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Veterans Medical Care: FY2009 Appropriations

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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. The VA provides these benefits through three major operating units: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), and the National Cemetery Administration (NCA). The VHA is primarily a direct service provider of primary care, specialized care, and related medical and social support services to veterans through the nation's largest integrated health care system.

On February 4, 2008, the President submitted his FY2009 budget proposal to Congress. The Administration requested a total of $39.2 billion (excluding collections) for VHA. This is a 5.3% increase (or $2.0 billion) over the FY2008 enacted level. Including total available resources (including medical collections) the Administration's budget would have provided $41.1 billion for VHA.

On March 7, 2008, the House (H.Con.Res. 312) and Senate (S.Con.Res. 70) reported their respective budget resolutions. After negotiations between the House and Senate, the House agreed to an amended version of S.Con.Res. 70 (Conference Report; H.Rept. 110-659). The conference agreement provided $48.2 billion for FY2009 for discretionary veterans' programs, including medical care, and provided $45.1 billion in mandatory funding for veterans programs.

On June 24, the House Appropriations Committee marked up the Military Construction and Veterans Affairs Appropriations bill (H.R. 6599; H.Rept. 110-775) for FY2009. On August 1, the House passed H.R. 6599. The House-passed measure provided $40.8 billion (excluding collections) for VHA. On July 17, 2008, the Senate Appropriations Committee marked up its version of the FY2009 Military Construction and Veterans Affairs and Related Agencies Appropriations bill (S. 3301; S.Rept. 110-428). The Senate Appropriations Committee recommended $41.1 billion (excluding collections) for VHA for FY2009.

On September 30, the President signed the H.R. 2638, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, into law as P.L. 110-329. This act included the Military Construction and Veterans Affairs Appropriations Act, 2009. In total H.R. 2638 provides a total of $40.9 billion (excluding collections) for VHA.

P.L. 110-329 *does not* include bill language authorizing fee increases as requested by the Administration's budget proposal for the VHA for FY2009. P.L. 110-329 has provided additional funding to increase Priority Group 8 enrollment in FY2009, and to increase the mileage reimbursement rate to 41.5 cents per mile.

With the passage of H.R. 2638 (P.L. 110-329), the appropriation process for funding VHA for FY2009 was completed by Congress. This report will not be updated.

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Most Recent Developments

On September 30, 2008, the President signed H.R. 2638, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, into law as P.L. 110-329. This act included the Military Construction and Veterans Affairs Appropriations Act, 2009 (MILCON-VA Appropriations Act of 2009), as its Division E.[1] The House passed H.R. 2638 on September 24 and the Senate passed it on September 27. The MILCON-VA Appropriations Act of 2009 provides a total of $40.9 billion for the Veterans Health Administration (VHA) for FY2009 (see **Table 1**), a $1.7 billion increase over the Administrations request and a $3.7 billion over the FY2008 enacted amount. P.L. 110-329 *did not* include any bill language authorizing fee increases as requested by the Administration's budget proposal for the VHA for FY2009.

This report provides a brief background on the veterans health care system, followed by a discussion of the FY2009 VHA budget request, House and Senate Appropriations Committee action, and the final enacted appropriations for VHA. The report concludes with a discussion of major VHA budget proposals included in the President's budget request for FY2009.

[1] Division A provides continuing appropriations for FY2009 for activities that were funded in the prior fiscal year by nine different regular appropriations acts. Division B provides supplemental appropriations for FY2008 to various departments and agencies for disaster relief and recovery activities. The remaining divisions each set forth funding for regular appropriations for FY2009: Division C, the Department of Defense Appropriations Act; and Division D, the Homeland Security Appropriations Act. For details on the Consolidated Appropriations Act for FY2009, see CRS Report RL34711, *Consolidated Appropriations Act for FY2009 (P.L. 110-329): An Overview*, by Robert Keith.

Table 1. VA Appropriations, FY2008-FY2009

($ thousands)

	FY2008 request	FY2008 House	FY2008 Senate	FY2008 enacted	FY2009 request	FY2009 House (H.R. 6599)	FY2009 Senate Committee (S.Rept. 110-428)	FY2009 Enacted (P.L. 110-329)
Total Department of Veterans Affairs (VA)	83,903,751	87,696,839	87,501,280	88,111,519	90,761,057	93,685,057	94,792,750	94,351,057
Total Mandatory	44,487,250	44,487,250	44,487,250	44,487,250	45,996,925	45,996,925	46,742,925	46,742,925
Total Discretionary	39,416,501	43,209,589	43,014,030	43,624,269	44,764,132	47,688,132	48,049,825	47,608,132
Total Veterans Health Administration (VHA)	34,612,671	37,122,000	37,213,220	37,201,220	39,178,503	40,783,270	41,078,232	$40,958,903

Sources: S.Rept. 109-286; H.Rept. 109-464; H.Rept. 110-186; S.Rept. 110-85; Congressional Record, vol. 153 (December 17, 2007), pp.H16249-H16431; H.Rept. 110-775; S.Rept. 110-428; and Congressional Record, vol.154, (September 24, 2008), pp.H9868-H9869.

Note: FY2008 enacted includes funding provided in the Supplemental Appropriation Act, 2008 (P.L. 110-252).

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, assistance to homeless veterans,[2] home loan guarantees, and death benefits that cover burial expenses.[3] The 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.[4] The Veterans Benefits Administration (VBA) is responsible for, among other things, providing compensations, pensions, and education assistance.[5] The National Cemetery Administration (NCA)[6] 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.

The 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 FY2008 discretionary budget authority accounted for about 49% of the total VA budget authority of approximately $88 billion with about 86% of this discretionary funding going toward supporting VA health care programs.

The Veterans Health Care System

The VHA operates the nation's largest integrated direct health care delivery system.[7] The VA's health care system is organized into 21 geographically defined Veterans Integrated Service Networks (VISNs). Although 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.[8]

Recently, VA's Inspector General (IG) for Health Care Inspections has stated that the current VISN management structure is ineffective. According to the IG's statement "VHA has an organizational bias in favor of local decision makers over national leaders which impedes the provision of one standard of excellent medical care for all eligible veterans. The lack of a

[2] For detailed information on homeless veterans programs, see CRS Report RL34024, *Veterans and Homelessness*, by Libby Perl.

[3] 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.

[4] For a detailed description of veterans' health care issues, see CRS Report RL33993, *Veterans' Health Care Issues*, by Sidath Viranga Panangala.

[5] For a detailed description of veterans' benefits issues, see CRS Report RL33985, *Veterans' Benefits: Issues in the 110th Congress*, coordinated by Carol D. Davis.

[6] Established by the National Cemeteries Act of 1973 (P.L. 93-43).

[7] Established on January 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.

[8] Kizer Kenneth, John Demakis, and John Feussner, "Reinventing VA health care: Systematizing Quality Improvement and Quality Innovation." *Medical Care*. vol.38,no.6 (June 200), Suppl 1:I7-16.

standard organizational structure leads to differences in financial systems, medical data systems, and management and committee structures from VISN to VISN."[9]

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.[10] 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, the VHA provides care directly to veterans.

In FY2008, VHA operated 153 medical centers, 135 nursing homes, 795 ambulatory care and community-based outpatient clinics (CBOCs),[11] 6 independent outpatient clinics, and 232 Readjustment Counseling Centers (Vet Centers). [12] The VHA also pays for care provided to veterans by private-sector providers on a fee basis under certain circumstances. Inpatient and outpatient care are also provided in the private sector to eligible dependents of veterans under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).[13] The VHA also 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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[9] U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies Appropriations, *Military Construction, Veterans Affairs, and Related Agencies Appropriations for FY2009*, hearings, 110th Congress, 2nd sess., February 2008, p. 295.

[10] 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 can also retain collections from insurance reimbursements and copayments and use these funds for the care of veterans.

[11] Data on the number of CBOCs differ from source to source. Some sources count outpatient clinics located at VA hospitals while others count only freestanding CBOCs. The number represented in this report excludes clinics located in VA hospitals. On June 26, 2008, VA announced that it would be establishing 44 new CBOCs in FY2008 and FY2009. The new CBOCs are to be located in: Marshall County, and Wiregrass, AL; Matanuska-Susitna Borough area, AK; Ozark, and White County, AR; East Bay-Alameda County area, CA; Summerfield, FL; Baldwin County, Coweta County, Glynn County, and Liberty County, GA; Miami County, and Morgan County, IN; Wapello County, IA; Lake Charles, Leesville, Natchitoches, St. Mary Parish, and Washington Parish, LA; Lewiston-Auburn area, ME; Douglas County, and Northwest Metro, MN; Franklin County, MO; Rio Rancho, NM; Robeson County, and Rutherford County, NC; Grand Forks County, ND; Gallia County, OH; Altus, Craig County, Enid, and Jay, OK; Giles County, Maury County, and McMinn County, TN; Katy, Lake Jackson, Richmond, Tomball, and El Paso County, TX; Augusta County, Emporia, and Wytheville, VA; and Greenbrier County, WV.

[12] On July 9, 2008, VA announced that it would be establishing 39 new Vet Centers. The new Vet Centers are to be located in the following counties: Madison, AL; Maricopa, AZ; Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, and San Diego, CA; Fairfield, CT; Broward, Palm Beach, Pasco, Pinellas, Polk, and Volusia, FL; Cobb, GA; Cook, and DuPage, IL; Anne Arundel, Baltimore, and Prince George's, MD; Macomb and, Oakland, MI; Hennepin, MN; Greene, MO; Onslow, NC; Ocean, NJ; Clark, NV; Comanche, OK; Bucks, and Montgomery, PA; Bexar, Dallas, Harris, and Tarrant, TX; Virginia Beach, VA; King, WA; and Brown, WI. VA plans to have the 39 sites fully operational by the end of December 2009.

[13] For further information on CHAMPVA, see CRS Report RS22483, *Health Care for Dependents and Survivors of Veterans*, by Sidath Viranga Panangala and Susan Janeczko.

The Veteran Patient Population

During FY2008, the VHA had an estimated total enrolled veteran population of 7.9 million and provided medical care to about 5.2 million unique veteran patients (see **Tables 2** and **3**).[14] According to VHA estimates, the number of unique veteran patients is estimated to increase by approximately 69,000, from 5.189 million in FY2008 to 5.258 million in FY2009. As shown in **Table 3**, there would be a 1.6% increase in the total number of unique patients (both veterans and non-veterans), from 5.681 million in FY2008 to approximately 5.771 million in FY2009. This number includes veterans from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). In FY2009, VHA estimates that it will treat 333,275 OIF and OEF veterans, an increase of 39,930 patients, or 13.6%, over the FY2008 level. In FY2009, VA would be treating over 513,000 non-veterans, an increase of over 21,000, or 4.3%, over the FY2008 level.[15]

The total number of outpatient visits, including visits to Vet Centers, reached 63 million during FY2007 and is projected to increase to approximately 65 million in FY2008 and 70.4 million in FY2009.[16] In FY2008, the VHA estimates that it will spend approximately 63.7% of its medical services obligations on outpatient care.[17]

Table 2. Number of Veterans Enrolled in the VA Health Care System

Priority Groups	FY2006 Actual	FY2007 Actual	FY2008 Estimate	FY2009 Estimate
1	912,787	977,389	957,792	977,773
2	522,829	545,196	566,829	584,605
3	996,063	1,023,256	1,047,724	1,063,512
4	241,716	244,159	250,920	260,106
5	2,538,228	2,413,796	2,461,855	2,468,941
6	265,253	312,256	274,482	278,437
Subtotal Priority Groups 1-6	*5,476,876*	*5,516,052*	*5,559,302*	*5,633,374*
7	218,248	202,049	615,581	625,570
8	2,177,314	2,115,344	1,738,801	1,728,535
Subtotal Priority Groups 7-8	*2,395,562*	*2,317,393*	*2,354,382*	*2,354,105*
Total Enrollees	**7,872,438**	**7,833,445**	**7,913,684**	**7,987,479**

[14] "Enrolles" are veterans who have enrolled in the VA health care system. "Unique patients" are those receiving medical care who are counted only once. In any given year, some enrollees do not seek any medical care, either because they do not become sick or because they rely on other health care systems, such as private health insurance, for care.

[15] 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.

[16] This number excludes outpatient care provided on a contract basis and outpatient visits to readjustment counseling centers. U.S. Department of Veterans Affairs, *FY2009 Budget Submission, Medical Programs and Information Technology Programs*, Vol. 2 of 4.

[17] Ibid., p.1C-20.

Source: U.S. Department of Veterans Affairs, *FY2009 Budget Submission, Medical Programs and Information Technology Programs*, Vol. 2 of 4.

Note: See **Appendix A** for the Priority Groups and their eligibility criteria.

Table 3. Number of Patients Receiving Care from VA

Priority Groups	FY2006 Actual	FY2007 Actual	FY2008 Estimate	FY2009 Estimate
1	768,537	820,410	815,432	832,622
2	342,023	358,270	374,182	386,660
3	568,740	590,860	605,066	616,123
4	177,563	181,572	200,001	207,994
5	1,645,781	1,544,328	1,657,210	1,672,504
6	134,425	155,939	143,483	145,666
Subtotal Priority Groups 1-6	3,637,069	3,651,379	3,795,374	3,861,569
7	197,901	173,149	373,285	380,934
8	1,195,612	1,191,161	1,020,644	1,015,616
Subtotal Priority Groups 7-8	1,393,513	1,364,310	1,393,929	1,396,550
Subtotal Unique Veteran Patients[a]	*5,030,582*	*5,015,689*	*5,189,303*	*5,258,119*
Non-Veterans[b]	*435,488*	*463,240*	*492,117*	*513,232*
Total Unique Patients	**5,466,070**	**5,478,929**	**5,681,420**	**5,771,351**

Source: U.S. Department of Veterans Affairs, *FY2009 Budget Submission, Medical Programs and Information Technology Programs*, Vol. 2 of 4.

a. Unique veteran patients include Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans. These patients numbered: 155,272 in FY2006 and 205,628 in FY2007 and are estimated to be 293,345 in FY2008 and 333,275 in FY2009.

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.

Eligibility for Veterans' Health Care

"Promise of Free Health Care"

To understand some of the issues discussed in this report, it is important to understand eligibility for VA health care, the 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 the VA.[18] Prior to eligibility reform in 1996, provisions of law governing eligibility for VA care were complex and

[18] For a detailed discussion of "promised benefits," see CRS Report 98-1006, *Military Health Care: The Issue of "Promised" Benefits*, by David F. Burrelli.

not uniform across all levels of care. All veterans were technically "eligible" for hospital care and nursing home care, but eligibility did not by itself ensure access to care.

The Veterans' Health Care Eligibility Reform Act of 1996, P.L. 104-262, established two eligibility categories and required the VHA to manage the provision of hospital care and medical services through an enrollment system based on a system of priorities.[19] P.L. 104-262 authorized the 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 (see **Appendix A**, discussed in more detail below).[20] The other category of veterans are those with no service-connected disabilities and with attributable incomes above an established means test (see **Appendix C**).

P.L. 104-262 also authorized the 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."[21]

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."[22]

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."[23]

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.[24] A veteran may apply for enrollment by completing the

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

[20] Ibid., p.5.

[21] Ibid., p.6.

[22] Ibid., p.5.

[23] Ibid., p.4.

[24] Veterans do not need to apply for enrollment in the VA's health care system if they fall into one of the following categories: veterans with a service-connected disability rated 50% or more (percentages of disability is based upon the severity of the disability; those with a rating of 50% or more are placed in Priority Group 1); less than one year has (continued...)

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 medical center or clinic of the veteran's choosing.[25] Once a veteran is enrolled in the VA health care system, the veteran remains in the system and does not have to reapply for enrollment annually. However, those veterans who have been enrolled in Priority Group 5 (see **Appendix A**, discussed in more detail below) 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.[26]

Veteran's Status

Eligibility for VA health care is based primarily 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 an 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. Servicemembers discharged at any time because of service-connected disabilities are not held to this requirement. Also, reservists that were called to active duty and who completed the term for which they were called, and who were granted an other than dishonorable discharge, are exempt from the 24 continuous months of active duty requirement. National Guard members who were called to active duty by federal executive order are also exempt from this two-year requirement if they (1) completed the term for which they were called and (2) were granted an other than dishonorable discharge.

When not activated to full-time federal service, members of the reserve components and National Guard have limited eligibility for VA health care services. Members of the reserve components may be granted service-connection for any injury they incurred or aggravated in the line of duty while attending inactive duty training assemblies, annual training, active duty for training, or while going directly to or returning directly from such duty. In addition, reserve component service members may be granted service-connection for a heart attack or stoke if such an event occurs during these same periods. The granting of service-connection makes them eligible to receive care from the VA for those conditions. National Guard members are not granted service-connection for any injury, heart attack, or stroke that occurs while performing duty ordered by a governor for state emergencies or activities.[27]

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

(...continued)

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 the VA only for a service-connected disability (even if the rating is only 10%).

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

[26] 38 C.F.R. §17.36 (d)(3)(iv) (2007).

[27] 38.U.S.C. §101(24); 38 C.F.R. §3.6(c).

- veterans in need of care for a service-connected disability;[28]
- 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
- veterans who have an annual income and net worth below a VA-established means test threshold.

The VA 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 the VA with information on any health insurance coverage they have, including coverage through employment or through a spouse. The 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 B** provides information on what categories of veterans pay for which services.

The second group of veterans is composed of those who do not fall into one of the first six priority groups—primarily veterans 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.[29] **Appendix C** provides information on income thresholds for VA health care benefits.

Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans

The National Defense Authorization Act (NDAA), FY2008 was signed by the President (P.L. 110-181) on January 28, 2008. This act extended the period of enrollment for VA health care from two to five years for veterans who served in a theater of combat operations after November 11, 1998 (generally, OEF and OIF veterans who served in a combat theater).

[28] The term "service-connected" means that, with respect to disability, such disability was incurred or aggravated in the line of duty in the active military, naval, or air service. The 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%.

[29] The 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 includes interest earned, dividends received, money from retirement funds, Social Security payments, annuities, and 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 C.F.R. § 17.36(b)(7) (2006).

According to the VA, currently enrolled combat veterans will have their enrollment eligibility period extended to five years from their most recent date of discharge. New servicemembers discharged from active duty on or after January 28, 2003, could enroll for a period of up to five years after their most recent discharge date from active duty. Veterans who served in a theater of combat, and who never enrolled, and were discharged from active duty between November 11, 1998 and January 27, 2003, may apply for this enhanced enrollment opportunity through January 27, 2011.

Generally, new OEF and OIF veterans are assigned to Priority Group 6, unless eligible for a higher Priority Group, and are not charged copays for medication and/or treatment of conditions that are potentially related to their combat service. Veterans who enroll in the VA health care system under this extended enrollment authority will continue to be enrolled even after the five-year eligibility period ends. At the end of the five-year period, veterans enrolled in Priority Group 6 may be re-enrolled in Priority Group 7 or 8, depending on their service-connected disability status and income level, and may be required to make copayments for nonservice-connected conditions. The above criteria apply to National Guard and Reserve personnel who were called to active duty by federal executive order and served in a theater of combat operations after November 11, 1998.

Priority Groups and Scheduling Appointments

The VHA is mandated to provide priority care for non-emergency outpatient medical care for *any* condition of a service-connected veteran rated 50% or more, or for a veteran's service-connected condition.[30] According to VHA policies, patients with emergency or urgent medical needs must be provided care, or must be scheduled to receive care as soon as practicable, independent of service-connected status, and whether care is purchased or provided directly by the VA. Veterans who are service-connected 50% or more need to be scheduled to be seen within 30 days of the desired date for any condition.

Veterans who are rated less than 50% service-connected disabled, and who require care for a service-connected condition, need to be scheduled to be seen within 30 days of the desired date. When VHA staff are in doubt as to whether the request for care is for a service-connected condition, they are required to assume, on behalf of the veteran, that the veteran is entitled to priority access and schedule within 30 days of the desired date.[31]

Veterans in other priority groups are to be scheduled to be seen within 120 days of the desired date. According to VHA policies, all outpatient appointment requests must be acted on as soon as possible, but no later than seven calendar days from the date of the request. The VHA also requires that priority scheduling of any veteran must not affect the medical care of any other previously scheduled veteran. Furthermore, VHA guidelines state that veterans with service-connected conditions cannot be prioritized over other veterans with more acute health care needs.[32]

[30] VHA Directive 2006-055, October 11, 2006.

[31] Ibid.

[32] Ibid.

Formulation of VHA's Budget

Each year, VHA reviews the demand for health care services from veterans and projects an estimate of the cost to deliver care against that demand. It utilizes the VA Enrollee Health Care Demand Model (Demand Model) to develop estimates of veteran enrollment, expected utilization of 55 health care services by those enrollees, and the costs associated with that utilization. The 55 health care services include such services as inpatient medical, surgical, and psychiatric care; ambulatory care; pharmacy, including over the counter medications; and hearing aids and prosthetics. The Demand Model does not include projected expenditures for long-term care services, CHAMPVA, readjustment counseling provided primarily through Vet Centers, the Spina Bifida program, or care for non-veterans. Because of the unique characteristics of these programs, the budget estimates for these programs are developed by the respective program offices.

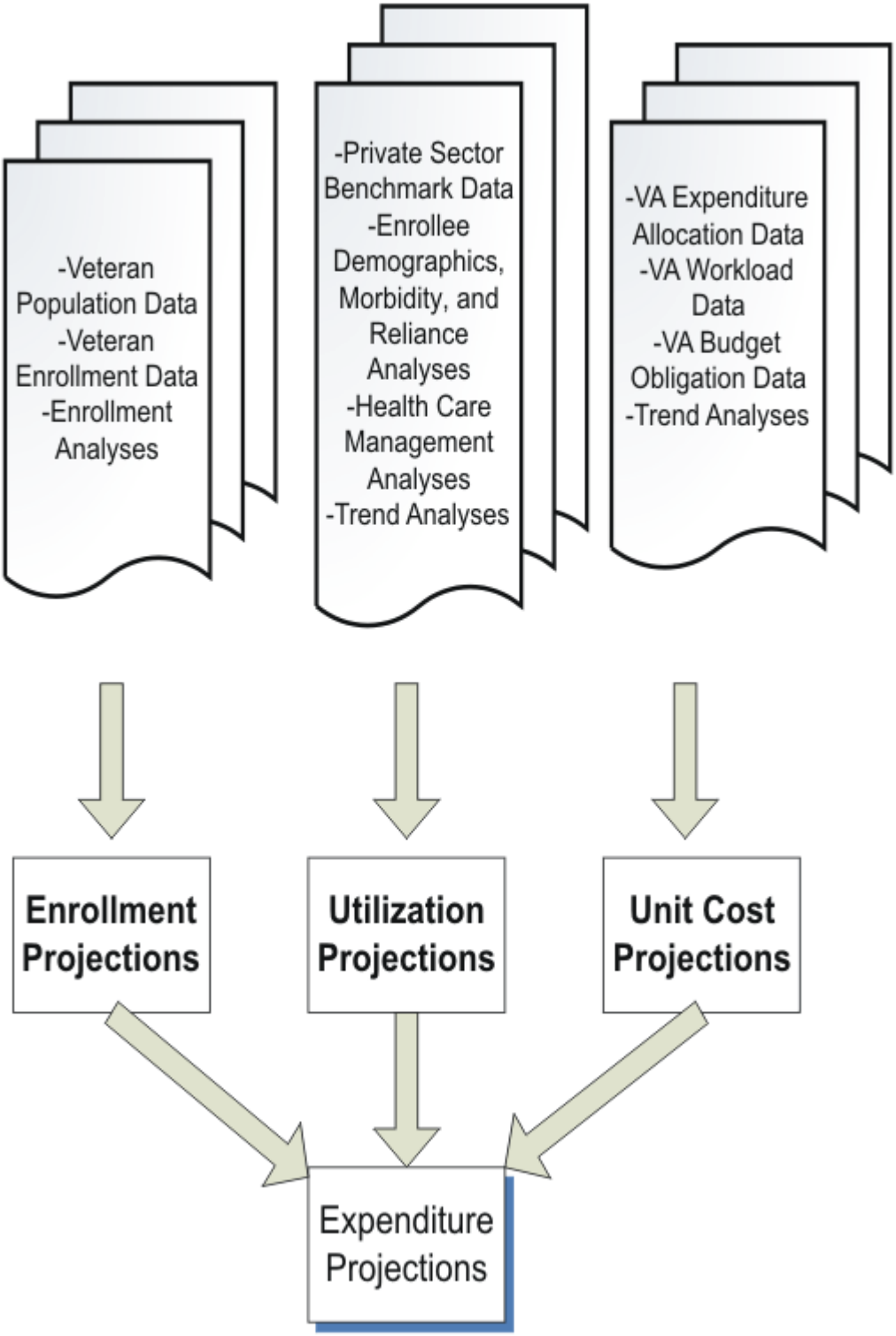
The Demand Model also makes risk adjustments to reflect veteran enrollee's mortality, morbidity, and changing health care needs. It also takes into account the veterans' reliance on VA health care (that is, how much care veteran enrolles receive from VA versus other sources such as Medicare and private health insurance). Based on private sector health care utilization benchmarks, the Demand Model projects future use of health care services by veteran enrollees. These benchmarks are adjusted for unique demographics of veterans enrolles, and health care characteristics of the VA health care system. According to the VA, the model also generates future trend data for health care utilization, cost, and intensity of medical services.[33] These trend data reflect historical and future changes in the entire health care industry and are adjusted to reflect the unique attributes of the VA health care system. **Figure 1** provides a conceptual overview of the Demand Model.

While the VHA actuarial model works well in a steady state environment, it does not perform as well in a dynamic environment, such as when veterans are returning from combat theaters and enrolling in the VA health care system. According to VHA officials, VHA has added higher enrollee estimates to the Demand Model to ensure it has enough resources.[34] However, in the long term, the Demand Model still has limitations, because the changes in the nation's economy and future military conflicts could have a profound impact on predicting future veterans enrollments and expenditures.

[33] Congressional Research Service meeting with the VA on projections and reliance on VA's actuarial model, January 17, 2008.

[34] Ibid.

Figure 1. Conceptual Overview of VA Enrollee Health Care Demand Model



Source: Adapted from Testimony of Dr. Michael J. Kussman, Under Secretary for Health, Veterans Health Administration Department of Veterans Affairs, before the Senate Committee on Veterans Affairs, July 25, 2007.

Funding for the VHA

The 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, the appropriation accounts used to support the VHA traditionally 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. In FY2004, "to provide better oversight and [to] receive a more accurate accounting of funds," Congress changed the VHA's appropriations structure.[35] The Department of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act, 2004 (P.L. 108-199, H.Rept. 108-401), funded VHA through four accounts: (1) medical services, (2) medical administration, (3) medical facilities, and (4) medical and prosthetic research. Provided below are brief descriptions of these accounts.

Medical Services

The medical services account covers expenses for furnishing inpatient and outpatient care and treatment of veterans and certain dependents, including care and treatment in non-VA facilities; outpatient care on a fee basis; medical supplies and equipment; salaries and expenses of employees hired under Title 38, United States Code; and aid to state veterans homes. In its FY2008 budget request to Congress, the VA requested the transfer of food service operations costs from the medical facilities appropriations to the medical services appropriations. The House and Senate Appropriations Committees have concurred with this request.[36]

In its FY2009 budget request to Congress, the Administration requested the consolidation of the medical services and medical administration account. While the House Appropriations Committee did not concur with this request, the Senate Appropriations Committee has consolidated the medical services and medical administration accounts (see discussion under Senate Committee Action below).

Medical Support and Compliance (Previously Medical Administration)

The medical support and compliance account provides funds for the expenses in the administration of hospitals, nursing homes, and domiciliaries, billing and coding activities, public health and environmental hazard program, quality and performance management, medical inspection, human research oversight, training programs and continuing education, security, volunteer operations, and human resources.

[35] U.S. Congress, Conference Committees, *Consolidated Appropriations Act, 2004*, conference report to accompany H.R. 2673, 108th Cong., 1st sess., H.Rept. 108-401, p. 1036.

[36] The cost of food service operations support hospital food service workers, provisions, and supplies related to the direct care of patients.

Medical Facilities

The medical facilities account covers, among other things, expenses for the maintenance and operation of VHA facilities; administrative expenses related to planning, design, project management, real property acquisition and deposition, construction, and renovation of any VHA facility; leases of facilities; and laundry services.

Medical and Prosthetic Research

This account provides funding for VA researchers to investigate a broad array of veteran-centric health topics, such as treatment of mental health conditions; rehabilitation of veterans with limb loss, traumatic brain injury, and spinal cord injury; organ transplantation; and the organization of the health care delivery system. VA researchers receive funding not only through this account but also from the DOD, the National Institutes of Health (NIH), and private sources.

Medical Care Collections Fund (MCCF)

In addition to direct appropriations for the above accounts, the Committees on Appropriations include medical care cost recovery collections when considering the amount of resources needed to provide funding for the VHA. The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), enacted into law in 1986, gave the 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.[37] This law also established means testing for veterans seeking care for nonservice-connected conditions. However, P.L. 99-272 did not provide the VA with specific authority to retain the third-party payments it collected and VA was required to deposit these third-party collections in the General Fund of the U.S. Treasury.

The Balanced Budget Act of 1997 (P.L. 105-33) gave the VHA the authority to retain these funds in the Medical Care Collections Fund (MCCF). Instead of returning the funds to the Treasury, the VA can use them for medical services for veterans without fiscal year limitations.[38] To increase the VA's third-party collections, P.L. 105-33 also gave the VA the authority to change its basis of billing insurers from "reasonable costs" to "reasonable charges."[39] This change in billing was intended to enhance VA collections to the extent that reasonable charges result in higher payments than reasonable costs.[40] In FY2004, the Administration's budget requested consolidating several medical existing collections accounts into one 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

[37] Veterans' Health-Care and Compensation Rate Amendments of 1985;100 Stat. 372, 373, 383.

[38] 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.

[39] Under "reasonable costs," the VA billed insurers based on its average cost to provide a particular episode of care. Under "reasonable charges," the VA bills insurers based on market pricing for health care services.

[40] 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.

Revolving Fund (former name) should be deposited in MCCF.[41] The Consolidated Appropriations Act of 2005; (P.L. 108-447, H.Rept. 108-792) provided the VA with permanent authority to deposit funds from these five accounts into the MCCF. The funds deposited into the 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.

The conferees of the FY2006 Military Construction, Military Quality of Life and Veterans Affairs Appropriations Act (P.L. 109-114, H.Rept. 109-305) required the VA to establish a revenue improvement demonstration project. The purpose of this pilot project is to provide a "comprehensive restructuring of the complete revenue cycle including cash-flow management and accounts receivable."[42] The conferees included this provision because the Appropriations Committees were concerned that the VHA was collecting only 41% percent of the billed amounts from third-party insurance companies. Currently, the VHA has established a pilot Consolidated Patient Account Center (CPAC) in VISN 6. There are eight VA medical centers under the CPAC management initiative. In a report issued in June 2008, the Government Accountability Office (GAO) stated that VA had ineffective controls over medical center billings.[43]

As shown in **Table 4**, MCCF collections increased by 45%, from $1.5 billion in FY2003 to $2.2 billion in FY2007. During this same period, first-party collections increased by 33.6%, from $685 million to $915 million. In FY2007, first-party collections represented approximately 41% of total MCCF collections.

Table 4. Medical Care Collections, FY2003-FY2007

($ in thousands)

	FY2003 Actual	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 Actual
First-party pharmacy copayments[a]	576,554	623,215	648,204	723,027	760,616
First-party copayments for inpatient and outpatient care	104,994	113,878	118,626	135,575	150,964
First-party long-term care copayments[b]	3,461	5,077	5,411	4,347	3,699
Third-party insurance collections	804,141	960,176	1,055,597	1,095,810	1,261,346
Enhanced use leasing revenue[c]	234	459	26,861	3,379	1,692
Compensated work therapy collections[d]	38,834	40,488	36,516	40,081	43,296
Parking fees[e]	3,296	3,349	3,443	3,083	3,136

[41] For a detailed description of these former accounts, see CRS Report RL32548, *Veterans' Medical Care Appropriations and Funding Process*, by Sidath Viranga Panangala.

[42] U.S. Congress, Conference Committees, *Military Construction, Military Quality of Life and Veterans Affairs Appropriations Act, 2006*, conference report to accompany H.R. 2528, 109th Congress, 1st session, H.Rept. 109-305, p. 43.

[43] For details on whether medical centers under the CPAC initiative had more effective controls over third-party billings and collections, see U.S. Government Accountability Office, *VA Health Care: Ineffective Controls over Medical Center Billings and Collections Limit Revenue from Third- Party Insurance Companies*, GAO-08-675, June 2008.

	FY2003 Actual	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 Actual
Compensation and pension living expenses[f]	376	634	2,431	2,075	1,904
MCCF Total	**1,531,890**	**1,747,276**	**1,897,089**	**2,007,377**	**2,226,653**

Sources: Table prepared by CRS based on data provided by the VA, and U.S. Department of Veterans Affairs, *FY2009 Budget Submission, Medical Programs and Information Technology Programs*, Vol. 2 of 4, pp. 1C-11.

Notes: The following accounts were not consolidated into the 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 FY2003 are provided for comparison purposes.

a. In FY2002, Congress created the Health Services Improvement Fund (HSIF) to collectincreases 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 the VA the authority to consolidate the HSIF with the 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. Under the enhanced-use lease authority, the VA may lease land or buildings to the private sector for up to 75 years. In return the VA receives fair consideration in cash and/or in-kind. Funds received as monetary considerations may be used to provide care for veterans.

d. 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 into the MCCF.

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

f. 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.

FY2008 Budget Summary[44]

On February 5, 2007, the President submitted his FY2008 budget proposal to Congress. The total amount requested by the Administration for the VHA for FY2008 was $34.6 billion, a 1.93% increase in funding compared with the FY2007 enacted amount. The total amount of funding that would have been available for the VHA under the President's budget proposal for FY2008, including collections, was approximately $37.0 billion (see **Table 7** and **Appendix E**). For FY2008, the Administration requested $27.2 billion for medical services, a $1.2 billion, or 4.8%, increase in funding over the FY2007 enacted amount. The Administration's budget proposal also requested $3.4 billion for medical administration, $3.6 billion for medical facilities, and $411 million for medical and prosthetic research (see **Table 7** and **Appendix E**). As in FY2003,

[44] For a detailed description of VA Medical Care Appropriations for FY2008, see CRS Report RL34063, *Veterans' Medical Care: FY2008 Appropriations*, by Sidath Viranga Panangala.

FY2004, FY2005, FY2006, and FY2007, the Administration' FY2008 budget request included several cost-sharing proposals.

House Action

On June 6, 2007, the House Appropriations Committee recommended $37.1 billion for the VHA for FY2008, a 9.3% increase over the FY2007 enacted amount of $34.0 billion and 7.3% above the President's request. The Military Construction and Veterans Affairs appropriations bill for FY2008 (H.R. 2642, H.Rept. 110-186) was reported out of committee on June 11.

On June 15, 2007, the House passed H.R. 2642.[45] As amended, H.R. 2642 provided $29.0 billion for medical services. The MILCON-VA appropriations bill, as amended, also provided: $3.5 billion for the medical administration account, $68.6 million above the FY2008 request and $82.6 million above the FY2007 enacted amount; $4.1 billion for medical facilities, a 14% increase over the President's request; and $480 million for medical and prosthetic research, a 17% increase over the President's request of $411 million (see **Table 7**).

Senate Action

On June 14, 2007, the Senate Appropriations Committee approved its version of the MILCON-VA appropriations bill. The bill was reported to the Senate on June 18 (S. 1645, S. Rept.110-85). S. 1645, as reported, provided a total of $37.2 billion for the VHA.

On September 6, 2007, the Senate passed H.R. 2642 with an amendment in the nature of a substitute to reflect the Senate Appropriations Committee-approved measure (S. 1645, S. Rept.110-85). As amended by the Senate, H.R. 2642 provided $29.1 billion for medical services—a $3.2 billion (12.3%) increase over the FY2007 enacted amount and $1.9 billion over the FY2008 budget request—and $3.5 billion would have been available for medical administration, $75 million above the FY2008 Administration's request. H.R. 2642, as passed by the Senate, provided $4.1 billion for medical facilities—a 14.0% increase over the FY2008 request and 1.7% less than the FY2007 enacted amount—and $500 million for medical and prosthetic research—a 12% increase over the FY2007 enacted amount, a 22.0% increase over the FY2008 request, and 4.2% above the House-passed amount (see **Table 7**).

Consolidated Appropriations Act for FY2008

At the end of 2007, Congress passed the Consolidated Appropriations Act for FY2008 (H.R. 2764), an omnibus measure that combined the 11 outstanding appropriations bills for FY2008.[46] H.R. 2764 was passed by the House on December 17, 2007; the Senate passed the measure the next day, December 18, with an amendment (McConnell Amendment—adding funding for the Iraq war). The House agreed to the McConnell Amendment on December 19. The bill was signed into law (P.L. 110-161) on December 26. Division I of H.R. 2764 included the Military

[45] H.R. 2642 as passed by the House on June 15, 2007, was not enacted into law. Provisions in this bill were amended and later incorporated into the Consolidated Appropriations Act, 2008 (H.R. 2764, P.L. 110-161). H.R. 2642 subsequently became the vehicle for the Supplemental Appropriations Act, 2008 (P.L. 110-252).

[46] The only appropriations bill that passed as a stand alone measure was the Department of Defense Appropriations Act, 2008 (H.Rept. 110-434), which was signed into law on November 13, 2007 (P.L. 110-116).

Construction and Veterans Affairs and Related Agencies Appropriations Act, 2008 (MILCON-VA Appropriations Act).

The MILCON-VA Appropriation Act provided $37.2 billion for VHA for FY2008, which is $2.6 billion above the Administration's request for FY2008 (see **Table 7**). Of this amount $2.6 billion (the amount above the Administration's request) was designated as contingent emergency funding, and was to be available for obligation only after the President submitted a budget request to Congress. On January 17, 2008, the President submitted a budget request to Congress, requesting this additional amount and designating it as an emergency requirement.

Supplemental Appropriation Act, 2008 (P.L. 110-252)

On June 30, 2008, the President signed into law the Supplemental Appropriation Act of 2008. Among other things, this act provided $396.4 million for the construction major projects account to complete planned construction of Level I polytrauma rehabilitation centers identified by VA's capital planning process. A new polytrauma center is under design for construction in San Antonio, Texas, and is expected to be opened in 2011.[47]

FY2009 VHA Budget

On February 4, 2008, the President submitted his FY2009 budget proposal to Congress. The Administration requested a total of $39.2 billion (excluding collections) for VHA. This is a 5.3% increase, or a $2.0 billion increase, over the FY2008 enacted level. Including total available resources (including medical collections) the Administration's budget would have provided $41.1 billion for VHA. The President's FY2009 budget submission also proposed to abolish the medical administration account and consolidate these activities in the medical services account. Under this account structure the Administration requested $34.1 billion for the medical services account which is approximately $5 billion above the FY2008 enacted amount (**Table 7**). The VHA estimated an overall medical inflation rate of 4.63% for FY2009. The major cost drivers for VHA medical care are increases in costs of goods and services beyond the control of the VHA, as well as increases in utilization of services by existing patients, and increases in intensity of care (more complex care).

The President's budget proposal also requested $4.7 billion for the medical facilities account, an increase of $561 million over the FY2008 enacted level. The Administration's budget proposal for FY2009 requested $442 million for the medical and prosthetic research account, a 7.9% decrease ($38 million) below the FY2008 enacted level. According to the Senate Committee on Veterans' Affairs, the President's proposal would have resulted in the loss of 49 full time positions and 294 research projects.[48]

[47] The polytrauma network of care consists of four regional Polytrauma Rehabilitation Centers (PRC) located in Richmond, VA; Tampa, FL; Minneapolis, MN; and Palo Alto, CA.

[48] Senate Committee on Veterans Affairs (majority), *Views and Estimates Letter for FY2009*, to the Senate Committee on the Budget, February 22, 2008.

As in FY2003, FY2004, FY2005, FY2006, FY2007, and FY2008. the Administration included several cost-sharing proposals. These legislative proposals are discussed in detail in the key budget issues section at the end of this report.

FY2009 Congressional Budget Resolution[49]

On March 7, 2008, the House (H.Con.Res. 312) and Senate (S.Con.Res. 70) reported their respective budget resolutions.[50] The House budget resolution provided $48.2 billion in funding for discretionary veterans programs and $45.1 billion in mandatory spending for FY2009. The House budget resolution also rejected health care enrollment fees and prescription drug copayment increases as proposed by the President. Similar to the House amounts, the Senate budget resolution provided $48.2 billion for discretionary veterans programs including health care, and $45.1 billion for mandatory programs. The House passed its budget resolution on March 13 and the Senate passed its version the following day. After negotiations between the House and Senate, the House agreed to an amended version of S.Con.Res. 70 (Conference Report; H.Rept. 110-659). The Senate adopted H.Rept. 110-659 on June 4 and the House adopted the conference agreement the next day. The conference agreement provides $48.2 billion for FY2009 for discretionary veterans' programs, including medical care. This amount is $4.9 billion more than the FY2008 enacted level, and $3.3 billion more than the President's budget proposal for FY2009. The conference agreement also provides $45.1 billion in mandatory funding for veterans programs.

House Action

On June 12, 2008, the House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, marked up a draft Military Construction and Veterans Affairs Appropriations bill. On June 24, the House Appropriations Committee marked up the Military Construction and Veterans Affairs Appropriations bill (H.R. 6599; H.Rept. 110-775), for FY2009 (MILCON-VA Appropriations bill). On August 1, the House passed H.R. 6599. The House-passed bill provided $40.8 billion for VHA, a $1.6 billion increase over the Administration's FY2009 request, and $3.6 billion over the FY2008 enacted amount. This amount included $31billion for the medical services account. The committee did not concur with the President's proposed account structure of consolidating the medical administration account with the medical services account. The House -passed amount for the medical services account was 6% above the FY2008 enacted amount (**Table 7**). H.R. 6599 included bill language stipulating that VA must spend at least $3.8 billion on specialty mental health care, including Post-Traumatic Stress Disorder (PTSD).

The MILCON-VA Appropriations bill provided $4.4 billion for the medical support and compliance account (previously known as the medical administration account). This amount is 25% above the FY2008 enacted amount. H.R. 6599 also provides approximately $5 billion for the medical facilities account, a $368 million increase over the Administration's request, and $929 million above the FY2008 enacted level. This increase includes funding for non-recurring maintenance. The Committee directed the VHA to use these funds to address life/safety and

[49] For a detailed analysis of the FY2009 budget resolution see CRS Report RL34419, *The Budget for Fiscal Year 2009*, by D. Andrew Austin.

[50] H.Rept. 110-543 and S.Rept. 110-039.

suicide prevention deficiencies in mental health wards. Lastly, the House MILCON-VA appropriations bill provided $500 million for the medical and prosthetic research account, a 13.1 % increase over the FY2009 request, and a 4.2 % increase over the FY2008 enacted amount (**Table 7**).

Construction Projects

The MILCON-VA appropriations bill (H.R. 6599) provided $923 million for the construction major account, a 58% increase over the FY2009 request and a 37 % decrease from the FY2008 enacted level. H.R. 6599 also provided $991.5 million for the construction minor projects account, an increase of 200% over the FY2009 request and 57% above the FY2008 enacted amount. Of the amount provided for the construction minor projects account, $7 million was for the installation of alternative fueling stations at 35 VA medical centers. In total (excluding grants for construction of state veterans cemeteries), the House-passed bill has provided $2.1 billion for VA construction projects, including construction projects identified under the Capital Asset Realignment for Enhanced Services (CARES) initiative, and grants for construction of state extended care facilities. This level of funding is a 108% increase in funding over the FY2009 request, and a 8% decrease when compared to the FY2008 enacted amount (**Table 8**).

Senate Committee Action

On July 17, 2008, the Senate Appropriations Committee marked up its version of the FY2009 Military Construction and Veterans Affairs and Related Agencies Appropriations bill (S. 3301, S.Rept. 110-428). The Senate Appropriations Committee recommended $41.1 billion (excluding collections) for VHA for FY2009 (see **Table 7**). This is a 4.8% increase over the FY2009 request, and $294 million above the House Appropriations Committee-recommended amount. The Senate Appropriations Committee concurred with the President's proposal to merge the medical services account with the medical administration account. The Committee stated that the "current account structure has created bureaucratic confusion at the medical center level often slowing effective delivery of health care."[51] The Committee recommended merging the medical services account with the medical administration account in order to provide more spending flexibility to medical center directors.

Under the proposed new account structure the Committee recommended $35.6 billion for the medical services account, a 4.4% ($1.5 billion) increase over the FY2009 request. S. 3301, as marked up by the Committee, also provided $5.0 billion for medical facilities. This is a 21% increase compared to the FY2008 enacted amount, 6.4% above the FY2009 request, and $68 million below the House Committee-recommended amount (see **Table 7**).

The Senate marked up MILCON-VA appropriations bill also provided $527 million for the medical and prosthetic research account. This is a 19.2% increase over the FY2009 request and 9.8% above the FY2008 enacted amount.

[51] U.S. Congress, Senate Committee on Appropriations, *Military Construction, and Veterans Affairs, and Related Agencies Appropriations Bill, 2009*, report to accompany S. 3301, 110th Cong., 2nd sess., S.Rept. 110-428, p. 40.

Construction Projects

The Committee-recommended bill (S. 3301) provides $1.2 billion for the construction major projects account, a 109% increase over the FY2009 request and 32% above the House Appropriations Committee-recommended amount. S. 3301 also provided $729 million for the construction minor projects account, a 26% decrease from the House Committee recommended amount (see **Table 8**). In total, S. 3301 provided $2.2 billion for VA construction projects (excluding grants for state veterans cemeteries), including projects identified under the CARES initiative.

Final MILCON-VA Appropriations Act of 2009

Prior to the start of FY2009, a compromised version of H.R. 6599 and S. 3301 was included as Division E in the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (H.R. 2638). The bill was signed into law on September 30, 2008, as P.L. 110-329. The MILCON-VA Appropriations Act of 2009 provides a total of $40.9 billion (excluding collections) for VHA (see **Table 7**). This includes $30.9 billion for the medical services account, a 6.4% increase over the FY2008 enacted amount and 20% over the FY2007 enacted amount. Of the amount allocated to the medical services account not less than $3.8 billion is required to be spent on mental health care, and $250 million for the rural health outreach initiatives.

The final MILCON-VA Appropriations Act also provides $4.4 billion for the medical support and compliance account (previously known as the medical administration account). This amount is 26.5% above the FY2008 enacted amount and 29.8% over the FY2007 enacted amount. P.L 110-329 also provides $5 billion for the medical services account, a $368 million over the FY2009 request and $929 million over the FY2008 enacted amount. Lastly, the MILCON-VA Appropriations Act provides $510 million for the medical and prosthetic research account.

Construction Projects

P.L. 110-329 provides $1.8 billion for VA construction projects (excluding grants for construction of state veterans cemeteries) (See **Table 8**). This amount includes $923 million for the construction major projects account, $741 million for the construction minor projects account, and $175 million for grants for construction state extended care facilities.

Major Areas of Committee Interest

Mental Health Care and Traumatic Brain Injuries

The mental health care of servicemembers and veterans returning from current OEF and OIF operations has become a major area interest to congressional committees. The final MILCON-VA Appropriations Act of 2009 includes bill language requiring the VA to spend at least $3.8 billion for mental health care. **Table 5** provides a break down of VA spending for mental health care, including suicide prevention, PTSD treatment, and substance abuse treatment by both treatment site and program. VA estimates that it will spend approximately $3.9 billion in FY2009 for VA mental health care. This is would be a 19% increase in spending from the FY2007 funding level. The FY2009 estimated spending level includes $319 million for PTSD treatment and $15.5 million for suicide prevention initiatives.

The House and Senate Appropriations Committees have expressed concern with regard to the diagnosis and treatment of Traumatic Brain Injuries (TBI). The Senate Appropriations Committee has noted that many soldiers returning from Iraq and Afghanistan have faced a combination of PTSD and TBI, and that the relationship between the two injuries is not well understood. It has included report language encouraging the VA to increase the level of funding for the National Centers for Post-Traumatic Stress Disorder by least $2 million above the requested amount, to expand programs that would ensure the proper understanding of the combined impact of PTSD and TBI.

Table 6 provides VA spending levels for TBI. In FY2009, of the total amount allocated for TBI, about 88% would be spent on treatment of non-OIF and OIF veterans with TBI because they make-up the majority of TBI patients using the VA health care system.

Table 5. Mental Health Spending, FY2007-FY2009

($ in thousands)

Description	FY2007 Actual	FY2008 Estimate	FY2009 Estimate
Treatment Modality			
Inpatient Hospital	972,524	1,042,554	1,083,898
Psychiatric Residential Rehabilitation Treatment	195,777	209,899	218,223
Outpatient	1,421,340	1,523,990	1,584,424
VA Domiciliary	334,214	395,690	443,553
Mental Health Initiative	325,835	370,029	531,283
Mental Health Total	3,249,690	3,542,162	$3,861,381
Major Characteristic of Program			
Serious Mental Illness (SMI) Post-Traumatic Stress Disorder (PTSD)	222,518	265,633	319,032
SMI- Substance Abuse Treatment (SABT)	436,748	497,580	583,074
SMI - Other than PTSD & SABT	2,222,706	2,427,515	2,600,832
Subtotal, SMI	2,881,972	3,190,728	3,502,938
Other Mental Health (Non-SMI)	367,718	351,434	358,443
Total Mental Health	3,249,690	3,542,162	3,861,381
Mental Health Information Included Above			
Suicide Prevention	8,635	15,472	15,509
PTSD (OIF/OEF)	34,920	44,724	54,829
PTSD (Non-OIF/OEF)	187,598	220,909	264,203
Total PTSD	222,518	265,633	319,032
Vet Centers—Readjustment Counseling	110,016	157,954	173,380

Source: Department of Veterans Affairs, Congressional Budget Submission (2008) vol. 2 of 4.

Table 6. Traumatic Brain Injury (TBI) Spending, FY2007-FY2009
($ in thousands)

Description	FY2007 Actual	FY2008 Estimate	FY2009 Estimate
OIF and OEF Veterans	15,826	19,230	24,890
Non OIF and OEF Veterans	150,063	170,020	187,254
Total	**165,889**	**189,250**	**212,144**

Source: Department of Veterans Affairs, Congressional Budget Submission (2008) Vol 2 of 4.

Priority Group 8 Veterans

The Veterans Health Care Eligibility Reform Act of 1996 (P.L. 104-262) included language that stipulated that medical care to veterans will be furnished to the extent appropriations were made available by Congress on an annual basis. Based on this statutory authority, the Secretary of Veterans Affairs announced on January 17, 2003 that VA would temporarily suspend enrolling Priority Group 8 veterans.[52] Those who were in VA's health care system prior to January 17, 2003 were not affected by this suspension.

The House Appropriations Committee, in its report to accompany H.R. 6599 (H.Rept. 110-775) states that the VA "should do everything possible to increase access to medical care for all our veterans, but not in a manner that will negatively impact the medical care [provided to] currently enrolled patients."[53] The Committee is directing the VA to increase Priority Group 8 enrollment by 10%, and has provided $568 million above the Administration's request for this purpose.

Likewise the Senate Appropriations Committee has included $350 million within the medical services account so that the VA could "raise the income threshold to an amount commensurate with the increased level of funding" in order to enroll more Priority Group 8 veterans.[54]

The final MILCON-VA Appropriations Act of 2009 (P.L. 110-329) provides $375 million within the medical services account to increase the enrollment of Priority Group 8 veterans whose incomes exceed the current VA means test and geographic means test thresholds by 10% or less.

Beneficiary Travel Mileage Reimbursement

In general, the beneficiary travel program reimburses certain veterans for the cost of travel to VA medical facilities when seeking health care. P.L. 76-432, passed by Congress on March 14, 1940, mandated VA to pay either the actual travel expenses, or an allowance based upon the mileage traveled by any veteran traveling to and from a VA facility or other place for the purpose of examination, treatment, or care. P.L. 85-857, signed into law on September 2, 1958, authorized

[52] Department of Veterans Affairs, "Enrollment—Provision of Hospital and Outpatient Care to Veterans Subpriorities of Priority Categories 7 and 8 and Annual Enrollment Level Decision; Final Rule," *68 Federal Register* 2670, January 17, 2003.

[53] U.S. Congress, House Committee on Appropriations, *Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2009*, report to accompany H.R. 6599, 110th Cong., 2nd sess., H.Rept. 110-775, p. 39.

[54] U.S. Congress, Senate Committee on Appropriations, *Military Construction, and Veterans Affairs, and Related Agencies Appropriations Bill, 2009*, report to accompany S. 3301, 110th Cong., 2nd sess., S.Rept. 110-428, p. 50.

VA to pay necessary travel expenses to any veteran traveling to or from a VA facility or other place in connection with vocational rehabilitation counseling or for the purpose of examination, treatment, or care. However, this law changed VA's travel reimbursement into a discretionary authority by stating that VA "may pay" expenses of travel.

Due to rapidly increasing costs of the beneficiary travel program, on March 12, 1987, VA published final regulations that sharply curtailed eligibility for the beneficiary travel program.[55] Under these regulations beneficiary travel payments to eligible veterans were paid when specialized modes of transportation, such as ambulance or wheelchair van, were medically required. In addition, payment was authorized for travel in conjunction with compensation and pension examinations, as well as travel beyond a 100-mile radius from the nearest VA medical care facility. It also authorized the VA to provide transportation costs, when necessary, to transfer any veteran from one health care facility (either a VA or contract care facility) to another in order to continue care paid for by the VA. The following transportation costs were not authorized under these regulations:

- Cost of travel by privately owned vehicle in any amount in excess of the cost of such travel by public transportation unless public transportation was not reasonably accessible or was medically inadvisable.
- Cost of travel in excess of the actual expense incurred by any person as certified by that person in writing.
- Cost of routine travel in conjunction with admission for domiciliary care, or travel for family members of veterans receiving mental health services from the VA except for such travel performed beyond a 100-mile radius from the nearest VA medical care facility.

Travel expenses of all other veterans were not authorized unless the veterans were able to present clear and convincing evidence to show the inability to pay the cost of transportation; or except when medically-indicated ambulance transportation was claimed and an administrative determination was made regarding the veteran's ability to bear the cost of such transportation.[56]

The Veterans' Benefits and Services Act of 1988 (P.L. 100-322, section 108), in large part restored VA travel reimbursement benefits. It required that if VA provides any beneficiary travel reimbursement under Section 111 of Title 38 U.S.C. in any given fiscal year, then payments must be provided in that year in the case of travel for health care services for all the categories of beneficiaries specified in the statute. In order to limit the overall cost of this program, the law imposed a $3 one-way deductible applicable to all travel, except for veterans otherwise eligible for beneficiary travel reimbursement who are traveling by special modes of transportation such as ambulance, air ambulance, wheelchair van, or to receive a compensation and pension examination. In order to limit the overall impact on veterans whose clinical needs dictate frequent travel for VA medical care, an $18-per-calendar-month cap on the deductible was imposed for those veterans who are pre-approved as needing to travel on a frequent basis.

Veterans may qualify for travel reimbursement if (1) they have a service-connected disability rated 30% or more; (2) they are traveling for treatment of a service-connected disability; (3) they

[55] Veterans Administration, "Transportation of Claimants and Beneficiaries," final regulations, 52 FR 7575-01, March 12, 1987. These regulations became effective on April 13, 1987.

[56] Ibid.

receive a VA pension; (4) their income does not exceed the maximum annual VA pension rate; or (5) they are traveling for a scheduled compensation or pension examination.

The FY2008 Appropriations Act (P.L. 110-161) provided funding for VA to increase the beneficiary travel mileage reimbursement rate from 11 cents per mile to 28.5 cents per mile. The increase went into effect on February 1, 2008. While increasing the payment, VA, as mandated by law, also increased proportionately the deductible amounts applied to certain mileage reimbursements. The new deductibles are $7.77 for a one way trip, $15.54 for a round trip, with a maximum of $46.62 per calendar month. However, these deductibles can be waived if they cause a financial hardship to the veteran.

VA regulation with respect to waiving deductibles

Under current regulations 38 CFR 17.144 (b) when it is determined that charging a deductible would cause a severe financial hardship to the veteran, the VA could waive the deductible requirement. Currently, VA determines severe financial hardship as (1) annual income for the year immediately preceding the application for benefits does not exceed the maximum annual rate of pension which would be payable if the person were eligible for pension; or (2) the person is able to demonstrate that due to circumstances such as loss of employment, or incurrence of a disability, income in the year of application will not exceed the maximum annual rate of pension which would be payable if the person were eligible for pension.

With the rise in gasoline prices, the House and Senate Appropriations Committees included report language to further increase the mileage reimbursement rate. The House Appropriations Committee provided an additional $100 million to increase the beneficiary travel reimbursement mileage rate to 41.5 cents per mile from the current rate of 28.5 cents per mile. The Senate Appropriations Committee included an additional $138 million above the Administration's request to raise the mileage reimbursement rate to 50.5 cents per mile, which raises VA's reimbursement rate to conform with the General Services Administration's (GSA) rate at which federal employees are reimbursed when using private automobiles for official business.[57]

The final MILCON-VA Appropriations Act of 2009 provided an additional $133 million to increase the mileage reimbursement rate to 41.5 cents a mile and included an administrative provision to freeze the deductible at the FY2008 levels (i.e. $7.77 for a one way trip, $15.54 for a round trip, with a maximum of $46.62 per calendar month).

The Veterans' Mental Health and Other Care Improvements Act of 2008 (S. 2162, P.L. 110-387), which was signed into law on October 10, contained a provision that would require the VA to raise its current reimbursement rate to conform with the GSA rate at which federal employees are reimbursed when using private automobiles for official business. The provision would also amend current law that allows the VA to raise or lower the deductible for reimbursements in proportion to a change in the mileage rate. The VA will no longer be able to increase the deductible rate unless new deductible rates are mandated by Congress. Also it would reinstate the amount of the deductible for the beneficiary travel reimbursement program to the amount in effect prior to February 1, 2008, when VA increased the deductible rate (i.e $3 for a one way trip, $6 for a round trip, with a maximum of $18 per calendar month).

[57] It should be noted that on August 1, 2008, the GSA raised the mileage reimbursement rate to 58.5 cents a mile http://www.gsa.gov/mileage.

Table 7. VHA Appropriations by Account, FY2007-FY2009

($ in thousands)

Program	FY2007 Enacted	FY2008 Request	FY2008 House	FY2008 Senate	FY2008 Enacted	FY2009 Request	FY2009 House (H.R. 6599)	FY2009 Senate Committee (S.Rept. 110-428)	FY2009 Enacted (P.L. 110-329)
Medical Services	25,518,254	27,167,671	29,031,400	29,104,220	27,167,671	34,075,503	30,854,270	35,590,432	30,969,903
Emergency appropriations—U.S. Troop Readiness, Veterans' Care, Katrina Recovery (P.L. 110-28)	400,778[a]	—	—	—	—	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	1,936,549	—	—	—	—
Subtotal Medical Services	***25,919,032***	***27,167,671***	***29,031,400***	***29,104,220***	***29,104,220***	***34,075,503***	***30,854,270***	***35,590,432***	***30,969,903***
Medical Support and Compliance (Previously Medical Administration)	3,177,968	3,442,000	3,510,600	3,517,000	3,442,000	—	4,400,000	—	4,450,000
Emergency appropriations—U.S. Troop Readiness, Veterans' Care, Katrina Recovery (P.L. 110-28)	250,000	—	—	—	—	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	75,000	—	—	—	—
Subtotal Medical Support and Compliance (Previously Medical Administration)	***3,427,968***	***3,442,000***	***3,510,600***	***3,517,000***	***3,517,000***	**—**	***4,400,000***	—	***4,450,000***
Medical Facilities	3,569,533	3,592,000	4,100,000	4,092,000	3,592,000	4,661,000	5,029,000	4,961,000	5,029,000
Emergency appropriations—U.S. Troop Readiness, Veterans' Care, Katrina Recovery (P.L. 110-28)	595,000	—	—	—	—	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	508,000	—	—	—	—
Subtotal Medical Facilities	***4,164,533***	***3,592,000***	***4,100,000***	***4,092,000***	***4,100,000***	***4,661,000***	***5,029,000***	***4,961,000***	***5,029,000***
Medical and Prosthetic Research	413,980	411,000	480,000	500,000	411,000	442,000	500,000	526,800	510,000
Emergency appropriations—U.S. Troop Readiness, Veterans' Care, Katrina Recovery (P.L. 110-28)	32,500	—	—	—	—	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	69,000	—	—	—	—

Program	FY2007 Enacted	FY2008 Request	FY2008 House	FY2008 Senate	FY2008 Enacted	FY2009 Request	FY2009 House (H.R. 6599)	FY2009 Senate Committee (S.Rept. 110-428)	FY2009 Enacted (P.L. 110-329)
Subtotal Medical and Prosthetic Research	***446,480***	***411,000***	***480,000***	***500,000***	***480,000***	***442,000***	***500,000***	***526,800***	***510,000***
Total VHA appropriations (without collections)	**33,958,013**	**34,612,671**	**37,122,000**	**37,213,220**	**37,201,220**	**39,178,503**	**40,783,270**	**41,078,232**	**40,958,903**
Medical care cost collections (MCCF)	2,329,000	2,414,000	2,414,000	2,414,000	2,414,000	1,879,000	2,544,000	2,544,000	2,544,000
Total VHA appropriations (with collections)	**36,287,013**	**37,026,671**	**39,536,000**	**39,627,220**	**39,615,220**	**41,057,503**	**43,327,270**	**43,622,232**	**43,502,903**

Sources: Table prepared by the Congressional Research Service based on H.Rept. 109-464; H.Rept. 109-494; S.Rept. 109-286; P.L. 110-5; H.Rept. 110-64; S.Rept. 110-37; H.Rept. 110-60; Congressional Record, vol. 153, (May 24, 2007), pp.H5786-H5787; H.Rept. 110-186; S.Rept. 110-85; Congressional Record, vol. 153, (September 7, 2007), S11271-S11278; Congressional Record, vol. 153 (December 17, 2007), pp. H16249-H16431; H.Rept. 110-775; S.Rept. 110-428; and Congressional Record, vol. 154, (September 24, 2008), pp.H9868-H9869.

a. P.L. 110-161 (H.R. 2764) transferred $66 million from the FY2007 medical services account to the construction major, projects account for FY2007.

Table 8. Appropriations for VA Construction Projects, FY2008-FY2009

($ in thousands)

	FY2008 Request	FY2008 House	FY2008 Senate	FY2008 enacted	FY2009 Request	FY2009 House (H.R. 6599)	FY2009 Senate Committee (S.Rept. 110-428)	FY2009 Enacted (P.L. 110-329)
Construction, major projects[a]	727,400	1,410,800	727,400	727,400	581,582	923,382	1,217,747	923,382
Contingent emergency (P.L. 110-161)	—	—	—	341,700	—	—	—	—
Emergency appropriations (P.L. 110-252)	—	—	—	396,377	—	—	—	—
Subtotal construction, major projects	***727,400***	***1,410,800***	***727,400***	***1,465,477***	***581,582***	***923,382***	***1,217,747***	***923,382***
Construction, minor projects[b]	233,396	615,000	751,398	233,396	329,418	991,492	729,418	741,534
Contingent emergency	—	—	—	397,139	—	—	—	—

	FY2008 Request	FY2008 House	FY2008 Senate	FY2008 enacted	FY2009 Request	FY2009 House (H.R. 6599)	FY2009 Senate Committee (S.Rept. 110-428)	FY2009 Enacted (P.L. 110-329)
(P.L. 110-161)								
Subtotal construction, minor projects	***233,396***	***615,000***	***751,398***	***630,535***	***329,418***	***991,492***	***729,418***	***741,534***
Grants for construction of state extended care facilities[c]	85,000	165,000	250,000	85,000	85,000	165,000	250,000	175,000
Contingent emergency								
(P.L. 110-161)	—	—	—	80,000	—	—	—	—
Subtotal Grants for construction of state extended care facilities	***85,000***	***165,000***	***250,000***	***165,000***	***85,000***	***165,000***	***250,000***	***175,000***
Total	**1,045,796**	**2,190,800**	**1,728,798**	**2,261,012**	**996,000**	**2,079,874**	**2,197,165**	**1,839,916**

Sources: Table prepared by CRS based on H.Rept. 110-186; S.Rept. 110-85; Congressional Record, vol. 153 (September 7, 2007), S11271-S11278; Congressional Record, vol. 153 (December 17, 2007), pp. H16249-H16431; H.Rept. 110-775; S.Rept. 110-428; and Congressional Record, vol. 154, (September 24, 2008), pp. H9868-H9869.

Note: This table excludes grants for construction of state veterans cemeteries.

a. This account provides funds for constructing, altering, extending, and improving any VA facility, including planning, assessments of needs, architectural and engineering services, CARES projects, and site acquisition, where the estimated cost of a project is *$10 million or more* or where funds for a project were made available in a previous major project appropriation. Emphasis is placed on correction of safety code deficiencies in existing VA medical facilities.

b. This account provides funds for constructing, altering, extending and improving any VA facility, including planning, architectural and engineering services, CARES projects, and site acquisition, where the estimated cost of a project is *less than $10 million*. VA medical center projects that need minor improvements costing $500,000 or more are funded from this account.

c. This account provides grants to states to acquire or construct state nursing home and domiciliary facilities, and to remodel, modify, or alter existing hospitals, nursing homes, and domiciliary facilities in state homes. A grant may not exceed 65% of the total cost of the project. P.L. 102-585 granted permanent authority for this program, and P.L. 104-262 added Adult Day Health Care as another level of care that may be provided by state homes. This is a no-year account.

Key Budget Issues

In its FY2009 budget request, the Administration has put forward several legislative proposals. These proposals are similar to previous ones included in the Administration's budget requests for FY2003, FY2004, FY2005, FY2006, FY2007, and FY2008 and rejected by Congress each year.[58] Similar to the FY2008 budget proposals, revenue from the proposals in the FY2009 budget request would not be deposited in the Medical Care Collections Fund (MCCF), but would be classified as mandatory receipts to the Treasury. None of these proposals have received any consideration by the House and Senate Appropriation Committees.

The President's FY2009 budget request includes three major policy proposals:

- Assess a tiered annual enrollment fee for all Priority 7 and 8 veterans based on the family income of the veteran.
- Increase pharmaceutical copayments from $8 to $15 (for each 30-day prescription) for all enrolled veterans in Priority Groups 7 and 8.
- Bill veterans receiving treatment for nonservice-connected conditions for the entire copayment amount.

A detailed description of these budget proposals follows.

Assess an Annual Enrollment Fee

The Administration is proposing a tiered annual enrollment fee, which is structured to charge $250 for Priority 7 and 8 veterans with family incomes from $50,000 to $74,999; $500 for those with family incomes from $75,000 to $99,999; and $750 for those with family incomes equal to or greater than $100,000. The VA has estimated that this proposal would contribute more than $129 million to the Treasury annually, beginning in FY2010, and will increase revenue by $1.1 billion over 10 years.

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 the VA on an outpatient basis for the treatment of a nonservice-connected condition. The Administration put forward this proposal in its FY2004, FY2005, FY2006, FY2007, and FY2008 budget requests as well, but did not receive any approval from Congress. At

[58] In FY2003, the VA proposed a $1,500 deductible for all Priority Group 7 veterans for nonservice-connected disabilities. For proposals included in FY2004, FY2005, FY2006, FY2007,and FY2008, see CRS Report RL32548, *Veterans' Medical Care Appropriations and Funding Process*, by Sidath Viranga Panangala; CRS Report RL32975, *Veterans' Medical Care: FY2006 Appropriations*, by Sidath Viranga Panangala; CRS Report RL33409, *Veterans' Medical Care: FY2007 Appropriations*, by Sidath Viranga Panangala; and CRS Report RL34063, *Veterans' Medical Care: FY2008 Appropriations*, by Sidath Viranga Panangala.

present, veterans in Priority Groups 2-8 pay $8 for a 30-day supply of medication, including over-the-counter medications.[59]

The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) authorized the 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 the 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.[60] When veterans reach the annual cap, they continue to receive medications without making a copayment.

On November 15, 2005, the 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.[61] There is no cap for veterans in Priority Groups 7 and 8 (see **Appendixes B** and **C**). The VA estimates that if the current proposal to raise the copayment were enacted, it would contribute $355 million to the Treasury in FY2009 and will increase revenue by $3.7 billion over 10 years.

Impact of Fee Proposals

According to the VA, in FY2009, as many as 444,000 veterans would choose not to enroll in the VA health care system and 146,000 unique veteran patients would not seek VA health care if enrollment fees are imposed and pharmacy copays are increased.

Third-Party Offset of First-Party Debt

The Administration is requesting that Congress amend the VA's statutory authority by eliminating the practice of reducing first-party copayment debts with third-party health insurance collections. The VA asserts that this proposal would align the 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 the VA to collect payments from third-party health insurers for the treatment of veterans with nonservice-

[59] The following veterans are exempt from paying copayments: veterans receiving a pension for a nonservice-connected disability from the VA; veterans with incomes below $11,181 (if no dependents) and $14,643 (with one dependent plus $1,909 for each additional dependent); veterans receiving care for conditions such as Agent Orange or Military Sexual Trauma, and combat veterans within five years of discharge; and veterans who are former POWs.

[60] This law allowed the 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, the 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 increases in whole dollar amounts. The amount of the annual cap increases $120 for each $1 increase in the copayment amount.

[61] VHA Directive 2005-052, *Implementation of Medication Copayment Changes*, November 15, 2005.

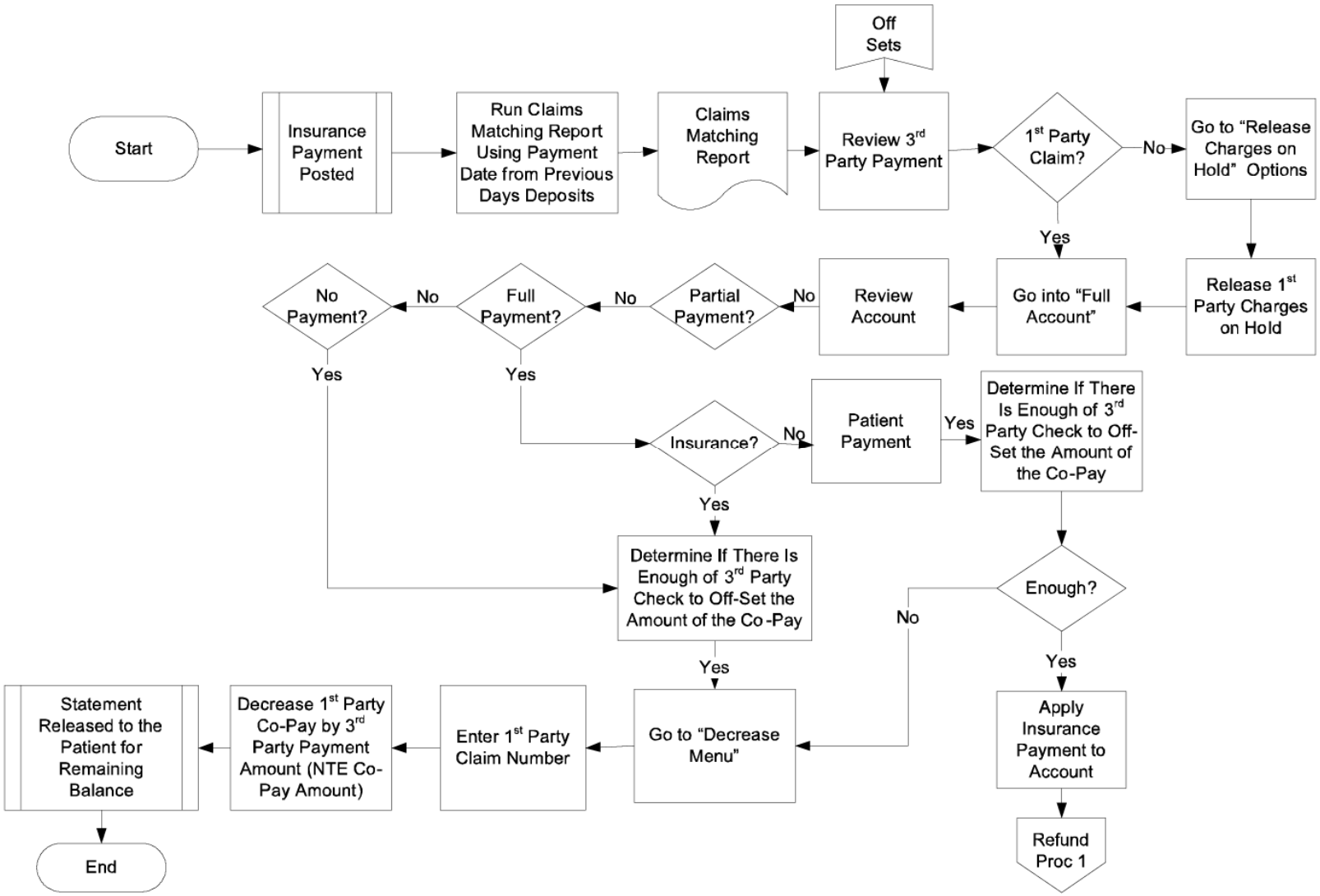
connected disabilities; it also established copayments from veterans for this care.[62] Under current law, the VA is authorized to collect from third-party health insurers to offset the cost of medical care furnished to a veteran for the treatment of a nonservice-connected condition.[63] If the VA treats an insured veteran for a nonservice-connected disability, and the veteran is also determined by the VA to have copayment responsibilities, the 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, the 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, a bill is sent to the veteran for the full copayment amount. However, when insurers reimburse the VA after the 90-day period, the 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 (see **Figure 2**).

[62] Consolidated Omnibus Budget Reconciliation Act of 1985, 100 Stat. 372, 373, 383.

[63] 38 U.S.C. §1729; 38 U.S.C. §1710; and 38 U.S.C. 1722A.

Figure 2. Present Copayment Process



Source: Department of Veterans Affairs.

Under the Administration's proposal, veterans receiving medical care services for treatment of nonservice-connected disabilities will receive a bill for their entire copayment, and the copayment will not be reduced by collection recoveries from third-party health plans. This proposal would apply to all veterans who make copayments.

According to VA estimates, this proposal will increase revenue by $44 million in FY2009 and $415 million over 10 years. The House and Senate Appropriations Committees have not addressed this issue because it is an issue in the purview of the authorizing committees.

Appendix A. Priority Groups and Their Eligibility Criteria

Priority Group 1

Veterans with service-connected disabilities rated 50% or more disabling

Priority Group 2

Veterans with service-connected disabilities rated 30% or 40% disabling

Priority Group 3

Veterans who are former POWs

Veterans awarded the Purple Heart[a]

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"

Priority Group 4

Veterans who are receiving aid and attendance or housebound benefits

Veterans who have been determined by the VA to be catastrophically disabled

Priority Group 5

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

Priority Group 6

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.

Priority Group 7

Veterans who agree to pay specified copayments who have income and/or net worth *above* the VA Means Test threshold and income *below* 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

Priority Group 8

Veterans who agree to pay specified copayments with income and/or net worth *above* 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

Source: Department of Veterans Affairs.

Notes: 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.

a. 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.

Appendix B. Copayments for Health Care Services: 2008

	Inpatient care	Outpatient care	Outpatient medication	Long-term care services
	($10/day + $1024 for first 90 days and $512 after 90 days—based on 365-day period)	**($15 Primary Care; $50 Specialty Care; $0 for x-rays, lab, immunizations, etc.)**	**($8 per 30-day supply; Priority Groups 2-6 calendar year cap - $960)**	**(Institutional nursing home care units, respite care, geriatric evaluation - $0-97 per day. Non-institutional respite care, geriatric evaluation, adult day healthcare - $15 per day; domiciliary care - $5 per day)**
Priority Group 1 (service-connected disabilities rated 50% or more disabling)	NO	NO	NO	NO
Priority Groups 2 and 3 (Veterans with service-connected disabilities rated 10% - 40% disabling)[a]	NO	NO	YES	NO
Priority Group 4 Copay rules apply if placed from lower priority group based on VHA catastrophic disability determination	NO	NO	NO	NO
Priority Group 5[b]	NO	NO	YES	YES
Priority Group 6[c]	NO	NO	NO	NO
Priority Group 7[d]	YES	YES	YES	YES
Priority Group 8[e]	YES	YES	YES	YES

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

a. No medication copayments if medication is for a service-connected disability. Former POWs are exempt from all medications copayments.

b. No medication or long-term care copayments if veterans is in receipt of VA pension or has an income below applicable pension threshold.

c. Priority Group 6 are veterans claiming exposure to Agent Orange; veterans claiming exposure to environmental contaminants; veterans exposed to Ionizing Radiation; combat veterans within five 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 medication 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 that is not related to exposure, if it is nonservice-connected, will be billed to the insurance carrier and copayments can apply.

d. 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.

e. 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.

OEF/OIF Combat Veterans Enhanced Eligibility for Health Care Benefits: Combat veterans discharged from active duty on or after January 28, 2003, are eligible for enrollment in Priority Group 6 for five years following discharge unless eligible for a higher enrollment priority. Combat veterans discharged from active duty before January 28, 2003, who apply for enrollment on or after January 28, 2008, are eligible for enrollment in Priority Group 6 until January 27, 2011. After the special eligibility period ends, these veterans will be reassigned to the appropriate priority group and will be subject to copayments if applicable. Copayments are applicable for Priority Group 6 combat veteran enrollees for care related to a condition that is congenital or developmental (e.g., scoliosis) that existed before military service (unless aggravated by combat service) or has a specific etiology that began after military service, such as a common cold, etc.

Appendix C. Financial Income Thresholds for VA Health Care Benefits, Calendar Year 2008

Veterans with—	Free VA prescriptions and travel benefits for veterans with incomes of—	Free VA inpatient and outpatient care for veterans with incomes of—
No dependents	11,181 or less	28,429 or less
1 dependent	14,643 or less	34,117 or less
2 dependents	16,552 or less	36,026 or less
3 dependents	18,461 or less	37,935 or less
4 dependents	20,370 or less	39,844 or less
For each additional dependent, add:	1,909	1,909

Source: Department of Veterans Affairs.

Appendix D. VHA Appropriations for FY2005 and FY2006

($ in thousands)

Program	FY2005 Request	FY2005 House	FY2005 Senate	FY2005 Enacted	FY2006 Request	FY2006 House	FY2006 Senate	FY2006 Enacted
Medical services	—	19,498,600	19,498,600[a]	19,316,995	19,995,141	20,995,141	21,331,011	21,322,141
Supplemental appropriations (P.L. 108-324)	38,283	—	—	38,283	—	—	—	—
Supplemental appropriations	975,000[b]	975,000[c]	1,500,000[d]	1,500,000[e]	—	—	—	—
Emergency appropriations	—	—	—	—	1,977,000[f]	—	1,977,000[g]	1,225,000[h]
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
Subtotal medical services	***1,013,283***	***20,473,600***	***20,998,600***	***20,855,278***	***22,197,406***	***20,995,141***	***23,308,011***	***22,772,406***
Medical administration	—	4,705,000	4,705,000	4,667,360	4,517,874	4,134,874	2,858,442	2,858,442
Supplemental appropriations (P.L. 108-324)	1,940	—	—	1,940	—	—	—	—
Subtotal medical administration	***1,940***	***4,705,000***	***4,705,000***	***4,669,300***	***4,517,874***	***4,134,874***	***2,858,442***	***2,858,442***
Medical facilities	—	3,745,000	3,745,000	3,715,040	3,297,669	3,297,669	3,297,669	3,297,669
Supplemental appropriations (P.L. 108-324)	46,909	—	—	46,909	—	—	—	—
Subtotal medical facilities	***46,909***	***3,745,000***	***3,745,000***	***3,761,949***	***3,297,669***	***3,297,669***	***3,297,669***	***3,297,669***
Medical and prosthetic research	384,770	384,770	405,593	402,348	393,000	393,000	412,000	412,000
Information technology	—	—	—	—	—	—	1,456,821	—
Medical care[i]	26,748,600	—	—	—	—	—	—	—

Program	FY2005 Request	FY2005 House	FY2005 Senate	FY2005 Enacted	FY2006 Request	FY2006 House	FY2006 Senate	FY2006 Enacted
Total VHA appropriations (without collections)	**28,195,502**	**28,308,370**	**28,854,193**	**29,688,875**	**30,405,949**	**28,820,684**	**31,332,943**	**29,340,517**
Medical care cost collection (MCCF)[j]	2,002,000	2,002,000	2,002,000	1,985,984	2,170,000	2,170,000	2,170,000	2,170,000
Total: VHA (appropriations and collections)	**30,197,502**	**31,310,370**	**30,856,193**	**31,674,859**	**32,575,949**	**30,990,684**	**33,502,943**	**31,510,517**

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.

Notes: 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 the 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.

Appendix E. VHA Appropriations for FY2007 and FY2008

($ in thousands)

Program	FY2007 request	FY2007 House	FY2007 Senate	FY2007 enacted	FY2008 request	FY2008 House	FY2008 Senate	FY2008 enacted
Medical services	25,512,000	25,412,000	28,689,000	25,518,254	27,167,671	29,031,400	29,104,220	27,167,671
Emergency appropriations—U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability (P.L. 110-28)	—	414,982	454,131	400,778[a]	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	—	—	—	1,936,549
Subtotal medical services	***25,512,000***	***25,826,982***	***29,143,131***	***25,919,032***	***27,167,671***	***29,031,400***	***29,104,220***	***29,104,220***
Medical administration	3,177,000	3,277,000	—	3,177,968	3,442,000	3,510,600	3,517,000	3,442,000
Emergency appropriations (P.L. 110-28)	—	256,300	250,000	250,000	—	—	—	—
Contingent emergency (P.L. 110-161)								75,000
Subtotal medical administration	***3,177,000***	***3,533,300***	***250,000***	***3,427,968***	***3,442,000***	***3,510,600***	***3,517,000***	***3,517,000***
Medical facilities	3,569,000	3,594,000	3,569,000	3,569,533	3,592,000	4,100,000	4,092,000	3,592,000
Emergency appropriations (P.L. 110-28)	—	595,000	595,000	595,000	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	—	—	—	508,000
Subtotal medical facilities	***3,569,000***	***4,189,000***	***4,164,000***	***4,164,533***	***3,592,000***	***4,100,000***	***4,092,000***	***4,100,000***
Medical and prosthetic research	399,000	412,000	412,000	413,980	411,000	480,000	500,000	411,000
Emergency appropriations (P.L. 110-28)	—	35,000	30,000	32,500	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	—	—	—	69,000
Subtotal medical and prosthetic research	***399,000***	***447,000***	***442,000***	***446,480***	***411,000***	***480,000***	***500,000***	***480,000***

Program	FY2007 request	FY2007 House	FY2007 Senate	FY2007 enacted	FY2008 request	FY2008 House	FY2008 Senate	FY2008 enacted
Total VHA appropriations (without collections)	**32,657,000**	**33,996,282**	**33,999,131**	**33,958,013**	**34,612,671**	**37,122,000**	**37,213,220**	**37,201,220**
Medical care cost collection (MCCF)	2,329,000	2,329,000	2,329,000	2,329,000	2,414,000	2,414,000	2,414,000	2,414,000
Total: VHA (appropriations and collections)	**34,986,000**	**36,325,282**	**36,328,131**	**36,287,013**	**37,026,671**	**39,536,000**	**39,627,220**	**39,615,220**

Sources: Table prepared by the Congressional Research Service based on H.Rept. 109-95; S.Rept. 109-105; H.Rept. 109-305; H.Rept. 109-359; H.Rept. 109-464; H.Rept. 109-494; S.Rept. 109-286; P.L. 110-5; H.Rept. 110-64; S.Rept. 110-37; H.Rept. 110-60; Congressional Record, vol. 153, (May 24, 2007), H5786-H5787; H.Rept. 110-186; S.Rept. 110-85; Congressional Record, vol. 153, (September 7, 2007), S11271-S11278; and Congressional Record, vol. 153 (December 17, 2007), H16249-H16431.

Note: FY2008 enacted does not include funding included in the Supplemental Appropriation Act, 2008 (P.L. 110-252).

a. P.L. 110-161 (H.R. 2764) transferred $66 million from the FY2007 medical services account to the construction major, projects account for FY2007.

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