CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 25, 2005

H.R. 515
Assured Funding for Veterans Health Care Act of 2005

As introduced on February 2, 2005

SUMMARY

H.R. 515 would replace annually appropriated discretionary funding for veterans' health care with permanent direct spending authority determined by a formula specified in law. Funding in 2007 would be equal to 130 percent of the obligations made by the Veterans Health Administration (VHA) in 2005 for certain specified accounts. The amounts in succeeding years would be adjusted for medical inflation and growth in the number of veterans enrolled in VHA's health care system and other nonveterans eligible for care from VHA.

Although the bill would primarily affect funding for health care services provided by VHA, it also would result in some savings in direct spending for other government programs, primarily Medicare and Medicaid.

CBO estimates that enacting H.R. 515 would result in a net increase in direct spending totaling about $179 billion over the 2007-2010 period and $518 billion over the 2007-2015 period. Under the bill, funding for VHA would no longer be subject to annual appropriations, so CBO estimates that discretionary outlays for VHA and other government programs would decline—relative to baseline projections—by $3 million in 2006 and $294 billion over the 2006-2015 period. That potential discretionary savings assumes that appropriations are reduced by the estimated amounts from the baseline levels underlying the current Congressional budget resolution.

Pursuant to section 407 of H. Con. Res. 95 (the Concurrent Resolution on the Budget, Fiscal Year 2006), CBO estimates that enacting H.R. 515 would cause an increase in direct spending greater than $5 billion in all of the next four 10-year periods beginning after 2015.

H.R. 515 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). Lower Medicaid spending for veterans who would, under the bill, receive services through the Veterans Health Administration would result in savings to states totaling more than $4 billion over the 2007-2015 period.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 515 is shown in Table 1. The costs or savings from this legislation fall within budget functions 050 (national defense), 550 (health), 570 (Medicare), and 700 (veterans benefits and services).

TABLE 1. ESTIMATED BUDGETARY IMPACT OF H.R. 515

	By Fiscal Year, in Millions of Dollars				
	2006	2007	2008	2009	2010
CHANGES IN DIRECT SPENDING					
Estimated Budget Authority	0	38,450	48,370	53,070	56,760
Estimated Outlays	0	32,450	39,170	49,070	57,860
CHANGES IN SPENDING SUBJECT TO APPROPRIATION					
Estimated Authorization Level	0	-29,628	-30,564	-31,485	-32,419
Estimated Outlays	-3	-26,123	-29,865	-31,044	-32,028

BASIS OF ESTIMATE

This estimate assumes that the bill will be enacted by the end of fiscal year 2005 and that future appropriations are reduced by the estimated amounts.

Direct Spending

Under H.R. 515, direct spending for VHA would increase significantly. That increase would be offset in part by lower direct spending for other government programs, including Medicare and Medicaid. On balance, CBO estimates that enacting H.R. 515 would result in a net increase in direct spending totaling about $179 billion over the 2007-2010 period and $518 billion over the 2007-2015 period (see Table 2).

TABLE 2. ESTIMATED CHANGES IN DIRECT SPENDING UNDER H.R. 515

	By Fiscal Year, in Millions of Dollars									
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
CHANGES IN DIRECT SPENDING										
Veterans Health Administration										
Estimated Budget Authority	0	39,800	51,100	56,300	60,400	64,500	68,100	71,400	74,800	78,200
Estimated Outlays	0	33,800	41,900	52,300	61,500	68,600	71,000	71,800	74,600	77,400
Medicare										
Estimated Budget Authority	0	-1,100	-2,300	-2,800	-3,100	-3,500	-3,800	-4,000	-4,300	-4,600
Estimated Outlays	0	-1,100	-2,300	-2,800	-3,100	-3,500	-3,800	-4,000	-4,300	-4,600
Medicaid										
Estimated Budget Authority	0	-300	-500	-500	-600	-600	-700	-700	-700	-800
Estimated Outlays	0	-300	-500	-500	-600	-600	-700	-700	-700	-800
Veterans Benefits Administration										
Estimated Budget Authority	0	60	110	110	110	110	0	0	0	0
Estimated Outlays	0	60	110	110	110	110	0	0	0	0
Federal Employees Health Benefits Program										
Estimated Budget Authority	0	-10	-40	-40	-50	-50	-60	-60	-60	-70
Estimated Outlays	0	-10	-40	-40	-50	-50	-60	-60	-60	-70
Total Changes										
Estimated Budget Authority	0	38,450	48,370	53,070	56,760	60,460	63,540	66,640	69,740	72,730
Estimated Outlays	0	32,450	39,170	49,070	57,860	64,560	66,440	67,040	69,540	71,930

Veterans Health Administration. Under current law, funding for VHA is provided in an annual appropriation. That appropriation typically includes funds for medical care for veterans (the bulk of the appropriation); funds for construction or renovation of hospitals, nursing homes, and clinics; and funds to pay operating expenses. Under H.R. 515, beginning in fiscal year 2007, the funding for all of VHA's programs, functions, and activities would be provided through a permanent, indefinite appropriation, except for construction projects and a program that provides grants to states to build long-term care facilities. CBO estimates that, under H.R. 515, direct spending for veterans health care would increase by about $190 billion over the 2007-2010 period and $553 billion over the 2007-2015 period.

Under H.R. 515, VHA would be given budget authority (that is, the authority to obligate funds) in 2007 equal to 130 percent of the obligations made by VHA in fiscal year 2005 for the specified accounts. According to VHA, such obligations are expected to total

$30.6 billion.[1] Thus, CBO estimates that under H.R. 515 VHA would have the authority to obligate almost $40 billion in 2007, resulting in direct spending outlays of about $34 billion. (The corresponding reduction in discretionary spending under the bill is discussed below under the heading of "Spending Subject to Appropriation.")

For each year after 2007, H.R. 515 would establish a baseline per capita cost based on the budget authority provided in fiscal year 2007 divided by the number of veterans enrolled to receive medical care from VHA at the end of fiscal year 2005. CBO estimates that this per capita cost would be about $5,100 in 2007. This baseline amount would then be increased each year at the rate for medical inflation published by the Bureau of Labor Statistics (BLS). CBO projects that rate of increase to be about 4.5 percent per year. For each year after 2007, VHA would have budget authority equal to the inflated per capita amount for that fiscal year times the number of veterans enrolled to receive medical care from VHA as of July 1 of the previous fiscal year. Under current law, most veterans have to enroll with VHA before they can receive care from VHA, though many enrolled veterans do not actually receive such care.

Some nonveterans are eligible to receive care from VHA without being enrolled with VHA. Under the bill, the number of those nonenrolled individuals who received care from the VHA in the previous fiscal year also would be counted for the purposes of determining funding for VHA. Nonenrolled individuals who are eligible to receive health care from VHA include dependents of veterans who are either 100 percent disabled or who have a total and complete disability.

Estimate of the Number of Enrolled and Nonenrolled Individuals. Using data from VHA, CBO estimates that about 7.8 million veterans will be enrolled in VHA's health care system at the end of 2005. CBO estimates that number will grow to about 8.3 million by 2015 under current law and VA's policy to not accept new enrollments from priority 8 veterans, who are veterans without a service-connected disability and with income above certain thresholds. (VHA has stopped enrolling new priority 8 veterans and now gives veterans with service-connected disabilities higher priority when providing health care because, it indicates, its appropriation is not sufficient to meet the health care demands of all currently enrolled veterans.) Under H.R. 515, CBO estimates that by 2015 total enrollment would increase by 2.4 million veterans (or about 30 percent) above our current projection, to about 10.7 million veterans.

1. The Administration has requested an additional $1.3 billion for VHA in 2005. If the Congress enacts that supplemental appropriation, CBO expects that VHA would be able to obligate a significant portion of the new funds in 2005. Thus, spending under H.R. 515 would be $1 billion to $2 billion a year higher than we currently estimate because future spending would be partially based on VHA's obligations in 2005.

CBO believes enrollment would be higher under H.R. 515 than under current law because veterans would have a greater incentive to enroll and VHA would be increasingly motivated to enroll them. That greater incentive stems from the fact that the bill would provide a guaranteed funding source for medical benefits. VHA provides generous health care benefits that many veterans already receive today. Data and projections from VHA indicate that enrollment has been and continues to increase even though VHA cannot provide all of the health care that veterans are seeking. Using the increased and guaranteed funding that would be made available under H.R. 515, VHA would be able to provide health care to more veterans and provide that health care in a more timely manner, thus increasing the likelihood of more veterans enrolling.

In addition, under H.R. 515, VHA's budget authority would be directly linked to the number of veterans it is able to enroll, not the number of veterans who actually receive care at VHA. As mentioned above, many enrolled veterans do not actually receive any health care from VHA. Thus, the more veterans VHA enrolls, the more effectively it would be able to fulfill its mission to provide health care to all veterans who seek that care from VHA. Accordingly, CBO estimates that the total number of enrolled veterans would increase significantly above current projections.

With the increased resources under H.R. 515, CBO believes that VHA would remove its current ban on new enrollments for priority 8 veterans. Of the projected increase of 2.4 million new enrollees by 2015, CBO estimates that 900,000 would be priority 8 veterans who would want to enroll under the current system, but cannot.

In addition to providing care to enrolled veterans, VHA also provides health care to many individuals who are not veterans. Dependents and survivors of certain veterans, primarily those who are either 100 percent disabled or have a total and complete disability, can participate in a program called CHAMPVA, which acts as a third-party insurance provider for those individuals. Using information from VHA, CBO estimates that in 2007 about 180,000 individuals in the CHAMPVA program would be counted in the formula to determine VHA's annual budget authority under H.R. 515.

Estimate of VHA Spending. Using the formulas specified in H.R. 515 and the above estimates of population and per capita costs, CBO estimates that under H.R. 515 direct spending by VHA would increase by $190 billion over the 2007-2010 period and $553 billion over the 2007-2015 period.

Under the bill, the amount VHA would receive for medical care in 2008 would be significantly more than what it would receive in 2007. That difference would occur because the budget authority for the two years would be calculated differently. For 2007, budget authority would be equal to 130 percent of obligations in 2005. For 2008, budget authority

would be equal to the inflated, per capita amount multiplied by the number of veterans enrolled to receive health care from VHA as of July 1, 2007, plus the number of individuals in the CHAMPVA program who received care from VHA in fiscal year 2007. The baseline per capita amount is derived by dividing the 2007 budget authority ($39.8 billion) by the number of enrolled veterans at the end of 2005 (7.8 million), which is then inflated at the medical inflation rate published by the BLS. CBO estimates that the number of veterans and other individuals enrolled in VHA's health care system in 2007 would be 1.8 million people more than in 2005—generating the large increase in budget authority for 2008. About 400,000 of the 1.8 million increase results from VHA's projected increases under current law. Another 400,000 would result from CBO's assumption that VHA lifts the current ban on enrolling new priority 8 veterans, and 800,000 would result from the projected increase in enrollment due to VHA's increased funding. The remaining increase comes from the 180,000 CHAMPVA beneficiaries who are not counted when determining the per capita amounts. The increase in the enrolled population accounts for most of the projected increase in budget authority.

Under the bill, VHA's budget authority would increase rapidly. Because it would take some time before VHA could adjust its operations to reflect the larger budget authority, CBO estimates that increases in outlays would lag the increases in budget authority. By 2011, CBO expects that VHA would be able to obligate and spend the increased amounts in a normal manner (close to historical rates of spending). Estimated outlays would exceed budget authority over the 2010-2013 period because a significant amount of spending from prior years' budget authority would be combined with the higher, first-year spending of the new budget authority in those years. CBO expects that the adjustment back to historical outlay rates would take only a few years because VHA has extensive authority to contract with non-VHA health care facilities—especially to meet long-term care needs such as nursing home care, home health care, adult day care, and respite care for veterans that it cannot provide in its own facilities.

Medicare. About half of all enrolled veterans are also eligible for Medicare benefits. While benefits provided by VHA include many benefits provided by Medicare, VHA also provides a long-term care benefit that is not currently provided by Medicare. Because, under H.R. 515, VHA would be able to provide health care to more veterans and increase its spending per veteran, CBO expects that veterans treated by VHA would use Medicare somewhat less than they currently do.

However, the increased spending by VHA would not result in dollar-for-dollar savings in Medicare. Much of the increased spending would be for services that the veterans are currently not receiving. In particular, because VHA provides substantial long-term care benefits that Medicare does not currently provide, CBO believes that under H.R. 515 many veterans would continue to seek some health care services covered by Medicare as well as

long-term care provided by the Veterans Health Administration. Accordingly, the reduction in spending by Medicare would only partially offset the increased spending by VHA. After accounting for the higher copayments veterans pay under Medicare, CBO estimates that, under H.R. 515, Medicare spending would decline by about $9 billion over the 2007-2010 period and about $30 billion over the 2007-2015 period.

Medicaid. Using data from the Current Population Survey (CPS) and VHA, CBO estimates that as many as 180,000 veterans eligible for Medicaid also receive health care from VHA. Furthermore, under H.R. 515, CBO estimates that about 6,000 veterans who would have used Medicaid would now use VHA for health care in 2007; that number would grow to almost 26,000 by 2015. CBO believes that most of the veterans who would initially switch to VHA for health care would be those who are eligible for a pension from the Veterans Benefits Administration (VBA) and receive nursing home care paid for by Medicaid. Under current law, veterans who receive nursing home care paid for by Medicaid and are also eligible for a pension from VBA must forfeit the majority of their pension; those veterans may keep only about $90 a month. If, however, veterans are in a VHA-sponsored nursing home, the veterans forfeit a much smaller percentage of their pension. Because VHA would have more money to spend on nursing home care under H.R. 515, CBO expects that many veterans would choose to use VHA for nursing home care instead of Medicaid.

Under current law, CBO estimates that, in 2007, almost 19,000 veterans who are eligible for a pension would be in nursing homes paid for by Medicaid; that number is projected to decline to about 16,000 by 2015. CBO assumes that, under H.R. 515, about 25 percent of those veterans would switch to receive their nursing home care from VHA in 2007 and about 50 percent would switch in the years 2008-2015. We estimate that the federal savings for those veterans leaving Medicaid would be about $21,000 per veteran in 2007. CBO estimates that the number of Medicaid-eligible veterans who are not in nursing homes that would begin to use VHA for some health care would total about 1,100 in 2007, and grow to about 18,000 by 2015. CBO estimates that the federal savings associated with veterans who currently receive some health care from VHA and some paid for by Medicaid would be much less—about $1,600 per veteran in 2007—because they do not receive institutional care. Accordingly, CBO estimates that federal savings in the Medicaid program would be about $2 billion over the 2007-2010 period and more than $5 billion over the 2007-2015 period.

Veterans Benefits Administration. As mentioned above, veterans who are eligible for a pension from VBA and receive nursing home care paid for by Medicaid must forfeit most of that pension. Thus, under H.R. 515, CBO estimates that VBA would have to pay significantly more each year in pension payments for each veteran who is eligible for a pension and who would now receive nursing home care from VHA instead of Medicaid. CBO estimates that the additional pension payments would be about $12,000 per veteran in 2007. Using the above assumption that ultimately 50 percent of those veterans who receive

nursing home care paid for by Medicaid (4,500 in 2007) would choose to receive nursing home care from VHA, CBO estimates that the costs to VBA would be $500 million over the 2007-2011 period. There would be no costs from 2012 through 2015 because VBA's authority to reduce pensions for veterans in Medicaid-approved nursing homes expires at the end of 2011.

Federal Employees Health Benefits (FEHB) Program. Using data from the CPS and VHA, CBO estimates that in 2015, under current law, about 46,000 civilian retirees of the federal government who are not eligible for Medicare also would receive health care from VHA. Under H.R. 515, that number would increase to about 53,000, CBO estimates. (Most civil service retirees age 65 and over are eligible for Medicare and thus would have little incentive to use VHA services except for benefits not covered by Medicare and the FEHB program, primarily long-term care.) In addition, CBO estimates that about 52,000 federal workers would use VHA for some health care services in 2015. If H.R. 515 is enacted, that number would increase to about 59,000, CBO estimates. The savings for active workers (about $2,300) would be lower on a per capita basis than for FEHB annuitants (about $2,900) because medical costs are highly correlated with age.

Using this information, CBO estimates that the total savings to the FEHB program under H.R. 515 would be about $1.9 billion over the 2007-2015 period. However, that savings would be shared by the federal government (72 percent) and participants in the FEHB program (28 percent). About 35 percent of the federal savings would be realized through lower contributions to premiums for annuitants—those contributions are considered direct spending. (The remaining savings would be for active workers, which would affect discretionary spending—discussed below—or for postal workers and annuitants, which would be reflected in postal rates and would thus have no net budgetary impact.) Accordingly, CBO estimates that under H.R. 515 direct spending by the FEHB program for annuitants would decline by $440 million over the 2007-2015 period relative to spending under current law.

Tricare For Life. The Department of Defense (DoD) operates a program called TRICARE For Life (TFL) that pays all copayments and deductibles for Medicare-covered services and provides a generous prescription drug benefit for all retirees of the uniformed services who are eligible for Medicare. Those retirees also would be eligible to receive health care from VHA, but given the extent of their current insurance, CBO does not expect many retirees to use VHA for health care except for long-term care needs, which are not covered by Medicare

or TFL. Thus, CBO does not estimate any significant savings in the TFL program from enacting H.R. 515.

Spending Subject to Appropriation

H.R. 515 also would affect discretionary spending by reducing VHA's need for future appropriations and increasing the amount of offsetting collections deposited to the Medical Care Collections Fund (MCCF). CBO estimates that implementing H.R. 515 would lower discretionary outlays by $3 million in 2006, $119 billion over the 2006-2010 period (see Table 3), and $294 billion over the 2006-2015 period, assuming appropriations are reduced by the estimated amounts.

Reduced Appropriations for VHA. Under H.R. 515, VHA would no longer need most of its annual appropriation. The only remaining appropriated spending for VHA would be for construction, the spending of offsetting collections, and grants that are made to states to construct long-term care facilities. CBO estimates that providing direct spending authority to VHA would reduce discretionary outlays by about $118 billion over the 2007-2010 period and $292 billion over the 2007-2015 period, assuming appropriations are reduced by the estimated amounts. Those are the amounts in the CBO baseline underlying the current Congressional budget resolution. That baseline is derived by inflating the most recent full-year appropriation for the program. Future appropriation levels may be either higher or lower than such baseline projections.

Offsetting Collections. Under current law, certain veterans must make copayments when receiving health care from VHA. In addition, VHA can bill a veteran's third-party insurance when the veteran is treated for nonservice-connected conditions. These payments are deposited into the MCCF and, under current law, are treated as offsets to discretionary spending. Spending from the MCCF is subject to appropriation.

As mentioned earlier, CBO estimates that under H.R. 515 total enrollment in VHA's health care system would increase by about 700,000 in 2006 and by 2.4 million by 2015. Although direct funding from the Treasury would not begin under the bill until 2007, CBO expects that enrollment would begin to increase in 2006 in anticipation of guaranteed funding in 2007, assuming VHA stops barring priority 8 veterans from enrolling to receive health care. CBO estimates that the number of veterans who actually receive care from VHA would increase more slowly—with about 40,000 new users in 2006, growing to more than 700,000 by 2015.

TABLE 3. ESTIMATED CHANGES IN SPENDING SUBJECT TO APPROPRIATION FOR H.R. 515
(By fiscal year, in millions of dollars)

	2005	2006	2007	2008	2009	2010
VETERANS HEALTH ADMINISTRATION						
Baseline Spending Under Current Law						
Estimated Authorization Level [a]	28,890	29,823	30,639	31,560	32,433	33,363
Estimated Outlays	28,387	29,239	30,189	31,242	32,074	32,935
Proposed Changes						
Veterans Medical Care						
Estimated Authorization Level	0	0	-29,528	-30,394	-31,275	-32,179
Estimated Outlays	0	0	-26,021	-29,690	-30,830	-31,787
Offsetting Collections						
Estimated Authorization Level	0	0	0	0	0	0
Estimated Outlays	0	-3	-12	-15	-14	-11
Subtotal						
Estimated Authorization Level	0	0	-29,528	-30,394	-31,275	-32,179
Estimated Outlays	0	-3	-26,033	-29,705	-30,844	-31,798
Spending Under H.R. 515						
Estimated Authorization Level	28,890	29,823	1,111	1,166	1,158	1,184
Estimated Outlays	28,387	29,236	4,156	1,537	1,230	1,137
DEFENSE HEALTH PROGRAM						
Baseline Spending Under Current Law						
Estimated Authorization Level [a]	18,175	18,555	18,910	19,315	19,720	20,132
Estimated Outlays	17,837	18,398	18,853	19,142	19,506	19,911
Proposed Changes						
Estimated Authorization Level	0	0	-70	-130	-160	-180
Estimated Outlays	0	0	-60	-120	-150	-170
Spending Under H.R. 515						
Estimated Authorization Level	18,175	18,555	18,840	19,185	19,560	19,952
Estimated Outlays	17,837	18,398	18,793	19,022	19,356	19,741
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM						
Baseline Spending Under Current Law						
Estimated Authorization Level [a]	8,810	9,468	10,158	10,874	11,612	12,372
Estimated Outlays	8,810	9,468	10,158	10,874	11,612	12,372
Proposed Changes						
Estimated Authorization Level	0	0	-30	-40	-50	-60
Estimated Outlays	0	0	-30	-40	-50	-60
Spending Under H.R. 515						
Estimated Authorization Level	8,810	9,468	10,128	10,834	11,562	12,312
Estimated Outlays	8,810	9,468	10,128	10,834	11,562	12,312
SUMMARY OF CHANGES IN SPENDING SUBJECT TO APPROPRIATION						
Estimated Authorization Level	0	0	-29,628	-30,564	-31,485	-32,419
Estimated Outlays	0	-3	-26,123	-29,865	-31,044	-32,028

a. The 2005 level is the estimated net amount appropriated for that year. No full-year appropriation has yet been provided for fiscal year 2006. The current-law amounts for the 2006-2010 period assume that appropriations remain at the 2005 level with adjustments for anticipated inflation.

Based on that estimated increase, CBO estimates that collections would increase by $17 million in 2006, about $900 million over the 2006-2010 period, and more than $2 billion over the 2006-2015 period. When the amounts in the MCCF are appropriated, the negative budget authority from collections and the budget authority for spending the collections offset each other exactly in each year, but the additional spending does not occur as quickly as the receipts are collected. As a result, CBO estimates that net outlays would decrease by $3 million in 2006, by $55 million over the 2006-2010 period, and by $82 million over the 2006-2015 period, assuming the appropriation of the amounts in the MCCF.

Health Care for DoD Retirees. All military retirees are, by definition, veterans. DoD provides third-party health care insurance as well as direct care in military hospitals and clinics to retirees. Spending on health care for military retirees who are under age 65 and not eligible for Medicare is subject to appropriation. While exact numbers are not available, CBO estimates that, under H.R. 515, about 100,000 retirees would receive some health care from VHA in 2008; that number would remain fairly constant through 2015. Assuming per capita savings similar to those for federal civilian retirees, CBO estimates that implementing H.R. 515 would reduce DoD's spending for military retirees' health care by $500 million over the 2007-2010 period and $1.6 billion over the 2007-2015 period, assuming appropriations are reduced by the estimated amounts.

Federal Employees Health Benefits Program. As discussed above, enacting H.R. 515 would lower costs for the FEHB program by about $1.9 billion over the 2007-2015 period. CBO estimates that spending on active workers who do not work for the Postal Service, which comes from appropriated accounts, represents about 40 percent of total spending for that program. After accounting for the 72 percent of costs that the federal government is responsible for, CBO estimates that implementing H.R. 515 would reduce expenditures for the FEHB program by $520 million over the 2007-2015 period, assuming appropriations are reduced by the estimated amounts.

LONG-TERM DIRECT SPENDING EFFECTS

Pursuant to section 407 of H. Con. Res. 95 (the Concurrent Resolution on the Budget, Fiscal Year 2006), CBO estimates that enacting H.R. 515 would cause an increase in direct spending greater than $5 billion in all of the next four 10-year periods beginning after 2015. As shown in Table 2, CBO estimates that enacting H.R. 515 would increase total direct spending in 2015 by about $72 billion. That cost would grow in subsequent years.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 515 contains no intergovernmental or private-sector mandates as defined in UMRA. Lower Medicaid spending for veterans that would now receive services through the Veterans Health Administration would result in savings to states totaling more than $1 billion over the 2007-2010 period and more than $4 billion over the 2007-2015 period.

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