services, expanding eligibility would not create as much demand for care. In such a system, the potential costs would be lowered. However, the benefit could also take on more of the characteristics of a budgetary entitlement if a veteran's enrollment legally required the VA to provide the covered services. The VA already has a form of enrollment system: individuals are enrolled if they follow the prescribed process of presenting their discharge papers and other documentation related to disability or income. But the current system of enrollment would have little or no effect on holding down costs if eligibility was expanded.

A priority system might call for veterans with the most severe service-connected disabilities to have first claim to funding. It could rank other categories of veterans so that those without disabilities and with relatively high incomes had the last claim on funding for medical care. Yet, although any system that defined the order in which veterans received medical care might help the VA to administer the program, it would not hold down costs. As long as more veterans were eligible for care or a greater range of services was available, the appropriation process would be faced with the same claim for more funding that it would face without the priority system.

CONCLUSION

In sum, CBO's cost estimates assume that appropriations would be raised to accommodate any new workload that might result from expanding access to outpatient care. That assumption allows us to give the Congress and the appropriations committees a sense of how much more funding might be expected for veterans' medical care. It is not a prediction; rather, it is a way of putting changes to discretionary programs of all committees on an equal footing.

CBO is working hard to address the difficult questions of how demand for outpatient and inpatient care would change and what each of those changes would cost. To find answers, we will consult the VA and the General Accounting Office, among others.