CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 10, 2014

H.R. 3230
Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014

As passed by the Senate on June 11, 2014

SUMMARY

By expanding for two years the ability of the Department of Veterans Affairs (VA) to pay for health care services provided to veterans, authorizing VA to hire additional staff and enter into long-term leases for certain major medical facilities, and expanding eligibility for certain educational benefits, H.R. 3230 would result in additional direct spending totaling $35 billion over fiscal years 2014-2024, CBO estimates.

Implementing H.R. 3230 also would increase federal revenues by $2.5 billion and increase discretionary spending by $1.8 billion (subject to future appropriation action) over the same period, CBO estimates. (The estimated budgetary effects of H.R. 3230 are detailed in the attached table.) Other than costs of about $1 billion for additional hiring and training of health care staff, those estimates do not include added costs for increased utilization of the VA health care system after October 2017, when the expanded authority provided by the act to contract with non-VA health care providers would expire.

Most of the budgetary costs of this act would stem from implementing title III, which would expand VA's ability to pay for health care services provided to veterans. That title would have effects on direct spending and revenues that would increase budget deficits by a total of about $30 billion over the 2014-2017 period; it would also result in additional offsetting collections and lead to future appropriations that would, on net, increase discretionary outlays by an estimated $0.7 billion from 2016 through 2018.

For fiscal years 2014-2016, title VIII would authorize and appropriate such sums as may be necessary to carry out this act. Thus, all spending under the act in those years would be direct spending. Under the legislation, the spending would be classified as an emergency requirement for the purpose of enforcing certain budgetary rules.

For this estimate, CBO assumes that H.R. 3230 will be enacted early in August 2014.

ESTIMATED COSTS TO THE FEDERAL GOVERNMENT

Estimated Costs of Title III

Title III would, for two years, greatly expand the VA's ability to contract with health care providers who are not employed by VA in order to increase the provision of timely health care services to veterans; title VIII would appropriate such sums as may be necessary for that purpose. CBO estimates that enacting title III (along with the appropriations provided by title VIII for 2014-2016) would increase direct spending by $33.5 billion over the 2014-2017 period and would increase federal tax revenues by $2.5 billion over that same period.

In addition, we estimate that this title would increase offsetting collections (from certain payments made by veterans and third-party insurers) by $0.5 billion in 2015, $1.2 billion in 2016, and $0.5 billion in 2017. Those collections in 2015 would be considered an offset to direct spending (because appropriations for veterans' health care have already been provided for fiscal year 2015); the collections in 2016 and 2017 are classified as discretionary and would offset future discretionary appropriations.

This estimate reflects CBO's expectation that veterans' utilization of contracted care under this act would ramp up over time. Thus, the estimated costs in 2015 and 2016 are smaller than the amounts that CBO would anticipate if lawmakers continued the program after 2016. CBO estimates that the cost, if the program was fully phased in, would be $38 billion in 2016 (as contrasted with the $22 billion direct spending cost in 2016 estimated for title III of H.R. 3230); that cost would increase with growth in the number of enrolled veterans and medical inflation in subsequent years.

This legislation would lead to increased enrollment in VA's health care system and increased utilization of health care services provided by, or financed by, VA in 2015 and 2016. If VA was to continue to provide more care to current or new enrollees after 2016, additional funding would be necessary, either for continuation of the expanded contracting authority or for operation of VA's health care system.

Changes to Federal Funding for Veterans' Health Care Under H.R. 3230. Under title III, VA would receive expanded authority and unlimited funds for two years to pay for health care from non-VA providers. Specifically, VA would be required to authorize

and pay for non-VA care for veterans when waiting times at VA facilities grew too long, and veterans who live more than 40 miles from the nearest VA facility could receive such care without needing an authorization. As a result, many veterans would probably face shorter waiting times for both initial and follow-up appointments. In addition, accessing health care through VA would lower health care costs for veterans because the copayments that VA collects are much smaller than those required by Medicare or by most private insurance policies and because VA imposes no premiums or deductibles. Reduced waiting times, the convenience of using familiar community-based providers, and the opportunity to reduce their out-of-pocket health care costs would probably entice many veterans who are already enrolled in VA's health care system to shift more of their health care costs to VA. (On average, veterans enrolled in VA's health care system currently obtain care from VA accounting for about 30 percent of the cost of all their health care.) Those factors also would encourage some veterans who are eligible for VA health care but currently not enrolled in that program to enroll.

Estimating spending on contracted care under H.R. 3230 is difficult because whether such care would be authorized depends partly on current waiting times for care in the VA system (about which there is substantial uncertainty) and partly on how much demand for VA-financed care would increase under the legislation. Depending on the available capacity at a given facility, CBO envisions two different scenarios unfolding under H.R. 3230. In some cases, contracted care would not be needed or authorized because veterans seeking care could be accommodated at VA facilities within VA's waiting-time goals, so the additional authority provided by the legislation would not be triggered very often and overall demand for care at those facilities would not increase substantially. Other facilities, however, appear to have long waiting times for some or all types of care provided. Under the act, veterans seeking care at those facilities would receive VA-financed care from non-VA providers, which would increase their demand for VA-financed care. That increase in demand would require the department to provide contracted care for an increased share of veterans.

Although substantial uncertainty exists about the length of current waiting times across VA facilities and the capacity of those facilities to absorb additional demand for care, CBO judged that contracted care would be authorized for about 80 percent of the increased demand for VA's services under H.R. 3230 in 2016. That share would probably be smaller initially, but would increase gradually over time because, under current law for 2015 and CBO's baseline projections for 2016, VA's appropriations for health care are not projected to keep pace with growth in the patient population or growth in per capita spending for health care—meaning that waiting times will tend to increase in the absence of this legislation and that more areas and services will qualify for contracted care under the legislation.

VA currently provides a relatively small amount of health care—about $4 billion a year—through contracts with non-VA providers. Some of those contracts are local agreements with a single provider or facility, while others, such as Project Access Received Closer to Home (ARCH) and Patient-Centered Community Care (PC3), include networks of providers in multiple locations.[1] CBO expects that VA would expand usage of those existing contracts to provide much of the care under title III.

Key Aspects of CBO's Cost Estimate. CBO's estimate of the costs of title III depends primarily on the following factors:

- The likelihood that VA would authorize a veteran to receive contracted care;
- The amount of contracted care that currently enrolled veterans would use if it was made available to them;
- The number of eligible but currently unenrolled veterans who would choose to enroll when contracted care became available, and the share of their health care services that would be paid for under those contracts;
- The payment rates for doctors, hospitals, and other providers of care that would be established for contracted care;
- Administrative costs for the expanded contracting program;
- The speed at which the VA would implement and veterans would take advantage of the contracted care program; and
- The extent of any offsetting effects on spending for Medicare and Medicaid and on tax revenues.

In estimating the effects of this title, CBO used data provided by VA on the number of veterans currently receiving VA health care and the share of their health care they are receiving from VA (often called the reliance rate), as well as on the number of veterans eligible for such care but not yet enrolled. Reliable data on waiting times and the capacity of the VA health care system are not available. Instead, CBO used survey data provided by VA that attempts to measure veterans' current demand for health care and how much of that care they currently receive from VA. CBO then estimated how the care that

1. The relatively new PC3 program provides contracted health care nationwide to eligible veterans through two networks of non-VA medical providers. For the PC3 program, VA contracts with Health Net Federal Services LLC and the Triwest Healthcare Alliance Corporation, which manage the care from non-VA providers. Project ARCH is a 3-year pilot program which provides limited non-VA health care services to rural veterans in five locations. For Project ARCH, which expires in August 2014, VA contracts with Cary Medical Center and Humana Veterans Health Services.

veterans now receive from other sources is financed and how much more care veterans would choose to receive through VA under the legislation. The agency also accounted for a number of other factors described below.

Veterans' Enrollment and Spending on Health Care Under Current Law. In 2013, 8.6 million veterans were enrolled in VA's health care program. Of the remaining roughly 13 million veterans, CBO estimates (on the basis of data provided by VA) that about 7 million qualify to enroll in VA's health care program but have not done so. In 2013, VA spent about $44 billion to provide health care services to veterans, or about $5,200 per enrollee. (That amount does not include spending on programs that CBO expects would not be increased under this legislation, such as programs for long-term care, caregivers, and aiding homeless veterans.) To help allocate those funds, VA has sorted veterans into 8 priority groups depending on the extent of any service-connected disabilities they have, their income, and certain other factors.

Veterans currently receive a large amount of health care from sources other than VA. On the basis of information from VA, CBO estimates that the department provides health care accounting for about 30 percent of all health care spending for enrolled veterans. Those figures imply that enrolled veterans receive at least $100 billion worth of health care per year outside the VA system. According to VA's estimates, about half of enrolled veterans are also covered by Medicare or Medicaid, and most of the rest have some other form of health insurance; for about one-fifth of enrolled veterans, VA is their only source of coverage.

In addition, a large amount of health care is received by the millions of veterans who are eligible for but not enrolled in VA's health care programs.

Use of Contracted Care by Current Enrollees. A primary consideration in CBO's analysis of how much contracted care veterans would seek is that cost-sharing requirements for care provided through or paid for by the VA are significantly lower than those in Medicare or private insurance plans. Most VA enrollees face no cost sharing requirement for a broad range of services, and in other cases VA collects only a portion of the copayments that it is authorized to collect. On the basis of data from VA, CBO estimates that such out-of-pocket spending, on average, covers less than 1 percent of the cost of the care veterans receive from VA.

By contrast, employment-based health insurance plans typically cover between 80 percent and 90 percent of enrollees' health care costs—so enrollees are responsible for the remaining 10 percent to 20 percent. Medicare's cost-sharing requirements are higher than that, on average; enrollees in the traditional Medicare program are responsible for 20 percent to 25 percent of the costs of covered services, on average. However, roughly half of Medicare enrollees also have coverage from Medicaid or a supplemental insurance policy that covers all or nearly all of those cost-sharing requirements, so CBO

anticipates that those enrollees would not be motivated to seek VA payment for their care. The remaining Medicare beneficiaries and most other VA enrollees, however, would have incentives to seek VA payment in order to reduce or eliminate their cost-sharing obligations.

Under the legislation, many veterans could arrange to have the VA pay for their care while still obtaining that care—including both emergency and inpatient care—from local non-VA doctors and hospitals; in many cases, veterans could use the same providers they are currently using. As a result, CBO estimates that a substantial share of them would do so. Veterans could shift payment for their care to VA while still retaining any other source of insurance coverage they have, and CBO does not anticipate that they would necessarily drop other insurance coverage.

The appeal of lower-cost health care paid for by VA would affect utilization of VA-financed care in two ways:

- CBO estimates that, on average, currently enrolled veterans would ultimately increase the share of their current health care that is provided or paid for by VA from about one-third under current law to about 55 percent. That estimate takes into account the shares of enrolled veterans with and without Medicare, Medicaid, or Tricare coverage.

- In addition, for enrollees who would be able to have VA pay for contracted care, the resulting reductions in their cost-sharing requirements would provide an incentive to increase the total amount of care they would use. Reflecting the findings of studies that have examined the effect of changes in cost-sharing on the use of health care, CBO estimated that affected veterans would increase their use of VA-financed services by about 20 percent, on average.[2]

VA's Costs for New Enrollees. Of the 7 million veterans who are estimated to be eligible to enroll for VA care but have not done so, CBO estimates that 15 percent to 20 percent would ultimately choose to enroll in the program because they could obtain access to contracted care—if the legislation was in effect for several years. A smaller percentage would probably enroll in the two-year period covered by H.R. 3230. By CBO's estimate, about 400,000 veterans in 2015 and 900,000 in 2016 would newly enroll as a result of this legislation, and they would choose to have about half of their care provided or paid for by VA. As discussed above, CBO estimates that veterans who are also enrolled in Medicare would be less likely to newly enroll than younger veterans because a smaller share of Medicare enrollees face substantial cost-sharing requirements.

2. For additional discussion of the effects of cost-sharing requirements on health care spending, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pages 61-62; and Congressional Budget Office, *Health-Related Options for Reducing the Deficit: 2014 to 2023* (December 2013), pages 31-34.

To estimate the VA's costs for new enrollees, CBO relied on an analysis of data from the Medical Expenditure Panel Survey, which indicated that veterans who are not enrolled in VA's program spend less on health care, on average, than enrolled veterans. Reflecting that difference, CBO estimated that costs to VA for new enrollees who are also eligible for Medicare would be about 10 percent lower than costs for current VA enrollees on Medicare, and that costs for other new enrollees would be about 50 percent lower than cost for current VA enrollees who are not eligible for Medicare.

Payment Rates for Contracted Care. Under H.R. 3230, VA would be expected to seek payment rates for providers of contracted care (such as doctors and hospitals) equal to Medicare's rates, but the department would be authorized to negotiate higher rates under certain circumstances. Eligible veterans would be allowed to obtain care from almost any provider they choose, however, and VA would be required to negotiate a payment rate with that provider. In CBO's judgment, those provisions would put the VA in a somewhat weak bargaining position and make it likely that, in at least some instances, the department would pay rates closer to those paid by private health insurance plans; private payers' rates are generally higher than Medicare's rates. CBO expects that, on average, VA's payment rates for contracted care would be about 10 percent higher than Medicare's rates.

Administrative Costs. CBO's estimate of administrative costs is based on the amounts paid to companies administering the Tricare benefit (a similar program for military retirees) and the costs that VA would probably incur to authorize care by non-VA providers. In sum, CBO estimated that VA would need an additional $300 per enrollee to cover contractors' fees and administrative costs. Those administrative costs would come to $0.7 billion in 2015 and $1.6 billion in 2016, by CBO's estimate.

Pace of Implementation and Utilization. CBO first assessed the potential costs of title III as if it would be in effect for several years and then reduced those costs for 2015 and 2016 to reflect its judgment that VA would not be able to fully implement its new authority immediately and that utilization of the newly authorized services would ramp up gradually. If the program established under title III had operated for several years, so that veterans and others could fully adjust to those new arrangements, CBO anticipates that VA's spending would increase by roughly $38 billion in 2016; that amount would grow in future years because of growth in the number of veterans and in health care costs per person.

The costs for the two years in which the program would be authorized by this legislation would be smaller, however. Title III would require VA to publish interim final regulations within 90 days after the bill's enactment and to terminate the program two years after the date such regulations were published. For the purposes of this estimate, CBO assumes that H.R. 3230 will be enacted near the beginning of August and that the program therefore would be in force from November 1, 2014, through October 30, 2016

(which is in the first quarter of fiscal year 2017), although no appropriations would be provided for fiscal year 2017. Taking into account the time it would take to expand existing contracts, negotiate new ones, and authorize individual veterans to use those contracts, as well as the time it might take for veterans to decide to change how they obtain some of their health care, CBO expects that usage of contracted care would increase only gradually. Specifically, CBO estimates that, of the potential long-term increase in the use of contracted care, about 30 percent would occur in 2015 and 60 percent in 2016.

On that basis, CBO projects gross outlays for title III (before any offsetting savings) of $500 million in fiscal year 2014 (for administrative expenses), $10.7 billion in 2015, $25.5 billion in 2016, and $4.9 billion in 2017. (Because no funding is provided in the act for 2017, $2.1 billion of the 2017 outlays is assumed to come from funds provided in an appropriation act.)

Savings in Other Federal Programs. Under H.R. 3230, some health care services that would otherwise have been financed by Medicare or Medicaid will instead be paid for by the VA. CBO estimates that savings for those programs would total $1.7 billion in 2015 and $4.0 billion in 2016.

Effects on Tax Revenues. Some of the additional health care costs borne by VA would have been financed by employment-based health insurance, so shifting those costs to VA would reduce the amounts that employers would pay for their employees' insurance. In general, those amounts are not treated as taxable income and thus are not subject to income or payroll taxes. CBO anticipates that the reductions in costs for employment-based insurance plans under title III would generate roughly offsetting increases in wages and other taxable forms of compensation, keeping total compensation about the same.[3] (In the near term, before wages would adjust, reductions in costs for employment-based insurance would generate higher taxable profits for firms.) CBO estimates that the resulting increases in federal tax revenues would amount to $2.5 billion over the 2015-2017 period.

Increased Collections. VA is authorized to bill third-party insurance plans for certain care provided to veterans and to collect a variety of fees and copayments from veterans. (However, two specific authorities in this area will expire at the end of fiscal year 2014: Those authorities allow VA to collect a daily payment from some veterans for hospital stays and to bill insurance plans for care given to veterans who have a disability related to their service but are being treated for a non-service-connected disability.)

3. For additional discussion of such substitution of taxable compensation for nontaxable compensation, see Congressional Budget Office, *CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance* (March 2012).

CBO expects that, in 2015, VA will collect $2.4 billion in such payments under current law and about $500 million more under H.R. 3230. Appropriations for VA's health care services have already been enacted for fiscal year 2015, as has the authority to spend any amounts collected in 2015; because the additional 2015 collections would partially offset existing spending authority, they are shown in this estimate as affecting direct spending. In contrast, spending of amounts that would be collected in 2016 and 2017 would be subject to future appropriation action. Thus, the estimated $1.2 billion in additional collections for 2016 and $500 million in 2017 are shown as offsets to discretionary spending.

Summary of the Costs of Title III for Different Groups of Veterans. Most of the projected costs of this title would stem from an increase in the utilization of VA-financed health care services by veterans who would be enrolled in the VA health care system under current law. CBO estimates that the additional costs to VA for those veterans would total $31 billion from 2015 through 2017, and that savings to Medicare and Medicaid would offset about $5 billion of that cost. Veterans who would not be enrolled in the VA health care system under current law but would choose to enroll under H.R. 3230 would account for another $8 billion in added costs to VA and would generate savings of less than $1 billion to Medicare and Medicaid over the 2015-2017 period. Those amounts do not include the added discretionary collections ($1.7 billion) or the increase in tax revenues ($2.5 billion) that would result from the legislation.

Estimated Costs of Other Titles

Because title VIII of H.R. 3230 would appropriate whatever sums are necessary to carry out the provisions of this act for fiscal years 2014 through 2016, all of the additional outlays for in those years for other titles would also be classified as direct spending. Increased costs for VA health care in other years would be subject to future appropriation action and therefore would be considered discretionary.

Direct Spending Costs of Other Titles. Altogether, the titles of H.R. 3230 other than title III would increase direct spending by a total of $1.9 billion over the 2017-2019 period, CBO estimates.

Title I would require the Secretary of Veterans Affairs to establish a technology task force to review the department's system for scheduling appointments and to implement improvements recommended by that task force. VA reports that it plans to enter into a contract shortly for an upgrade of its scheduling system. Based on VA's description of that plan, CBO believes that the planned upgrade conforms with the requirements of the bill; thus, there are no estimated additional costs to meet that requirement.

The Secretary would also be required to contract for an independent assessment of the operation of each VA medical facility. That assessment would include a review of the adequacy of scheduling systems, staffing levels, systems for documenting and

coordinating patient care, methods of purchasing and distributing supplies and medical devices, and systems for paying and collecting from third parties. CBO estimates that enacting that provision would increase direct spending by $2 million over the 2014-2024 period.

Title II would require the Inspector General of the VA to identify staffing shortages within the VA health care system. The Secretary would be authorized to recruit and appoint staff to address those shortages, give priority for scholarships to applicants pursuing training in occupations with the largest shortages, and establish a clinic management training program. The Secretary also would be required to submit a biennial report to the Congress, through 2024, assessing the staffing of each VA medical facility. Title II would allow the Secretary to use any unobligated amounts available in 2014 and 2015 from three Veterans Health Administration accounts (Medical Services, Medical Support and Compliance, and Medical Facilities) to carry out the provisions of the title. Those amounts would remain available until expended. CBO estimates that use of those funds would increase direct spending by about $620 million over the 2014-2017 period.

Title IV contains a wide variety of provisions that would affect the administration of VA's health care system. Specifically, title IV contains provisions that would:

- Require the Secretary to establish operating standards for mobile vet centers (community-based facilities that provide readjustment counseling to veterans and their family members), including the requirement that such centers have the capability to provide telemedicine services;

- Establish an Independent Commission on Department of Veterans Affairs Construction Projects to review VA's current programs for constructing, maintaining, and leasing facilities; and a Commission on Access to Care to examine how best to deliver health care to veterans over the next 10 to 20 years;

- Require the Secretary to modify performance plans to ensure that waiting-time goals are not used as factors in determining performance, publish information on waiting times at VA facilities, develop a database containing information on patient safety and the quality of care, provide information on the training and credentials of VA physicians, and establish policies to penalize VA employees who submit falsified data on waiting times or other quality measures;

- Require the Government Accountability Office to study how VA oversees and verifies the credentials of physicians with whom VA has contracts;

- Require the President's annual budget submission to include information on the cost of providing contracted care and the number of VA employees on paid administrative leave; and

- Authorize the Secretary to remove certain individuals from the VA Senior Executive Service.

CBO estimates that enacting all of those provisions would increase direct spending by $4 million over the 2014-2016 period.

Title V would expand eligibility for counseling and treatment for sexual trauma experienced by veterans who were on inactive duty training and authorize the Secretary to provide such treatment to active-duty members of the Armed Forces. The title also would require the Secretary to submit reports to the Congress on those activities. CBO estimates that direct spending to implement title V would total about $1 million from 2014 through 2016.

Title VI would authorize VA to enter into leases to obtain the use of major medical facilities at specified locations. Based on VA's long-established practice, CBO expects that the department would implement that authorization by awarding contracts for the construction and long-term use of those facilities without recording the full amount of the government's commitment as an obligation of its appropriated funds.[4] Thus, title VI would effectively be providing budget authority for an amount of obligations that exceeds what we expect VA initially would charge against its appropriation. By CBO's estimate, that additional budget authority would amount to $1.2 billion in 2017 and the resulting direct spending would amount to $1.2 billion over the 2017-2024 period.

Title VII would expand the Marine Gunnery Sergeant John David Fry Scholarship to include surviving spouses of service members who die or have died in the line of duty on or after September 11, 2001. The title also would make other changes to the All-Volunteer Force and the Post 9/11 Educational Assistance programs. CBO estimates that, on net, enacting title VII would increase direct spending by $71 million over the 2014-2024 period.

Discretionary Costs of Other Titles. Several provisions of H.R. 3230 would affect spending subject to appropriation. Because the act would appropriate funds for 2014 through 2016 to pay any costs in those years, there would be no change in discretionary spending until 2017 (other than the additional collections in 2016 that would result from title III, as discussed above).

In total, CBO estimates that additional discretionary spending from other titles would come to $1.1 billion over the 2017-2019 period, assuming appropriation of the necessary amounts. (All told, including the 2016 collections of $1.2 billion, the 2017 collections of

4. For more information on CBO's budgetary treatment of long-term leases, see Testimony of Robert A. Sunshine, Deputy Director, Congressional Budget Office Before the House Committee on Veterans' Affairs, *The Budgetary Treatment of Medical Facility Leases by the Department of Veterans Affairs* (June 27, 2013), www.cbo.gov/publication/44368.

$500 million, and the increase in discretionary spending under title III in October 2017, the act would lead to an increase of $1.8 billion in discretionary outlays over the 2016-2019 period, CBO estimates, assuming appropriation of the estimated amounts.)

Other than title III, most of the added discretionary costs would stem from implementing title II. As discussed above, that title would increase direct spending for training and hiring by $305 million in 2015 and $315 million in 2016, CBO estimates. Because the requirements for expanded training and the need to compensate the added employees would continue beyond 2016, CBO estimates increased discretionary costs after 2016 based on the funds provided in 2015 and 2016. Accounting for inflation, CBO estimates costs of about $1 billion over the 2017-2019 period.

Title V would expand eligibility for counseling and treatment for sexual trauma and require the Secretary to submit reports to the Congress on that topic. CBO estimates that implementing title V would cost $6 million from 2017 through 2019.

Title VI would authorize VA to enter into leases to obtain the use of major medical facilities at specified locations. CBO believes that most of the costs related to those leases would constitute direct spending (as discussed above), but the agency estimates that a small part of the total—$127 million—would be charged against VA's discretionary appropriations at the time the leases were entered into. VA would obligate those appropriations for certain special features of the facilities; the initial annual lease payments would begin later, after the facilities were constructed. Thus, CBO estimates that implementing title VI would increase discretionary costs by $127 million over the 2017-2019 period.

PREVIOUS CBO ESTIMATES

On June 11, 2014, CBO published a preliminary estimate for title III of H.R. 3230, the Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014, as introduced in the Senate on June 10, 2014. Since then, CBO has received additional and updated information from VA and has considered additional factors that might affect that preliminary estimate—some of which decreased the estimated costs and some of which increased the estimated costs. Specifically, CBO made the following adjustments that decreased the estimated cost of title III:

- Reduced the estimate of the number of veterans who are eligible to enroll in VA health care but have not done so from 8 million to 7 million in 2013, based on updated data from VA;

- Reduced the estimate of health care costs of new enrollees under the legislation to reflect data indicating that non-enrolled veterans use less health care overall than enrolled veterans;
- Reduced the estimate of payment rates for contracted care to reflect the likelihood that such care could be provided under existing contracts at close to Medicare rates; and

- Increased the estimated probability that portions of the VA health care system would have sufficient capacity to avoid the need for additional contracted care, reflecting greater uncertainty about current waiting times and capacity problems and more extensive analysis of the likely impact on VA spending in areas where existing capacity is sufficient.

CBO also made adjustments that increased the estimated cost of title III:

- Increased the estimate of how quickly and fully VA could implement H.R. 3230, based on information regarding contracts that VA has recently entered into to access nationwide networks of health care providers;

- Incorporated an increase in the total amount of health care that veterans would seek in response to the lower out-of-pocket costs they would face when using VA-financed care; and

- Increased the estimate of the cost of care for veterans who live further than 40 miles from a VA health care facility, based on two factors: new data from VA on the number of such veterans and the share of such veterans who are currently enrolled in VA health care, and the expectation that those veterans would not be required to seek authorization from VA for each episode of care received through a non-VA provider.

On net, those changes reduced CBO's estimate of mandatory spending attributable to Title III from $35 billion over the 2014-2017 period to $33 billion.

In addition, the current estimate includes an estimate of the increased revenues—$2.5 billion— that would result from shifting some of the costs of veterans' health care from the private to the public sector. The current estimate also includes an estimate of increased collections—of about $2.2 billion; some of those collections would be offsets to discretionary spending.

Taken together, CBO now estimates that the effects of title III on direct spending and revenues would increase budget deficits by about $30 billion between 2014 and 2017, compared with $35 billion in the agency's preliminary estimate. In addition, CBO now

estimates that title III would lead to an increase of $700 million in discretionary costs. If the program was fully phased in by 2016, CBO now estimates that the net increase in direct spending would be $38 billion in that year, compared with roughly $50 billion in the agency's preliminary estimate; such spending would increase over time with growth in the number of veterans and rising medical costs per enrollee.

On February 10, 2014, CBO transmitted an estimate of the effects on direct spending of S. 1982, the Comprehensive Veterans Health and Benefits and Military Retirement Pay Restoration Act of 2014, as introduced on February 3, 2014. The agency estimated that leases for 27 medical facilities that would be authorized by section 381 of that bill would increase direct spending by $1.4 billion. Section 601 of H.R. 3230 would authorize leases for all but one of those same facilities at a cost of $1.2 billion, CBO estimates.

On May 16, 2013, CBO transmitted an estimate for H.R. 357, the GI Bill Tuition Fairness Act of 2013, as ordered reported by the House Committee on Veterans' Affairs on May 8, 2013. Section 3 of H.R. 357 contains language similar to that in section 702 of H.R. 3230. The difference between the estimated costs of the two proposals reflects different eligibility criteria and the use of different baseline projections.

On November 12, 2013, CBO transmitted an estimate for S. 944, the Veterans Health and Benefits Improvement Act of 2013, as ordered reported by the Senate Committee on Veterans' Affairs on July 24, 2013. Section 201 of S. 944 contains language similar to that in section 702 of H.R. 3230. The difference between the estimated costs of the two proposals reflects the use of different baseline projections. In addition, section 104 of S. 944 contains language similar to that in section 701 of H.R. 3230. The difference between the estimated costs of the two proposals reflects different effective dates and the use of different baseline projections.

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ESTIMATED BUDGETARY EFFECTS OF H.R. 3230 AS PASSED BY THE SENATE

	By Fiscal Year, in Millions of Dollars							
	2014	2015	2016	2017	2018	2019	2014-2019	2014-2024
CHANGES IN DIRECT SPENDING								
Title I – Improvement of Scheduling System for Health Care Appointments								
Estimated Budget Authority	*	2	0	0	0	0	2	2
Estimated Outlays	*	2	0	0	0	0	2	2
Title II – Training and Hiring of Health Care Staff								
Estimated Budget Authority	0	305	315	0	0	0	620	620
Estimated Outlays	0	122	309	189	0	0	620	620
Title III – Improvement of Access to Care from Non-Department of Veterans Affairs Providers								
Estimated Budget Authority	500	9,500	23,000	0	0	0	33,000	33,000
Estimated Outlays	500	8,600	21,600	2,300	0	0	33,000	33,000
Title IV – Health Care Administrative Matters								
Estimated Budget Authority	1	3	*	0	0	0	4	4
Estimated Outlays	1	3	*	0	0	0	4	4
Tile V – Health Care Related to Sexual Trauma								
Estimated Budget Authority	*	*	1	0	0	0	1	1
Estimated Outlays	*	*	1	0	0	0	1	1
Title VI – Major Medical Facility Leases								
Estimated Budget Authority	0	0	0	1,208	0	0	1,208	1,208
Estimated Outlays	0	0	0	61	326	398	785	1,208
Title VII – Veterans Benefits Matters								
Estimated Budget Authority	18	14	8	7	6	4	57	71
Estimated Outlays	15	16	8	8	6	4	57	71
Total Changes in Direct Spending								
Estimated Budget Authority	519	9,824	23,324	1,215	6	4	34,892	34,906
Estimated Outlays	516	8,743	21,918	2,558	332	402	34,469	34,906

(Continued)

Table Continued.

	By Fiscal Year, in Millions of Dollars							
	2014	2015	2016	2017	2018	2019	2014-2019	2014-2024
CHANGES IN REVENUES								
Increase in Revenues	0	500	1,500	500	0	0	2,500	2,500
NET INCREASE IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES								
Impact on the Deficit	516	8,243	20,418	2,058	332	402	31,969	32,406
CHANGES IN SPENDING SUBJECT TO APPROPRIATION								
Title II – Training and Hiring of Health Care Staff								
Estimated Authorization Level	0	0	0	325	338	350	1,013	n.a.
Estimated Outlays	0	0	0	293	337	349	979	n.a.
Title III – Improvement of Access to Care from Non-Department of Veterans Affairs Providers[a]								
Estimated Authorization Level	0	0	-1,200	1,900	0	0	700	n.a.
Estimated Outlays	0	0	-1,200	1,700	200	0	700	n.a.
Title V – Health Care Related To Sexual Trauma								
Estimated Authorization Level	0	0	0	2	2	2	6	n.a.
Estimated Outlays	0	0	0	2	2	2	6	n.a.
Title VI – Major Medical Facility Leases								
Estimated Authorization Level	0	0	0	127	0	0	127	n.a.
Estimated Outlays	0	0	0	89	32	6	127	n.a.
Total Changes in Spending Subject to Appropriation								
Estimated Authorization Level	0	0	-1,200	2,354	340	352	1,846	n.a.
Estimated Outlays	0	0	-1,200	2,084	571	357	1,812	n.a.

Source: Congressional Budget Office.

Notes: Numbers in this estimate may not add to totals because of rounding.

n.a. = not applicable; * = less than $500,000.

a. For Title III, the changes in spending subject to appropriation represent the first-party and third-party collections that would result from the additional VA-sponsored health care provided over the 2014-2016 period and the estimated costs for additional contracted services for the first month in fiscal year 2017. If VA was to provide health care to the new enrollees that joined the VA health care system as a result of the expanded contracted care, additional discretionary funding would probably be necessary after 2016.