CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

January 17, 2018

S. 2193
Caring for Our Veterans Act of 2017

As ordered reported by the Senate Committee on Veterans' Affairs
on December 5, 2017

SUMMARY

S. 2193 would increase the use of community health care and long-term care by the Department of Veterans Affairs (VA) by broadening eligibility for such care and allowing VA to enter into agreements with health care providers in the private sector without complying with the Federal Acquisition Regulation (FAR). The bill also would make changes to VA's health care programs and compensation of employees, including expanding the caregivers program, increasing pay for employees, and reimbursing medical staff for professional training. In total, CBO estimates that implementing the bill would cost $43.3 billion over the 2018-2022 period, assuming appropriation of the necessary amounts.

In addition, S. 2193 would directly appropriate $4 billion for the Veterans Choice Program (VCP) and $1 billion to provide educational assistance for health professionals at VA. The bill also would expand VA's authority to enter into leases for medical facilities. In total, CBO estimates that enacting the bill would increase direct spending by $5.6 billion over the 2018-2027 period.

Pay-as-you-go procedures apply because enacting S. 2193 would affect direct spending. Enacting the bill would not affect revenues.

CBO estimates that enacting S. 2193 would not increase net direct spending or on-budget deficits by more than $2.5 billion in any of the four consecutive 10-year periods beginning in 2028.

S. 2193 would impose an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) by preempting state laws that prohibit VA physicians from practicing telemedicine to treat veterans across state lines. Although it would limit the application of state regulations, the bill would impose no duty on state governments that would result in additional spending or any significant loss of revenues.

The bill contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effects of S. 2193 are shown in Table 1. The costs of this legislation fall within budget function 700 (veterans benefits and services).

TABLE 1. ESTIMATED BUDGETARY EFFECTS OF S. 2193, THE CARING FOR OUR VETERANS ACT OF 2017

	By Fiscal Year, in Millions of Dollars											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018-2022	2018-2027
INCREASES IN SPENDING SUBJECT TO APPROPRIATION												
Estimated Authorization Level	811	7,300	9,880	12,966	15,642	n.a.	n.a.	n.a.	n.a.	n.a.	46,599	n.a.
Estimated Outlays	638	6,342	9,213	12,249	14,895	n.a.	n.a.	n.a.	n.a.	n.a.	43,337	n.a.
INCREASES IN DIRECT SPENDING												
Estimated Budget Authority	5,000	0	0	140	140	140	140	140	140	140	5,280	5,980
Estimated Outlays	558	3,599	145	169	197	247	284	118	132	132	4,668	5,581

n.a. = not applicable.

BASIS OF ESTIMATE

For this estimate, CBO assumes that the bill will be enacted near the beginning of calendar year 2018 and that the estimated amounts will be appropriated each year. Estimated outlays are based on historical spending patterns for the affected programs.

Spending Subject to Appropriation

CBO estimates that implementing S. 2193 would cost $43.3 billion over the 2018-2022 period, subject to appropriation of the necessary amounts (see Table 2). Most of the bill's estimated costs stem from provisions that would expand community health care for veterans, increase eligibility and benefits for caregivers, and increase pay for medical staff.

Veterans Community Care Program. Section 101 would establish the Veterans Community Care Program (VCCP) under which VA would be required to enter into contracts to establish networks of health care providers outside of VA to furnish hospital care, medical services, and extended-care services to veterans enrolled in the VA health care system.

TABLE 2. ESTIMATE OF THE EFFECTS ON SPENDING SUBJECT TO APPROPRIATION OF S.2193, THE CARING FOR OUR VETERANS ACT OF 2017

	By Fiscal Year, in Millions of Dollars					
	2018	2019	2020	2021	2022	2018-2022
INCREASES IN SPENDING SUBJECT TO APPROPRIATION						
Veterans Community Care Program						
Estimated Authorization Level	200	1,900	3,800	5,600	7,000	18,500
Estimated Outlays	200	1,700	3,500	5,300	6,600	17,300
Veterans Care Agreements						
Estimated Authorization Level	*	4,400	4,500	4,700	4,800	18,400
Estimated Outlays	*	3,800	4,300	4,500	4,700	17,300
Expansion of Family Caregivers Program						
Estimated Authorization Level	11	12	341	1,069	1,968	3,401
Estimated Outlays	10	11	298	962	1,815	3,096
Pay Caps for Nurses						
Estimated Authorization Level	400	480	580	680	790	2,930
Estimated Outlays	350	460	550	650	760	2,770
Walk-In Clinics						
Estimated Authorization Level	*	82	170	333	438	1,023
Estimated Outlays	*	71	156	306	414	947
Agreements for State Veterans Homes						
Estimated Authorization Level	0	80	110	130	160	480
Estimated Outlays	0	70	100	130	150	450
Prompt Payment to Providers						
Estimated Authorization Level	3	55	68	89	111	326
Estimated Outlays	3	48	64	84	106	305
Shared Medical Facilities						
Estimated Authorization Level	100	100	100	107	107	514
Estimated Outlays	4	19	49	75	91	238
Staffing Vacant Medical Positions						
Estimated Authorization Level	15	59	54	56	58	242
Estimated Outlays	13	53	53	54	57	230
Reimbursement for Education of Nurses						
Estimated Authorization Level	34	34	34	34	34	170
Estimated Outlays	30	33	33	33	33	162
Transplant Donors						
Estimated Authorization Level	2	17	35	47	49	150
Estimated Outlays	2	15	32	44	47	140

Continued

TABLE 2. CONTINUED

	By Fiscal Year, in Millions of Dollars					
	2018	2019	2020	2021	2022	2018-2022
Compensation for Medical Directors						
Estimated Authorization Level	0	16	21	26	29	92
Estimated Outlays	0	14	20	25	28	87
Modify Threshold for Major Medical Facilities						
Estimated Authorization Level	16	16	16	36	36	120
Estimated Outlays	1	3	8	28	32	72
Mobile Deployment Teams						
Estimated Authorization Level	6	10	15	20	26	77
Estimated Outlays	5	9	14	19	25	72
Podiatrists						
Estimated Authorization Level	9	10	10	12	13	54
Estimate Outlays	8	10	10	12	13	53
Peer Specialist Program						
Estimated Authorization Level	4	9	9	10	10	42
Estimate Outlays	3	8	9	10	10	40
Demonstration Program on Dental Care						
Estimated Authorization Level	4	5	5	5	6	25
Estimate Outlays	3	5	5	5	6	24
Pilot Program for Tuition Reimbursement						
Estimated Authorization Level	4	4	4	5	5	22
Estimate Outlays	3	4	4	5	5	21
Coordinated-Care Program						
Estimated Authorization Level	0	5	5	5	0	15
Estimate Outlays	0	4	5	5	1	15
Pay for Perfusionists						
Estimated Authorization Level	1	1	1	1	1	5
Estimate Outlays	1	1	1	1	1	5
Studies, Reports, and Training						
Estimated Authorization Level						
Estimate Outlays	2	5	2	1	1	11
	2	4	2	1	1	10
Total Changes in Spending Subject to Appropriation						
Estimated Authorization	811	7,300	9,880	12,966	15,642	46,599
Estimated Outlays	638	6,342	9,213	12,249	14,895	43,337

* = less than $500,000.

Under this program, subject to appropriations, VA would be required to provide care through those networks, at the veteran's discretion, in the following situations:

- VA does not offer the care needed,
- The veteran resides in New Hampshire, or
- The veteran, as of the day before enactment, lives 40 miles away from a VA medical facility.

VA also would be required to provide such community care if the veteran's primary care provider and the veteran agree it is in the best medical interest of the veteran to do so, based on criteria to be developed by VA that consider the nature and frequency of the needed care and how accessible that care is to the veteran. In addition, VA would be authorized to offer community care if it determines that a VA medical center is not meeting the standards for timeliness and quality that would be developed by the department for different types of care. Section 101 would require VA to promulgate regulations to implement the program within one year.

The VCCP would replace an existing program that authorizes VA to provide community care to veterans with service-connected disabilities (SCDs) when VA does not offer the needed care or when that care is geographically inaccessible to the veteran and to women veterans who need hospital care. Under its existing program, VA currently spends roughly $9 billion a year for community care (excluding emergency care). CBO expects the VCCP could cost several times more than the existing program although several factors would limit the rate and ultimate extent of cost growth. Cost would be higher because:

- VA would be required, subject to appropriations, rather than authorized to provide community care,
- The number of eligible veterans would be several times larger than the number eligible for the current program,
- The criteria for offering community care would be broader, and
- The convenience of community care could encourage more veterans to enroll in the VA health care system.

However, CBO expects these factors would limit the rate and ultimate extent of cost growth:

- A greater number of enrolled veterans receiving community care could shorten wait times for care provided in VA facilities, and thus reduce the number of veterans that need to be referred to community care because VA care is not available in a timely fashion.

- Many of the regulations that need to be written to implement the program could curtail use. For instance, VA would probably require all veterans to be seen by a VA caregiver before being referred for community care.

- The community care networks could be limited in size and scope, particularly in more rural areas, reducing the accessibility of such care.

- VA might implement the program slowly, as happened with the VCP.

To estimate the cost of this program over the next five years, CBO focused primarily on the extent to which the number of veterans eligible for VCCP would be larger than those eligible for the existing community care program. The currently eligible population—veterans with SCDs and women veterans needing hospital care—represents about 30 percent of enrolled veterans. Under VCCP, the eligible population would more than triple because all enrolled veterans would be eligible.

After accounting for the factors that might restrict use, CBO estimates that in the early years of the program, the newly eligible population would use community care at about half the rate of veterans in the current community care program. In addition, CBO expects that the program would be implemented gradually. On that basis, CBO estimates that implementing section 101 would cost $17.3 billion over the 2018-2022 period.

Veterans Care Agreements. Section 102 would allow VA to enter into Veterans Care Agreements with health care providers in the community to provide hospital care, medical services, or extended care to eligible veterans. Such agreements would:

- Exempt VA from using the competitive bidding procedures as required under the FAR,

- Require VA to verify that those community providers meet the conditions for certification, and

- Require VA to periodically review the necessity of the agreements.

Under current law, VA must comply with the FAR for agreements and contracts with community health care and extended-care providers. The FAR is an extensive and complex set of rules governing the federal government's purchasing processes.

According to VA, the FAR's requirements are appropriate for large and long-term agreements for contracted health care services but may not be practical for case-by-case arrangements in all regions of the United States. This bill would allow VA to use other agreements for certain health care services and extended care provided outside the VA system.

For 2018, the Congress has provided roughly $10 billion for community health care at VA (excluding the VCP). Using information from VA, CBO estimates that implementing section 102 would give VA the legal authority to continue to provide about 40 percent (or $4 billion annually) of that community health care. After adjusting for inflation and accounting for existing appropriations, CBO estimates that implementing this section would cost $17.3 billion over the 2018-2022 period.

Expansion of the Family Caregivers Program. Section 301 would expand access to the Family Caregivers Program, which provides stipends, health insurance, respite care, training, and other forms of support to caregivers of eligible veterans enrolled in the program. Veterans are eligible for the program if they require assistance in activities of daily living, such as bathing, eating, or grooming, as a result of injuries incurred during military service on or after September 11, 2001. Section 301 would open that program in two stages to eligible veterans of any era and would expand its benefits to include legal and financial-planning services. In total, CBO estimates that implementing section 301 would cost $3.1 billion over the 2018-2022 period.

Under stage one, eligible veterans who were injured during service on or before May 7, 1975, could enter the Family Caregivers Program. That stage would begin within two years of enactment (after VA develops and certifies a new information technology [IT] system to track benefits, as required under section 302). Stage two would begin two years after stage one and would open the program to the remaining eligible veterans—those injured during service after May 7, 1975, and before September 11, 2001. For the purposes of this estimate, CBO assumes that the bill will be enacted near the beginning of calendar year 2018, that stage one of the proposal will begin early in 2020, and that stage two will begin early in 2022.

In 2016, costs for the Family Caregivers Program totaled $493 million, about $19,000 per participating veteran. Most of that cost resulted from monthly stipends paid to caregivers. Stipends are based on the hours of daily care the veteran requires and the prevailing wage for home health aides. In 2016, the annual stipends paid under the program ranged from $7,800 to $30,000 and averaged roughly $20,000. Caregivers also are eligible to participate in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), a program run by VA that provides health insurance for dependents and survivors of certain disabled veterans. In addition, the Family Caregivers Program provides up to 30 days of respite care each year as well as training and 15 other

support services. In 2016, costs under the Family Caregivers Program for CHAMPVA and the remaining services averaged about $2,600 per veteran.

CBO's estimate of the cost of expanding the caregivers program is based on the patterns of use and the average costs of the existing program and the number of veterans with significant, service-connected disabilities in the cohorts that would be newly eligible. Furthermore, to account for the advanced age of the newly eligible veterans, the estimate reflects the following findings from a 2014 RAND study:[1]

- Disabled veterans rely more heavily on assistance for daily activities as they age,
- Older veterans tend to rely on older caregivers, and
- Health care costs for caregivers increase with age.

For stage one, CBO estimates that about 22,000 additional veterans would participate in the program in 2020, increasing to roughly 46,000 by 2022. CBO expects that the youngest would be in their late 60s. After factoring in a heavier reliance on caregiver assistance for activities of daily living and higher health care costs for an older group of caregivers, CBO estimates that the average cost per participant in 2020 would be about $30,500. However, VA already provides respite care to assist some caregivers through its General Caregiver Program, which provides limited support services to caregivers of eligible veterans from all eras. Accounting for those current benefits in the estimate reduces the average added cost per participant to $30,000. After accounting for gradual implementation and incorporating annual inflation, CBO estimates that stage one of the proposal would cost $2.6 billion over the 2020-2022 period.

For stage two, CBO estimates that about 30,000 additional veterans would use the Family Caregivers Program in 2022. Because those veterans would be younger than the group under the initial expansion, they would have less need for caregiver assistance (with a correspondingly lower stipend amount) and the caregivers would be younger (and have lower CHAMPVA costs). After accounting for existing benefits under the General Caregiver Program, the average incremental cost per participant in 2022 would be $29,000, about 12 percent lower than the cost for participants under stage one in that year. After factoring in a gradual implementation for the second stage of expansion and incorporating annual inflation, CBO estimates that the additional costs for stage two of the Family Caregivers Program would be $417 million in 2022. Those costs would rise to billions of dollars a year by the end of the 10-year window, CBO estimates.

1. Rajeev Ramchand and others, Hidden Heroes: America's Military Caregivers (RAND Corporation, 2014), www.rand.org/pubs/research_reports/RR499.html.

In addition, CBO estimates that roughly 30,000 caregivers in the current Family Caregivers Program (for veterans injured during service on or after September 11, 2001) would receive legal and financial support services. On the basis of the resources necessary to provide counseling under the existing program, CBO estimates an average annual cost of $130 per beneficiary for legal and financial services. CBO estimates a cost of $15 million over the 2018-2022 period to provide those benefits to individuals eligible for the Family Caregivers Program under current law. The costs of providing that additional benefit for newly eligible enrollees in the Family Caregivers Program under this provision are included in the estimates above for adding those people to the program.

Furthermore, in anticipation of the surge of new applications upon expansion of the Family Caregivers Program, VA would need to hire and train additional staff to manage the program (to staff a caregiver support line, provide outreach, and monitor the program). On the basis of program data from 2014 and adjusting for inflation, CBO estimates overhead costs of about $400 per participant to process 22,000 new applications starting in 2020. As a result, CBO estimates the additional overhead costs would be $17 million over the 2018-2022 period.

Pay Caps for Nurses. Section 224 would increase the maximum rate of pay for registered nurses at VA to executive level III ($172,100 in 2017) from the current maximum of executive level IV ($161,900 in 2017)—an increase of 6.3 percent. VA employs roughly 68,000 registered nurses. CBO expects that such a change would result in average pay for registered nurses increasing by that same percentage, from $89,000 to $94,600 in 2017. In addition, the higher pay level could help ameliorate VA's current difficulties in recruiting and retaining registered nurses and would thus increase the total number of nurses employed by VA. Using data from VA on hiring and retaining nurses, CBO estimates that, under section 224, VA would employ roughly 71,000 registered nurses by 2022 (or a 4 percent increase above current staffing). On that basis, CBO estimates that implementing section 224 would cost $2.8 billion over the 2018-2022 period for increased compensation for registered nurses.

Section 224 also would increase the maximum rate of pay for nurse executives at VA to executive level I ($207,800 in 2017) from the current maximum of executive level IV ($161,900 in 2017)—an increase of 28 percent. VA employs about 160 nurse executives at average salaries of $136,995. CBO expects that VA would gradually increase the salaries of the nurse executives to reach a 28 percent increase, on average, by 2022. As a result, CBO estimates that increasing the cap for nurse executives would cost $16 million over the 2018-2022 period. In total, CBO estimates that implementing section 224 would cost $2.8 billion over the 2018-2022 period.

Walk-In Clinics. Within a year of enactment, section 105 would require VA to provide access to walk-in clinics operated by non-VA entities for veterans actively using the VA health care system. For their first two visits to a private clinic in any year, veterans'

copayments would be limited to the amount, if any, required at VA facilities, as determined by the department. For subsequent visits, the veterans would be required to make copayments in an amount set by the department.

Using information from VA, CBO estimates that the department would reimburse about 2.7 million claims for visits to walk-in clinics each year, at an average of $200 per visit. After adjusting for time to prepare the regulations and a gradual implementation, CBO estimates that implementing section 105 would cost $947 million over the 2018-2022 period.

Agreements for State Veterans Homes. Section 103 would waive the requirements of the FAR for contracts and agreements that VA enters into with state-run nursing homes for veterans. Under current law, the state veterans' homes (SVHs) must fill 75 percent of their beds with veterans. VA pays SVHs the full cost of care for veterans with an SCD rating of 70 percent or more, under a contract or agreement. For all other veterans, VA pays SVHs a grant based on a fixed daily allowance.

According to VA, in 2015 the department used such agreements to reimburse state-run nursing homes at a daily rate of $380 for each veteran with an SCD of 70 percent or more—at an annual cost of roughly $350 million (or 37 percent of the total reimbursed to SVHs). However, those agreements do not comply with the FAR, and VA does not expect to be able to enter into new FAR agreements with any of the SVHs. In the absence of this legislation, CBO expects that VA would gradually phase out the use of such agreements as veterans who are currently under that payment structure die or leave the SVHs. Those veterans would probably be replaced by veterans under the lower daily allowance rate of roughly $100 per patient. By allowing VA to enter into agreements outside of the FAR framework, CBO estimates, this proposal would nearly triple VA's reimbursements to SVHs for veterans with SCDs of 70 percent or more.

As a result, after factoring in a gradual phase out of existing non-FAR agreements, CBO estimates that enacting this provision would cost $450 million over the 2018-2022 period. The additional costs from waiving the FAR requirements would begin in 2019. Because appropriations have already been provided for such agreements in 2018, we estimate no additional funding would be necessary in that year.

Prompt Payment to Providers. Section 111 would establish standards for prompt payment of claims for reimbursement for health care provided to veterans in the community, and it would require VA to enter into a contract or agreement with a nondepartment entity to process those claims. In total, CBO estimates, implementing this section would cost $305 million over the 2018-2022 period.

Expedited Processing of Claims. Currently, department standards require VA to process 90 percent of claims for reimbursement of non-VA health care within 30 days. However,

VA has been unable to meet such standards. Under section 111, VA would be required to reimburse non-VA providers within 30 to 45 days of receiving a completed claim form. On the basis of a report by the Government Accountability Office and information from VA, CBO estimates that the department would need 340 additional claims processors at an average annual compensation of $51,000 to meet the expedited time frame for reimbursing existing non-VA health care. After factoring in the period for VA to prepare regulations in 2018, CBO estimates that expediting the processing of claims for such health care would cost $62 million over the 2018-2022 period.

Contracted Claims Processors. Section 111 also would require VA to outsource the processing of claims for non-VA health care. Currently, VA employs about 2,000 claims processors for that purpose at an average compensation of $51,000. CBO expects that the costs for using contractors rather than VA employees would be the same; therefore, no additional costs are estimated for replacing existing VA claims processors with contractors.

Upon entering into contracts for claims processors, CBO expects that VA would offer current existing claims processors the following options:

- Accept placement in another vacant local position at VA,
- Relocate to a position that already exists in another VA location, or
- Voluntarily separate from VA employment.

CBO estimates that placing one-third (or about 600) of the claims processors in other local positions would present minimal costs for administrative duties to select and train the staff. CBO expects that the other two-thirds (about 1,100 claims processors) would relocate or voluntarily end their employment at VA. Using information from VA, CBO estimates that the average cost for relocation or incentive payments for voluntary separation would be $20,000 per employee. As a result, CBO estimates that relocating or ending employment for VA claims processors would cost $24 million over the 2019-2020 period.

Processing New Claims. In order to handle the additional claims of the VCCP established under section 101 of the legislation, CBO estimates that VA would gradually expand the contract discussed above to account for the more than doubling of non-VA health care. By 2022, an additional 2,230 processors would be needed at an average annual compensation of $51,000. After factoring in a gradual implementation of the program, adding those claims processors would cost about $220 million over the 2018-2022 period.

Shared Medical Facilities. Section 242 would allow VA to enter into agreements with other federal departments to construct shared medical facilities.

Implementing this section could reduce VA's share of the cost of some construction projects and some projects would no longer require legislative authorization. Using information from VA, CBO estimates that the total cost for such major construction projects would average about $100 million each year. On that basis, CBO estimates costs of $225 million over the 2018-2022 period for additional construction projects.

Section 242 also would expand VA's authority to enter into leases for medical facilities. CBO estimates that VA would enter into one additional lease each year, with a total annual rent payment of $3 million. For those leases, VA would record obligations of $7 million each year as it enters those contracts at a cost of $13 million over the 2021-2022 period for additional leases. Entering into those leases also would increase direct spending; which is discussed below under the heading "Direct Spending."

In total, CBO estimates section 242 would cost $238 million over the 2018-2022 period.

Staffing Vacant Medical Positions. Within 180 days of enactment, section 206 would require VA to identify and fill vacant positions in the areas of mental health care (such as psychologists, psychiatrists, and additional therapists and counselors) and staff on Patient Aligned Care Teams or PACTs (such as mental health professionals and primary care physicians). PACTs use a team-based model of care to address the comprehensive needs of patients receiving health care at VA medical centers.

VA has advertised vacant positions for mental health professionals and primary care physicians. CBO estimates about 130 vacant positions for mental health professionals and 130 positions for primary care physicians in PACTs would be filled under this section. Using information from VA, CBO expects an average compensation of $120,000 for a mental health care provider and $220,000 for a primary care physician in 2018. VA would probably need to offer special recruitment incentives (such as hiring bonuses) to meet the hiring deadline under this proposal. Under current law, VA offers up to 25 percent of the rate of basic pay as a recruitment bonus. Such onetime bonuses would amount to roughly $23,000 for mental health providers and $43,000 for physicians. After accounting for the expected growth in wages, CBO estimates that implementing this section would cost $230 million over the 2018-2022 period.

Reimbursement for Education of Nurses. Section 213 would require VA to reimburse nurses for up to $1,000 of the cost of continuing professional education. Under current law, VA is only required to reimburse physicians and dentists for such costs. However, the department currently reimburses registered nurses an average of $500 per year. VA employs roughly 68,000 registered nurses. CBO estimates that this provision would increase reimbursement for continuing professional education by $500 per nurse, on

average. As a result, CBO estimates that implementing this section would cost $162 million over the 2018-2022 period.

Transplant Donors. Section 252 would allow VA to cover costs related to organ transplant procedures for veterans and their living donors at nondepartment facilities. Currently, VA covers the medical and service expenses (such as transportation and lodging) for veterans and their living donors only for procedures performed at the Department of Veterans Affairs Transplant Centers (VATCs). For procedures that take place at nondepartment facilities, VA reimburses donors only for transportation and lodging. In 2017, VA provided 560 organ transplants, most of which occurred at VATCs. Of those operations, about 200 were for kidney transplants and about 20 were with living donors.

Section 252 would authorize VA to pay for transplant procedures at various locations nationwide with minimal out-of-pocket expenses for veterans and their living donors. As a result, CBO expects more veterans would use VA for such procedures and more people would be willing to donate organs. In determining the additional number of transplant procedures, CBO considered the other sources of health care coverage carried by enrolled veterans and the likelihood, under this proposal, that those veterans would instead use VA for their transplant procedures.

Using information from the Census Bureau, VA, and the Department of Health and Human Services (HHS), CBO estimates that under this section roughly 60 additional veterans would undergo transplants at nondepartment facilities each year, at an average cost of $750,000 per patient. CBO estimates that VA would cover the medical expenses of an additional 50 living donors (some for procedures that will occur under current law but for which VA would not pay medical expenses) each year, at an average cost of $80,000 per donor. In addition, CBO believes that implementing this section would allow veterans to undergo transplants closer to home. As a result, CBO estimates a reduction in costs for transportation reimbursements of about $4 million each year. Based on the expectation that VA would implement the bill gradually, CBO estimates that implementing section 252 would have a net cost of $140 million over the 2018-2022 period.

Compensation for Medical Directors. Section 205 would remove the cap on basic pay for directors of regional and medical facilities at the department. Under current law, the salary for those positions is capped at level V of the executive schedule. CBO expects that this section would allow VA to offer competitive pay (based on compensation in the private market) for those positions. VA employs about 130 directors at an average compensation amount of $282,000 in 2017. On average, compensation for medical directors in the private sector is about $320,000. As a result of the increase in salary, CBO estimates that VA would be able to fully staff the 140 medical director positions by

2021. After factoring in a one-year delay and additional hiring, CBO estimates that implementing this provision would cost $87 million over the 2018-2022 period.

Modify Threshold for Major Medical Facilities. Section 241 would expand the authority of VA to construct and lease medical facilities.

Section 241 would allow VA to construct medical facilities with total costs of up to $20 million without legislative authorization. Under current law, VA must receive legislative authorization to construct medical facilities with total expenses above $10 million.

Using information on planned construction projects in VA's 2018 budget submission, CBO estimates that implementing this section would authorize one additional construction project each year with an average cost of $16 million. On that basis, CBO estimates costs of $36 million over the 2018-2022 period for construction of new facilities.

In addition, this section would expand VA's authority to enter into leases for medical facilities. CBO estimates that VA would enter into six additional leases each year with a total annual rent payment of $7 million. In that case, VA would record obligations of $20 million each year as it enters those contracts at a cost of $36 million over the 2021-2022 period for additional leases. CBO estimates that this authority also would increase direct spending, which is discussed below under the heading "Direct Spending."

In total, CBO estimates implementing section 241 would cost $72 million over the 2018-2022 period.

Mobile Deployment Teams. Section 233 would require VA to establish a program to provide mobile deployment teams of medical personnel to provide health care at underserved VA facilities. On the basis of costs in the private-sector to operate mobile clinics, CBO estimates start-up costs of $300,000 per team and annual costs to operate each mobile clinic of $375,000. In addition, CBO estimates a medical team of three physicians would cost $450,000 per clinic. CBO expects that VA would implement this program gradually, starting with five mobile deployment teams in 2018 and growing to 25 by 2022. As a result, CBO estimates that implementing this section would cost $72 million over the 2018-2022 period.

Podiatrists. Section 202 would add podiatrists to the same pay schedule as physicians and dentists and thereby increase their pay. Currently, VA employs about 400 podiatrists nationwide at an average annual salary of about $130,000. On the basis of information from VA about the average increase necessary for podiatrists to move to a pay schedule comparable to that of physicians and dentists, CBO estimates that the base salary for podiatrists would increase by about 15 percent to $150,000 in 2018. In addition, using

data on hiring from VA, CBO estimates that VA would be able to hire an additional 30 podiatrists because the increased pay would make working at VA more attractive. After accounting for projected pay raises, CBO estimates that implementing the provision would cost $53 million over the 2018-2022 period.

Peer Specialist Program. Section 208 would require that VA establish a program to include at least two peer specialists in PACTs to promote services for mental health, substance use disorders, and behavioral health in primary care. The program would require a rapid rollout, being implemented in at least 25 medical centers in 2018 and in at least 50 medical centers in 2019. CBO expects the department would implement the program in two PACTs per medical center. Using information from VA, CBO estimates that the 200 additional peer specialists by 2019 would receive an average salary of $41,000. After adjusting for wage growth, CBO estimates that implementing this section would cost $40 million over the 2018-2022 period.

Demonstration Program on Dental Care. Section 215 would require VA to establish a demonstration program to increase veterans' access to dental care that would require hiring and training alternative dental health providers. Those employees would include community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professionals that the Secretary determines appropriate.

Based on the scope of a similar demonstration program operated by HHS, CBO expects that developing and operating the program would require two additional full-time employees at each facility to engage in research, training, and assessment of the program. Based on the costs of similar proposals, CBO expects this program would operate within 10 medical facilities and that the annual cost per staff person would be $100,000 in 2018 and $11 million over the 2018-2022 period.

CBO expects that the use of alternative dental care providers would increase VA's delivery of dental care to veterans. CBO estimates VA would hire two additional dental health providers at each of the 10 medical facilities at an average compensation of $150,000. As a result, CBO estimates that hiring additional dental health providers would cost $14 million over the 2018-2022 period.

In total, implementing section 215 would cost $24 million over the 2018-2022 period.

Pilot Program for Tuition Reimbursement. Section 232 would require VA to carry out a six-year pilot program to repay the education loans of certain physicians. Eligible physicians would include those who are licensed as well as those in their last year of residency who agree to work at VA for a certain period in rural locations. The department

would be required to select employees in at least three medical centers and seven ambulatory care facilities.

The program would pay up to the full amount of the medical loans for newly licensed physicians and up to $50,000 of loans for current physicians at VA. For this estimate, CBO expects that VA would repay the loans of 50 physicians in each year of the pilot program, and that one-third of the participants would be newly licensed physicians and two-thirds would be established physicians at VA. Based on information from the National Center for Education Statistics and the Association of American Medical Colleges, newly licensed physicians would have an estimated average education loan debt of $170,000 in 2017. For established physicians, CBO expects that VA would reimburse about $40,000 of their student loan debt. After factoring in the growth in costs for higher education, CBO estimates that implementing the pilot program would cost $21 million over the 2018-2022 period.

Coordinated-Care Program. Section 251 would require VA to provide grants to certain public or nonprofit entities. Grant recipients would coordinate wellness care for veterans receiving mental health care from VA. The grantees also would assess the usefulness of coordinating such care and report on that assessment. That program would begin a year after enactment and continue for three years.

Based on VA's implementation of other programs of similar scope (such as using meditation for veterans with post-traumatic stress disorder), CBO expects that VA would award grants to coordinate care at 10 VA medical facilities and that each grant would cover the costs of about four employees to deliver services and analyze and report to the Congress on the results of their efforts. CBO estimates that the average compensation for those employees would be about $120,000 in 2018. In total, after accounting for inflation, CBO estimates the cost to implement the program would be $15 million over the 2018-2022 period.

Pay for Perfusionists. Section 203 would increase the maximum salary for perfusionists employed by VA by exempting them from certain salary limitations. (Perfusionists are medical professionals responsible for operating heart-lung machines during cardiac surgery.) Currently VA employs 28 perfusionists (in the 41 VA medical facilities offering the type of cardiac surgery requiring such services) at an average salary of $101,000. On the basis of information from VA, CBO estimates that implementing this proposal would increase the salary of perfusionists at the department by 18 percent. As a result, CBO also expects that VA would see higher retention and recruitment for this position, resulting in a 20 percent increase in staff—an additional 6 perfusionists by 2022. In total, CBO estimates that implementing this section would cost $5 million over the 2018-2022 period.

Studies, Reports, and Training. S. 2193 would require VA to conduct studies, issue reports, and provide training for staff. Based on the costs of similar activities, CBO estimates that meeting those requirements would cost $10 million over the 2018-2022 period.

- By December 31, 2018, section 302 would require VA to develop and implement an IT system to track and assess data from the Family Caregiver Program. VA reports that it is currently working to enhance its existing IT system for tracking caregivers to allow for an easier application process and for tracking stipend awards and other benefits. As a result, CBO estimates that this requirement would mostly codify existing practice and would have no budgetary effect. However, the provision also includes assessment and reporting requirements that CBO estimates would cost $2 million over the 2018-2022 period.

- Section 104 would require that VA establish benchmark guidelines for access to health care at VA medical facilities. Such guidelines would assist medical providers on whether to refer veterans into the community for health care. The section also would establish quality standards for health care at the department. CBO estimates that this section would cost $1 million over the 2018-2022 period.

- Starting in 2019 and every two years thereafter, section 106 would require that VA conduct market area assessments on the health care services provided by the department. Every four years, this section also would require VA to develop a strategic plan to meet the demand for health care provided by the department. CBO estimates that implementing this section would cost $1 million over the 2018-2022 period.

- Other provisions, including sections 108, 121, 122, 123, 201, 207, and 222 would require periodic reports on education and training programs, personnel, telemedicine, and performance awards and bonuses for employees at VA. Furthermore, section 231 would require VA to develop criteria to assess underserved facilities. In total, CBO estimates that those reports and criteria would cost $6 million over the 2018-2021 period.

Direct Spending

S. 2193 would appropriate funds for the Veterans Choice Program and for health care at VA. In addition, the bill would increase VA's ability to lease medical facilities without subsequent legislative authorization. On that basis, CBO estimates that the legislation would increase direct spending by $5.6 billion over the 2018-2027 period (see Table 3).

Veterans Choice Program. Section 402 would appropriate $4 billion for VCP, which pays for certain veterans to receive health care from participating providers in the private

sector. For fiscal year 2018, VCP has about $4 billion in available funds, which CBO estimates will be completely committed in 2018. Under current law, the program will terminate once its funding is exhausted. CBO expects that enacting this provision would extend the life of VCP through most of 2019. On that basis, CBO estimates that section 402 would increase direct spending by $4 billion over the 2018-2027 period.

TABLE 3. ESTIMATE OF THE EFFECTS ON DIRECT SPENDING OF S. 2193, THE CARING FOR OUR VETERANS ACT OF 2017

	By Fiscal Year, in Millions of Dollars											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018-2022	2018-2027
INCREASES IN DIRECT SPENDING												
Veterans Choice Program												
Budget Authority	4,000	0	0	0	0	0	0	0	0	0	4,000	4,000
Estimated Outlays	500	3,500	0	0	0	0	0	0	0	0	4,000	4,000
Health Professionals Education Assistance Program												
Budget Authority	1,000	0	0	0	0	0	0	0	0	0	1,000	1,000
Estimated Outlays	58	99	145	163	170	178	187	0	0	0	635	1,000
Major Medical Facilities												
Estimated Budget Authority	0	0	0	100	100	100	100	100	100	100	200	700
Estimated Outlays	0	0	0	4	19	49	69	84	94	94	23	413
Shared Medical Facilities												
Estimated Budget Authority	0	0	0	40	40	40	40	40	40	40	80	280
Estimated Outlays	0	0	0	2	8	20	28	34	38	38	10	168
Total Changes in Direct Spending												
Estimated Budget Authority	5,000	0	0	140	140	140	140	140	140	140	5,280	5,980
Estimated Outlays	558	3,599	145	169	197	247	284	118	132	132	4,668	5,581

Health Professionals Education Assistance Program. Section 401 would appropriate $1 billion for reimbursing employees at VA for their professional education. Specifically, the appropriations would be used to increase the number of graduate medical residents at VA (under sections 202 and 203 of this bill), increase bonuses and awards for VA employees (under section 204), and increase the payments for reducing student loan debt for certain VA staff (under section 213). CBO estimates that the appropriated amounts would be sufficient to fund those programs through 2024. Beyond that year, CBO estimates that the increased program costs would continue, subject to appropriation of the necessary amounts. CBO estimates section 401 would increase direct spending by $1 billion over the 2018-2027 period.

Major Medical Facilities. Sections 241 would expand VA's authority to enter into leases for medical facilities. (Provisions also would expand the authority to construct medical facilities, discussed above under the heading "Spending Subject to Appropriation.") In total, CBO estimates that enacting this section would increase direct spending by $413 million over the 2018-2027 period.

VA classifies its contracts for acquiring such facilities as operating leases and thus records its obligations for lease payments on an annual basis over the term of each lease. However, CBO has reviewed several contracts and has concluded that they are akin to government purchases of facilities built specifically for VA's use—but instead of being financed by the Treasury, they rely on third-party financing (that is, funds raised by a nonfederal entity), which is generally more expensive.[2] That conclusion is based on those leases having many of the following key features:

- The facilities are designed and constructed to the unique specifications of the government;
- The facilities are constructed at the request of the federal government;
- The leases on the newly constructed facilities are long term—usually 20 years;
- Payments from the federal government are the only or the primary source of income for the facilities;
- The term of the contractual agreements coincides with the term of the private partner's financing instrument for developing and constructing the facility (that is, a facility financed with a 20-year bond will have a 20-year lease term);
- The federal government commits to make fixed annual payments that are sufficient to service the debt incurred to develop and construct the facility, regardless of whether the agency continues to occupy the facility during the guaranteed term of the lease; and
- The fixed payments over the life of the lease are sufficient to retire the debt for the facility.[3]

2. For more information on the budgetary treatment of third-party financing, see Congressional Budget Office, Third-Party Financing of Federal Projects (June 2005), www.cbo.gov/publication/16554.

3. 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.

Thus, although those transactions are structured as leases, they are essentially government purchases. Under the normal procedures governing the budgetary treatment of the purchase of capital assets, budget authority should be available and obligations should be recorded at the time the acquisitions are initiated, and amounts recorded should equal the full development and construction costs of the medical facilities. Instead, VA records a small fraction of those costs as obligations when it awards the contracts for such transactions.

To the extent that the full costs of developing and constructing the facilities exceeds the relatively small amount that VA would initially record as obligations against its appropriation, CBO treats the legislative authorization for those transactions as contract authority—a type of budget authority that allows an agency to enter into a contract and incur an obligation before receiving an appropriation for those activities. Because the contract authority would be provided in an authorizing bill, rather than in an appropriation act, the resulting spending is categorized as direct spending (as distinguished from discretionary spending, which results from appropriation acts). In addition, at the time the contracts are signed, VA typically obligates some amounts from available appropriations; those costs are considered discretionary.

Section 241 would allow VA to enter into leases without legislative authorization for medical facilities with annual lease payments of up to $1.5 million. Under current law, VA must receive legislative authorization to lease medical facilities with annual rent payments in excess of $1 million.

After reviewing VA's 2018 budget request for leases of medical facilities, CBO estimates that enacting this provision would allow VA to enter into six additional leases, on average, each year. In total, the annual rent payments for those leases would be about $7 million. CBO expects that the initial contracts for those facilities would be entered into starting in 2021 and that similar contracts would be signed each year thereafter.

When the government leases a facility the lessor charges the government for the cost to construct the facility plus interest on those costs over the period it takes to recover them through the lease payments. CBO's estimate of direct spending reflects an amount equal to the cost of constructing the facilities, plus the net present value of the portion of lease costs attributable to interest rates that would exceed U.S. Treasury interest rates. (Borrowing costs equivalent to the amount of Treasury interest that would be paid if the equipment was financed with appropriated funds are not included in our estimate because, for the enforcement of Congressional budget rules, changes in Treasury interest costs are not counted as a cost or savings related to any particular legislative provision.) CBO's estimate of outlays reflects its judgment as to when the facilities would be provided—typically over a six-year period.

On that present value basis for each lease over the term of the lease agreement, CBO estimates that enacting this provision would increase direct spending by $413 million over the 2021-2027 period.[4]

Shared Medical Facilities. Section 242 would allow VA to enter into sharing agreements with other federal agencies to lease medical facilities. VA's portion of the annual rent payments for leased medical facilities could be lowered by enough that some leases would no longer require legislative authorization. Using information from VA, CBO estimates that, on average, this section would allow construction of one medical facility each year with an average annual rent payment of $3 million. CBO expects that VA would enter into the first such contract in 2021 and that similar contracts would take effect each year thereafter. On a present value basis for each lease over the term of the lease agreement, CBO estimates that enacting this section would increase direct spending by $168 million over the 2021-2027 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in Table 4.

TABLE 4. CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS OF S. 2193, THE CARING FOR OUR VETERANS ACT OF 2017, AS ORDERED REPORTED BY THE SENATE COMMITTEE ON VETERANS' AFFAIRS ON NOVEMBER 29, 2017

	By Fiscal Year, in Millions of Dollars											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018-2022	2018-2027
NET INCREASE IN THE ON-BUDGET DEFICIT												
Statutory Pay-As-You-Go Impact	558	3,599	145	169	197	247	284	118	132	132	4,668	5,581

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting the draft bill would not increase net direct spending or on-budget deficits by more than $2.5 billion in any of the four consecutive 10-year periods beginning in 2028.

4. A present value is a single number that expresses a flow of past and future income or payments in terms of an equivalent lump sum received or paid today. The value depends on the rate of interest, known as the discount rate, used to translate past and future cash flows into current dollars. CBO calculated costs for the 20-year leases by discounting the expected annual rent payments using the rate on Treasury securities of comparable maturity.

MANDATES

S. 2193 would impose an intergovernmental mandate as defined in UMRA by preempting state laws that prohibit VA physicians from practicing telemedicine to treat veterans across state lines. Although it would limit the application of state regulations, the bill would impose no duty on state governments that would result in additional spending or any significant loss of revenues.

The bill contains no private-sector mandates as defined in UMRA.

PREVIOUS CBO ESTIMATES

On November 13, 2017, CBO transmitted a cost estimate for H.R. 4243, the VA Asset and Infrastructure Review Act of 2017, as ordered reported by the House Committee on Veterans' Affairs on November 8, 2017. Sections 201 and 204 in H.R. 4243 are similar to sections 241 and 242 of S. 2193 and the estimated costs for both sections are the same. On November 8, 2017, CBO transmitted a cost estimate for H.R. 1133, the Veterans Transplant Coverage Act of 2017, as ordered reported by the House Committee on Veterans' Affairs on July 19, 2017. H.R. 1133 is similar to section 252 of S. 2193 and the estimated costs are the same.

On July 24, 2017, CBO transmitted a cost estimate for H.R. 1058, the VA Provider Equity Act, as ordered reported by the House Committee on Veterans' Affairs on July 19, 2017. The language in H.R. 1058 that affects podiatrists is similar to section 202 of S. 2193 and the estimated costs are the same.

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