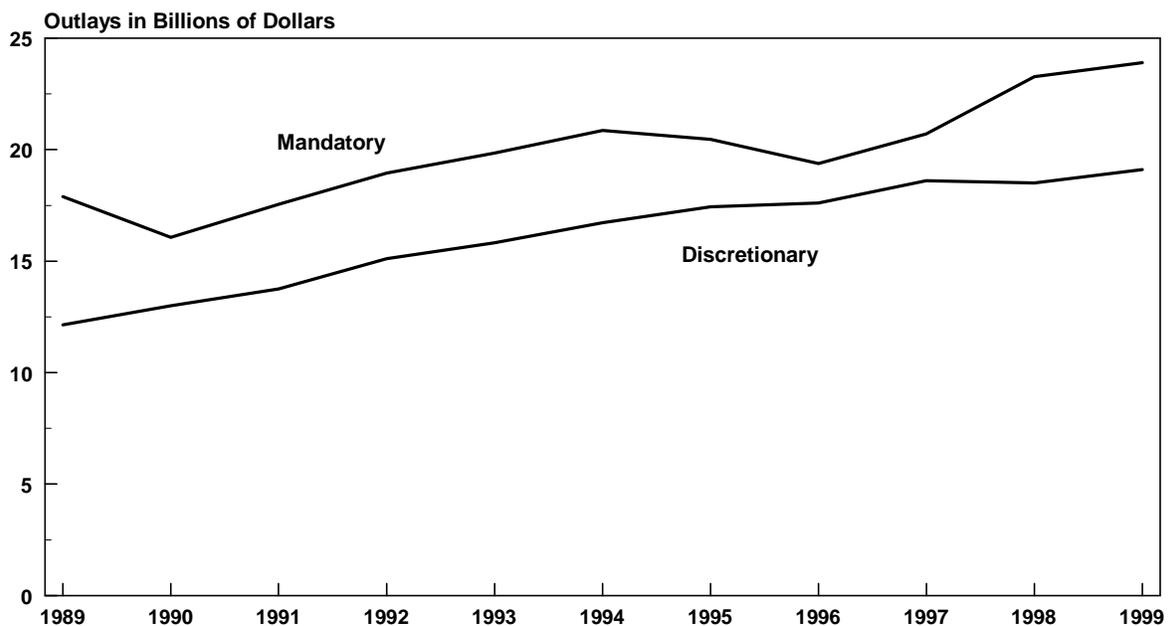


700

Veterans Benefits

Budget function 700 funds programs that offer benefits to military veterans. Those programs, most of which are run by the Department of Veterans Affairs, provide health care, disability compensation, pensions, life insurance, education and training, and guaranteed loans. CBO estimates that outlays for function 700 will be \$43 billion in 1999, including discretionary outlays of \$19 billion. Discretionary budget authority provided for the function this year is also about \$19 billion. Over the past 10 years, outlays for veterans' benefits have remained at about 2.5 percent of federal spending.



700-01 SUSPEND FUNDING FOR MAJOR CONSTRUCTION PROJECTS IN THE VETERANS' HEALTH CARE SYSTEM

Savings
(Millions of dollars)
Budget
Authority Outlays

Annual

| | | |
|------|-----|-----|
| 2000 | 142 | 6 |
| 2001 | 142 | 45 |
| 2002 | 71 | 88 |
| 2003 | 71 | 103 |
| 2004 | 71 | 92 |
| 2007 | 71 | 79 |
| 2006 | 71 | 73 |
| 2007 | 71 | 71 |
| 2008 | 71 | 71 |
| 2009 | 71 | 71 |

Cumulative

| | | |
|-----------|-----|-----|
| 2000-2004 | 498 | 334 |
| 2000-2009 | 854 | 700 |

SPENDING CATEGORY:

Discretionary

The Department of Veterans Affairs (VA) operates a nationwide health care delivery system for eligible veterans that comprises 172 hospitals, 132 nursing homes, and 551 outpatient clinics. The VA spends about \$500 million a year to construct and modernize those facilities. Although in 1996 the Congress gave the VA authority to purchase health care services from community providers, the department continues to receive funds to build facilities and alter existing ones in ways that would increase patient capacity.

This option would suspend funding for major construction projects for two years but leave funds for minor repair and modernization intact. Funding for major construction would then resume in fiscal year 2002 at 50 percent of projected levels. Those reductions would save \$854 million over 10 years compared with the 1999 funding level.

Proponents of this option would argue that funding for major construction weakens the VA's incentive to purchase care from private-sector providers who already have facilities in place. Moreover, the VA's 22 regional health care networks are still developing ways to better plan and coordinate services among VA facilities. While that process is going on, constructing and renovating facilities may not necessarily be the most efficient way to ensure access to care. Before the VA enlarges its direct care system, the regional networks should be required to develop long-range planning models that compare the costs of capital expansion and the costs of contracting with local providers in their geographic areas.

Opponents of this option would claim that funding for new construction has already slowed down because of the VA's emphasis on building outpatient clinics rather than large hospital facilities. They would also argue that some locations are underserved by the private sector as well as by the VA, which will make the department's new contract authority ineffective in creating access to care. Without the availability of funds for construction, the VA may not be able to provide care to deserving veterans in some locations.

700-02 END FUTURE VETERANS' COMPENSATION PAYMENTS FOR CERTAIN VETERANS WITH LOW-RATED DISABILITIES

| Savings (Millions of dollars) | | |
|----------------------------------|-----------|---------|
| Budget | | |
| | Authority | Outlays |
| Annual | | |
| 2000 | 21 | 19 |
| 2001 | 66 | 62 |
| 2002 | 113 | 109 |
| 2003 | 162 | 158 |
| 2004 | 214 | 209 |
| 2003 | 290 | 285 |
| 2006 | 324 | 324 |
| 2007 | 354 | 351 |
| 2008 | 445 | 439 |
| 2009 | 509 | 503 |
| Cumulative | | |
| 2000-2004 | 576 | 557 |
| 2000-2009 | 2,498 | 2,459 |
| <hr/> | | |
| <u>SPENDING CATEGORY:</u> | | |
| Mandatory | | |
| | | |
| <u>RELATED OPTION:</u> | | |
| 700-03 | | |

Approximately 2.3 million veterans who have service-connected disabilities receive veterans' disability compensation benefits. The amount of compensation is based on a rating of the individual's impairment that is intended to reflect an average reduction in the ability to earn wages in civilian occupations. Veterans' disability ratings range from zero to 100 percent (most severe). Veterans who are unable to maintain gainful employment and who have ratings of at least 60 percent are eligible to be paid at the 100 percent disability rate. Additional allowances are paid to veterans who have disabilities rated 30 percent or higher and who have dependent spouses, children, or parents.

About 50,000 veterans with disability ratings below 30 percent are added to the rolls every year, receiving benefits of between \$70 and \$185 a month. Federal outlays could be reduced by almost \$2.5 billion during the 2000-2009 period by ending benefits for those low-rated disabilities in future cases.

Making veterans with new disability ratings below 30 percent ineligible for compensation would concentrate spending on the most impaired veterans. Performance in civilian jobs depends less now on physical labor than when the disability ratings were originally set, and improved reconstructive and rehabilitative techniques are now available, so physical impairments rated below 30 percent may not reduce veterans' earnings. Those impairments include conditions such as mild arthritis, moderately flat feet, or amputation of part of a finger—conditions that would not affect the ability of veterans to work in many occupations today.

Veterans' compensation could be viewed, however, as career or lifetime indemnity payments owed to veterans disabled to any degree while serving in the armed forces. Moreover, some disabled veterans—especially older ones who have retired—might find it difficult to increase their working hours or otherwise make up the loss in compensation payments.

700-03 END FUTURE AWARDS OF VETERANS' DISABILITY OR DEATH COMPENSATION WHEN A DISABILITY IS UNRELATED TO MILITARY DUTIES

Savings
(Millions of dollars)
Budget
Authority Outlays

| | Annual | |
|-----------|-------------------|-------|
| 2000 | 53 | 48 |
| 2001 | 165 | 155 |
| 2002 | 283 | 274 |
| 2003 | 409 | 399 |
| 2004 | 543 | 532 |
| 2005 | 734 | 730 |
| 2006 | 837 | 837 |
| 2007 | 917 | 914 |
| 2008 | 1,166 | 1,151 |
| 2009 | 1,343 | 1,329 |
| | Cumulative | |
| 2000-2004 | 1,453 | 1,408 |
| 2000-2009 | 6,450 | 6,369 |

SPENDING CATEGORY:

Mandatory

RELATED OPTIONS:

700-02 and 700-04

Veterans are eligible for disability compensation if they either receive or aggravate disabilities while on active-duty service. Service-connected disabilities are defined as those resulting from diseases, injuries, or other physical or mental impairments that occurred or were intensified during military service (excluding those resulting from willful misconduct). Disabilities need not be incurred or made worse while performing military duties to be considered service-connected; for example, disabilities incurred while on leave also qualify. The federal government gives death compensation awards to survivors when a service-connected disability is related to the cause of death.

As many as 50 percent of veterans receiving compensation payments may qualify on the basis of injuries or diseases that were neither incurred nor aggravated while performing military duties. Ending disability and death compensation awards in such cases in the future would reduce outlays by almost \$6.4 billion over 10 years. Approximately 5 percent of those savings would come from reduced death compensation awards.

This option would make disability compensation of military personnel comparable with that of federal civilian employees under workers' compensation arrangements. However, because military personnel are assigned to places where situations may sometimes be volatile, they have less control than civilians over where they spend their off-duty hours. Therefore, in many cases it might be difficult to determine whether a veteran's disease, injury, or impairment was entirely unrelated to military duties. The formal appeals system of the Department of Veterans Affairs (VA) could be extended to cover rulings specifying that disabling conditions were unrelated to military duties.

Data collected by the VA indicate that about 200,000 veterans receive a total of \$1.2 billion a year in VA compensation payments for diseases that, according to the General Accounting Office (GAO), are generally neither caused nor aggravated by military service. Those diseases include arteriosclerotic heart disease, diabetes mellitus, multiple sclerosis, Hodgkin's disease, chronic obstructive pulmonary disease (including chronic bronchitis and pulmonary emphysema), hemorrhoids, schizophrenia, osteoarthritis, and benign prostatic hypertrophy. Ending new awards only for veterans with those diseases would have a more limited impact than this option because it would not affect all veterans whose compensable disabilities are unrelated to military service. However, it could eliminate compensation for some veterans whose disabilities are not generally service-connected, according to GAO, but whose circumstances constitute an exception to that general conclusion. Such an approach would yield smaller savings than the main option—about \$1.1 billion over the 2000-2009 period.

700-04 ELIMINATE "SUNSET" DATES ON CERTAIN PROVISIONS FOR VETERANS IN THE BALANCED BUDGET ACT OF 1997

| Savings (Millions of dollars) | | |
|----------------------------------|-----------|---------|
| Budget | | |
| | Authority | Outlays |
| Annual | | |
| 2000 | 0 | 0 |
| 2001 | 0 | 0 |
| 2002 | 0 | 0 |
| 2003 | 672 | 672 |
| 2004 | 692 | 692 |
| 2005 | 748 | 748 |
| 2006 | 732 | 732 |
| 2007 | 714 | 714 |
| 2008 | 772 | 771 |
| 2009 | 794 | 793 |
| Cumulative | | |
| 2000-2004 | 1,364 | 1,364 |
| 2000-2009 | 5,124 | 5,122 |

SPENDING CATEGORY:

Mandatory

RELATED OPTIONS:

700-03, 700-05, and 700-06

Five provisions in law that affect veterans will cease to apply on September 30, 2002—their "sunset" date. As a result, starting in 2003, outlays will be higher than if the provisions remained in effect. Those provisions:

- o Protect the monthly benefit for certain pensioners who have no dependents and are eligible for Medicaid coverage for nursing home care, thus lowering pension costs for the Department of Veterans Affairs (VA) but increasing costs for the Medicaid program, which is paid for by the federal and state governments;
- o Authorize the Internal Revenue Service to help the VA verify incomes reported by beneficiaries, for the purpose of establishing eligibility for pensions and benefits;
- o Increase the fees charged for first-time and repeated use of the veterans' home loan program and make the VA more cost-effective in securitizing loans and acquiring property;
- o Authorize the VA to collect from any health insurer that contracts to insure a veteran with service-connected disabilities the reasonable cost of medical care that the VA provides for the treatment of non-service-connected disabilities; and
- o Authorize the VA to charge copayments to certain veterans receiving inpatient and outpatient care and outpatient medication from VA facilities.

This option would make the effects of those provisions permanent by eliminating the sunset date in each case. In addition, it would eliminate the VA's current authority to spend the medical care collections. Beginning in 2003, those collections would revert back to the Treasury. If all five provisions were made permanent and medical receipts were deposited in the Treasury, savings during the 2000-2009 period, compared with the current level of spending, would total \$5.1 billion.

The main advantage of this option is that it would convert the temporary savings achieved by those provisions into continuing savings. The main disadvantage is that certain veterans or their insurers would be worse off financially. States would also face higher Medicaid costs because of withdrawn federal funds for nursing home care.

700-05 EXTEND AND INCREASE COPAYMENTS FOR OUTPATIENT PRESCRIPTIONS FILLED AT VA PHARMACIES

| | Savings (Millions of dollars) | |
|---------------------------|----------------------------------|---------|
| | Budget Authority | Outlays |
| Annual | | |
| 2000 | 0 | 0 |
| 2001 | 0 | 0 |
| 2002 | 0 | 0 |
| 2003 | 137 | 137 |
| 2004 | 186 | 186 |
| 2005 | 236 | 236 |
| 2006 | 239 | 239 |
| 2007 | 243 | 243 |
| 2008 | 247 | 247 |
| 2009 | 250 | 250 |
| Cumulative | | |
| 2000-2004 | 323 | 323 |
| 2000-2009 | 1,538 | 1,538 |
| <u>SPENDING CATEGORY:</u> | | |
| Mandatory | | |
| <u>RELATED OPTION:</u> | | |
| 700-04 | | |

In 1990, the Congress gave the Department of Veterans Affairs (VA) temporary authority to charge copayments for care and services at VA facilities to certain veterans—namely, those with relatively high income and no service-connected disabilities. Copayments for outpatient prescriptions filled at VA pharmacies were set at \$2 for a 30-day supply of drugs. The Congress has since extended the authority to collect that copayment through 2002 but has not increased the copayment amount, even though the VA's prescription drug expenditures have risen by an average of 9 percent per year between 1991 and 1998.

This option would make three sets of changes. First, it would eliminate the provision under which the copayment will expire and would extend that payment indefinitely. It would also require the VA to collect copayments in all applicable cases and would remove the department's discretion to waive the copayment. Currently, the VA bills veterans from a central office on the basis of information forwarded by VA pharmacies. Under this option, copayments would be collected by those pharmacies as they dispensed prescriptions. Second, this option would increase the copayment amount by \$1 each year until it reached \$5 for a 30-day supply. Third, the option would send those collections to the Treasury rather than allowing the VA to spend them, as under current law. Those three actions would take effect in 2003 and save more than \$1.5 billion through 2009.

Proponents would argue that eventually requiring a \$5 copayment for prescription drugs would encourage more prudent consumption and make the VA drug benefit consistent with that of other health delivery systems, including managed care plans in the private sector.

Opponents, by contrast, would charge that some veterans with multiple chronic illnesses could be overburdened by the higher cost sharing. Even limiting the number of prescriptions subject to copayments in one month could place an undue financial burden on chronically ill veterans and their families, according to critics.

700-06 INCREASE BENEFICIARIES' COST SHARING FOR CARE AT VA-OPERATED NURSING FACILITIES

Savings
(Millions of dollars)
Budget
Authority Outlays

| | Annual | |
|-----------|-------------------|-------|
| 2000 | 195 | 195 |
| 2001 | 202 | 202 |
| 2002 | 209 | 209 |
| 2003 | 216 | 216 |
| 2004 | 220 | 220 |
| 2005 | 227 | 227 |
| 2006 | 234 | 234 |
| 2007 | 242 | 242 |
| 2008 | 250 | 250 |
| 2009 | 258 | 258 |
| | Cumulative | |
| 2000-2004 | 1,043 | 1,043 |
| 2000-2009 | 2,255 | 2,255 |

SPENDING CATEGORY:

Mandatory

RELATED OPTION:

700-04

Veterans may receive long-term care in nursing homes operated by the Department of Veterans Affairs (VA) depending on the availability of resources. That care is rationed primarily on the basis of service-connected disabilities and income. Under certain conditions, a veteran may receive care at the VA's expense in state-operated or privately run nursing facilities.

The VA may charge copayments to veterans with no service-connected disabilities and high enough income when they receive more than 90 days of care in VA-run nursing homes. In 1998, the copayment rate was equivalent to about \$13 a day. A study by the General Accounting Office found that the copayment recovers just 0.1 percent of the costs of providing nursing home care. In contrast, state-operated nursing facilities for veterans and community long-term care facilities that treat veterans have their own copayment policies. As a result, those facilities offset a larger share of their operating expenses than the VA, recovering as much as 43 percent through copayments. (Estate recovery programs are another way they offset costs.)

This option would authorize the VA to revise its cost-sharing policies to recover more of the cost of providing care in VA nursing facilities. The department would be required to collect a minimum of 10 percent of its operating costs, but it could determine the type of copayments charged and who would be eligible to pay them. For example, it could apply the current copayment to a broader category of veterans or could require the veterans who now make copayments to pay more. Recovering 10 percent of the VA's operating costs would save \$195 million in 2000 and almost \$2.3 billion over 10 years. Achieving those savings would require not allowing the VA to retain and spend the receipts; instead, they would be deposited in the Treasury.

Proponents of this option would argue that veterans in VA nursing facilities are getting a far more generous benefit than similar veterans in non-VA facilities. Because VA-run nursing homes are relatively scarce, veterans lucky enough to be admitted to one receive an unfair advantage over similarly situated veterans. Recovering more of the expense at VA facilities would make that benefit more equitable among veterans and different sites of care.

Opponents of this option would argue that beneficiaries in nursing facilities may be less able to make copayments than beneficiaries receiving other types of care. They would also argue that allowing the VA to charge veterans with service-connected disabilities would be inconsistent with other medical benefits that those veterans receive. The department could continue to exempt those veterans, but it would have to charge high-income veterans without service-connected disabilities even more to achieve the 10 percent recovery level.

700-07 REVISE THE MONTGOMERY GI BILL PROGRAM

Savings
(Millions of dollars)
Budget
Authority Outlays

Annual

| | | |
|------|-----|-----|
| 2000 | 104 | 104 |
| 2001 | 116 | 116 |
| 2002 | 128 | 128 |
| 2003 | 140 | 140 |
| 2004 | 153 | 153 |
| 2005 | 165 | 165 |
| 2006 | 177 | 177 |
| 2007 | 191 | 191 |
| 2008 | 206 | 206 |
| 2009 | 221 | 221 |

Cumulative

| | | |
|-----------|-------|-------|
| 2000-2004 | 640 | 640 |
| 2000-2009 | 1,601 | 1,601 |

SPENDING CATEGORY:

Mandatory

The Montgomery GI Bill—which provides funds for higher education to former service members—was created as a form of military compensation and an incentive in recruiting. Recruits on active duty can participate by contributing \$1,200 during their first year of service (the same amount as in 1986). Reservists can participate too, but they make no contribution. Veterans of active duty and the selected reserves receive \$453 or \$212 a month, respectively, for full-time enrollment in an authorized program of study. The size of those benefits is indexed to the consumer price index (CPI).

This option would limit the cost of the program in three ways. First, it would lower the cost-of-living adjustment (COLA) for benefits to half the annual change in the CPI. Second, it would raise the initial contribution of active-duty personnel from \$1,200 to about \$1,600 in 2000 and increase it in subsequent years by the same percentage that benefits increase. Third, the option would require reserve personnel to make contributions proportional to those of active-duty members and would subject their benefits to the lower COLA. Those three changes would save \$104 million in 2000 and a total of \$1.6 billion through 2009.

Opponents of the option would argue that the Montgomery GI Bill is an effective tool (more so than enlistment bonuses) for recruiting the kinds of people the military needs to operate high-technology weapons and other equipment. It encourages recruits to complete their initial term of enlistment and increases the probability that they will join a reserve component. Current and prospective service members could view this option as an erosion of benefits. Moreover, the option might force the Department of Defense to expand other recruiting programs, diluting the potential savings from curtailing these benefits. Opponents would also observe that college costs have continued to rise faster than the CPI. Finally, opponents would argue that the annual CPI-based adjustment is not primarily a COLA but rather a mechanism for maintaining the value of the Montgomery GI Bill as an enlistment incentive. Reducing the automatic adjustment could force the Congress to raise benefits periodically, as it did in the past.

Allowing benefits to increase with inflation while contributions remain fixed provides a richer net benefit each year. At the program's inception, benefits were nine times greater than contributions, but they are now more than 16 times greater—and the multiple will continue to grow every year under current law. Proponents of this option might argue that such a situation is unnecessary to recruit a high-quality force. In recent years, the Department of Defense has met or exceeded its goals for the percentages of recruits having high school diplomas and above-average scores on the Armed Forces Qualifying Test. Moreover, the armed forces need a smaller percentage of the targeted population now than they did in the 1980s, when the program was created and the force was 50 percent larger. Proponents of this option would argue that fine-tuning these educational benefits to the post-Cold War environment would still allow the military to maintain a highly skilled force. Finally, the program did not provide any automatic COLAs to benefits for its first seven years and provided only a half-size COLA when such adjustments were initially made.