Veterans Medical Care: FY2011 Appropriations

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November 15, 2010

Congressional Research Service
7-5700
www.crs.gov
R41343

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

The Department of Veterans Affairs (VA) provides benefits to veterans who meet certain eligibility criteria. 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).

This report focuses on the VHA. 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. Veterans generally must enroll in the VA health care system to receive medical care. Eligibility for enrollment is based primarily on previous military service, disability, and income. VA provides free inpatient and outpatient medical care to veterans for service-connected conditions and to low-income veterans for nonservice-connected conditions.

The Obama Administration released its FY2011 budget on February 1, 2010. The President requests an overall funding amount of $48.8 billion for VHA for FY2011, an increase of $3.7 billion over the enacted amount in FY2010. Furthermore, as required by P.L. 111-81, the Administration is requesting $50.6 billion in advance appropriations for FY2012 for the three medical care appropriations: medical services, medical support and compliance, and medical facilities. In FY2012, the administration's budget request would provide $39.6 billion for the medical services account, $5.5 billion for medical support and compliance account, and $5.4 billion for the medical facilities account.

On July 15, 2010, the Senate Committee on Appropriations marked up its version of the MILCON-VA Appropriations bill for FY2011(S. 3615; S.Rept. 111-226). The Senate Appropriations Committee version of the bill provides $48.9 billion for VHA for FY2011. This amount includes $48.1 billion authorized in FY2010, an additional $120 million for the medical services and medical facilities accounts, and $590 million for the medical and medical and prosthetic research account. The Senate Appropriations Committee recommended amount is thus $120 million more than the President's request for VHA for FY2011. S. 3615 also provides a advance appropriations of $50.6 billion for medical services, medical support and compliance, and medical facilities accounts to be available in FY2012.

On July 28, 2010, the House passed its version of the FY2011 Military Construction and Veterans Affairs and Related Agencies Appropriations bill (MILCON-VA Appropriations bill for FY2011, H.R. 5822; H.Rept. 111-559). The House-passed bill provides a total of $48.8 billion for the Veterans Health Administration (VHA) for FY2011, which includes 48.1 billion authorized in the FY2010 Military Construction and Veterans Affairs and Related Agencies Appropriations Act (P.L. 111-117) and $590 million for the medical and medical and prosthetic research account. H.R. 5822 provides advance appropriations of $50.6 billion for medical services, medical support and compliance, and medical facilities accounts to be available in FY2012. This is the same as the Administration's request and 5.0% above the FY2011 total amount for the same three accounts.

This report will track the FY2011 appropriations process for funding VHA, and will be updated as legislative activities warrant.

Contents

Figures

Tables

Appendixes

Contacts

Advance Appropriations: A Note to the Reader

In 2009, Congress enacted the Veterans Health Care Budget Reform and Transparency Act of 2009 (P.L. 111-81) that authorized advance appropriations for three of the four accounts that comprise the Veterans Health Administration (VHA): medical services, medical support and compliance, and medical facilities. (The medical and prosthetic research account is not funded as an advance appropriation.) This law also required the Department of Veterans Affairs (VA) to submit a request for advance appropriations for VHA with its President's budget request each year.

The House and Senate Military Construction and Veterans Affairs Appropriations bills for FY2010 (H.R. 3082 and S. 1407), and Division E of the Consolidated Appropriations Act 2010 (Military Construction and Veterans Affairs Appropriations Act, 2010, P.L. 111-117) provided budget authority for FY2011 for the following accounts: medical services, medical support and compliance, and medical facilities. Under current budget scoring guidelines new budget authority for an advance appropriation is scored in the fiscal year in which the funds become available for obligation. Therefore, throughout this report funding for FY2011 refers to the budget authority authorized in the FY2010 Military Construction and Veterans Affairs Appropriations Act, and any additional funding recommended by the appropriators for FY2011, including funding for the medical and prosthetic research account, during the FY2011 appropriations process. Furthermore, in the tables of this report funding for FY2011 is recorded in the FY2011 column. Likewise, the FY2011 Military Construction and Veterans Affairs Appropriations bills (H.R. 5822 and S. 3615) would be authorizing advance appropriations for FY2012, which the tables of this report display in the FY2012 column.

Most Recent Developments

Since none of the 12 regular appropriations bill were enacted into law by the beginning of the fiscal year on October 1, on September 30, 2010, Congress passed the Continuing Appropriations Act, 2011 (H.R. 3081, P.L. 111-242). This act extends funding for FY2011 for the Department of Veterans Affairs (VA) at generally FY2010-enacted spending levels, through December 3, 2010. However, three accounts of the Department, medical services, medical support and compliance, and medical facilities, would not be affected by P.L. 111-242 because these accounts were already funded for FY2011 through an advance appropriation.[1]

On July 28, 2010, the House passed its version of the FY2011 Military Construction and Veterans Affairs and Related Agencies Appropriations bill (MILCON-VA Appropriations bill for FY2011, H.R. 5822; H.Rept. 111-559). The House-passed measure provides a total of $48.8 billion for the Veterans Health Administration (VHA) for FY2011 which includes $48.1 billion authorized in the FY2010 Military Construction and Veterans Affairs and Related Agencies Appropriations Act (P.L. 111-117) and $590 million for the medical and medical and prosthetic research account. This is same as the President's request for FY2011 and 8.2% above the FY2010 enacted amount of $45.1 billion for VHA (**Table 1**). Moreover, H.R. 5822 provides an advance appropriation of $50.6 billion for medical services, medical support and compliance, and medical facilities accounts to be available in FY2012. This is the same as the Administration's request and 5.0% above the FY2011 total amount for the same three accounts (**Table 1**).

On July 15, 2010, the Senate Committee on Appropriations marked up its version of the MILCON-VA Appropriations bill for FY2011 (S. 3615; S.Rept. 111-226). The Senate Appropriations Committee version of the bill provides $48.9 billion for VHA for FY2011. This amount includes $48.1 billion authorized in FY2010, and additional $120 million for the medical services and medical facilities accounts, and $590 million for the medical and medical and

[1] For more information on the continuing resolution providing funding for FY2011, see CRS Report RL30343, *Continuing Resolutions: Latest Action and Brief Overview of Recent Practices*, by Sandy Streeter.

prosthetic research account (**Table 1**). The Senate Appropriations Committee recommended amount is thus $120 million more than the House Appropriations Committee recommended amount and the President's request for VHA for FY2011. Similar to the House version, S. 3615 also provides advance appropriations of $50.6 billion for medical services, medical support and compliance, and medical facilities accounts to be available in FY2012.

Table 1. VA Appropriations, FY2010-FY2011, and Advance Appropriations, FY2012

($ in Thousands)

	Enacted (P.L. 111-117)		Request		House (H.R. 5822; H.Rept. 111-559)		Senate Committee (S. 3615; S.Rept. 111-226)	
	FY2010	FY2011	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012
Total Department of Veterans Affairs (VA)	$109,607,626[a]	—	$120,791,880	—	$120,812,964	—	$120,842,779	—
Total Mandatory	56,568,316	—	63,849,146	—	63,849,146	—	63,849,146	—
Total Discretionary	53,039,310	—	56,942,734	—	56,963,818	—	56,993,633	—
Total Veterans Health Administration (VHA)[b]	$45,077,500	—	$48,773,000	—	$48,773,000	—	$48,893,000[c]	—
Memorandum: Advance appropriations VHA[d]	—	$48,183,000	—	$50,610,985	—	$50,610,985	—	$50,610,985

Source: Prepared by the Congressional Research Service, based on figures from the *Congressional Record*, vol.171, (November 18, 2009), pp. S11503-S11508, Division E of H.Rept. 111-366; H.Rept. 111-559, and S.Rept. 111-226.

Notes:

a. The Supplemental Appropriations Act, 2010 (P.L. 111-212),enacted on July 29, 2010, provided $13.4 billion in mandatory funding for FY2010. This amount is *not* included in this total amount for VA.

b. Includes funding for medical services, medical support and compliance, medical facilities, and medical and prosthetic research accounts, and excludes collections deposited into the Medical Care Collections Fund (MCCF). The FY2011 VHA appropriation also includes advance appropriations for VHA provided in the FY2010 enacted appropriations bill (P.L. 111-117) and the amount for the medical and prosthetic research account, which was not funded as an advance appropriation.

c. The Senate Appropriations Committee recommendation includes additional funding for FY2011 above the advance appropriations amount enacted in the FY2010 appropriations bill (P.L. 111-117).

d. The House and Senate Military Construction and Veterans Affairs Appropriations bills (H.R. 5822 and S. 3615) for FY2011 provide budget authority for FY2012 for the following accounts: medical services, medical support and compliance, and medical facilities. Under current budget scoring guidelines new budget authority for an advance appropriation is scored in the fiscal year in which the funds become available for obligation. Therefore, in this table the budget authority is recorded in the FY2012 column.

The remainder of this report is structured into three major areas. The first area of the report includes sections providing an overview of the Department of Veterans Affairs (VA), the VA health care system, eligibility for VA health care, and a description of the veteran patient population. The second area includes sections describing the formulation of the Veterans Health Administration (VHA) budget, funding for the VHA, the FY2010 budget summary, and the FY2011 VHA budget. The third area of the report discusses major areas of congressional interest as they pertain to the FY2011 budget.

Overview of the Department of Veterans Affairs

The history of the present day VA can be traced back to July 21, 1930, when President Hoover issued Executive Order 5398 consolidating separate veterans' programs and creating an independent federal agency known as the Veterans Administration.[2] On October 25, 1988, President Reagan signed legislation (P.L. 100-527) creating a new federal cabinet-level Department of Veterans Affairs to replace the Veterans Administration effective March 15, 1989.

The VA provides a range of benefits and services to veterans who meet certain eligibility rules including hospital and medical care, disability compensation and pensions,[3] education,[4] vocational rehabilitation and employment services,[5] assistance to homeless veterans,[6] home loan guarantees,[7] administration of life insurance as well as traumatic injury protection insurance for servicemembers, and death benefits that cover burial expenses.

The Department 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 and prosthetic research programs. The Veterans Benefits Administration (VBA) is responsible for, among other things, providing compensations, pensions, and education assistance. The National Cemetery Administration (NCA)[8] 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.

[2] In the 1920s three federal agencies, the Veterans Bureau, Bureau of Pensions in the Department of the Interior, and the National Home for Disabled Volunteer Soldiers administered various benefits for the nation's veterans.

[3] For a detailed description of disability compensation and pension programs see, CRS Report RL34626, *Veterans' Benefits: Benefits Available for Disabled Veterans*, by Christine Scott and Carol D. Davis; CRS Report RL33323, *Veterans Affairs: Benefits for Service-Connected Disabilities*, by Douglas Reid Weimer; and CRS Report RS22804, *Veterans' Benefits: Pension Benefit Programs*, by Christine Scott and Carol D. Davis.

[4] For a discussion of education benefits see, CRS Report R40723, *Educational Assistance Programs Administered by the U.S. Department of Veterans Affairs*, by Cassandria Dortch.

[5] For details on VA's vocational rehabilitation and employment see, CRS Report RL34627, *Veterans' Benefits: The Vocational Rehabilitation and Employment Program*, by Christine Scott and Carol D. Davis.

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

[7] For details on the home loan guarantee program see CRS Report RS20533, *VA-Home Loan Guaranty Program: An Overview*, by Bruce E. Foote.

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

The VA has also announced that it has begun the process of transforming itself "into a 21st - century organization."[9] The Department has established six high priority performance goals to support this transformation: (1) reducing the disability claims backlog; (2) eliminating veteran homelessness; (3) automating the GI Bill benefit system; (4) establishing a Virtual Lifetime Electronic Record (VLER);[10] (5) improving mental health care; and (6) deploying a Veterans Relationship Management System.[11]

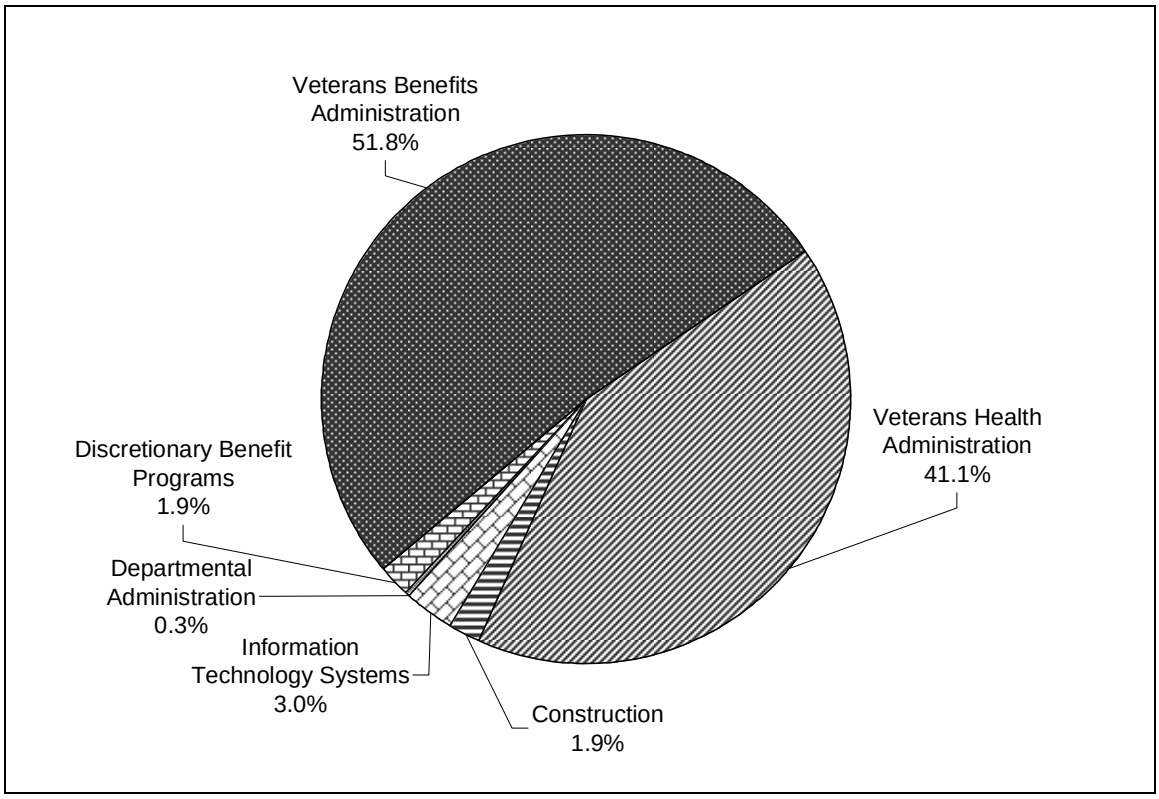
The VA's budget includes both mandatory and discretionary spending accounts. Mandatory funding supports disability compensation, pension benefits, education, vocational rehabilitation, and life insurance, among other benefits and services. Discretionary funding supports a broad array of benefits and services including medical care. **Figure 1** provides a breakdown of FY2010 budget allocations for both mandatory and discretionary programs. In FY2010 the total VA budget authority was approximately $110 billion; discretionary budget authority accounted for about 48.3% ($53.0 billion) of the total, with about 85% of this discretionary funding going toward supporting VA health care programs including medical research. For details on VHA appropriations from FY2005 through FY2010, see **Appendix E**.

[9] Statement of Secretary Eric Shinseki in U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, *Military Construction, Veterans Affairs, and Related Agencies Appropriations for 2011*, 111th Cong., 2nd sess., March 4, 2010 (Washington: GPO, 2010), pp. 86-91.

[10] VLER is an interagency federal initiative, in collaboration with the private sector, to create a secure exchange for electronically sharing and proactively identifying the entire spectrum of health and benefits for servicemembers, veterans, and their dependents. In December 2009, VA began a health record pilot program between the VA Medical Center in San Diego and a local Kaiser Permanente hospital to exchange electronic health record (EHR) information using the Nationwide Health Information Network (NHIN) created by the Department of Health and Human Services. The Department of Defense (DOD) joined the pilot during the second quarter of FY2010.

[11] According to the VA, the Veterans Relationship Management (VRM) Program would provide veterans with self-service options for obtaining and submitting information related to their claims. VRM would provide Internet and telephone capabilities with self-service options. Veterans would be able to conduct secure Internet transactions seamlessly across multiple VA service lines, without repeating information. These will include such things as changing an address, reviewing the status of a claim, reporting changes in dependency, notices of death, and certification for educational and home loan purposes.

Figure 1. FY2010 VA Budget Allocations



Source: Chart prepared by Congressional Research Service based on figures contained in Division E of H.Rept. 111-366, and the Joint Explanatory Statement of the Committee of Conference contained in H.Rept. 111-366.

The Veterans Health Care System

The Veterans Health Administration (VHA) operates the nation's largest integrated direct health care delivery system.[12] While Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are also publicly funded programs, most health care services under these programs are delivered by private providers in private facilities. In contrast, the VA health care system could be categorized as a veteran-specific national health care system, in the sense that the federal government owns the medical facilities and employs the health care providers.[13] The VA's health care system is organized into 21 geographically defined Veterans Integrated Service Networks (VISNs) (see **Figure 2**). 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.[14] As of FY2010, VHA operates 153

[12] U.S. Department of Veterans Affairs, *FY 2009 Performance and Accountability Report*, Washington, DC, November 16, 2009, p. I-42. 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.

[13] Adam Oliver, "The Veterans Health Administration: An American Success Story?" *The Milbank Quarterly*, vol. 85, no. 1 (March 2007), pp. 5-35.

[14] Kenneth Kizer, John Demakis, and John Feussner, "Reinventing VA health care: Systematizing Quality Improvement and Quality Innovation." *Medical Care*, vol. 38, no. 6 (June 2000), Suppl 1:I7-16.

hospitals (medical centers), 135 nursing homes, 783 community-based outpatient clinics (CBOCs),[15] 6 independent outpatient clinics, and 299 Readjustment Counseling Centers (Vet Centers).[16] In 2009, VA began a pilot Mobile Vet Center (MVC) program to improve access to services for veterans in rural areas, and the Department has deployed 50 MVCs. VHA also operates 10 mobile outpatient clinics.

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. VISNs, in turn, allocate funds to the medical centers within their networks. Prior to the implementation of the VERA system, resources were allocated to facilities based primarily on their historical expenditures. While a thorough description of VERA is beyond the scope of this report, generally VERA has two types of funds known as General Purpose funds and Specific Purpose funds.

General Purpose funds encompass about 80% of VHA total budget allocations to the VISNs. The Department generally allocates 94% of the congressional appropriation to the 21 VISNs within the first 45 days after enactment of the appropriation bill, with another 3% distributed within 90 days of enactment, and the remainder going to the VISNs over the remaining months of the fiscal year.[17] General Purpose funds are comprised of 11elements. These elements include basic care; complex care; adjustments for long stay patients; adjustments for high cost patients; geographic price adjustments; research support; education support; equipment; non-recurring maintenance; Priority Group 8 expansion; and mental health initiatives. Prior to FY2010, mental health initiatives were funded through the Specific Purpose fund. Beginning with FY2010 budget funding previously associated with the mental health initiatives, and funded through the Specific Purpose fund, has been incorporated into the overall mental health funding amount, and is now funded through the General Purpose fund. **Table 2** provides VERA General Purpose fund allocations for the 21 networks in FY2010. It should be noted that VERA funding is not driven by veteran patient population alone, but is adjusted for differences in patient mix, high cost patients, and geographic costs, among other factors. Under VERA each network is provided an allocation that takes into account these unique characteristics and is also adjusted to account for those veterans who receive care in more than one network.

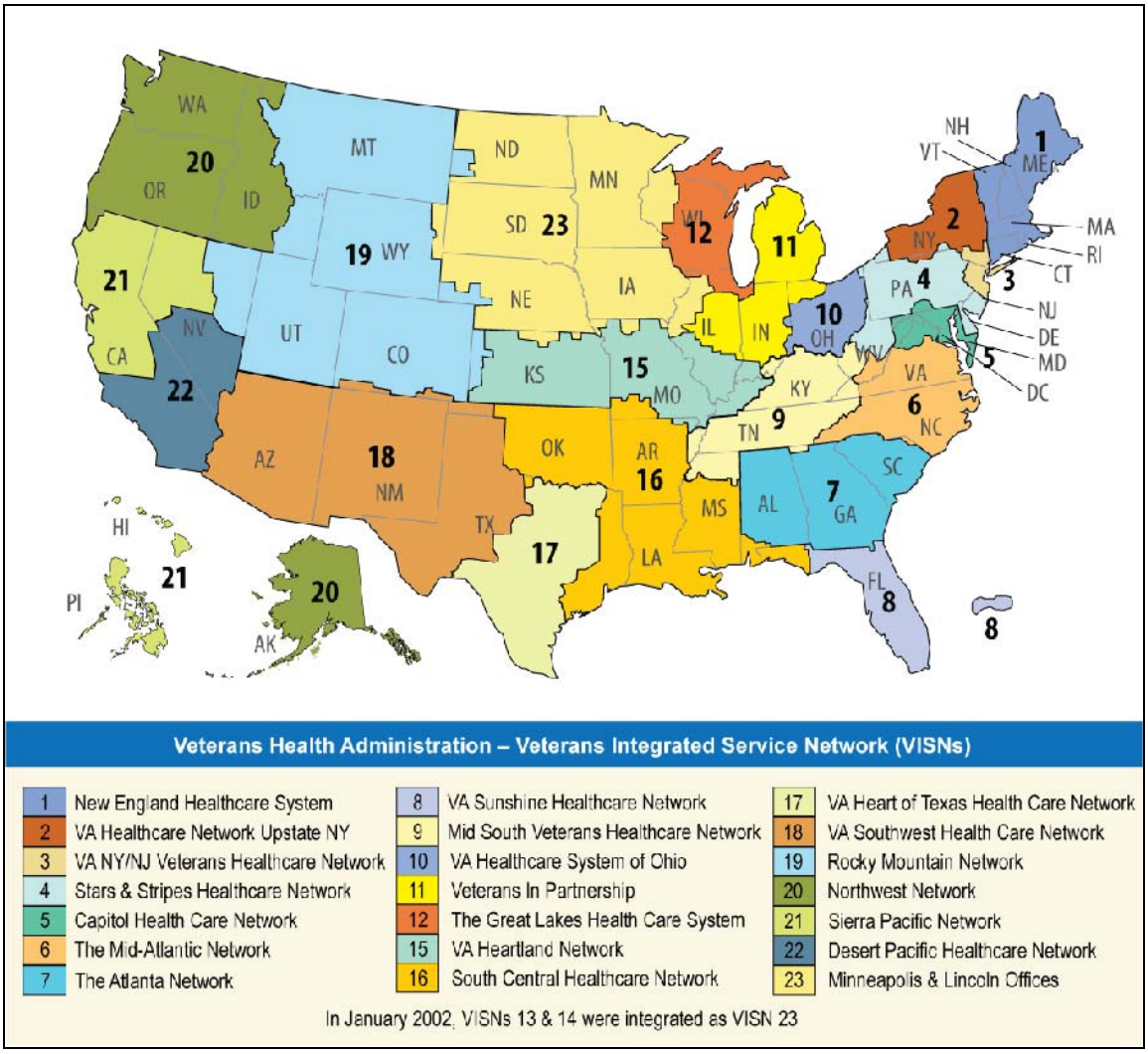
The Specific Purpose funds are given to the 21 VISNs during the fiscal year for specific activities including funding for prosthetics, state veterans nursing home per diems, clinical trainee salaries, readjustment counseling, homeless grant and per diem program, preventive and primary care transformation initiatives, and other specific purpose allocations to the program offices such as the foreign medical program which reimburses certain medical expenses of those veterans traveling abroad.

[15] For more information on CBOCs, see CRS Report R41044, *Veterans Health Administration: Community-Based Outpatient Clinics*, by Sidath Viranga Panangala.

[16] Vet Centers are a nation-wide system of community-based programs separate from VA medical centers (VAMCs). Client services provided by Vet Centers include psychological counseling and psychotherapy (individual and groups); screening for and treatment of mental health issues; substance abuse screening and counseling; employment/educational counseling; and bereavement counseling, among other services.

[17] Department of Veterans Affairs, *FY2011 Budget Submission, Medical Programs and Information Technology Programs*, Volume 2 of 4, February 2010, pp. 1A-15.

Figure 2. Veterans Integrated Service Networks (VISNs)



Source: Department of Veterans Affairs, adapted by Congressional Research Service.

Table 2. FY2010 VERA General Purpose Allocations

($ in Thousands)

VISN	Basic Care	Complex Care	Long Stay Allocation	High Cost Patient Allocations	Geographic Price Adjustment	Research Support	Education Support	Equipment	Non-Recurring Maintenance	Priority 8 Expansion	Mental Health Initiative	3.5% Floor Adjustment	Total General Purpose Allocation
1	$929,413	$260,864	$104,726	$110,283	$69,454	$52,841	$41,404	$42,051	$30,804	$10,677	$28,012	$419	$1,680,948
2	$514,266	$150,734	$83,637	$33,693	($24,789)	$5,845	$19,300	$23,290	$17,536	$5,456	$24,810	$10,040	$863,819
3	$727,915	$217,079	$146,979	$151,495	$101,424	$16,140	$46,589	$33,152	$32,094	$4,899	$18,800	$71,779	$1,568,344
4	$1,112,514	$290,679	$186,321	$84,958	($27,433)	$19,193	$23,411	$54,338	$25,346	$16,040	$28,269	($4,359)	$1,809,277
5	$505,052	$170,144	$110,649	$58,819	$38,536	$25,593	$20,103	$22,906	$10,764	$5,149	$24,443	($2,640)	$989,516
6	$1,190,325	$312,589	$123,684	$88,679	($30,180)	$19,161	$31,251	$51,318	$19,548	$18,135	$24,118	($4,847)	$1,843,781
7	$1,285,183	$359,429	$133,179	$84,095	($60,303)	$31,954	$37,421	$58,541	$18,989	$19,233	$29,202	($5,564)	$1,991,359
8	$2,128,938	$494,233	$156,084	$134,036	($126,869)	$21,153	$53,513	$91,586	$34,232	$32,040	$48,769	($5,120)	$3,062,594
9	$1,115,607	$301,809	$66,558	$67,790	($61,312)	$23,237	$42,576	$47,252	$15,755	$18,769	$22,304	($5,415)	$1,654,930
10	$808,598	$340,040	$113,155	$42,290	($24,550)	$19,054	$23,358	$35,629	$17,133	$14,421	$15,788	($2,657)	$1,402,260
11	$937,925	$250,608	$107,086	$60,433	($28,792)	$24,975	$26,854	$43,239	$19,577	$14,474	$25,565	($3,909)	$1,478,034
12[a]	$934,359	$308,899	$114,715	$90,209	$31,682	$32,581	$50,937	$41,747	$33,766	$13,504	$19,803	($5,805)	$1,666,397
15	$925,098	$241,462	$53,679	$61,765	($41,452)	$18,079	$26,516	$41,707	$19,358	$14,270	$26,518	($2,741)	$1,384,259
16	$1,880,768	$375,018	$110,380	$100,973	($34,177)	$20,031	$60,475	$81,836	$23,739	$32,520	$43,859	($6,076)	$2,689,346
17	$1,039,390	$299,217	$101,858	$67,743	($4,589)	$19,867	$31,395	$46,273	$14,000	$16,996	$28,194	($5,551)	$1,654,793
18	$972,416	$250,659	$68,689	$48,045	($37,065)	$14,004	$26,888	$42,076	$11,591	$13,561	$25,154	($3,603)	$1,432,415
19	$661,800	$163,615	$43,619	$42,544	($19,904)	$15,584	$20,084	$28,807	$11,413	$11,760	$17,246	($4,370)	$992,199
20	$987,619	$257,351	$48,306	$70,475	$16,481	$34,824	$25,581	$40,859	$34,718	$16,598	$23,056	($6,090)	$1,549,777
21	$958,548	$272,322	$134,146	$106,688	$190,061	$78,677	$36,982	$41,201	$20,724	$10,745	$36,135	($4,987)	$1,881,241
22	$1,153,021	$341,700	$74,870	$159,016	$111,897	$51,860	$60,043	$49,575	$29,496	$9,270	$30,703	($3,735)	$2,067,716
23	$1,070,780	$341,026	$112,664	$64,331	($38,120)	$35,346	$31,059	$51,618	$20,415	$17,913	$23,952	($4,767)	$1,726,217
VHA Total[b]	**$21,839,533**	**$5,999,477**	**$2,194,986**	**$1,728,359**	**($0)**	**$580,000**	**$735,739**	**$969,000**	**$461,000**	**$316,429**	**$564,697**	**($0)**	**$35,389,221**

Source: Department of Veterans Affairs, Veterans Health Administration, Office of Finance.

a. In January 2002, VISNs 13 and 14 were integrated as VISN 23.

b. Totals may not add up due to rounding.

The VHA pays for care provided to veterans by private-sector providers on a fee basis under certain circumstances. This program pays non-VA health care providers to treat eligible veterans when medical services are not available at VA medical facilities or in emergencies when delays are hazardous to life or health. Fee basis care includes inpatient, outpatient, prescription medication, and long-term care services.[18] 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).[19] The VHA also provides grants for construction of state-owned nursing homes and domiciliary facilities[20] and collaborates with the Department of Defense (DOD) in sharing health care resources and services.

Apart from providing direct patient care to veterans,[21] VHA's other statutory missions are to conduct medical research,[22] to serve as a contingency backup to the Department of Defense (DOD) medical system during a national security emergency,[23] to provide support to the National Disaster Medical System and the Department of Health and Human Services as necessary,[24] and to train health care professionals in order to provide an adequate supply of health personnel for VA and the Nation.[25]

Eligibility for Veterans Health Care

"The Promise of Free Health Care"

To understand the budget for VHA discussed in this report, it is important to understand eligibility for VA health care, the VA's enrollment process, and its enrollment priority groups (discussed later in this report). 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.[26] Prior to eligibility reform in 1996, provisions of law governing eligibility for VA care were complex and 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.

[18] For detailed discussion of contracted care see, CRS Report R41065, *Veterans Health Care: Project HERO Implementation* , by Sidath Viranga Panangala.

[19] For details on CHAMPVA see, CRS Report RS22483, *Health Care for Dependents and Survivors of Veterans*, by Sidath Viranga Panangala.

[20] Under the grant program VA may fund up to 65% of the cost of these state-owned facilities. States must fund the remaining 35%. The law requires that 75% of the residents in a state extended care facility must be veterans (38 U.S.C. § 8131-8138.) All non-veteran residents must be spouses of veterans or parents of children who have died while serving in the U.S. armed forces. VA is prohibited by law from exercising any supervision or control over the operation of a state veterans nursing home, including setting admission criteria. Admission requirements are determined exclusively by the state.

[21] 38 U.S.C. § 7301(b).

[22] 38 U.S.C. § 7303.

[23] 38 U.S.C. § 8111A.

[24] 38 U.S.C. § 8117(e).

[25] 38 U.S.C. § 7302.

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

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.[27] 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**, and discussed in more detail below).[28] 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."[29]

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."[30]

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."[31]

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

[27] 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.

[28] Ibid., p.5.

[29] Ibid., p.6.

[30] Ibid., p.5.

[31] Ibid., p.4.

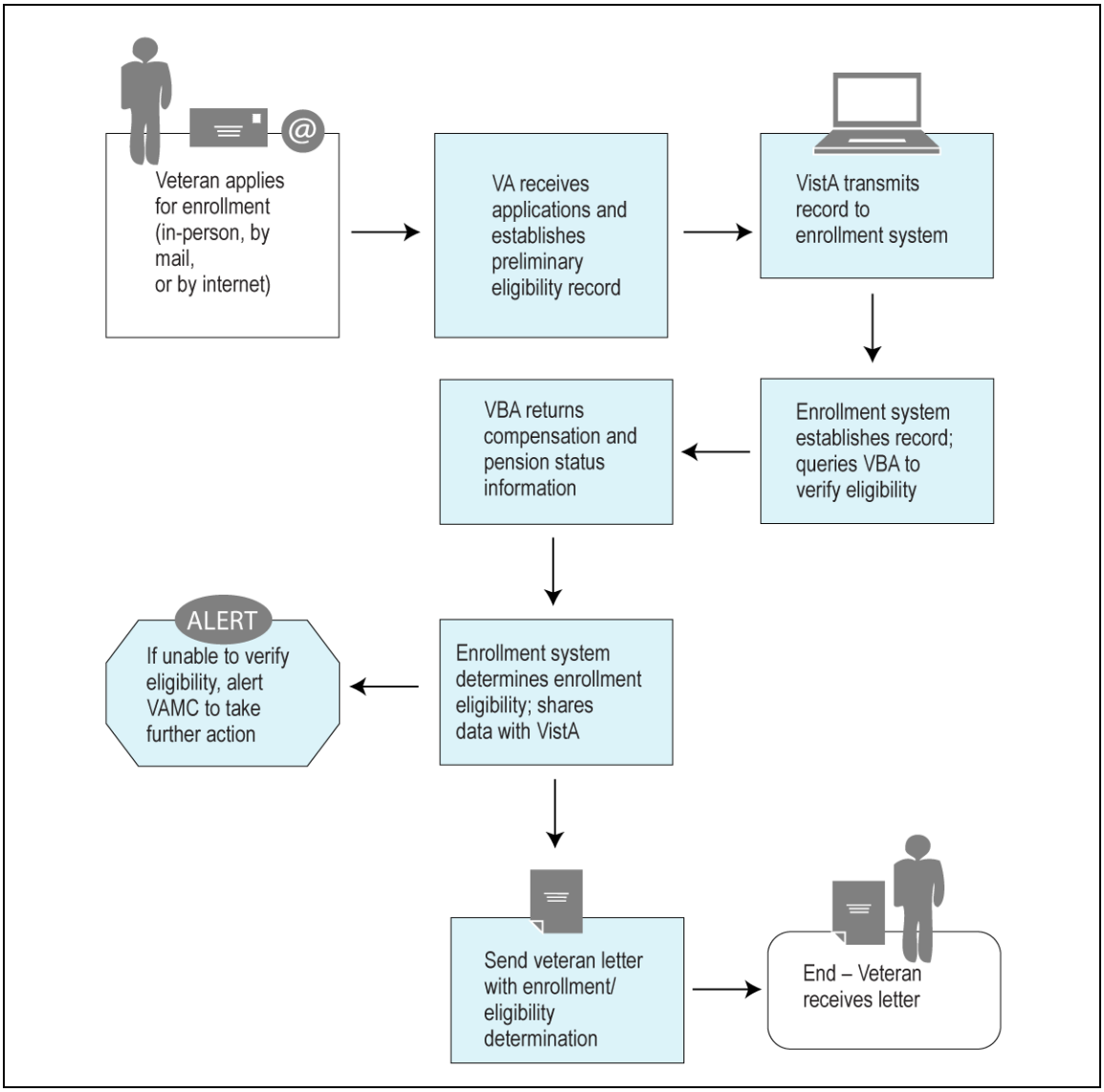
[32] Veterans do not need to apply for enrollment in the VA's health care system if they fall into one of the following categories: veterans with a service-connected disability rated 50% or more (percentages of disability are based upon the severity of the disability; and those with a rating of 50% or more are placed in Priority Group 1); veterans for whom less than one year has passed since the veteran was discharged from military service for a disability that the military determined was incurred or aggravated in the line of duty, but the VA has not yet rated; or the veteran is seeking care from the VA only for a service-connected disability (even if the rating is only 10%).

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 (see **Figure 3**).[33] 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 (**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.[34]

[33] VA Form 10-10EZ is available at https://www.1010ez.med.va.gov/sec/vha/1010ez/, accessed July 27, 2010.

[34] 38 C.F.R. §17.36 (d)(3)(iv) (2009).

Figure 3.VA Health Care Enrollment Process



Source: Institute of Medicine, *Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families*, 2010, p. 124, adapted by Congressional Research Service.

Notes: VistA= Veterans Health Information Systems and Technology Architecture; VBA=Veterans Benefits Administration; VAMC=VA Medical Center.

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. A veteran with an "other than

honorable" discharge or "bad conduct" discharge may still retain eligibility for VA health care benefits for disabilities incurred or aggravated during service in the military.[35]

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.[36]

After veterans' 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

- veterans in need of care for a service-connected disability;
- 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

[35] For a detailed description of discharge criteria see CRS Report RL33113, *Veterans Affairs: Basic Eligibility for Disability Benefit Programs*, by Douglas Reid Weimer.

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

- 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 (see discussion on premiums and copayments below).

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.[37] **Appendix C** provides information on income thresholds for VA health care benefits.

Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans

The National Defense Authorization Act (NDAA), FY2008 (P.L. 110-181), 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, OIF, and OND veterans who served in a combat theater).

Operation New Dawn (OND)

On September 1, 2010, OIF was named Operation New Dawn (OND) coinciding with the change of mission for U.S. forces in Iraq. VA considers OND to be part of the same contingency operation that was formerly called OIF. Therefore, VA will consider participants in OND to be eligible for health care under the legal authorities pertaining to OIF.

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, OIF, and OND 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

[37] 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) (2009).

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.

Medical Benefits Package

Once enrolled all veterans are offered a standard medical benefits package. This package includes a full range of inpatient, outpatient, and preventive medical services such as the following: medical, surgical, and mental health care, including care for substance abuse; prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system; durable medical equipment and prosthetic and orthotic devices, including eyeglasses and hearing aids; home health services, hospice care, palliative care, and institutional respite care; and noninstitutional adult day health care and noninstitutional respite care; and periodic medical exams, among other services.[38] It should be noted that eligibility for dental benefits is based on very specific guidelines and differs significantly from eligibility requirements for medical care.[39]

The medical benefits package does not include the following: abortions and abortion counseling; in vitro fertilization; drugs, biologicals, and medical devices not approved by the Food and Drug Administration (FDA) unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption; gender alterations; hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services; and membership in spas and health clubs.[40]

Premiums and Copayments

Veterans who are enrolled in the VA health care system do not pay in any premiums. However, some veterans are required to pay copayments for medical services and outpatient medications related to the treatment of a nonservice-connected condition (see **Appendix B**). Veterans in Priority Group 1 (those who have been rated 50% or more service-connected) are never charged a copayment even for treatment of a nonservice-connected condition. For veterans in other priority groups, VHA currently has four types of nonservice-connected copayments for which veterans may be charged: outpatient, inpatient, extended care services and medication. Veterans in all priority groups are not charged copayments for a number of outpatient services including the following: publicly announced VA health fairs; screenings and immunizations; smoking and weight loss counseling; telephone care and laboratory services; flat film radiology; and electrocardiograms.

[38] A detailed listing of VHA's standardized medical benefits package is available at 38 C.F.R. § 17.38.

[39] For details on dental benefit eligibility see, Department of Veterans Affairs, Veterans Health Administration, "Veteran Dental Benefits," fact sheet, April 2010, http://www4.va.gov/healtheligibility/Library/pubs/Dental/Dental.pdf.

[40] 38 C.F.R. § 17.38.

For primary care outpatient visits there is a $15 copayment charge and for specialty care outpatient visits a $50 copayment. Veterans do not receive more than one outpatient copayment charge per day. That is, if the veteran has a primary care visit and a specialty care visit on the same day, the veteran only pays for the specialty care visit. For veterans required to pay an inpatient copayment charge, rates vary based upon whether the veteran is enrolled in Priority Group 7 or not. Veterans enrolled in Priority Group 8 and certain other veterans are responsible for VA's full inpatient copayment and veterans enrolled in Priority Group 7 and certain other veterans are responsible for paying 20% of VA's inpatient copayment. Veterans in Priority Groups 1, 2, 3, 4 and 5 do not have to pay inpatient or outpatient copayments. Veterans in Priority Group 6 may be exempt due to special eligibility for treatment of certain conditions.

For veterans required to pay extended care service copayments these are based on three levels of nonservice-connected care including inpatient, non-institutional and adult day health care. Actual copayments vary depending on the veteran's financial situation. For medication copayments, veterans are not billed if they have a service-connected disability rated 50% or greater, they are former Prisoners of War, or if their medications are related to certain eligibility exceptions. Veterans enrolled in Priority Groups 2 thru 6 have a $960 calendar year cap on the amount that they can be charged for these copayments. Veterans who are unable to pay VA's copayment charges could complete requests for assistance including waivers, hardships, compromises and repayment plans.[41]

VHA bills private health insurers for medical care, supplies and prescriptions provided to veterans for their nonservice-connected conditions. VA cannot bill Medicare, but it can bill Medicare supplemental health insurance carriers for covered services.[42] Veterans are not responsible for paying any remaining balance of VA's insurance claim not paid or covered by their health insurance. Any payment received by VA is used to offset ''dollar for dollar'' a veteran's VA copayment responsibility.[43]

Priority Groups and Scheduling Appointments

Under current VHA policy, VHA provides priority care for non-emergency outpatient medical services for *any* condition of a service-connected veteran rated 50% or more or for a veteran's service-connected disability.[44] Furthermore, priority scheduling of any service-connected veteran must not impact the medical care of any other previously scheduled veteran. Veterans with service-connected conditions are not prioritized over other veterans with more acute health care needs. Emergency or urgent care is provided on an expedient basis.[45] According to VHA policy emergency and urgent care needs take precedence over a priority of service-connection.[46]

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[41] U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Identifying the Causes of Inappropriate Billing Practices by the U.S. Department of Veterans Affairs*, 111th Cong., 1st sess., October 15, 2009 (Washington: GPO, 2010), p. 43.

[42] 38 U.S.C. § 1729.

[43] U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Identifying the Causes of Inappropriate Billing Practices by the U.S. Department of Veterans Affairs*, 111th Cong., 1st sess., October 15, 2009 (Washington: GPO, 2010), p. 43.

[44] Department of Veterans Affairs, Veterans Health Administration , *VHA Outpatient Scheduling Processes and Procedures*, VHA DIRECTIVE 2010-027, June 9, 2010.

[45] VHA defines "emergency care" as the resuscitative or stabilizing treatment needed for any acute medical or psychiatric illness or condition that poses a threat of serious jeopardy to life, serious impairment of bodily functions, or (continued...)

The Veteran Patient Population

In FY2010 approximately 8.4 million of the 23.1 million living veterans in the nation were enrolled in the VA health care system (**Table 3**). From FY2007 through FY2010 the total number of enrollees has increased by 7.7%. Of the total number of enrolled veterans in FY2010, VA anticipated treating approximately 5.5 million unique veteran patients.[47] For FY2011,VHA estimates that it will treat about 5.6 million unique veteran patients (**Table 4**), and of these VA anticipates treating more than 439,000 Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans, an increase of over 20,000 (or 5%) above the FY2010 level. In FY2011, OEF and OIF patients would represent 7.2% of the overall VA patients served.

VHA also provides medical care to certain non-veterans; this population is expected to increase by over 11,000 patients or 2.2 % over the FY2010 level.[48] In total, including non-veterans, VHA is to treat nearly 6.1 million patients in 2011, an increase of 2.9 % over the number of patients treated in FY2010 (**Table 4**). Between FY2007 and FY2010, the number of patients treated by VA has grown by 10% (**Table 4**).

The total number of outpatient visits, including visits to Vet Centers, reached 74.6 million during FY2009 and is projected to increase to approximately 78.5 million in FY2010 and 82.7 million in FY2011. VHA estimates that in FY2010 it will spend approximately 57.8% of its medical services account obligations on outpatient care.[49]

Table 3. Number of Veterans Enrolled in the VA Health Care System, FY2007-FY2011

Priority Groups[a]	FY2007 Actual	FY2008 Actual	FY2009 Actual	FY2010 Estimate	FY2011 Estimate
1	977,389	1,041,754	115,2180	1,134,117	1,210,963
2	545,196	550,634	600,522	618,701	628,154
3	1,023,256	1,011,568	1,095,989	1,118,059	1,109,754
4	244,159	237,208	236,680	230,759	231,673

(...continued)

serious dysfunction of any bodily organ or part. "Urgent care" is defined as care for an acute medical or psychiatric illness or for minor injuries for which there is a pressing need for treatment to manage pain or to prevent deterioration of a condition where delay might impair recovery. For example, urgent care includes the follow-up appointment for a patient discharged from a VA medical facility if the discharging physician directs the patient to return on a specified day for the appointment (Source: Department of Veterans Affairs, Veterans Health Administration, *VHA Outpatient Scheduling Processes and Procedures*, VHA DIRECTIVE 2010-027, June 9, 2010).

[46] Department of Veterans Affairs, Veterans Health Administration, *VHA Outpatient Scheduling Processes and Procedures*, VHA DIRECTIVE 2010-027, June 9, 2010.

[47] In a given year not all enrolled veterans receive care from the VA, either because they are not sick or they have other sources of care such as the private sector.

[48] Non-veterans include CHAMPVA patients (certain dependents of veterans), reimbursable patients with VA affiliated hospitals and clinics, care provided on a humanitarian basis, veterans of World War II allied nations, and employees receiving preventative occupational immunizations such as Hepatitis A&B and flu vaccinations.

[49] Department of Veterans Affairs, *FY2011 Budget Submission, Medical Programs and Information Technology Programs*, Volume 2 of 4, February 2010, pp. 1C-15 and 1C-17.

Priority Groups[a]	FY2007 Actual	FY2008 Actual	FY2009 Actual	FY2010 Estimate	FY2011 Estimate
5	2,413,796	2,274,668	2,216,957	2,350,211	2,270,371
6	312,256	425,588	469,642	370,649	417,121
Subtotal Priority Groups 1-6	*5,516,052*	*5,541,420*	*5,771,970*	*5,822,496*	*5,868,036*
7	202,049	164,986	154,762	1,058,811	1,074,983
8	2,115,344	2,128,357	2,121,828	1,557,535	1,556,141
Subtotal Priority Groups 7-8	*2,317,393*	*2,293,343*	*2,276,590*	*2,616,346*	*2,631,124*
Total Enrollees	**7,833,445**	**7,834,763**	**8048560**	**8,438,842**	**8,499,160**

Source: Table prepared by Congressional Research Service based on data from Department of Veterans Affairs, *FY2011 Budget Submission, Medical Programs and Information Technology Programs*, Volume 2 of 4, February 2010, p. 1C-14.

a. For a description of Priority Groups, see **Appendix A**.

Table 4. Number of Patients Receiving Care from the VA, FY2007-FY2011

Priority Groups[a]	FY2007 Actual	FY2008 Actual	FY2009 Actual	FY2010 Estimate	FY2011 Estimate
1	820,410	888,470	971,151	968,516	1,033,981
2	358,270	365,212	397,764	412,264	418,500
3	590,860	585,032	637,181	654,712	643,125
4	181,572	185,997	183,070	186,369	183,687
5	1,544,328	1,484,467	1,469,353	1,590,953	1,513,531
6	155,939	199,882	216,438	181,944	197,047
Subtotal Priority Groups 1-6	*3,651,379*	*3,709,060*	*3,874,957*	*3,994,758*	*3,989,871*
7	173,149	147,785	144,485	622,101	633,989
8	1,191,161	1,221,424	1,202,141	918,896	926,549
Subtotal Priority Groups 7-8	*1,364,310*	*1,369,209*	*1,346,626*	*1,540,997*	*1,560,447*
Subtotal Unique Veteran Patients[b]	5,015,689	5,078,269	5,221,583	5,535,755	5,550,318
Non-veterans[c]	*463,240*	*498,420*	*523,110*	*515,098*	*544,888*
Total Unique Patients	**5,478,929**	**5,576,689**	**5,744,693**	**6,050,853**	**6,095,206**

Source: Department of Veterans Affairs, *FY2011 Budget Submission, Medical Programs and Information Technology Programs*, Volume 2 of 4, February 2010, p. 1C-14.

a. For a description of Priority Groups, see **Appendix A**.

b. Unique veteran patients include Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans. These patients numbered: 155,272 in FY2006, 205,628 in FY2007, 261,019 in FY2008, 332,945 in FY2009, and are estimated to be 419,256 in FY2010 and 439,271 in FY2011.

c. Non-veterans include CHAMPVA patients, reimbursable patients with VA affiliated hospitals and clinics, care provided on a humanitarian basis, veterans of World War II allied nations, and employees receiving preventative occupational immunizations such as Hepatitis A&B and flu vaccinations.

Formulation of VHA's Budget

Historically, the major determinant of VHA's budget size and character was the number of operating beds—which was controlled by Congress.[50] The preliminary budget estimate, to a large extent, was based on the funding and activity of the previous year. VHA developed system-wide workload estimates, by type of care, by forecasts submitted by field stations. Unit costs were derived from the field stations' reports of the estimated distribution of expenses by type of care. Costs associated with new programs were estimated by VA central office and added to the budget estimate.[51] The costs associated with staffing improvements, pay increases and inflation were also added to this estimate. Therefore, it could be stated that the principal assumption at each phase of the budget formulation process was that the preceding year's budget was the starting point.[52]

In 1996, Congress enacted the Departments of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act of 1997 (P.L. 104-204). This Act required VHA to develop a plan for the allocation of health care resources to ensure that veterans eligible for medical care who have similar economic status and eligibility priority have similar access to such care, regardless of where they reside.[53] The plan was to "account for forecasts in expected workload and to ensure fairness to facilities that provide cost-efficient health care."[54]

In response to the above-mentioned Congressional mandate, as well as the mandate in the Health Care Eligibility Reform Act of 1996 (P.L. 104-262) that required the VHA to establish a priority-based enrollment system, VHA established the Enrollee Health Care Projection Model in 1998. The VHA's the Enrollee Health Care Projection Model (EHCPM), which has evolved over time, develops estimates of future veteran enrollment, enrollees' expected utilization of health care services, and the costs associated with that utilization. These 20-year projections are by fiscal year, enrollment priority, age, Veterans Integrated Service Networks (VISN), market, and facility. The VHA budget is formulated using the model projections.[55]

VHA's budget request to Congress begins with the formulations of the budget based on the EHCPM to estimate the demand for medical services among veterans in future years. These estimates are then used to develop a budget request that is then included with the total VA budget request to Congress.

[50] U.S. Congress, House Committee on Veterans' Affairs, *Health Care for American Veterans,* prepared by the National Academy of Sciences, National Research Council, 95th Cong., 1st sess., June 7, 1977, House Committee Print No. 36 (Washington: GPO, 1977), p. 37.

[51] Ibid, p .42.

[52] Ibid.

[53] Department of Veterans Affairs, Office of Inspector General, *Report of Audit Congressional Concerns Over Veterans Health Administration's Budget Execution,* Report No. 06-01414-160, Washington, DC, June 30, 2006, p. 2.

[54] Ibid.

[55] For a discussion of the EHCPM see CRS Report R40489, *Advance Appropriations for Veterans' Health Care: Issues and Options for Congress*, by Sidath Viranga Panangala, and also see Katherine M. Harris, James P. Galasso, and Christine Eibner, Review and Evaluation of the VA Enrollee Health Care Projection Model, The RAND Corporation, Center for Military Health Policy Research, 2008.

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.[56] 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 (currently known as medical support and compliance), (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 concurred with this request.[57]

Medical Support and Compliance (Previously Medical Administration)

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

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

[56] 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.

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

also from the Department of Defense (DOD), the National Institutes of Health (NIH), and private sources.

Unlike other federal agencies such as NIH and DOD, VA does not have the statutory authority to make research grants to colleges and universities, cities and states, or any other non-VA entities. In general, VA's research program is intramural, that is, research is performed by VA investigators at VA facilities and approved off-site locations.

Medical Care Collections Fund (MCCF)

In addition to direct appropriations accounts mentioned above, 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.[58] 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.[59] 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."[60] This change in billing was intended to enhance VA collections to the extent that reasonable charges result in higher payments than reasonable costs.[61] In FY2004, the Administration's budget requested consolidating several existing medical 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 Revolving Fund (former name) should be deposited in MCCF.[62] 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.

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

[59] 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.

[60] 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.

[61] 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.

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

As shown in **Table 5** MCCF collections increased from $1.5 billion in FY2003 to $2.8 billion in FY2009. During this same period, first-party collections (for pharmacy, inpatient and outpatient and long-term care copayments) increased by 30%, from $685 million to $892 million. In FY2009, first-party collections represented approximately 32% of total MCCF collections.

Table 5. Medical Care Collections, FY2003-FY2009

($ in Thousands)

	FY2003 Actual	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 Actual	FY2008 Actual	FY2009 Actual
First-party pharmacy copayments[a]	$576,554	$623,215	$648,204	$723,027	$760,616	$749,685	$720,238
First-party copayments for inpatient and outpatient care	104,994	113,878	118,626	135,575	150,964	168,274	168,092
First-party long-term care copayments[b]	3,461	5,077	5,411	4,347	3,699	3,751	3,419
Third-party insurance collections	804,141	960,176	1,055,597	1,095,810	1,261,346	1,497,449	1,843,202
Enhanced use leasing revenue[c]	234	459	26,861	3,379	1,692	1,422	1,601
Compensated work therapy collections[d]	38,834	40,488	36,516	40,081	43,296	52,372	56,106
Parking fees[e]	3,296	3,349	3,443	3,083	3,136	3,355	3,585
Compensation and pension living expenses[f]	376	634	2,431	2,075	1,904	1,572	1,952
MCCF Total	**$1,531,890**	**$1,747,276**	**$1,897,089**	**$2,007,377**	**$2,226,653**	**$2,477,880**	**$2,798,195**

Source: Department of Veterans Affairs, *FY2011 Budget Submission, Medical Programs and Information Technology Programs*, Volume 2 of 4, February 2010, p. 1A-14.

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 collect increases in pharmacy copayments (from $2 to $7 for a 30-day supply of outpatient medication), which 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.

FY2010 Budget Summary[63]

On February 26, 2009, the President submitted a preliminary budget outline for FY2010, and submitted his full FY2010 budget proposal to Congress on May 7, 2009. The Administration requested a total of $45.1 billion for VHA (excluding collections). This was a 7.5% increase over the FY2009 enacted level. Including total available resources (including medical care collections), the President's budget would have provided approximately $48 billion for VHA.

On July 10, the House passed its version of the Military Construction and Veterans Affairs Appropriations Act, 2010 (H.R. 3082, H.Rept. 111-188). The House-passed bill provided a total of $45.1 billion for VHA. H.R. 3082 also provided $48.2 billion in advance appropriations for VHA to be available in FY2011. On November 17, the Senate passed H.R. 3082 as amended. H.R. 3082 as amended by the Senate provided a total of $45.2 billion for VHA, a $160.0 million increase over the House passed amount, and $157.6 million over the President's request.

The Consolidated Appropriations Act was signed into law on December 16, 2009 (P.L. 111-117, H.Rept. 111-366). Division E of the Consolidated Appropriations Act 2010 included a compromised version of the House and Senate passed versions of Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2010. The Consolidated Appropriations Act provided a total of $45.1 billion for VHA, same as the Administration's request for FY2010, and 7.4% over the FY2009 enacted amount. P.L. 111-117 included an advance appropriation of $48.2 billion for the medical services, medical support and compliance, and medical facilities accounts to be available in FY2011.

FY2011 VHA Budget

President's Request

The Obama Administration released its FY2011 budget on February 1, 2010. The Administration's FY2011 budget request for three of the four accounts of VHA (medical services, medical support and compliance, medical facilities) was same as the funding amounts provided in the MILCON-VA Appropriations Act of 2010 (P.L. 111-117) which was $48.1 billion. Moreover, the President's request included $590 million of the medical and prosthetic research account. In total the FY2011 budget request for VHA is $48.8 billion excluding medical care collections (see **Table 6**). For FY2011, the Administration estimates that it will obtain $3.4 billion in medical collections, for a total VHA funding level of $52.1 billion. This is $4.1 billion, or 8.6% above FY2010 levels.

Furthermore, as required by the Veterans Health Care Budget Reform and Transparency Act of 2009 (P.L. 111-81), the President's budget is requesting $50.6 billion in advance appropriations for the three medical care appropriations (medical services, medical support and compliance, and medical facilities) for FY2012. In FY2012, the Administration's budget request would provide

[63] For a detailed description of appropriations for the Veterans Health Administration for FY2010 see, CRS Report R40737, *Veterans Medical Care: FY2010 Appropriations*, by Sidath Viranga Panangala.

$39.6 billion for the medical services account, $5.5 billion for medical support and compliance account, and $5.4 billion for the medical facilities account.

House Action

On July 28, 2010, the House passed its version of the version of the MILCON-VA Appropriations bill for FY2011 (H.R. 5822; H.Rept. 111-559). The House-passed bill includes $48.8 billion for VHA for FY2011, the same as the President's request (**Table 6**). For FY2012, H.R. 5822 provides an advance appropriation of: $39.6 billion for the medical services account an increase of $2.5 billion or 6.8% above the FY2011 enacted level and the same as the budget request; $5.5 billion for the medical support and compliance account, an increase of $228 million above the FY2011 level and the same as the Administration's budget request; and $5.4 billion for the medical facilities account for FY2012, a decrease $314 million below the FY2011 level and the same as the budget request. The House-passed bill recommends $590 million for the medical and prosthetic research account, an increase of $9 million above the FY2010 enacted level and the same as the budget request. During floor debate of H.R. 5822, among other amendments, the House adopted H.Amdt. 729, which would instruct the VA to set aside at least $20 million from the general operating expenses account for suicide prevention outreach via direct advertising and the use of online social media.

Senate Committee Action

On July 15, 2010, the Senate Appropriations Committee marked up its version of the MILCON-VA Appropriations bill for FY2011 (S. 3615; S.Rept. 111-226). The Committee recommendation includes $120 million above the FY2011 Administration's request, and the House Appropriations Committee recommendation. This amount includes a $100 million for medical services account, and $20 million for the medical facilities account (**Table 6**). In total, under S. 3615, VHA would receive $48.9 billion without medical care collections. All other amounts for accounts that comprise the VHA are same as the Administration's request. Likewise, the Senate Appropriations Committee advance appropriations recommendations for FY2012 is the same as the House Appropriations Committee recommendations and the President's request (see **Table 6**).

Table 6. VHA Appropriations by Account, FY2010-FY2011 and Advance Appropriations, FY2012

($ in Thousands)

Account	Enacted (P.L. 111-117)		Request		House (H.R. 5822; H.Rept. 111-559)		Senate Committee (S. 3615; S.Rept. 111-226)	
	FY2010	FY2011	FY2011[a]	FY2012	FY2011	FY2012	FY2011	FY2012
Medical Services	$34,707,500	—	$37,136,000	—	$37,136,000	—	$ 37,136,000	—
Additional Funding over FY2011 Advance Appropriation	—	—	—	—	—	—	100,000	—
Subtotal Medical Services	*34,707,500*	—	*37,136,000*	—	*37,136,000*	—	*37,236,000*	—
Medical Support and Compliance (Previously Medical Administration)	4,930,000	—	5,307,000	—	5,307,000	—	5,307,000	—
Subtotal Medical Support and Compliance (Previously Medical Administration)	*4,930,000*	—	*5,307,000*	—	*5,307,000*	—	*5,307,000*	—
Medical Facilities	4,859,000	—	5,740,000	—	5,740,000	—	5,740,000	—
Additional Funding over FY2011 Advance Appropriation	—	—	—	—	—	—	20,000	—
Subtotal Medical Facilities	*4,859,000*	—	*5,740,000*	—	*5,740,000*	—	*5,760,000*	—
Medical and Prosthetic Research	581,000	—	590,000	—	590,000	—	590,000	—
Subtotal Medical and Prosthetic Research	*581,000*	—	*590,000*	—	*590,000*	—	*590,000*	—
Total VHA Appropriations (without collections)	**45,077,500**	**—**	**48,773,000**	**—**	**48,773,000**	**—**	**48,893,000**	**—**
Medical Care Cost Collections (MCCF)	2,954,000	—	3,393,000	—	3,393,000	—	3,393,000	—
Total VHA Appropriations (with collections)	**$48,031,500**	**—**	**$52,166,000**	**—**	**$52,166,000**	**—**	**$52,286,000**	**—**

Account	Enacted (P.L. 111-117)		Request		House (H.R. 5822; H.Rept. 111-559)		Senate Committee (S. 3615; S.Rept. 111-226)	
	FY2010	FY2011	FY2011[a]	FY2012	FY2011	FY2012	FY2011	FY2012
Memorandum: Advance Appropriations[b]								
Medical Services	—	$37,136,000	—	$39,649,985	—	$39,649,985	—	$39,649,985
Medical Support and Compliance (Previously Medical Administration)	—	5,307,000	—	5,535,000	—	5,535,000	—	5,535,000
Medical Facilities	—	5,740,000	—	5,426,000	—	5,426,000	—	5,426,000
Total VHA Advance Appropriations (without collections)	**—**	**$48,183,000**	**—**	**$50,610,985**	**—**	**$50,610,985**	**—**	**$50,610,985**

Source: Table Prepared by the Congressional Research Service based on H.Rept. 111-559 and S.Rept. 111-226.

a. The President's Budget request for FY2011 reflects the same amounts appropriated for 2011 in the MILCON-VA Appropriations Act of 2010 (P.L. 111-117) as an advance appropriation.

b. The Veterans Health Care Budget Reform and Transparency Act of 2009 (P.L. 111-81) requires VA to submit a request for advance appropriations with its budget submission each year.

Major Areas of Congressional Interest

Family Caregivers

It has been reported that "many severely injured service members depend on family members for daily caregiving."[64] According to the 2007 Report of the President's Commission on Care for America's Returning Wounded Warriors, of a random sample of 1,730 OEF and OIF veterans, 21% of active-component, 15% of reserve-component, and 24% of retired service members had a family member or friend who had been forced to leave a job to care for an OIF or OEF veteran full-time.[65] In response to these findings, and testimony from family members, Congress enacted the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163). Among other things, this law would establish a program of comprehensive assistance for family caregivers of any veteran who is undergoing medical discharge from the Armed Forces, has a serious injury incurred or aggravated in the line of duty on or after September 11, 2001, and is in need of personal care services. According to the House and Senate Appropriations Committee reports to accompany the FY2011 MILCON-VA Appropriations bills, funding has been included to implement the caregiver provisions in P.L. 111-163 for eligible veterans.

Mental Health Care

Since 2001, more than 2.1 million U.S. troops have deployed in support of Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF).[66] Of this number, around 1.1 million OEF and OIF veterans have left active duty and become eligible for VA health care, and 47.4% of separated OEF and OIF veterans have sought VA health care. While the majority of these veterans function well, according to some studies, approximately 10%-20% evidence psychological difficulties significant enough to warrant treatment. While posttraumatic stress disorder (PTSD) has received the most publicized attention to date, service in OEF and OIF is also associated with generalized anxiety, depression, substance abuse, physical health problems, aggression, risk-taking behavior, and suicide.[67]

Providing adequate resources to treat mental health conditions of veterans is a major area of interest for Congress.[68] For example, in its View and Estimates letter to the House Budget Committee, the House Committee on Veterans' Affairs states:

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[64] Institute of Medicine (IOM), *Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families*, Washington, DC, 2010, p. 32.

[65] President's Commission on Care For America's Returning Wounded Warriors, *Serve, Support, Simplify: Report of the President's Commission on Care For America's Returning Wounded Warriors*, July 2007, p. 76.

[66] Veterans Health Administration (VHA), Office of Public Health and Environmental Hazards, June 2010.

[67] Peter W. Tuerk, Maria Steenkamp, and Sheila A. M. Rauch, "Combat-Related PTSD: Scope of the Current Problem, Understanding Effective Treatment, and Barriers to Care" *Developments in Mental Health Law*, vol. 29, no. 1 (January 2010), pp. 49-58.; and Karen H. Seal et al., "Trends and Risk Factors for Mental Health Diagnoses Among Iraq and Afghanistan Veterans Using Department of Veterans Affairs Health Care, 2002–2008," *American Journal of Public Health* , vol. 99, no. 9 (September 2009), pp. 1651-1657.

[68] Opening statement of Chairman Chet Edwards in U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, *Military Construction, Veterans Affairs, and Related Agencies Appropriations for 2011*, 111th Cong., 2nd sess., March 23, 2010 (Washington: GPO, (continued...)

> [the] Committee acknowledges the VA's robust investments in mental health; however, addressing mental health issues continues to be a challenge. This is evidenced by the rising rates of suicide, incarceration, and homelessness among our veterans. The Committee believes that the VA must not only expand existing efforts but also must explore new evidence-based initiatives with a proven track record for yielding positive program results.[69]

In FY2010 VHA's budget for mental health care is estimated to be $4.8 billion, and it is estimated to reach $5.2 billion in FY2011 (**Table 7**). VHA has also increased the number of mental health providers by over 6,000 full-time equivalent (FTE) in its system from FY2008 through FY2010 (**Table 7**).

Table 7. VHA Funding for Mental Health Care

($ in Thousands)

	FY2008 Actual	FY2009 Actual	FY2010 Estimate	FY2011 Estimate
Treatment Modality:				
Inpatient Hospital	$1,228,044	$1,322,505	$1,435,250	$1,557,246
Psychiatric Residential Rehabilitation Treatment	245,883	263,687	286,167	310,491
VA Domiciliary Residential Rehabilitation Treatment	352,837	414,587	449,931	488,175
Outpatient	2,052,428	2,445,432	2,653,907	2,879,490
Mental Health Total	**$3,879,192**	**$4,446,211**	**$4,825,255**	**$5,235,402**
Major Characteristic of Program:				
Seriously Mentally Ill (SMI) - Post-Traumatic Stress Disorder (PTSD)	$271,863	$311,514	$354,190	$396,075
SMI - Substance Abuse Treatment Program (SABT)	461,893	490,468	520,199	551,609
SMI - Other Than PTSD & SABT	2,563,695	2,902,301	3,094,530	3,340,739
Subtotal, SMI	3,297,451	3,704,283	3,968,919	4,288,423
Suicide Prevention	4,456	35,897	62,000	66,650
Other Mental Health (Non-SMI)	577,285	706,031	794,336	880,329
Total Mental Health	**$3,879,192**	**$4,446,211**	**$4,825,255**	**$5,235,402**
Readjustment Counseling Centers (Vet Centers) not included in above totals	$125,178	$154,104	$171,600	$179,000

(...continued)

2010), p.647.

[69] Letter from House Committee on Veterans' Affairs to House Committee on the Budget, Views and Estimates with regard to programs and matters within the jurisdiction of the Committee to be set forth in the concurrent resolution on the Budget for Fiscal Year 2011, March 4, 2010.

	FY2008 Actual	FY2009 Actual	FY2010 Estimate	FY2011 Estimate
Total Number of VHA Mental Health Providers (FTE)	30,805	35,197	37,151	37,151

Source: Department of Veterans Affairs, *FY2011 Budget Submission, Medical Programs and Information Technology Programs*, Volume 2 of 4, February 2010, p. 1K-18.

Priority Group 8 Veterans

Since January 17, 2003, the VA has not enrolled veterans in Priority Group 8 unless they had been previously enrolled in another priority group and no longer qualified for enrollment in that previous priority group (see **Appendix A**). Since the suspension was promulgated, veterans advocates have urged Congress to lift the suspension on Priority Group 8 veterans since they believe that all veterans must be able to receive care from the VA because they have served their country.[70]

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. Those who enrolled prior to January 17, 2003 in VA's health care system were not to be affected by this suspension. VA claimed that, despite its funding increases, it could not provide all enrolled veterans with timely access to medical services because of the increase in the number of veterans seeking care from VA.

The Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (P.L. 110-329) was enacted on September 30, 2008. The accompanying report language stated that funding "has been provided within the Medical Services; Medical Support and Compliance; Medical Facilities; Construction, Minor Projects; and Information Technology Systems accounts to support increased enrollment for Priority 8 veterans whose income exceeds the current veterans means test and geographic means test income thresholds by 10% or less." P.L. 110-329 provided $375 million for FY2009 to fund this increased enrollment. On January 21, 2009, VA issued regulations indicating that it plans to enroll an estimated 258,705 new Priority Group 8 veterans. VA began enrolling new veterans starting June 15, 2009. According to VHA, it is estimated that 193,000 veterans will enroll for care by the end of 2010 due to this policy change.[71] VA has stated that in 2011 VA will further expand health care eligibility for Priority Group 8 veterans to those whose incomes exceed the geographic and VA means-test thresholds by no more than 15% compared to the levels in effect prior to expanding enrollment in 2009. It is estimated that this additional expansion of eligibility for care will result in 99,000 more enrollees in 2011, bringing the total number of new enrollees from 2009 to the end of 2011 to 292,000. The President's

[70] U.S. Congress, House Committee on Veterans' Affairs, Priority Group 8 Veterans, 110th Cong., 1st sess., June 20, 2007 (Washington: GPO, 2008), pp. 61-63.

[71] Statement of Secretary Eric Shinseki in U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, *Military Construction, Veterans Affairs, and Related Agencies Appropriations for 2011*, 111th Cong., 2nd sess., March 4, 2010 (Washington: GPO, 2010), pp. 86-91.

budget request for FY2011estimates that by FY2013 nearly 550,000 eligible Priority Group 8 veterans will be enrolled into the VA health care system.[72]

[72] Office of Management and Budget, *Budget of the U.S. Government for FY201* , Appendix, February 1, 2010, p. 1066.

Appendix A. VA Priority Groups and Their Eligibility Criteria

Table A-1. VA Priority Groups and Their Eligibility Criteria

Priority Group 1
Veterans with service-connected disabilities rated 50% or more disabling
Veterans determined by VA to be unemployable due to service-connected conditions
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 VA to be catastrophically disabled
Priority Group 5
Nonservice-connected 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 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 as follows:
- Veterans discharged from active duty on or after January 28, 2003, who were enrolled as of January 28, 2008 and veterans who apply for enrollment after January 28, 2008, for 5 years post discharge
-Veterans discharged from active duty before January 28, 2003, who apply for enrollment after January 28, 2008, until January 27, 2011

Priority Group 7

Veterans who agree to pay specified copayments with income and/or net worth *above* the VA means test threshold and income *below* the VA national geographic income thresholds

Priority Group 8

Veterans who agree to pay specified copayments with income and/or net worth *above* the VA means test threshold and the VA national geographic threshold

Subpriority a: Noncompensable 0% service-connected and enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status

Subpriority b: Noncompensable 0% service-connected and enrolled on or after June 15, 2009 whose income exceeds the current VA means test threshold or VA national geographic income thresholds by 10% or less

Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status

Subpriority d: Nonservice-connected veterans enrolled on or after June 15, 2009 whose income exceeds the current VA means test threshold or VA national geographic income thresholds by 10% or less

Subpriority e: Noncompensable 0% service-connected veterans not meeting the above criteria

Subpriority g: Nonservice-connected veterans not meeting the above criteria

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: 2010

Table B-1. Copayments for Health Care Services: 2010

	Inpatient care ($10/day + $1,068 for first 90 days and $534 after 90 days—based on 365-day period)	Outpatient care ($15 Primary Care; $50 Specialty Care; $0 for x-rays, lab, immunizations, etc.)	Outpatient medication ($8 per 30-day supply; calendar year cap - $960 for Priority Groups 2-6; $9 for 30-day supply for Priority Groups7 and 8)[a]	Long-term care services (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 here (Veterans with service-connected disabilities rated 10% - 40% disabling)[b]	NO	NO	YES	NO
Priority Group 4	NO	NO	NO	NO
Priority Group 5[c]	NO	NO	YES	YES
Priority Group 6[d]	NO	NO	NO	NO
Priority Group 7[e]	YES	YES	YES	YES
Priority Group 8[f]	YES	YES	YES	YES

Source: Table prepared by the Congressional Research Service based on information from the Department of Veterans Affairs.

a. For the period from July 1, 2010, through December 31, 2011, the copayment amount for veterans in Priority Groups 2 through 6 is $8. There is an annual cap of $960 per calendar year. When Veterans reach the annual cap, they continue to receive medications without making a co-payment. For veterans in Priority Groups 7 and 8 the copayment amount from July 1, 2010, through December 31, 2011, is $9. There is no annual cap for these priority groups.

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

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

d. 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.

e. 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.

f. 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/OND 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 2010

Veterans with—	Free VA prescriptions and travel benefits for veterans with incomes of—	Free VA Heath Care for veterans with incomes of—
No dependents	$11,830 or less	$29,402 or less
1 dependent	$15,493 or less	$35,284 or less
2 dependents	$17,513 or less	$37,304 or less
3 dependents	$19,533 or less	$39,324 or less
4 dependents	$21,553 or less	$41,344 or less
For each additional dependent, add:	$2,020	$2,020

Source: Department of Veterans Affairs.

Appendix D. Increase to Financial Income Thresholds for VA Health Care Enrollment, in Priority Group 8, Calendar Year 2010

Veterans with—	Enrollment in the VA Health Care System with required copayments for veterans with 0% service-connected ratings and nonservice-connected veterans with incomes of—
No dependents	$32,342
1 dependent	$38,812
2 dependents	$41,034
3 dependents	$43,256
4 dependents	$45,478
For each additional dependent, add:	$2,222

Source: Department of Veterans Affairs.

Appendix E. VHA Appropriations by Account FY2005-FY2009

Table E-1.VHA Appropriations by Account, FY2005-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	$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	975,000	1,500,000	1,500,000	—	—	—	—
Emergency appropriations	—	—	—	—	1,977,000	—	1,977,000	1,225,000
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	26,748,600	—	—	—	—	—	—	—
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)	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;H.Rept. 109-305, and H.Rept. 109-359.

Table E-2. VHA Appropriations by Account, FY2007-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	—	—	—	—	—	—	—	—
Emergency appropriations—Defense, the Global War on Terror, and Hurricane Recovery (P.L. 109-234)	—	—	—	—	—	—	—	—
Emergency appropriations—Avian Flu Pandemic (P.L. 109-148)	—	—	—	—	—	—	—	—
Emergency appropriations—U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability (P.L. 110-28)	—	414,982	454,131	400,778	—	—	—	—
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*
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**

Source: Table prepared by the Congressional Research Service based on H.Rept. 109-464; S.Rept. 109-286; ;H.Rept. 110-64; H.Rept. 110-186; S.Rept. 110-85; *Congressional Record*, vol. 153 (December 17, 2007), pp.H16249-H16431; H.Rept. 110-775; and S.Rept. 110-428.

Table E-3. VHA Appropriations by Account, FY2009

($ in Thousands)

Account	FY2009 Request	FY2009 House (H.R. 6599)	FY2009 Senate Committee (S.Rept. 110-428)	FY2009 Enacted
Medical Services	$34,075,503	$30,854,270	$35,590,432	$30,969,903
Subtotal Medical Services	*34,075,503*	*30,854,270*	*35,590,432*	*30,969,903*
Medical Support and Compliance (Previously Medical Administration)	—	4,400,000	—	4,450,000
Subtotal Medical Support and Compliance (Previously Medical Administration)	—	*4,400,000*	—	*4,450,000*
Medical Facilities	4,661,000	5,029,000	4,961,000	5,029,000
American Recovery and Reinvestment Act, 2009 (P.L. 111-5)	—	—	—	1,000,000
Subtotal Medical Facilities	*4,661,000*	*5,029,000*	*4,961,000*	*6,029,000*
Medical and Prosthetic Research	442,000	500,000	526,800	510,000
Subtotal Medical and Prosthetic Research	*442,000*	*500,000*	*526,800*	*510,000*
Total VHA appropriations (without collections)	**39,178,503**	**40,783,270**	**41,078,232**	**41,958,903**
Medical care cost collections (MCCF)	1,879,000	2,544,000	2,544,000	2,544,000
Total VHA appropriations (with collections)	**$41,057,503**	**$43,327,270**	**$43,622,232**	**$44,502,903**

Source: Table prepared by the Congressional Research Service based H.Rept. 110-775; S.Rept. 110-428; H.Rept. 111-188; and S.Rept. 111-40.

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