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## **Veterans' Medical Care: FY2007 Appropriations**

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# Veterans' Medical Care: FY2007 Appropriations

## Summary

The Department of Veterans Affairs (VA) provides benefits to veterans who meet certain eligibility rules. Benefits to veterans range from disability compensation and pensions to hospital and medical care. VA provides these benefits to veterans through three major operating units: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), and the National Cemetery Administration (NCA). VHA is primarily a direct service provider of primary care, specialized care, and related medical and social support services to veterans through an integrated health care system.

The President's FY2007 budget proposal to Congress requested \$32.7 billion for VHA, an 11.3% increase over the FY2006 enacted amount of \$29.3 billion, and a 10% increase over the FY2005 enacted amount of \$29.7 billion. As in previous budget proposals, the President's FY2007 budget request also includes a set of legislative proposals. The Administration is requesting authorization from Congress to assess an annual enrollment fee of \$250 for all Priority 7 and 8 veterans, increase veterans' share of pharmaceutical copayments from \$8 to \$15 (for each 30-day prescription) for all enrolled veterans in Priority Groups 7 and 8, and bill veterans receiving treatment for nonservice-connected conditions for the entire copayment amount.

On March 9, 2006, the Senate Budget Committee marked up the FY2007 Concurrent Resolution on the Budget (S.Con.Res. 83), and the Senate passed it on March 16. On the Senate floor, \$823 million was added to the committee-recommended amount to provide an additional \$795 million to VA Medical Services, in lieu of enactment of the proposed pharmacy copayment increase and the new enrollment fee, and \$28.0 million to increase VA's medical and prosthetic research funding. In total, S.Con.Res. 83 calls for \$74.8 billion for VA programs for FY2007. This includes approximately \$37.0 billion for VA's discretionary programs, which consists mainly of VA medical care, and \$37.8 billion for VA's mandatory programs. On March 31, 2006, the House Budget Committee reported its version of the FY2007 Concurrent Resolution on the Budget (H.Con.Res. 376, H.Rept. 109-402), providing \$36.9 billion for VA's discretionary programs, and \$37.8 billion for VA's mandatory programs. In total, H.Con.Res. 376 calls for \$74.7 billion for VA programs for FY2007. The committee-recommended amount does not assume the President's proposal to implement enrollment fees and increase drug copayments for Priority Group 7 and 8 veterans. The House budget resolution is awaiting floor action.

On May 4, 2006, the House Appropriations Committee, Subcommittee on Military Quality of Life and Veterans Affairs, and Related Agencies recommended \$32.7 billion for VHA for FY2007, an 11.4% increase over the FY2006 enacted amount. The subcommittee **did not** recommend any fee increases as requested by the President's FY2007 budget proposal.

This report tracks the VHA's FY2007 appropriations process, and will be updated as legislative events warrant.

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# Veterans' Medical Care: FY2007 Appropriations

## Most Recent Developments

On May 4, 2006, the House Appropriations Committee, Subcommittee on Military Quality of Life and Veterans Affairs, and Related Agencies recommended \$32.7 billion for the Veterans Health Administration (VHA) for FY2007, almost the same amount as the President's request. This includes \$25.4 billion for medical services, a \$2.6 billion (11.6%) increase over the FY2006 enacted amount and \$100 million less than the President's requested amount of \$25.5 billion. The subcommittee recommendation also includes \$3.3 billion for medical administration, a \$100 million increase over the President's request; \$3.6 billion for medical facilities; and \$412 million for medical and prosthetic research, a \$13.0 million increase over the Administration's request. The subcommittee **did not** recommend any fee increases as requested by the Administration's budget proposal for VHA for FY2007.

## Background

The Department of Veterans Affairs (VA) provides a range of benefits and services to veterans who meet certain eligibility rules, including disability compensation and pensions, education, training and rehabilitation services, hospital and medical care, home lone guarantees, and death benefits that cover burial expenses.<sup>1</sup> VA carries out its programs nationwide through three administrations and the board of veterans appeals (BVA). The Veterans Health Administration (VHA) is responsible for health care services and medical research programs.<sup>2</sup> The Veterans Benefits Administration (VBA) is responsible, among other things, for providing compensations, pensions, and education assistance.<sup>3</sup> The National Cemetery Administration (NCA) is responsible for maintaining national veterans cemeteries, providing grants to states for establishing, expanding or improving state veterans cemeteries, and providing headstones and markers for the graves of eligible persons, among other things.

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<sup>1</sup> For a detailed description on eligibility for veterans disability benefits programs, see CRS Report RL33113 *Veterans Affairs: Basic Eligibility for Disability Benefit Programs*, by Douglas Reid Weimer.

<sup>2</sup> For a detailed description of veterans' health care issues, see CRS Report RL32961, *Veterans' Health Care Issues in the 109<sup>th</sup> Congress*, by Sidath Viranga Panangala.

<sup>3</sup> For a detailed description of veterans' benefits issues, see CRS Report RL33216, *Veterans Benefits Issues in the 109th Congress* by Paul J. Graney.

VA's budget includes both mandatory and discretionary spending accounts. Mandatory funding supports disability compensation, pension benefits, vocational rehabilitation, and life insurance, among other benefits and services. Discretionary funding supports a broad array of benefits and services, including medical care. In FY2006, discretionary budget authority accounted for about 48% of the total VA budget authority, with most of this discretionary funding going toward supporting VA health care.

VHA operates the nation's largest integrated direct health care delivery system.<sup>4</sup> VA's health care system is organized into 21 geographically defined Veterans Integrated Service Networks (VISNs). While policies and guidelines are developed at VA headquarters to be applied throughout the VA health care system, management authority for basic decision making and budgetary responsibilities are delegated to the VISNs.<sup>5</sup> Congressionally appropriated medical care funds are allocated to the VISNs based on the Veterans Equitable Resource Allocation (VERA) system, which generally bases funding on patient workload.<sup>6</sup> Prior to the implementation of the VERA system, resources were allocated to facilities primarily on the basis of their historical expenditures. Unlike other federally funded health insurance programs, such as Medicare and Medicaid, which finance medical care provided through the private sector, VHA provides care directly to veterans.

In FY2005, VHA operated 156 hospitals, 135 nursing homes, 43 residential rehabilitation treatment centers, and 711 community-based outpatient clinics (CBOCs).<sup>7</sup> VHA also pays for care provided to veterans by independent providers and practitioners on a fee basis under certain circumstances. Inpatient and outpatient care is provided in the private sector to eligible dependents of veterans under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). In addition, VHA provides grants for construction of state-owned nursing homes and domiciliary facilities, and collaborates with the Department of Defense (DOD) in sharing health care resources and services.

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<sup>4</sup> Established on Jan. 3, 1946, as the Department of Medicine and Surgery by P.L. 79-293, succeeded in 1989 by the Veterans Health Services and Research Administration, renamed the Veterans Health Administration in 1991. This report will use VA and VHA interchangeably to refer to the Veterans Health Administration (VHA).

<sup>5</sup> Jian Gao, Ying Wang and Joseph Engelhardt, "Logistic Analysis of Veterans' Eligibility-Status Change," *Health Services Management Research*, vol.18, (Aug. 2005), p.175.

<sup>6</sup> About 90% of the VHA appropriation is allocated through VERA. Networks also receive appropriated funds not allocated through VERA for such things as prosthetics, homeless programs, readjustment counseling, and clinical training programs. VA facilities could also retain collections from insurance reimbursements and copayments, and use these funds for the care of veterans.

<sup>7</sup> Data on the number of hospitals and nursing homes includes facilities damaged by Hurricane Katrina. Data on the number of CBOCs differ from source to source. Some count clinics located at VA hospitals while others count only freestanding CBOCs. The number represented in this report excludes clinics located in VA hospitals. The data are current as of Dec. 1, 2005.

During FY2005, VHA provided medical care to about 4.9 million unique veteran patients, a caseload that is estimated to increase by about 108,000, or 2.2% in FY2006 (**Table 1**). According to VHA estimates, the number of unique veteran patients is estimated to increase by approximately 45,000 in FY2007.<sup>8</sup> As shown in **Table 1**, there would be a 3.6% increase in the total number of unique patients (both veterans and non-veterans) from 5.3 million in FY2005 to 5.5 million in FY2007.

The total number of outpatient visits reached 52.3 million during FY2005 and is projected to increase to 55.5 million in FY2006 and 58.5 million in FY2007.<sup>9</sup> In FY2005, VHA spent approximately 61.7% of its medical care obligations on outpatient care.

**Table 1. Number of Patients Receiving Care from VA**

	<b>FY2005 Actual</b>	<b>FY2006 Estimate</b>	<b>FY2007 Estimate</b>
<b>Priority Groups 1-6 Veterans</b>	3,561,709	3,733,496	3,813,457
<b>Priority Groups 7 and 8 Veterans</b>	1,301,283	1,237,144	1,202,345
<b>Total Unique Veteran Patients<sup>a</sup></b>	4,862,992	4,970,640	5,015,802
<b>Non-Veterans<sup>b</sup></b>	445,322	471,312	482,588
<b>Total Unique Patients</b>	5,308,314	5,441,952	5,498,390

**Source:** Table prepared by CRS, based on data from the Department of Veterans Affairs.

**a.** Unique veteran patients include Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veteran patients. These patients number : 100,808 in FY2005; 110,566 in FY2006; and 109,191 in FY2007.

**b.** Non-veterans include CHAMPVA patients, reimbursable patients with VA affiliated hospitals and clinics, care provided on a humanitarian basis, and employees receiving preventive occupational immunizations.

Since 1946, VHA has been associated with training physicians and other health care professionals and has become an essential component of health care higher education in the United States. Veterans' health care facilities are affiliated with 107 of the nation's 126 medical schools, and participate in graduate medical education (GME) through integrated residency programs administered through medical schools and academic health centers. VHA is also affiliated with over 1,200 other schools offering students allied and associated education degrees and certificates in 40 health

<sup>8</sup> Based on information provided by VA to the House Committee on Veterans' Affairs, Subcommittee on Health, Feb. 14, 2006.

<sup>9</sup> This number excludes outpatient care provided on a contract basis and outpatient visits to readjustment counseling centers. U.S. Department of Veterans Affairs, *FY2007 Congressional Budget Submissions, Medical Programs*, vol.1 of 4, p.3-17.

profession disciplines. In FY2005, about 31,000 physician residents and fellows — 17,000 medical students, 24,000 nursing students, and 18,000 allied health residents and fellows — received some or all of their training in VA medical centers.<sup>10</sup>

This report tracks VHA's FY2007 appropriations and provides a brief summary of funding levels for VHA for FY2006, including a discussion on supplemental appropriations for FY2005 and FY2006. It also discusses the Administration's budget proposal for FY2007, and other major budget issues. This report begins with a brief overview of eligibility for VA health care, VHA's enrollment process and its enrollment priority groups.

## Eligibility for Veterans Health Care and the Promise of Free Health Care

To understand VA's medical care appropriations and the Administration's major policy proposals discussed later in this report, it is important to understand eligibility for VA health care, VA's enrollment process, and its enrollment priority groups. Unlike Medicare or Medicaid, VA health care is not an entitlement program. Contrary to numerous claims made concerning "promises" to military personnel and veterans with regard to "free health care for life," not every veteran is automatically entitled to medical care from VA.<sup>11</sup> Prior to eligibility reform in 1996, all veterans were technically eligible for some care, however, the actual provision of care was based on available resources.<sup>12</sup>

The Veterans' Health Care Eligibility Reform Act of 1996, P.L. 104-262, established two eligibility categories and required VHA to manage the provision of hospital care and medical services through an enrollment system based on a system of priorities.<sup>13</sup> P.L. 104-262 authorized VA to provide all needed hospital care and medical services to veterans with service-connected disabilities, former prisoners of war, veterans exposed to toxic substances and environmental hazards such as Agent Orange, veterans whose attributable income and net worth are not greater than an established "means test", and veterans of World War I. These veterans are generally known as "higher priority" or "core" veterans.<sup>14</sup> The other category of veterans are

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<sup>10</sup> U.S. Department of Veterans Affairs, *FY2007 Congressional Budget Submissions, Medical Programs*, vol.1 of 4, p. 9-8.

<sup>11</sup> For a detailed discussion of "promised benefits," see CRS Report 98-1006F, *Military Health Care: The Issue of "Promised" Benefits*, by David F. Burrelli.

<sup>12</sup> Barbara Sydell, *Restructuring the VA Health Care System: Safety Net, Training and Other Considerations*, National Health Policy Forum, Issue Brief no. 716, March 1998. Available at [[http://www.nhpf.org/pdfs\\_ib/IB716\\_VA\\_3-25-98.pdf](http://www.nhpf.org/pdfs_ib/IB716_VA_3-25-98.pdf)].

<sup>13</sup> U.S. Congress, House Committee on Veterans Affairs, *Veterans' Health Care Eligibility Reform Act of 1996*, report to accompany H.R. 3118, 104<sup>th</sup> Cong. 2<sup>nd</sup> sess., H.Rept. 104-690 p.2.

<sup>14</sup> *Ibid.* p.5.



those with no service-connected disabilities and with attributable incomes above an established “means test.”

P.L.104-262 also authorized VA to establish a patient enrollment system to manage access to VA health care. As stated in the report language accompanying P.L.104-262, “the Act would direct the Secretary, in providing for the care of “core” veterans, to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment system would operate.”<sup>15</sup>

Furthermore, P.L.104-262 was clear in its intent that the provision of health care to veterans was dependent upon the available resources. The Committee report accompanying P.L.104-262 states that the provision of hospital care and medical services would be provided to “the extent and in the amount provided in advance in appropriations Acts for these purposes. Such language is intended to clarify that these services would continue to depend upon discretionary appropriations.”<sup>16</sup>

## **VHA Health Care Enrollment**

As stated previously, P.L. 104-262 required the establishment of a national enrollment system to manage the delivery of inpatient and outpatient medical care. The new eligibility standard was created by Congress to “ensure that medical judgment rather than legal criteria will determine when care will be provided and the level at which care will be furnished.”<sup>17</sup>

For most veterans, entry into the veterans’ health care system begins by completing the application for enrollment. Some veterans are exempt from the enrollment requirement if they meet special eligibility requirements.<sup>18</sup> A veteran may apply for enrollment by completing the Application for Health Benefits (VA Form 10-10EZ) at any time during the year and submitting the form online or in person at any VA medical center or clinic, or mailing or faxing the completed form to the

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<sup>15</sup> Ibid. p.6.

<sup>16</sup> Ibid. p.5.

<sup>17</sup> Ibid. p.4.

<sup>18</sup> Veterans do not need to apply for enrollment in VA’s health care system if they fall into one of the following categories: veterans with a service-connected disability rated 50% or more (percentage ratings represent the average impairment in earning capacity resulting from diseases and injuries encountered as a result of or incident to military service; those with a rating of 50% or more are placed in Priority Group 1); less than one year has passed since the veteran was discharged from military service for a disability that the military determined was incurred or aggravated in the line of duty, but the VA has not yet rated; or the veteran is seeking care from VA for only a service-connected disability (even if the rating is only 10%).

medical center or clinic of the veteran's choosing.<sup>19</sup> Once a veteran is enrolled in the VA health care system the veteran remains in the system and does not have to re-apply for enrollment annually. However, those veterans who have been enrolled in Priority Group 5 based on income must submit a new VA Form 10-10EZ annually with updated financial information demonstrating inability to defray the expenses of necessary care.<sup>20</sup>

Eligibility for VA health care is primarily based on "veteran's status" resulting from military service. Veteran's status is established by active-duty status in the military, naval, or air service and a honorable discharge or release from active military service. Generally, persons enlisting in one of the armed forces after September 7, 1980, and officers commissioned after October 16, 1981, must have completed two years of active duty or the full period of their initial service obligation to be eligible for VA health care benefits. Veterans discharged at any time because of service-connected disabilities are not held to this requirement. Furthermore, reservists who were called to active duty and who completed the term for which they were called, and who were granted an other than dishonorable discharge, or were National Guard members who were called to active duty by federal executive order, and who completed the term for which they were called, and who were granted an other than dishonorable discharge are also exempt from the 24 continuous months of active duty requirement.

After veteran's status has been established, VA next places applicants into one of two categories. The first group is composed of veterans with service-connected disabilities or with incomes below a established means test. These veterans are regarded by VA as "high priority" veterans, and they are enrolled in Priority Groups 1-6 (see **Appendix 1**). Veterans enrolled in Priority Groups 1-6 include:

- veterans in need of care for a service-connected disability;<sup>21</sup>
- veterans who have a compensable service-connected condition;
- veterans whose discharge or release from active military, naval or air service was for a compensable disability that was incurred or aggravated in the line of duty;
- veterans who are former prisoners of war (POWs);
- veterans awarded the purple heart;
- veterans who have been determined by VA to be catastrophically disabled;
- veterans of World War I;
- veterans who were exposed to hazardous agents (such as Agent Orange in Vietnam) while on active duty; and

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<sup>19</sup> VA Form 10-10EZ is available at [<https://www.1010ez.med.va.gov/sec/vha/1010ez/#Process>].

<sup>20</sup> 38 C.F.R. §17.36 (d)(3)(iv) (2005).

<sup>21</sup> The term "service-connected" means, with respect to disability, that such disability was incurred or aggravated in line of duty in the active military, naval, or air service. VA determines whether veterans have service-connected disabilities, and for those with such disabilities, assigns ratings from 0 to 100% based on the severity of the disability. Percentages are assigned in increments of 10%.

- veterans who have an annual income and net worth below a VA-established means test threshold.

VA also looks at applicants' income and net worth to determine their specific priority category and whether they have to pay copayments for nonservice-connected care. In addition, veterans are asked to provide VA with information on any health insurance coverage they have, including coverage through employment or through a spouse. VA may bill these payers for treatment of conditions that are not a result of injuries or illnesses incurred or aggravated during military service. **Appendix 2** provides information on what categories of veterans pay for which services.

The second group is composed of veterans who do not fall into one of the first six priority groups. These veterans are primarily those with nonservice-connected medical conditions and with incomes and net worth above the VA established means test threshold. These veterans are enrolled in Priority Group 7 or 8.<sup>22</sup> **Appendix 3** provides information on income thresholds for VA health care benefits.

## Funding for VHA

VHA is funded through multiple appropriations accounts that are supplemented by other sources of revenue. Although the appropriations account structure has been subject to change from year to year, traditionally the appropriation accounts used to support VHA include medical care, medical and prosthetic research, and medical administration. In addition, Congress also appropriates funds for construction of medical facilities through a larger appropriations account for construction for all VA facilities. Furthermore, the Committees on Appropriations include medical care cost recovery collections when considering the amount of resources needed to provide funding for VHA. The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), enacted into law in 1986, gave VHA the authority to bill some veterans and most health care insurers for nonservice-connected care provided to veterans enrolled in the VA health care system, to help defray the cost of delivering medical services to veterans.<sup>23</sup>

### Medical Care Collections Fund (MCCF)

The Balanced Budget Act of 1997 (P.L. 105-33) gave VHA the authority to retain these funds in the Medical Care Collections Fund (MCCF). Instead of returning the funds to the Treasury, VA can use them for medical services for

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<sup>22</sup> VA considers a veteran's previous year's total household income (both earned and unearned income as well as his/her spouse's and dependent children's income). Earned income is usually wages received from working. Unearned income can be interest earned, dividends received, money from retirement funds, Social Security payments, annuities, or earnings from other assets. The number of persons in the veterans family will be factored into the calculation to determine the applicable income threshold. 38.CFR. § 17.36(b)(7) (2005).

<sup>23</sup> Veterans' Health-Care and Compensation Rate Amendments of 1985, 100 Stat. 372, 373, 383.

veterans without fiscal year limitations.<sup>24</sup> To increase VA's third-party collections, P.L. 105-33 also gave VA the authority to change its basis of billing insurers from "reasonable costs" to "reasonable charges."<sup>25</sup> This change in billing was intended to enhance VA collections to the extent that reasonable charges result in higher payments than reasonable costs.<sup>26</sup> In FY2004, the Administration's budget requested consolidating several medical collections accounts into MCCF. The conferees of the Consolidated Appropriations Act of 2004 (H.Rept. 108-401) recommended that collections that would otherwise be deposited in the Health Services Improvement Fund (former name), Veterans Extended Care Revolving Fund (former name), Special Therapeutic and Rehabilitation Activities Fund (former name), Medical Facilities Revolving Fund (former name), and the Parking Revolving Fund (former name) should be deposited in MCCF.<sup>27</sup> The Consolidated Appropriations Act of 2005, (P.L. 108-447, H.Rept. 108-792) provided VA with permanent authority to deposit funds from these five accounts into MCCF. The funds deposited in MCCF would be available for medical services for veterans. These collected funds do not have to be spent in any particular fiscal year and are available until expended.

As shown in **Table 2**, MCCF collections increased by 56% from \$1.2 billion in FY2002 to almost \$1.9 billion in FY2005. During this same period, first-party collections increased by 59% from \$485 million in FY2002 to \$772 million in FY2005. In FY2005, first-party collections represented approximately 41% of total MCCF collections.

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<sup>24</sup> For a detailed history of funding for VHA from FY1995 to FY2004, see CRS Report RL32732, *Veterans' Medical Care Funding FY1995-FY2004*, by Sidath Viranga Panangala.

<sup>25</sup> Under "reasonable costs" VA billed insurers based on its average cost to provide a particular episode of care. Under "reasonable charges" VA bills insurers based on market pricing for health care services.

<sup>26</sup> U.S. Government Accountability Office(GAO), *VA Health Care: Third-Party Charges Based on Sound Methodology; Implementation Challenges Remain*, GAO/HEHS-99-124, June 1999.

<sup>27</sup> For a detailed description of these former accounts, see CRS Report RL32548, *Veterans' Medical Care Appropriations and Funding Process*, by Sidath Viranga Panangala.

**Table 2. Medical Care Collections, FY2002-FY2005**  
(\$ in thousands)

	<b>FY2002 Actual</b>	<b>FY2003 Actual</b>	<b>FY2004 Actual</b>	<b>FY2005 Actual</b>
First-party pharmacy copayments <sup>a</sup>	\$377,440	\$576,554	\$623,215	\$648,204
First-party copayments for inpatient and outpatient care	108,392	104,994	113,878	118,626
First-party long-term care copayments <sup>b</sup>	<sup>c</sup>	3,461	5,077	5,411
Third-party insurance collections	689,767	804,141	960,176	1,055,597
Enhanced use leasing revenue <sup>d</sup>	553	234	459	26,861
Compensated work therapy collections <sup>e</sup>	35,275	38,834	40,488	36,516
Parking fees <sup>f</sup>	3,283	3,296	3,349	3,443
Compensation and pension living expenses <sup>g</sup>	788	376	634	2,431
<b>MCCF Total</b>	<b>\$1,215,498</b>	<b>\$1,531,890</b>	<b>\$1,747,276</b>	<b>\$1,897,089</b>

**Source:** Table prepared by CRS based on data provided by the Department of Veterans Affairs.

**Note:** The following accounts were not consolidated into MCCF until FY2004: enhanced use leasing revenue; compensated work therapy collections; parking fees; and compensation and pension living expenses. Collection figures for these accounts for FY2002 and FY2003 are provided for comparison purposes.

**a.** In FY2002, Congress created the Health Services Improvement Fund (HSIF) to collect increases in pharmacy copayments (from \$2 to \$7 for a 30-day supply of outpatient medication) that went into effect on February 4, 2002. The Consolidated Appropriations Resolution, 2003 (P.L. 108-7) granted VA the authority to consolidate the HSIF with MCCF and granted permanent authority to recover copayments for outpatient medications.

**b.** Authority to collect long-term care copayments was established by the Millennium Health Care and Benefits Act (P.L. 106-117). Certain veteran patients receiving extended care services from VA providers or outside contractors are charged copayments.

**c.** VA started collecting long-term care copayments in June 2002; however, system changes weren't put in place until FY2003 to reflect them under long-term care copayments in FY2002.

**d.** Under the enhanced-used lease authority, VA may lease land or buildings to the private sector for up to 75 years. In return VA receives fair consideration in cash and/or in-kind. Funds received as monetary considerations may be used to provide care for veterans.

**e.** The compensated work therapy program is a comprehensive rehabilitation program that prepares veterans for competitive employment and independent living. As part of their work therapy, veterans produce items for sale or undertake subcontracts to provide certain products and/or services such as

providing temporary staffing to a private firm. Funds collected from the sale of these products and/or services are deposited in the MCCF.

**f.** Parking program provides funds for construction, and acquisition of parking garages at VA medical facilities. VA collects fees for use of these parking facilities.

**g.** Under the compensation and pension living expenses program, veterans who do not have either a spouse or child, would have their monthly pension reduced to \$90 after the third month a veteran is admitted for nursing home care. The difference between the veteran's pension and the \$90 is used for the operation of the VA medical facility.

## FY2006 Budget Summary<sup>28</sup>

During the past year, Congress considered several appropriation measures to provide funding for VHA. Aside from the regular FY2006 appropriations bill that provides funding for VHA, Congress passed several measures that included funding to bridge the shortfall for VHA for FY2005 and provided additional funding for FY2006. Given below is a brief description tracking Congressional action on FY2006 appropriations for VHA. **Table 3** provides details of funding levels for the various accounts that comprise funding for VHA.

### House Action

On May 23, 2005, the House Committee on Appropriations reported H.R. 2528, (H.Rept. 109-95) making appropriations for Military Quality of Life and Veterans Affairs and Related Agencies for FY2006 (MIL-QUAL appropriations bill). The House passed H.R. 2528 on May 26, 2005. The MIL-QUAL appropriations bill appropriated \$28.8 billion for VHA. Under the House-passed version of H.R. 2528, the total amount of funds available for VHA was \$31.0 billion, including \$2.2 billion in collections (**Table 3**).

### Budget Shortfall

On June 23, 2005, at a hearing of the House Veterans Affairs Committee the Administration announced that the increased medical care cost for FY2005 was about \$1 billion more than the FY2005 enacted amount. Moreover, at a subsequent hearing before the House Committee on Appropriations, Subcommittee on Military Quality of Life and Veteran Affairs, on June 28, 2005, the Secretary testified that for FY2006 veterans' health care programs would need \$1.1 to \$1.6 billion more than the FY2006 President's request. On June 30, 2005, and July 14, 2005, respectively, the President submitted to Congress a supplemental request to address the FY2005 shortfall and a budget amendment to address the additional funding needs of FY2006. These two requests totaled \$2.9 billion.

On July 26, 2005, the conferees of the Department of the Interior, Environment and Related Agencies, Appropriations bill, 2006 (H.R. 2361, H.Rept. 109-188) provided \$1.5 billion in supplemental appropriations for VA medical services for

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<sup>28</sup> For a detailed description of VA Medical Care Appropriations for FY2006, see CRS Report RL32975, *Veterans' Medical Care: FY2006 Appropriations*, by Sidath Viranga Panangala.

FY2005. The bill included language that would allow VA to carry over any unused funds into FY2006. The House passed H.R. 2361 on July 28, 2005, and the Senate passed the measure a day later. The FY2006 Department of the Interior, Environment, and Related Agencies appropriations bill was signed into law on August 2, 2005 (P.L. 109-54).

## Senate Action

On July 21, 2005, the Senate Committee on Appropriations reported out of committee H.R. 2528 (S.Rept. 109-105) making appropriations for Military Construction and Veterans Affairs and Related Agencies for FY2006 (MIL-CON appropriations bill). This bill appropriated approximately \$33.5 billion for VHA, including \$2.2 billion in collections (**Table 3**).

## Conference Agreement

On November 18, 2005, the House voted to adopt the conference report (H.Rept. 109-305) making appropriations for Military Quality of Life, Military Construction, Veterans Affairs, and Related Agencies for FY2006 (MIL-CON-QUAL-VA Appropriations Act). The Senate adopted H.Rept. 109-305 by unanimous consent that same day. The MIL-CON-QUAL-VA Appropriations Act was signed into law by the President on November 30, 2005 (P.L.109-114). The MIL-CON-QUAL-VA Appropriations Act appropriated \$ 29.1 billion for VHA (**not shown in Table 3**). This amount included \$22.5 billion for medical services, \$2.9 billion for medical administration, \$3.3 billion for medical facilities and \$412 million for medical and prosthetic research. When Congress passed P.L.109-114, it designated \$1.2 billion as an emergency requirement, and included bill language that required the President to declare the entire amount as an emergency. On January 28, 2006, the President designated \$1.2 billion in funding for veterans health care as an “emergency.”

## Defense Appropriations Bill FY2006

On October 28, 2005, President Bush submitted a reallocation request to Congress to transfer previously appropriated funds to several agencies, including the VA, to address various needs arising from the consequences of Hurricane Katrina. Congress responded to the President’s proposed reallocation by attaching the reallocation request to the conference version of the FY2006 Defense Appropriations bill (H.R. 2863).

The conference agreement includes \$225.2 million for VA medical services, including \$198.2 million to purchase medical equipment and supplies lost during the Gulf Coast hurricanes, and \$27.0 million for Avian Flu pandemic preparation (**shown in Table 3**). H.R. 2863 also included \$24.9 million for general operating expenses; \$200,000 to clean up and repair national cemeteries; \$368 million for construction major projects; and \$1.8 million for the construction minor projects accounts (**these amounts are not shown in Table 3**). The Department of Defense Appropriations Act, 2006 was signed into law on December 30, 2005 (P.L. 109-148).

## FY2006 Hurricane Supplemental for VA

On February 16, 2006, the Administration submitted two separate FY2006 supplemental appropriations requests.<sup>29</sup> One of these supplemental requests would provide \$19.8 billion for recovery and reconstruction activities in hurricane-affected Gulf Coast areas. In this request the Administration requested \$600 million for VA's construction major projects account to be used for rebuilding the VA Medical Center in New Orleans, which was damaged by Hurricane Katrina. Proposed funding for this project was previously included in the October 28, 2005 reallocation request, but Congress provided only \$75.0 million of the \$368 million, for the purpose of advance planning and design of the VA Medical Center in New Orleans. The conference committee did not include the full amount of funding because it felt that there was insufficient information to determine the actual cost of the project. In the FY2006 conference report, H.Rept. 109-359, VA was directed to report to the Committees on Appropriations of both Houses of Congress by February 28, 2006, on the long term plans for the replacement hospital construction. The report submitted by VA estimated that the cost of construction of a new VA Medical Center in New Orleans would be \$636 million.

**House Action.** On March 17, 2006, the House passed the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006 (H.R. 4939, H.Rept. 109-388). The House-passed bill provides \$550 million for rebuilding the VA Medical Center in New Orleans, \$50.0 million less than the Administration's request. In addition, the Secretary of Veterans Affairs is authorized to transfer up to \$275 million of this amount to the medical services account, to be used only for unanticipated costs related to the global war on terror. Availability of the \$550 million appropriation is made contingent on the enactment of authority for it by June 30, 2006.

**Senate Action.** On May 4, 2006, the Senate passed its version of H.R. 4939 (S.Rept. 109-230). The Senate-passed bill provides \$623 million for the construction major projects account, \$73.0 million above the House-passed amount. This includes \$561 million for the construction of a new VA Medical Center in New Orleans. Together with the previous appropriation of \$75.0 million in P.L. 109-148, the total amount of funding for reestablishing the VA Medical Center in New Orleans would be \$636 million. During the Senate Appropriations Committee mark up of H.R. 4939, the Committee designated \$62.0 million of the total amount provided for the construction major projects account to be used for the disposal and cleanup of land associated with the VA medical facility in Gulfport, Mississippi.

During floor consideration of H.R. 4939, the Senate adopted an amendment offered by Senator Akaka to provide \$430 million for the VHA medical services account for FY2006. Of this amount: \$168 million was designated to address veterans' mental health care needs, including Post-Traumatic Stress Disorder (PTSD); and \$80.0 million was designated for the provision of readjustment

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<sup>29</sup> For further information see CRS Report RL33298, *FY2006 Supplemental Appropriations: Iraq and Other International Activities; Additional Katrina Hurricane Relief*, coordinated by Paul M. Irwin, and Larry Nowels.



counseling services to veterans. The amendment also included language that requires the President to declare the entire amount of \$430 million as an emergency requirement. H.R. 4939 is awaiting conference committee action.

## FY2007 VHA Budget

### Administration's Budget Request

On February 6, 2006, the President submitted his FY2007 budget proposal to Congress. The Administration requested \$32.7 billion for VHA, an 11.3% increase over the FY2006 enacted amount of \$29.3 billion, and a 10% increase over FY2005 enacted amount of \$29.7 billion. (**Table 3**). The FY2007 request included \$25.5 billion for medical services, a 12% increase over the FY2006 enacted amount; \$3.2 billion for medical administration, an 11.2% increase over FY2006; \$3.6 billion for medical facilities, an 8.2% increase over FY2006; and \$399 million for medical and prosthetic research, a 3.2% decrease from the FY2006 enacted amount.

The President's FY2007 budget request also includes a set of legislative proposals that the Administration asserts "will continue to concentrate VA's health care resources to meet the needs of high priority core veterans — those with service-connected conditions, those with lower incomes, and veterans with special health care needs."<sup>30</sup> These legislative proposals are discussed in detail under the key budget issues section of this report.

### House and Senate Budget Resolutions

On March 31, 2006, the House Budget Committee reported H.Con.Res. 376 (H.Rept. 109-402), providing \$36.9 billion for VA's discretionary programs, which consist mainly of VA medical care. This amount includes an amendment offered by Representative Bradley increasing the discretionary budget authority by \$795 million over the President's recommended level. According to the Committee Report language, the recommended amount does not assume the President's proposal to implement enrollment fees and increase drug copayments for Priority Group 7 and 8 veterans.<sup>31</sup> H.Con.Res. 376 also calls for budget authority of \$37.8 billion for VA's mandatory programs. In total, the Committee reported budget resolution calls for \$74.7 billion for VA programs for FY2007. H.Con.Res. 376 is awaiting House action.

On March 9, 2006, the Senate Budget Committee marked up S.Con.Res. 83, and the Senate passed it on March 16, 2006. On the Senate floor, \$823 million was added to the Committee recommended amount to provide an additional \$795 million

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<sup>30</sup> Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2007, Appendix*, p. 956.

<sup>31</sup> U.S. Congress, House Committee on the Budget, *Concurrent Resolution on the Budget-Fiscal Year 2007*, report to accompany H.Con.Res. 376, 109<sup>th</sup> Cong., 2<sup>nd</sup> sess., H.Rept. 109-402, p. 45.

to VA Medical Services, in lieu of enactment of the proposed pharmacy copayment increase and the new enrollment fee, and \$28 million to increase VA's medical & prosthetic research funding. In total S.Con.Res. 83 calls for \$74.8 billion for VA programs for FY2007. This includes approximately \$37.0 billion for VA's discretionary programs, and approximately \$37.8 billion for mandatory programs.

### **House Subcommittee Action**

On May 4, 2006, the House Committee on Appropriations, Subcommittee on Military Quality of Life and Veterans Affairs, and Related Agencies approved by voice vote a draft bill providing appropriations for Military Quality of Life, Military Construction, and Veterans Affairs for FY2007. The subcommittee-approved bill provides \$32.7 billion for VHA, a \$3.4 billion (11.4%) increase over the FY2006 enacted amount of \$ 29.3 billion, and almost the same as the President's request. This amount includes \$25.4 billion for medical services, \$100 million less than the President's request and \$2.6 billion (11.6%) over the FY2006 enacted amount of \$22.8 billion (**Table 3**). The draft bill also provides \$3.3 billion for medical administration, \$100 million above the Administration's request of \$3.2 billion; \$3.6 billion for medical facilities; and \$412 million for medical and prosthetic research, a 3.2% increase over the President's request of \$399 million (**Table 3**). The subcommittee **did not** recommend any fee increases as requested by the Administration's budget proposal for VHA for FY2007. The draft bill now moves to the full House Appropriations Committee for markup.

**Table 3. VHA Appropriations for FY2005, FY2006, FY2007 Request, and FY2007 Subcommittee Recommendation**  
(\$ in thousands)

Program	FY2005 request	FY2005 House	FY2005 Senate	FY2005 enacted	FY2006 request	FY2006 House	FY2006 Senate	FY2006 enacted	FY2007 request	FY2007 House Subcommittee
Medical services	—	\$19,498,600	\$19,498,600 <sup>a</sup>	\$19,316,995	\$19,995,141	\$20,995,141	\$21,331,011	\$21,322,141	\$25,512,000	\$25,412,000
Supplemental appropriations (P.L. 108-324)	\$38,283	—	—	38,283	—	—	—	—	—	—
Supplemental appropriations	975,000 <sup>b</sup>	975,000 <sup>c</sup>	1,500,000 <sup>d</sup>	1,500,000 <sup>e</sup>	—	—	—	—	—	—
Emergency appropriations	—	—	—	—	1,977,000 <sup>f</sup>	—	1,977,000 <sup>g</sup>	1,225,000 <sup>h</sup>	—	—
Emergency appropriations- Gulf Coast Hurricanes (P.L. 109-148)	—	—	—	—	198,265	—	—	198,265	—	—
Emergency appropriations- Avian Flu Pandemic (P.L.109-148)	—	—	—	—	27,000	—	—	27,000	—	—
<b>Subtotal medical services</b>	<b>1,013,283</b>	<b>20,473,600</b>	<b>20,998,600</b>	<b>20,855,278</b>	<b>22,197,406</b>	<b>20,995,141</b>	<b>23,308,011</b>	<b>22,772,406</b>	<b>25,512,000</b>	<b>25,412,000</b>
Medical administration	—	4,705,000	4,705,000	4,667,360	4,517,874	4,134,874	2,858,442	2,858,442	3,177,000	3,277,000
Supplemental appropriations (P.L. 108-324)	1,940	—	—	1,940	—	—	—	—	—	—
<b>Subtotal medical administration</b>	<b>1,940</b>	<b>4,705,000</b>	<b>4,705,000</b>	<b>4,669,300</b>	<b>4,517,874</b>	<b>4,134,874</b>	<b>2,858,442</b>	<b>2,858,442</b>	<b>3,177,000</b>	<b>3,277,000</b>
Medical facilities	—	3,745,000	3,745,000	3,715,040	3,297,669	3,297,669	3,297,669	3,297,669	3,569,000	3,594,000
Supplemental appropriations (P.L. 108-324)	46,909	—	—	46,909	—	—	—	—	—	—
<b>Subtotal medical facilities</b>	<b>46,909</b>	<b>3,745,000</b>	<b>3,745,000</b>	<b>3,761,949</b>	<b>3,297,669</b>	<b>3,297,669</b>	<b>3,297,669</b>	<b>3,297,669</b>	<b>3,569,000</b>	<b>3,594,000</b>
Medical and prosthetic research	384,770	384,770	405,593	402,348	393,000	393,000	412,000	412,000	399,000	412,000
Information technology	—	—	—	—	—	—	1,456,821	—	—	—
Medical care <sup>i</sup>	26,748,600	—	—	—	—	—	—	—	—	—
<b>Total VHA appropriations (without collections)</b>	<b>28,195,502</b>	<b>28,308,370</b>	<b>28,854,193</b>	<b>29,688,875</b>	<b>30,405,949</b>	<b>28,820,684</b>	<b>31,332,943</b>	<b>29,340,517</b>	<b>32,657,000</b>	<b>32,695,000</b>
Medical care cost collection (MCCF) <sup>j</sup>	2,002,000	2,002,000	2,002,000	1,985,984	2,170,000	2,170,000	2,170,000	2,170,000	2,329,000	2,329,000
<b>Total: VHA (appropriations and collections)</b>	<b>\$30,197,502</b>	<b>\$31,310,370</b>	<b>\$30,856,193</b>	<b>\$31,674,859</b>	<b>\$32,575,949</b>	<b>\$30,990,684</b>	<b>\$33,502,943</b>	<b>\$31,510,517</b>	<b>\$34,986,000</b>	<b>\$35,024,000</b>

**Source:** Table prepared by the Congressional Research Service based on H.Rept. 108-674; S.Rept. 108-353; H.Rept. 109-95; S.Rept. 109-105; H.Rept. 109-305; H. Rept.109-359; and House Appropriations Committee data.

**Note:** Appropriation amounts for FY2005 adjusted to account for the 0.8% across-the-board reduction in most discretionary accounts as called for in Division J, Section 122 (a)(1) of P.L. 108-447. Supplemental appropriations for FY2005 are not subject to the 0.8% across-the-board reductions. Appropriation amounts for FY2006 **are not** subject to any cross-the-board reductions as stipulated in Division B, Title III, Section 3801(c)(2) of P.L.109-148.

- a. This amount includes \$1.2 billion designated as an emergency requirement.
- b. On June 30, 2005, the Administration requested an additional \$975 million for medical services for FY2005.
- c. On June 30, 2005, the House passed H.R. 3130.
- d. On June 29, 2005, the Senate passed an amendment to H.R. 2361, the Department of the Interior, Environment, and Related Agencies Appropriations bill, 2006 to add \$1.5 billion in emergency funds for medical services.
- e. On August 2, 2005, the FY2006 Department of the Interior, Environment, and Related Agencies appropriations bill (H.R 2361, P.L. 109-54) was signed into law.
- f. On July 14, 2005, the Administration requested an additional \$1.977 billion for medical services for FY2006.
- g. On July 21, 2005, the Senate Committee on Appropriations reported H.R. 2528 favorably out of committee (S.Rept. 109-105), and designated this amount as an emergency appropriation.
- h. On November 18, 2005, the House and Senate adopted the conference report (H.Rept.109-305) to accompany H.R. 2528, and designated this amount as an emergency appropriation.
- i. This amount includes funding for medical services, medical administration, and medical facilities.
- j. Medical Care Cost Collection Fund (MCCF) receipts are restored to VHA as an indefinite budget authority equal to the revenue collected, estimated to be \$1.985 billion in FY2005, \$2.17 billion in FY2006, and \$2.33 billion in FY2007.

## Key Budget Issues

In its FY2007 budget request, the Administration proposed several legislative changes that it asserts will “refocus the VA health care system to better meet the needs of highest priority veterans — those with service-connected conditions, those with lower incomes, and those with special health care needs.”<sup>32</sup> These proposals are similar to previous ones that were included in the Administration’s budget requests for FY2003, FY2004, FY2005, and FY2006, and were rejected by Congress.<sup>33</sup>

The President’s budget request includes three major policy proposals:

- assess an annual enrollment fee of \$250 for all Priority 7 and 8 veterans;
- increase pharmaceutical copayments from \$8 to \$15 (for each 30-day prescription) for all enrolled veterans in Priority Groups 7 and 8; and
- bill veterans receiving treatment for nonservice-connected conditions for the entire copayment amount.

A detailed description of these legislative proposals follows.

### Assess an Annual Enrollment Fee

The Administration proposes to establish an annual enrollment fee of \$250 beginning October 1, 2006, for all Priority 7 and 8 veterans. Priority Group 7 veterans have incomes above \$26,902 for a single veteran (see **Appendix 3** for VA income thresholds) and below the Department of Housing and Urban Development (HUD) geographic means test level.<sup>34</sup> Priority Group 8 veterans are those with incomes above \$26,902 for a single veteran and above the HUD geographic means test amount. The HUD geographic means test is established at a local level such as county or city. For instance, a veteran with no dependents residing in Grant County, Arkansas, whose annual income in 2005 was \$27,145, will be placed in Priority Group 7, because the veteran’s annual income is above VA’s means test threshold of \$26,902 and below the FY2005 geographic means test threshold of \$27,150 for that county. Similarly, a veteran with no dependents living in Orange County, California, whose annual income in 2005 was \$42,250, will be placed in Priority Group 7,

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<sup>32</sup> U.S. Department of Veterans Affairs, *FY2007 Congressional Budget Submissions, Medical Programs*, vol.1 of 4, p.3-9.

<sup>33</sup> In FY2003, VA proposed a \$1,500 deductible for all Priority Group 7 veterans for nonservice-connected disabilities. For proposals included in FY2004, FY2005, and FY2006, see CRS Report RL32548, *Veterans’ Medical Care Appropriations and Funding Process*, by Sidath Viranga Panangala, and CRS Report R.L.32975, *Veterans’ Medical Care: FY2006 Appropriations*, by Sidath Viranga Panangala.

<sup>34</sup> Geographic means test figures are available at [<http://www.va.gov/healtheligibility/DOCS/GMTIncomeThresholds2005.pdf>]. Also note that when determining if the veterans should be placed in Priority Group 7 or Priority Group 8 based on income, the veteran’s income from the previous year is compared with the appropriate geographic means test threshold for the previous fiscal year. For example, annual income for 2005 is compared to the geographic means test threshold for FY2005.

because the veteran's annual income is above VA's means test threshold of \$26,902 and below the FY2005 geographic means test threshold for of \$43,000 for Orange County. It should be noted that there is wide variation in annual incomes of veterans placed in Priority Groups 7 and 8.

In its FY2004, FY2005, and FY2006 budget submissions, the President requested authority from Congress to levy an annual enrollment fee on all Priority 7 and Priority 8 veterans. However, Congress did not approve imposing such a fee.

In its FY2007 Views and Estimates letter to the House Budget Committee, the House Veterans Affairs Committee did not support levying an enrollment fee. The letter states that "while the Committee understands the policy arguments providing the basis for the Administration's proposal for Priority 7 and 8 veterans to assume a greater share of the costs for their health care in the VA system, the majority of the Committee does not support these legislative proposals."<sup>35</sup>

The Chairman of the Senate Veterans' Affairs Committee, in his FY2007 views and estimates letter to the Senate Budget Committee, did agree that "during a time of high deficits and restrained spending in every account unrelated to national security, the President's proposal to shift a small portion of the cost of funding record growth in VA's budget on to lower priority veterans is reasonable. I have no objection to the proposals he has chosen, but I am not necessarily wed to them."<sup>36</sup>

It should be noted that at this time both the House and Senate Veterans Affairs Committees **have not** introduced any legislation to give VA the authority to assess an enrollment fee. Furthermore, the House Appropriations Committee, Subcommittee on Military Quality of Life and Veterans Affairs, and Related Agencies, **did not** recommend assessing an enrollment fee.

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<sup>35</sup> House Committee on Veterans Affairs, Views and Estimates of the Committee on Veterans' Affairs regarding the Administration's FY2007 budget request for veterans' programs, Feb 23, 2006. Available at [<http://veterans.house.gov/legislation/109/budrep07.pdf>].

<sup>36</sup> Senate Committee on Veterans' Affairs, Views and Estimates of the Committee on Veterans' Affairs regarding the Administration's FY2007 budget request for veterans' programs, March 2, 2006. Available at [<http://veterans.senate.gov/index.cfm?FuseAction=Newsroom.PressReleases&month=3&year=2006&id=484>].

## Increase Pharmacy Copayments

The Administration proposes increasing the pharmacy copayments from \$8 to \$15 for all enrolled Priority Group 7 and Priority Group 8 veterans, whenever they obtain medication from VA on an outpatient basis for the treatment of a nonservice-connected condition. The Administration put forward this proposal in its FY2004, FY2005, and FY2006 budget requests as well, but did not receive any approval from Congress. At present, veterans in Priority Groups 2-8 pay \$8 for a 30-day supply of medication, including over-the-counter medications.<sup>37</sup>

The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) authorized VA to charge most veterans \$2 for each 30-day supply of medication furnished on an outpatient basis for treatment of a nonservice-connected condition. The Veterans Millennium Health Care and Benefits Act of 1999 (P.L. 106-117) authorized VA to increase the medication copayment amount and establish annual caps on the total amount paid, to eliminate financial hardship for veterans enrolled in Priority Groups 2-6.<sup>38</sup> When veterans reach the annual cap, they continue to receive medications without making a copayment.

On November 15, 2005, VHA issued a directive stating that effective January 1, 2006, the medication co-payment will be increased to \$8 for each 30-day supply of medication furnished on an outpatient basis for treatment of a nonservice-connected condition, and that the annual cap for veterans enrolled in Priority Groups 2-6 will be \$960.<sup>39</sup> There is no cap for veterans in Priority Groups 7 and 8 (see **Appendixes 2 and 3**).

It should be noted that at this time, both the House and Senate Veterans Affairs Committees **have not** introduced any legislation to giving VA the authority to increase copayments. Furthermore, the House Appropriations Committee, Subcommittee on Military Quality of Life and Veterans Affairs, and Related Agencies, **did not** recommend an increase in copayments.

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<sup>37</sup> The following veterans are exempt from paying copayments: Veterans receiving a pension for a nonservice-connected disability from VA; veterans with incomes below \$10,579 (if no dependents), and \$13,855 (with one dependent plus \$1,806 for each additional dependent ); veterans receiving care for conditions such as Agent Orange, Military Sexual Trauma, and combat veterans within two years of discharge; and veterans who are former POW's.

<sup>38</sup> This law allowed VA to increase the copayment amount for each 30-day or less supply of medication provided on an outpatient basis (other than medication administered during treatment) for treatment of a nonservice-connected condition. Accordingly, VA increased the copayment amount from \$2 to \$7. The medication copayment charge for each subsequent calendar year after 2002 is established by using the prescription drug component of the Medical Consumer Price Index. When an increase occurs, the copayment will increase in whole dollar amounts. The amount of the annual cap increases \$120 for each \$1 increase in the copayment amount.

<sup>39</sup> VHA Directive 2005-052, *Implementation of Medication Copayment Changes*, Nov. 15, 2005.

## Impact of the Annual Enrollment Fee and Increase in Pharmacy Copayments

VA estimates that about 200,000 veterans in Priority Groups 7 and 8 would be affected by the \$250 annual enrollment fee and the increase in prescription drug copayments. According to VA's estimates, the enrollment fees and increased pharmacy copayments would generate \$514 million in revenue and save VA an additional \$251 million due to reduced demand, resulting in a decrease of \$765 million in appropriations for FY2007.

Together two recent studies suggest that veterans may be impacted by increased pharmaceutical copayments. In one published study it was indicated that patients with access to the VA's prescription drug coverage had lower rates of cost-related adherence problems than patients with Medicare or no insurance coverage. This study also found that VA patients were also less likely than some non-VA patients to report other detrimental consequences of medication cost pressures, such as foregoing necessities to pay for their medication or worrying frequently about how they could pay for their treatments.<sup>40</sup>

In another study that examined the impact of the increased copayment on veterans' use of antidepressant medication, VA researchers found that medication cost could be a prohibitive factor for veterans with copayment obligations. The researchers further state that veterans who had to pay copayments appear to fill the antidepressant prescriptions less frequently than veterans who are exempt from the copayment requirement.<sup>41</sup>

## Third-Party Offset of First-Party Debt

The Administration is requesting that Congress amend VA's statutory authority by eliminating the practice of reducing first-party copayment debts with third-party health insurance collections. VA asserts that this proposal would align VA with the DOD health care system for military retirees and with the private sector.

With the enactment of P.L. 99-272 in 1986, Congress authorized VA to collect payments from third-party health insurers for the treatment of veterans with nonservice-connected disabilities, and it also established copayments from veterans for this care.<sup>42</sup> Under current law, VA is authorized to collect from third-party health insurers to offset the cost of medical care furnished to a veteran for the treatment of

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<sup>40</sup> John D. Piette, and Michele Heisler, Problems Due to Medication Costs Among VA and Non-VA Patients With Chronic Illnesses, *American Journal of Managed Care*, vol. 10, no. 11, (November 2004), p.867.

<sup>41</sup> M.Zimmer, L.Petersen, M. Kubeler, and J.Cully, Effects of Increased Copayment on Antidepressant Prescription Fill Rates in VA Patients, poster presented at the 24th Annual VA Health Services Research and Development (HSR&D) Meeting, Washington, DC, Feb. 15-17, 2006 (this study has not been published yet).

<sup>42</sup> Consolidated Omnibus Budget Reconciliation Act of 1985, 100 Stat. 372, 373, 383.



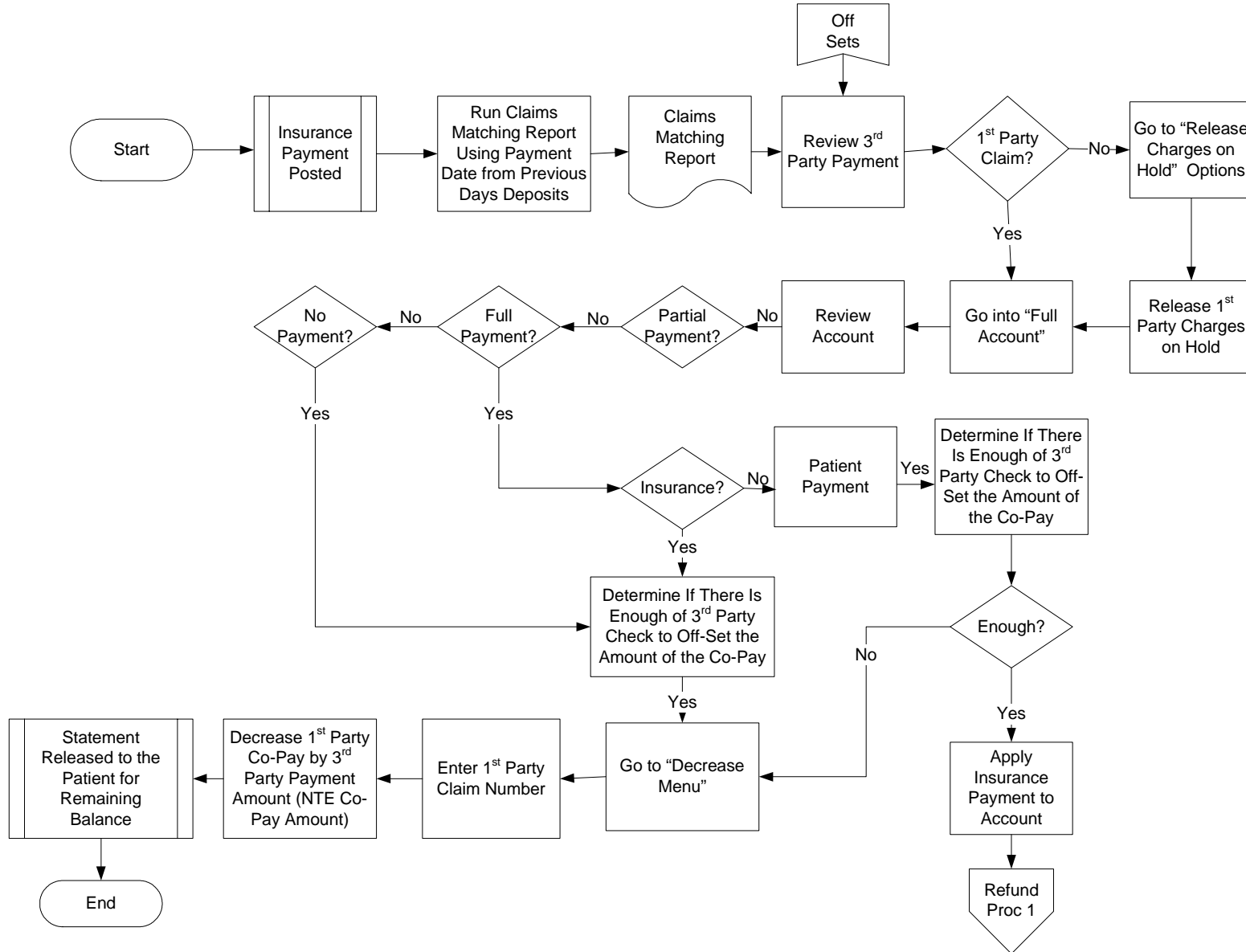
a nonservice-connected condition.<sup>43</sup> If VA treats an insured veteran for a nonservice-connected disability, and the veteran is also determined by VA to have copayment responsibilities, VA will apply the payment collected from the insurer to satisfy the veteran's copayment debt related to that treatment.

Under the current copayment billing process, in cases where the cost of a veteran's medical care for a nonservice-connected condition appears to qualify for billing under reimbursable insurance and copayment, VA medical facilities sends the bill to the insurance provider. The veteran's copayment obligation is placed on hold for 90 days pending payment from the third-party payer. If no payment is received from the third-party payer within 90 days, then a bill is sent to the veteran for the full copayment amount. However, when insurers reimburse VA after the 90-day period, VA must absorb the cost of additional staff time for processing a refund if the veteran has already paid the bill. On all insurance policies, the entire amount of the claim payment is applied first to the copayment. The veteran is then billed only for the portion of the copayment not covered by the insurance reimbursement and the portion of the copayment for services not covered by the veteran's insurance plan (**Figure 1**).

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<sup>43</sup> 38 U.S.C. §1729; 38 U.S.C. §1710; and 38, U.S.C. 1722A.

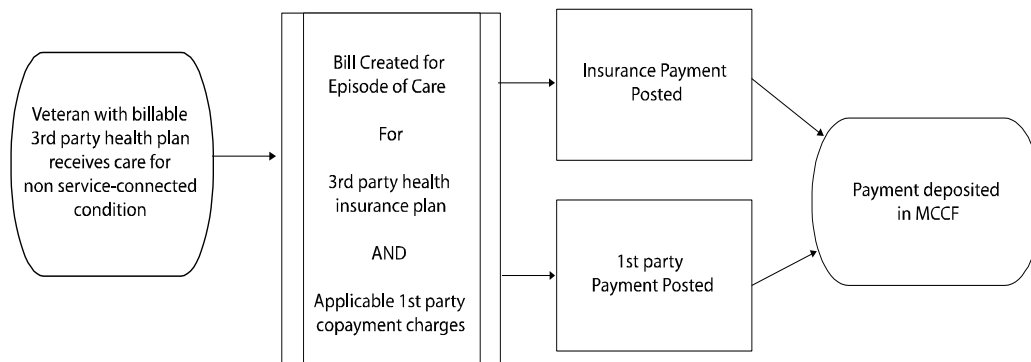
**Figure 1. Present Copayment Process**



**Source:** Department of Veterans Affairs.

According to two reports released by the Government Accountability Office (GAO), the practice of satisfying copayment debt with recoveries made from third-party insurers has resulted in reduced overall cost recoveries and increased administrative expenses.<sup>44</sup> Under the Administration's proposal, VA would bill and collect copayments from patients regardless of any amounts recovered from the veterans private health insurance plan. As the patient's bill is generated, VA would bill the insurer for the full cost of VA care provided to a veteran for a nonservice-connected condition (**Figure 2**).

**Figure 2. Copayment Process Under New Proposal**



**Source:** Chart prepared by CRS.

## Impact of Third-Party Offset of First-Party Debt

According to VA's estimates, if this proposal is enacted it would contribute approximately \$31.0 million toward VA's collections. It should be noted that at this time that the House and Senate Veterans Affairs Committees **have not** introduced any legislation to give VA the authority to implement this proposal.

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<sup>44</sup> U.S. Government Accountability Office (GAO), *VA Medical Care: Increasing Recoveries From Private Health Insurers Will Prove Difficult*, GAO/HEHS-98-4, Oct. 17 1997; and *VA Health Care: Guidance Needed for Determining the Cost to Collect from Veterans and Private Health Insurers*, GAO-04-938, July 2004.

## Appendix 1. Priority Groups and Their Eligibility Criteria

<p><b>Priority Group 1</b> Veterans with service-connected disabilities rated 50% or more disabling</p>
<p><b>Priority Group 2</b> Veterans with service-connected disabilities rated 30% or 40% disabling</p>
<p><b>Priority Group 3</b> Veterans who are former POWs Veterans awarded the Purple Heart Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty Veterans with service-connected disabilities rated 10% or 20% disabling Veterans awarded special eligibility classification under Title 38, U.S. C., Section 1151, “benefits for individuals disabled by treatment or vocational rehabilitation”</p>
<p><b>Priority Group 4</b> Veterans who are receiving aid and attendance or housebound benefits Veterans who have been determined by VA to be catastrophically disabled</p>
<p><b>Priority Group 5</b> Nonservice-connected disabled veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds Veterans receiving VA pension benefits Veterans eligible for Medicaid benefits</p>
<p><b>Priority Group 6</b> Compensable 0% service-connected disabled veterans World War I veterans Mexican Border War veterans Veterans solely seeking care for disorders associated with — exposure to herbicides while serving in Vietnam; or — ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or — for disorders associated with service in the Gulf War; or — for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.</p>
<p><b>Priority Group 7</b> Veterans who agree to pay specified copayments who have income and/or net worth <i>above</i> the VA Means Test threshold and income <i>below</i> the HUD geographic index — Subpriority a: Noncompensable 0% service-connected disabled veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date — Subpriority c: Nonservice-connected disabled veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date. — Subpriority e: Noncompensable 0% service-connected disabled veterans not included in Subpriority a above — Subpriority g: Nonservice-connected disabled veterans not included in Subpriority c above</p>
<p><b>Priority Group 8</b> Veterans who agree to pay specified copayments with income and/or net worth <i>above</i> the VA Means Test threshold and the HUD geographic index — Subpriority a: Noncompensable 0% service-connected disabled veterans enrolled as of January 16, 2003 and who have remained enrolled since that date — Subpriority c: Nonservice-connected disabled veterans enrolled as of January 16, 2003 and who have remained enrolled since that date — Subpriority e: Noncompensable 0% service-connected disabled veterans applying for enrollment after January 16, 2003</p>

**Source:** Department of Veterans Affairs.

**Note:** Service-connected disability means with respect to disability, that such disability was incurred or aggravated in the line of duty in the active military, naval or air service

## Appendix 2. Veterans' Payments for Health Care Services

	Copayments				Insurance Billing	Humanitarian Emergency Billing
	Inpatient		Outpatient	Medication <sup>a</sup>		
	Geographic Means Test Copayment	VA Means Test				
Priority Group 1	No	No	No	No	Yes, but only if care was for nonservice-connected condition	No
Priority Groups 2, 3, <sup>b</sup> 4 <sup>c</sup>	No	No	No	Yes, but only for veterans with less than 50% service connected disability and medication is for nonservice-connected condition. Former POWs are exempt from all medications copayments	Yes, but only if care was for nonservice-connected condition	No
Priority Group 5	No	No	No	Yes	Yes, but only if care was for nonservice-connected condition	No
Priority Group 6 (WWI, and 0% service-connected compensable)	No	No	No	Yes	Yes, but only if care was for nonservice-connected condition	No
Priority Group 6 (Veterans receiving care for exposure or experience) <sup>d</sup>	No	No <sup>d</sup>	No <sup>d</sup>	No <sup>d</sup>	Yes, but only if care was for nonservice-connected condition	No
Priority Group 7a	Yes	No	Yes	Yes, but only if care was for nonservice-connected condition	Yes, but only if care was for nonservice-connected condition	No

	Copayments			Insurance Billing	Humanitarian Emergency Billing	
	Inpatient		Outpatient			Medication <sup>a</sup>
	Geographic Means Test Copayment	VA Means Test				
Priority Group 7c	Yes	No	Yes	Yes, but only if care was for nonservice-connected condition	No	
Priority Group 8a	No	Yes	Yes	Yes, but only if care was for nonservice-connected condition	No	
Priority Group 8c	No	Yes	Yes	Yes, but only if care was for nonservice-connected condition	No	

**Source:** Table prepared by CRS based on information from the Department of Veterans Affairs.

- a. An annual medication copayment cap has been established for veterans enrolled in priority groups 2-6. Medication will continue to be dispensed after copayment cap is met. An annual copayment cap has not been established for veterans enrolled in Priority Groups 7 or 8.
- b. Veterans in receipt of a Purple Heart are in Priority Group 3. This change occurred with the enactment of the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) on Nov. 30, 1999.
- c. Priority Group 7 veterans who are determined to be catastrophically disabled and who are placed in Priority Group 4 for treatment are still subject to the copayment requirements as a Priority Group 7 veteran.
- d. Priority Group 6 — veterans claiming exposure to Agent Orange; veterans claiming exposure to environmental contaminants; veterans exposed to Ionizing Radiation; combat veterans within two years of discharge from the military; veterans who participated in Project 112/SHAD; veterans claiming military sexual trauma; and veterans with head and neck cancer who received nasopharyngeal radium treatment while in the military are subject to copayments when their treatment or mediation is not related to their exposure or experience. The initial registry examination and follow-up visits to receive results of the examination are not billed to the health insurance carrier and are not subject to copayments. However, care provided not related to exposure, if it is nonservice-connected will be billed to the insurance carrier and copayments can apply.

**Notes:** Priority Group 7a and 7c veterans have income above the VA Means Test threshold but below the Geographic Means Test threshold and are responsible for 20% of the inpatient copayment and 20% of the inpatient per diem copayment. The geographic means test copayment reduction does not apply to outpatient and medication copayment and veterans will be assessed the full applicable copayment charges. Note that reduced inpatient copayments can apply to veterans in Priority Groups 4 and 6 based upon the income of the veteran.

Priority Group 8a and 8c veterans have income above the VA Means Test threshold and above the Geographic Means Test threshold. Veterans enrolled in this priority group are responsible for the full inpatient copayment and the inpatient per diem copayment for care of their nonservice-connected conditions. Veterans in this priority group are also responsible for outpatient and medication copayments for care of their nonservice-connected conditions.

**Appendix 3. Financial Income Thresholds  
for VA Health Care Benefits**

<b>Veterans with:</b>	<b>Free VA Prescriptions and Travel Benefits for veterans with incomes of:</b>	<b>Free VA Inpatient and Outpatient care for veterans with incomes of:</b>
<b>No dependents</b>	\$10,579 or less	\$26,902 or less
<b>1 dependent</b>	\$13, 855 or less	\$32,285 or less
<b>2 dependents</b>	\$15, 661 or less	\$34,285 or less
<b>3 dependents</b>	\$17,467 or less	\$34,091 or less
<b>4 dependents</b>	\$19,273 or less	\$37,703 or less
<b>For each additional dependent, add:</b>	\$1,806	\$1,806

Source: Department of Veterans Affairs.