

# CBO

## Possible Higher Spending Paths for Veterans' Benefits



DECEMBER 2018

## At a Glance

The Department of Veterans Affairs (VA) administers a variety of programs for veterans and their families. VA spent \$180 billion on those benefits in 2017, nearly triple what it spent in 2000 after removing the effects of inflation. (Spending was higher in 2018; however, the Congressional Budget Office's analysis focused on 2017, because it lacked information to provide a detailed breakdown of VA's 2018 spending.) The two largest programs, VA's disability compensation and medical care programs, accounted for most of that growth. CBO briefly examined VA's past growth in spending and projected VA's spending through 2028 under three scenarios. (All spending amounts discussed here are in 2018 dollars.)

**Past Growth in Spending.** Between 1970 and 2017, VA's spending grew significantly faster than inflation; growth accelerated after 2000, averaging more than 6 percent annually above the rate of inflation through 2017.

- Spending on disability compensation to veterans grew from \$22 billion in 2000 to \$73 billion in 2017, an average annual increase of 7.5 percent.
- Medical care spending grew from \$27 billion in 2000 to \$69 billion in 2017, an average annual increase of 5.7 percent.
- The number of beneficiaries and the spending per beneficiary grew substantially for both programs after 2000, despite an overall decline in the number of veterans.

**Possible Future Growth in Spending.** The scenarios CBO analyzes in this report capture some possible trajectories for VA's future spending—a modified version of CBO's baseline projection and two scenarios that could result in more spending. (VA's spending could also be less than projected in the modified baseline; however, because of Congressional concern about budgetary risks, this report focuses on possible higher spending paths.) Although the growth in VA's spending would exceed the rate of inflation under all three scenarios, the growth in total spending would still be slower than VA has experienced in recent years—in part because the number of beneficiaries for the largest programs is projected to stay about the same or rise more slowly than in the past.

- Scenario 1 matches CBO's baseline projection for VA, modified to incorporate additional appropriations provided in the 2018 VA MISSION Act, which was enacted after the baseline was completed. Spending would grow by nearly 20 percent from 2017 to 2028, from \$180 billion to \$215 billion—an annual increase 1.6 percent above the rate of inflation.
- Scenario 2 is the same as Scenario 1 except that it assumes larger appropriations for medical care—extending VA's current policies for medical care spending and incorporating the projected spending required to implement the VA MISSION Act. It accounts for changes in enrollment, medical care spending, and other factors. Under Scenario 2, VA's spending could grow by about one-third, to \$238 billion in 2028—an average annual rate of 2.6 percent.
- Under Scenario 3, spending per beneficiary for the disability compensation and medical care programs would be greater than that in Scenario 2, growing at rates similar to those experienced over the past decade. In total, VA's spending would grow by just over 50 percent over the 2017–2028 period, to \$272 billion in 2028. That increase represents the highest growth of the scenarios considered here, an average annual rate of 3.8 percent.



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## Notes

Unless otherwise specified, all years referred to in this report are federal fiscal years, which run from October 1 to September 30 and are designated by the calendar year in which they end.

Unless otherwise specified, all spending amounts are reported in 2018 dollars. Amounts are adjusted to remove the effects of inflation using the gross domestic product price index, with values of that index for 2018 through 2028 projected by the Congressional Budget Office.

This report uses the term spending to refer to net outlays, which are outlays offset by payments such as deductibles or copayments. Net outlays may stem from obligations (a legal liability to disburse funds) incurred in a prior fiscal year or in the current year.

Unless otherwise specified, spending in a fiscal year is normalized to 12 monthly payments to veterans and their families. The number of payments in a fiscal year can vary depending on whether October 1 falls on a weekend, in which case certain payments scheduled for that date are made in September.

Numbers in the text and tables may not add up to totals because of rounding.

On the cover: Government and military leaders and guests attend the National Veterans Day Observance at Arlington National Cemetery, Arlington, Virginia, on November 11, 2018. Photo courtesy of the Department of Defense.

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# Possible Higher Spending Paths for Veterans' Benefits

## Summary

The Department of Veterans Affairs (VA) administers programs to aid former members of the armed forces and their families. By far the largest share of its budget is spent on two programs, one that pays compensation to veterans who have service-connected disabilities and one that provides medical care to veterans. VA's spending (adjusted to remove the effects of inflation) has grown rapidly—from \$64 billion, or 2.6 percent of all federal spending, in 2000 to \$180 billion, or 4.4 percent of spending, in 2017.<sup>1</sup> (The Congressional Budget Office estimates that spending was \$187 billion in 2018; however, CBO's analysis focused on 2017, because it lacked information required to provide a detailed analysis of VA's 2018 spending.) That large increase has prompted concerns about the long-run affordability of VA benefits, particularly if their cost continues to increase at the same rate as in recent years.

To help policymakers assess the risks associated with increased costs, CBO has projected VA's spending through 2028 under three different scenarios—a version of CBO's baseline (modified to reflect the effects on mandatory spending of recent legislation) and two alternative scenarios involving more rapid growth.<sup>2</sup> CBO's baseline budget projections are based on an assumption that current laws will generally remain in place. Under the rules for constructing the baseline, CBO assumes that VA's spending for disability compensation will increase as needed to comply with laws governing the program and that appropriations for VA's medical

care will increase at the rate of inflation in the general economy. In the other two scenarios, CBO relaxes the constraints governing the baseline. Instead, CBO extends VA's current policies for medical care, thereby assuming increases in discretionary appropriations that are greater than the rate of inflation; and in one of the scenarios, projects growth in both per-beneficiary medical care and disability compensation on the basis of VA's experience from 2008 to 2017. CBO also incorporates into those two scenarios the effects of recent legislation on discretionary spending.

In the modified baseline, VA's spending increases by nearly 20 percent (in 2018 dollars) from 2017 to 2028. Under the two higher-growth scenarios, VA's spending is projected to increase by about 33 percent or by just over 50 percent over that period. It could be higher or lower under other scenarios.

## How Much Does VA Spend on Care for Veterans?

Of the \$180 billion VA spent in 2017, the department paid disability compensation of \$73 billion to 4.5 million veterans with service-connected disabilities. VA spent a little less, \$69 billion, on medical care for more than 6 million veteran patients and medical research. Substantially less, \$14 billion, was spent on the next largest set of programs, which provide education and vocational rehabilitation benefits for about 1 million veterans and their dependents, and the remainder paid for other programs and administrative costs.

Between 1970 and 2017, VA's spending grew significantly faster than economywide inflation, even as the number of veterans waned. Growth was fastest in the years after 2000, averaging more than 6 percent annually above the rate of inflation. As a result, VA's spending nearly tripled between 2000 and 2017.

1. Unless otherwise specified, spending in a fiscal year is normalized to 12 monthly payments to veterans and their families. The number of payments in a fiscal year can vary depending on whether October 1 falls on a weekend, in which case certain payments scheduled for that date are made in September. Such timing shifts occurred in 2016, 2017, and 2018.
2. Mandatory spending is generally governed by provisions of permanent law, whereas discretionary spending is controlled by annual appropriation acts.

### How Will the Recent Legislation Expanding Access to Medical Services Affect VA's Spending?

In June 2018, lawmakers enacted the VA MISSION Act, which among other things increases veterans' access to VA's medical services and expands support to veterans' families. The law will affect discretionary and mandatory spending. CBO estimates that implementing the law will cost \$46.5 billion (or \$43.1 billion in 2018 dollars) through 2023 in discretionary spending, assuming that the Congress appropriates the necessary amounts each year. One provision expands veterans' access to medical care at non-VA medical providers and facilities. That new community care program will cost \$21.4 billion (\$19.9 billion in 2018 dollars) in discretionary funding over the next five years, CBO estimates.

The law also provided \$5.2 billion in mandatory funding for the Veterans Choice Program, a separate community care program enacted in 2014 and set to expire after all of its funds have been used. (CBO's cost estimate for the VA MISSION Act, H.R. 5674, which was enacted as S. 2372, provides details about the law's provisions and projected spending required to implement them.)

### How Might VA's Spending Grow Over the Next Decade?

The scenarios CBO analyzes in this report capture some possible trajectories for VA's future spending—CBO's modified baseline and two alternative scenarios involving more rapid growth. VA's spending could also be less than projected in the modified baseline; however, because of Congressional concern about budgetary risks, this report focuses on developments that could result in higher spending paths.

Although the growth in VA's total spending would exceed the rate of inflation under all three scenarios, the growth in total spending would still be slower than VA has experienced in recent years—in part because the number of beneficiaries for the largest programs is projected to stay about the same or rise more slowly than in the past.

**Scenario 1.** The first scenario is CBO's baseline projection, which the agency constructs using rules specified in law, modified to incorporate the mandatory funding provided in the VA MISSION Act. For discretionary programs—such as those for most of VA's medical spending—the baseline projects that future appropriations will equal the most recent appropriation, increasing only at the rate of inflation in the general economy. For

mandatory spending—which includes disability compensation—CBO's baseline projects that funding will be adequate to make all payments required by current laws. Therefore, to estimate mandatory spending, CBO uses detailed information on the eligibility and benefits established by those laws, the projected size of the veteran population, and other factors. For this scenario, CBO modified its most recently published baseline (from April 2018) to incorporate the mandatory funding for 2018 that was provided in the MISSION Act but did not incorporate its estimates of the discretionary costs of the law because the Congress did not provide any discretionary appropriations in the law.

Under Scenario 1, VA's total spending would grow by 19 percent, from \$180 billion in 2017 to \$215 billion in 2028 (in 2018 dollars; see Figure 1 and Table 1). The estimated average annual rate of growth of 1.6 percent over the 2017–2028 period would be substantially slower than the 5.5 percent rate that VA experienced between 2010 and 2017.

**Scenario 2.** The baseline's assumption that medical care appropriations would not grow faster than inflation does not accord with historical experience, suggesting a second scenario. Scenario 2 follows Scenario 1 except that VA's medical spending rises on the basis of current policies governing its programs and services (such as eligibility for care). To that end, CBO uses detailed enrollment information, the projected per-capita growth in medical costs in the general economy, and other data to project the costs of providing medical care to veterans. Scenario 2 also incorporates the discretionary spending that CBO projects will be needed under the VA Mission Act from 2019 to 2023, as provided in CBO's cost estimate for that legislation, and extends those estimates through 2028.

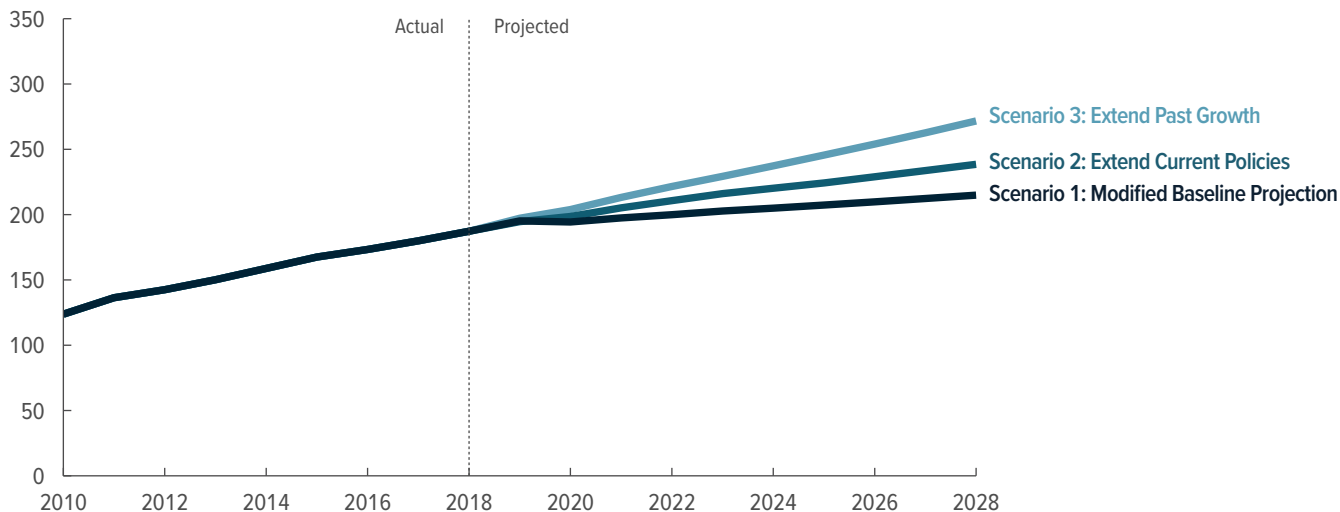
Under Scenario 2, VA's spending would grow by about one-third, from \$180 billion in 2017 to \$238 billion in 2028, an average annual increase of 2.6 percent above the rate of inflation. That rate is roughly 60 percent higher than that for Scenario 1 but a little less than half the rate of growth that VA experienced between 2010 and 2017.

**Scenario 3.** Because policies for the disability compensation and medical care programs have not remained constant over the past several years, CBO considered a third scenario. Under Scenario 3, spending per beneficiary for

Figure 1.

### Some Possible Higher Spending Paths for VA Through 2028

Billions of 2018 Dollars



Source: Congressional Budget Office.

Spending reflects net outlays and is adjusted for the number of monthly benefit payments (which can vary from 11 to 13) in a fiscal year. Because 11 payments were made in 2018, actual outlays for that year were about \$8 billion less than shown above.

CBO's modified baseline budget projection is based on the April 2018 baseline, adjusted to include appropriated spending for the VA MISSION Act of 2018. The baseline's starting point includes advance appropriations for 2019 for VA's discretionary medical care accounts and 2018 appropriations for VA's other discretionary accounts.

VA = Department of Veterans Affairs.

disability compensation and medical care would grow at rates that reflect VA's experience over the past 10 years: growth that incorporates, in part, VA's spending arising from government actions, changes in the economy, and world events. In effect, Scenario 3 reflects a path in which lawmakers, VA, or the courts take new actions—or changes occur in the health insurance market or the economy—that boost VA's spending and cause it to rise at the same rate as has occurred over the past 10 years. Any of those changes could occur in combination with others. For disability compensation, that historical rate of growth in spending per beneficiary is applied to each year of the projection period. For medical care, Scenario 3 is the same as Scenario 2 while the MISSION Act is being implemented (over the 2019–2023 period); for years after 2023, CBO applied the historical rate of increase in spending per beneficiary.

Under Scenario 3, spending would grow by just over 50 percent, from \$180 billion in 2017 to \$272 billion by 2028 (in 2018 dollars). That increase would represent an average annual rate of growth of 3.8 percent, which

is nearly 2.5 times the average annual rate of growth in Scenario 1—yet it is about 30 percent lower than the annual growth that VA experienced from 2010 to 2017.

### An Overview of VA's Benefits

This report focuses on VA's disability compensation and medical care programs, but VA also provides a variety of other benefits to aid veterans and their families.<sup>3</sup> Among them, the department offers education and vocational rehabilitation assistance; provides pensions to low-income veterans and benefits for surviving spouses and dependent children; provides life insurance; guarantees home loans to veterans; and manages veterans'

3. Basic eligibility for VA's benefits varies by program. Most programs set minimum active-duty requirements (such as length of active duty service and the nature of service). For example, to be eligible for VA medical care, veterans generally must have served 24 continuous months or the full period for which they were called to active duty, and left the military in any manner other than a dishonorable discharge. However, in addition to the basic eligibility rules, VA may also consider other factors, such as current income and time since discharge from the military, in providing specific benefits to veterans and their families.

Table 1.

**VA's Spending in 2028 Under Alternative Scenarios**

Billions of 2018 Dollars

	<b>Scenario 1: Modified Baseline Projection</b>	<b>Scenario 2: Extend Current Policies</b>	<b>Scenario 3: Extend Past Growth</b>
Disability Compensation	92	92	122
Medical Care	78	102	105
Education and Vocational Programs <sup>a</sup>	17	17	17
Other Spending	28	28	28
Total VA Spending	215	238	272
<b>Memorandum:</b>			
Percentage Change, 2017–2028	19	33	51

Source: Congressional Budget Office.

Spending reflects net outlays and is adjusted for the number of monthly benefit payments (which can vary from 11 to 13) in a fiscal year. Because 11 payments were made in 2018, actual outlays for that year were about \$8 billion less than shown above.

CBO's modified baseline budget projection is based on the April 2018 baseline, adjusted to include appropriated spending for the VA MISSION Act of 2018. The baseline's starting point includes advance appropriations for 2019 for VA's discretionary medical care accounts and 2018 appropriations for VA's other discretionary accounts.

VA = Department of Veterans Affairs.

a. Scenarios 2 and 3 incorporate the baseline projection for spending on education and other programs.

cemeteries. (The Department of Defense offers additional benefits, primarily to veterans who retired from military service or left service because of a qualifying medical disability.)

**Disability Compensation**

Disability compensation, one of VA's largest programs, provides payments to veterans with medical conditions or injuries that were incurred or aggravated during active-duty military service (service-connected disabilities). The conditions of veterans who receive such compensation vary widely, from tinnitus (ringing in the ears) to post-traumatic stress disorder, hypertension, or lost limbs. The amount of the base payment is linked to the composite disability rating that VA assigns the veteran. That rating is expressed from zero to 100 percent in increments of 10.<sup>4</sup> The rating for any individual condition is linked to the clinical severity of that veteran's condition; higher composite ratings generally reflect a greater number of disabilities or more severe disabilities

and are compensated at higher rates.<sup>5</sup> In calendar year 2018, base payments ranged from about \$135 per month for a 10 percent rating to about \$2,975 per month for a 100 percent rating. Some veterans receive supplemental benefits in addition to the base payment. Unlike some federal and private-sector disability programs, the employment status, earnings, ability to work, and age of the veteran are not factored into the disability rating and subsequent base payment. Payments usually continue for the duration of the veteran's life.

**Medical Care**

Medical care, the other major component of VA's services, includes hospital care, outpatient primary and specialty care, counseling services, rehabilitation and prosthetic care, diagnostic tests, prescriptions, and assistive devices such as prescription glasses, hearing aids and

4. The composite rating is not created by adding up the disability ratings for each physical or mental condition that VA determines is service-connected but rather is a nonlinear combination of ratings.

5. A rating of zero (not generally compensated) may be assigned for a condition that is not considered disabling, such as a small scar or minor limitation in the motion of a thumb. Impairments rated at 60 percent are considered significant; a rating of 100 percent is assigned to conditions that VA considers completely disabling, such as multiple amputations or chronic congestive heart failure. The same medical condition may be rated differently depending on its severity. For example, diabetes may be rated from 10 percent (controlled by diet) to 100 percent (multiple hospitalizations and other complications).



supplies, and mobility assistance. Most of those services or products are delivered at VA's facilities at little or no cost to the veterans. VA operates a network of about 170 medical centers as well as more than 1,000 outpatient clinics, rehabilitation facilities, and nursing homes. To facilitate access to medical care, some veterans receive reimbursement for travel to VA facilities; others receive care from private medical professionals in their communities that is paid for by VA. (The MISSION Act is expected to increase the amount of such care.) Beyond medical services, VA's medical care funding supports services and stipends for veterans' caregivers and initiatives such as efforts to reduce homelessness among veterans.

Most veterans are eligible for VA's medical care but must enroll to receive treatment. Veterans are assigned to one of eight priority groups based on their service-connected disabilities, income, combat status, and other factors when they apply.<sup>6</sup> VA determines how many priority groups it can serve with the funding approved by the Congress. Veterans in the lowest-priority groups would be the first to be denied service. Currently, new enrollment in priority group 8, which includes higher-income veterans without compensable service-connected disabilities, is restricted, and as a result some veterans who would be assigned to that group are not eligible to enroll. Although most veterans are neither disabled nor lower-income (as determined by VA), roughly two-thirds of VA's enrollees are assigned to priority groups that include service-connected disabled veterans (priority groups 1 through 3) or lower-income veterans (priority group 5).

### Education and Vocational Benefits

VA also offers a number of education and vocational rehabilitation or training benefits to veterans. Those benefits are often referred to as readjustment benefits because they are intended to ease the transition from military to civilian employment. Education is the

largest readjustment benefit. Today, most veterans who use education benefits do so through the Post-9/11 GI Bill, which went into effect August 1, 2009. The Post-9/11 GI Bill provides education and related benefits to veterans who served on or after September 11, 2001, as well as to certain service members and qualifying spouses and dependents. Generally, to be eligible for full benefits, an individual must have served on active duty for three years; veterans may be eligible for partial benefits sooner. VA pays tuition and fees for up to four years at public colleges and universities at the in-state rate, or up to about \$23,000 in the 2017–2018 academic year for a private school. For students enrolled more than half time, a monthly housing allowance may also be provided. (Veterans also use other education programs, including the usually less-generous Montgomery GI Bill; their eligibility for a specific program depends in part on the date and length of their previous active-duty service.) VA also offers job counseling, training, and adaptive aids or grants to certain veterans with service-connected disabilities.

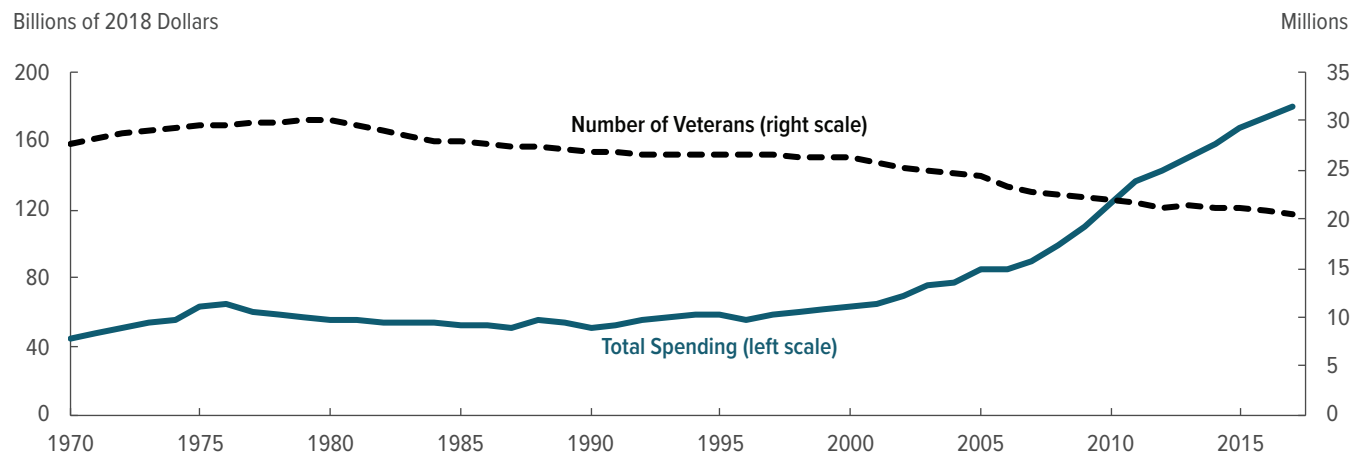
### Long-Term Trends in VA's Total Spending and Major Programs

Between 1970 and 2017, VA's total spending grew significantly faster than the rate of inflation (see Figure 2). VA spent about \$180 billion, or more than 4 percent of total federal outlays, in 2017. That is more than four times as much as the \$45 billion VA spent in 1970. (All amounts are in 2018 dollars.) Spending increased by about 40 percent, to \$64 billion, in 2000 and then accelerated—nearly tripling between 2000 and 2017. Over that period, annual increases averaged more than 6 percent above the rate of inflation. The growth of VA spending has slowed somewhat since 2010 but remains substantially higher than inflation in the general economy.

The increase in VA's spending is particularly noteworthy because the number of veterans, which grew from about 28 million in 1970 to 30 million in 1980, has declined in the decades since then to about 21 million in 2017. In short, VA is spending more to provide benefits for each veteran. Moreover, that growth has accelerated in recent decades. The agency's total spending per veteran (in 2018 dollars) rose from about \$1,600 in 1970 to about \$2,400 in 2000, an increase of about 50 percent over 30 years. That figure tripled over the following 17 years, reaching about \$8,800 in 2017. The higher cost of those veterans' benefits can be partly explained by the fact that

6. The highest priority groups, priority groups 1 to 3, primarily include veterans who have service-connected disabilities. Priority group 4 consists of veterans who receive aid and attendance benefits, are housebound, or are catastrophically disabled. Priority group 5 contains lower-income veterans. Priority group 6 includes special populations of veterans, including most Gulf War II veterans when they first enroll. The lowest priority groups, 7 and 8, include higher-income veterans without compensable service-connected disabilities. For a fuller description of the enrollment groups and criteria, see Department of Veterans Affairs, "VA Health Care Enrollment and Eligibility" (Accessed April 2, 2018), <https://go.usa.gov/xPktT>.

Figure 2.

**Spending on Veterans' Benefits Compared With the Number of Veterans, 1970 to 2017**

Source: Congressional Budget Office, using data from the Department of Veterans Affairs and the Current Population Survey.

Spending reflects net outlays. Data for 1970 to 1999 are not adjusted for the number of monthly payments in a fiscal year (which can vary from 11 to 13). Thereafter, data are adjusted for the timing of payments.

VA = Department of Veterans Affairs.

veterans, on average, are growing older—and health generally deteriorates as people age. The average age of veterans increased from 44 in 1970 to 60 in 2017 as the veterans of previous major wars aged—most Vietnam veterans are now older than 65—and the size of the military forces declined.

Because the disability compensation and medical care programs comprise the bulk of VA's budget, growth in those programs has had the largest effects on the agency's spending. Since 1970, those programs have experienced considerable growth, which has accelerated over the past two decades (see Figure 3). The costs per beneficiary and the number of beneficiaries have increased substantially for both programs despite the shrinking pool of veterans.<sup>7</sup>

### Trends in Disability Compensation

From 2000 through 2017, total payments to veterans for service-connected disabilities more than tripled. Measured in 2018 dollars, spending increased from \$22 billion in 2000 to \$73 billion in 2017 (see Table 2).<sup>8</sup>

**Number of Beneficiaries.** In 2017, some 4.5 million veterans received disability compensation, about twice the number of beneficiaries in 2000. That rise was caused by annual increases in the number of new veterans receiving compensation. In 2000, new recipients totaled 85,000. The figure peaked at 315,000 in 2015 and has since receded slightly to 295,000 in 2017. The share of veterans who receive disability payments grew from 9 percent of the veteran population in 2000 to 22 percent in 2017.

The increase in disability recipients is concentrated among veterans who left military service after September 11, 2001 (often referred to as veterans of the Gulf War II era). Of the 4 million Gulf War II veterans, CBO estimates that roughly 1.5 million received disability payments in 2017—about 35 percent of that group's total population, which is a much higher rate of receipt than that observed in previous eras. Combat veterans are fueling that rise, but non-combat veterans also have higher rates of service-connected disability than were seen in previous generations.

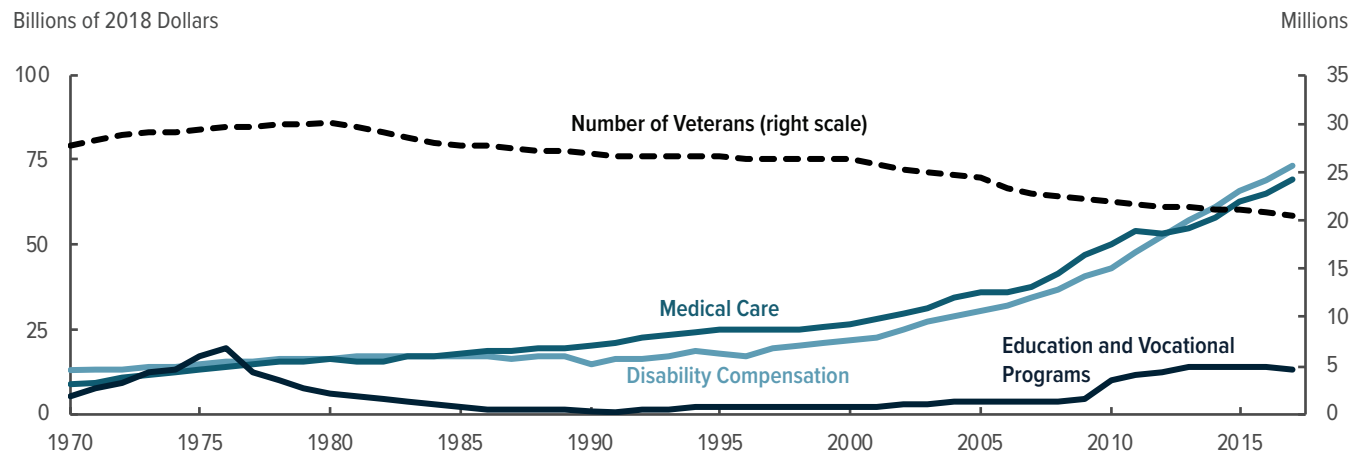
7. For the disability compensation program, beneficiary refers to a veteran who receives payments for VA-determined service-connected disabilities; for the medical care program, beneficiary refers to a veteran who is enrolled in the program, whether or not he or she receives care in a given year.

8. In this report, spending on service-connected disabilities includes recurring and nonrecurring payments from VA to veterans for

those disabilities. It excludes administrative costs and spending on information technology systems (IT). In 2017, general operating expenses for the Veterans Benefits Administration (VBA), which primarily administers VA's financial programs, were \$3 billion; for all of VA, more than \$4 billion was spent on IT. In 2005, IT spending was consolidated from individual program accounts, including medical care accounts.

Figure 3.

**VA's Spending on Major Programs Compared With the Number of Veterans, 1970 to 2017**



Source: Congressional Budget Office, using data from the Department of Veterans Affairs, Census Bureau, and Bureau of Labor Statistics.

Spending reflects net outlays. Data for 1970 to 1999 are not adjusted for the number of monthly payments in a fiscal year (which can vary from 11 to 13). Thereafter, data are adjusted for the timing of payments.

Spending on disability compensation includes recurring and nonrecurring payments from VA to veterans for those disabilities. It excludes administrative costs and information technology (IT) spending. In 2017, VA's Veterans Benefits Administration spent about \$3 billion on general operating expenses; across all of VA, IT spending comprised more than \$4 billion.

Spending on medical care includes outlays from discretionary medical care accounts (medical support and compliance, medical services, medical facilities, and medical community care) and the medical and prosthetic research account. That spending is offset by reimbursements to VA from third parties for medical care, which totaled about \$3.5 billion in 2017. Also included are care for nonveterans, which cost VA about \$2 billion in 2017 and outlays from mandatory funding provided in the VA Choice Act and in subsequent legislation that extended the Veterans' Choice Program. Spending to build VA medical facilities is not included.

Spending on education and vocational programs includes payments to beneficiaries—veterans, their family members, and some active-duty service members. It includes offsets to those accounts from contributions made by current service members (\$150 million in 2017), but not intragovernmental transfers, administrative costs, or IT spending associated with the programs.

Other spending (not shown) includes programs such as pensions, housing guarantees and life insurance, contributions from the Department of Defense, service members, and others for various benefit programs, and departmentwide expenses such as IT. In 2006, VA recategorized spending on IT from the medical care and other accounts into its own separate account.

VA = Department of Veterans Affairs.

Moreover, the number of veterans of previous eras who receive disability compensation has increased, particularly among Vietnam veterans. In 2017, they accounted for 1.4 million recipients—an additional 650,000 people, or 90 percent increase, since 2000. About 20 percent of all Vietnam veterans received disability payments in 2017, compared with about 10 percent in 2000.

The aging of the covered population and corresponding increase in their health needs are only some of the reasons the number of disability recipients has grown. An increase in combat-related medical conditions is another factor. However, policy changes since 2000 have probably also had a substantial impact on VA's spending

growth. Those policy changes include more outreach by VA to inform veterans of their postmilitary benefits; a streamlined application process for service members leaving the military that has probably resulted in more veterans receiving benefits sooner; and the designation of several medical conditions, primarily certain health problems related to the use of Agent Orange defoliant, as presumptive for certain Vietnam veterans (that is, VA presumes those conditions were caused by veterans' military service, so veterans with any of the conditions need not prove the condition is attributable to their service).

**Spending per Beneficiary.** Not only has the number of veterans receiving disability compensation nearly

Table 2.

**VA's Spending per Recipient for Major Programs, 2000 to 2017**

	2000	2010	2017	Average Annual Rate of Growth (Percent)	
				2000–2010	2010–2017
<b>Disability Compensation</b>					
Total spending (Billions of 2018 dollars)	22	43	73	7.2	7.8
Recipients (Millions)	2.3	3.1	4.5	3.2	5.1
Spending per beneficiary (2018 dollars)	9,400	13,800	16,500	3.9	2.6
<b>Medical Care</b>					
Total spending (Billions of 2018 dollars)	27	50	69	6.4	4.7
Recipients (Millions)	5.1	8.2	9.1	4.8	1.6
Spending per beneficiary (2018 dollars)	5,300	6,200	7,600	1.5	3.1
<b>Education and Vocational Programs</b>					
Total spending (Billions of 2018 dollars)	2	10	14	16.8	4.8
Recipients (Millions)	0.5	0.9	1.1	7.1	2.8
Spending per beneficiary (2018 dollars)	4,600	10,900	12,600	9.1	2.1
<b>Memorandum:</b>					
Total VA Spending (Billions of 2018 dollars) <sup>a</sup>	64	124	180	6.9	5.5

Source: Congressional Budget Office.

Spending reflects net outlays and is adjusted for the number of monthly benefit payments (which can vary from 11 to 13) in a fiscal year. Because 13 payments were made in 2000, actual outlays for that year were about \$3 billion more than shown above.

Spending for medical care includes outlays from mandatory funding provided in the VA Choice Act of 2014 and in subsequent legislation that extended the Veterans' Choice Program.

VA = Department of Veterans Affairs.

a. Includes spending on other programs not listed here.

doubled since 2000, but the average cost of disability compensation per beneficiary has also increased by about 75 percent after adjusting for inflation. That represents an average increase of 3.4 percent annually, from \$9,400 in 2000 to \$16,500 in 2017. (All costs are expressed in 2018 dollars and rates of growth are calculated after removing the effects of inflation.) That increase is partly attributable to the growing number of service-connected conditions per veteran (which climbed, on average, from 2.5 in 2000 to 5.1 in 2017) and the resulting rise in the average disability rating (from 33 percent in 2000 to 51 percent in 2017). Although both the average rating and the average benefit have increased for veterans of all eras, a disproportionate share is caused by the influx of Gulf War II veterans, particularly combat veterans. (In 2017, those combat veterans had an average of 7.6 disabilities and an average disability rating of 59 percent.) As a result, the average payment to Gulf War II veterans is higher than the average payments to Korean War and World War II veterans,

and those Gulf War II payments are rising faster than the other payments as well.

For veterans of all eras, spending per beneficiary grew for some of the same reasons that the number of beneficiaries increased: The population has aged and some policy changes have made it easier to both navigate the system and receive benefits. For instance, Vietnam veterans' medical conditions probably worsened or new conditions developed as they entered their 50s and 60s. Consequently, many of those veterans requested reevaluations of their disability rating. In 2017, VA increased the disability ratings of about 290,000 veterans (or 6.5 percent of compensated beneficiaries).

### Trends in Medical Care

From 2000 through 2017, VA's net spending on medical care (measured in 2018 dollars) more than

doubled—rising from \$27 billion to \$69 billion (see Table 2).<sup>9</sup> Net outlays for that care increased at an average annual rate of 6.4 percent between 2000 and 2010, after removing the effects of inflation. Since then, the pace of growth has slowed to an average of 4.7 percent annually. A continued rise in costs is a potential challenge for future federal budgets, particularly since current spending reflects only a fraction of the potential costs the agency could incur if all eligible veterans enrolled and sought all of their care from VA.

**Number of Beneficiaries.** In 1996, VA received statutory authority to offer medical care to all veterans to the extent that resources and facilities were available. VA also rapidly moved to increase outpatient services by adding outpatient facilities as well as new types of services. As a result, enrollment grew quickly. In 2000 (the year in which VA's enrollment system became fully operational), enrollment stood at 5.1 million. It reached 7.0 million in 2003, an average annual rate of growth of 11 percent over that three-year period. However, VA lacked the funding to treat more patients at that point, so it restricted the ability of higher-income veterans to enroll in VA's system. Enrollment grew at a slower pace thereafter, rising to 9.1 million by 2017. The share of veterans who enrolled in the VA system also grew sharply, from 20 percent to 46 percent between 2000 and 2017. The number of enrolled veterans who sought treatment grew at a similar pace: 3.5 million veterans were treated in 2000, 4.5 million in 2003, and 6.1 million in 2017. (In any year, the number of enrollees is larger than the number of patients: About one-third of enrollees do not seek treatment from VA in a given year.)

Between 2000 and 2017, enrollment grew in most of the VA's priority groups.<sup>10</sup> The number of veterans with service-connected disabilities (priority groups 1 to 3) more than doubled, from 1.8 million in 2000 to 4.4 million in 2017. The number of those rated 50 percent disabled or higher (priority group 1) tripled. The number of enrolled veterans with higher incomes (priority group 8) nearly doubled to about 1.7 million, partly because some new applicants from that group enrolled, primarily in the early 2000s, and partly because some eligible veterans from other priority groups were reassigned to group 8 (for example, because their income increased).

Gulf War II combat veterans enrolled at higher rates than veterans of other eras: About 1.6 million of those Gulf War II combat veterans signed up, more than half of that population. (More than 600,000 of those veterans are rated at least 50 percent disabled, thus contributing to the enrollment growth in priority group 1.) The higher enrollment of Gulf War II veterans is explained in part because VA expanded its outreach programs to service members leaving the military, and also because special eligibility was extended to those veterans. The aging of the Vietnam-era population also contributed to the rise in overall enrollment, because the health of those enrollees probably deteriorated when they entered their 50s and 60s. Some of those veterans had been eligible but had not previously enrolled with VA. Others became newly eligible for VA medical care once they began receiving disability compensation, possibly because of VA's declaration of new presumptive conditions associated with service in Vietnam.

**Spending per Beneficiary.** Since 2000, medical spending per enrollee has increased substantially, from \$5,300 in 2000 to \$7,600 in 2017 (in 2018 dollars). Between 2000 and 2010, average annual spending per enrollee grew by 1.5 percent more than the rate of inflation. Thereafter, that difference doubled to 3.1 percent. However, the increase was uneven. Expenditures per enrollee fell briefly after 2000 (by about 15 percent through 2003), as healthier veterans enrolled and used more of the newly available outpatient services rather than inpatient care. After 2003, spending per enrollee began to rise again, in part because the mix of enrollees shifted to higher-cost priority groups. Rising costs for health care in the general

9. In this report, spending on medical care includes outlays from the four discretionary medical care accounts (medical support and compliance, medical services, medical facilities, and medical community care) and the medical and prosthetic research account. It also nets out payments that offset spending, such as reimbursements to VA from third parties for medical care, which totaled about \$3.5 billion in 2017. Spending on nonveterans, which equaled about \$2 billion in 2017, is also included. VA medical care spending also includes outlays from mandatory funding provided in the VA Choice Act, and from subsequent legislation that extended the Veterans' Choice Program, for which spending equaled \$6 billion in 2017. However, it excludes funding for the construction of VA medical facilities.

10. Enrollment declined over the 2000–2017 period among just one group: veterans who were housebound or catastrophically disabled from non-service-connected conditions (priority group 4).



economy probably also affected VA's medical spending because the agency is subject to many of the same pressures as the private sector, such as higher prices for supplies and increased compensation costs for medical practitioners.

Another factor that may have increased VA's per-enrollee costs is a possible increase in the amount of care enrollees sought from VA as opposed to other sources of care—a ratio known as the rate of reliance. Taken as a group, enrollees rely on VA for about 35 percent of their medical care. (About 80 percent of enrollees have other medical care available to them.) The share that relies on VA is higher for veterans under age 65 and lower for older veterans who become eligible for Medicare. Some limited evidence suggests that the overall rate of reliance has increased over the past 10 years for both groups.

Although veterans in all priority groups have increased their enrollment in the VA system, spending per enrollee and spending growth per enrollee vary widely by priority group. In 2017, average annual expenditures per enrollee ranged from about \$5,500 for the higher-income veterans (priority group 8) to \$32,900 for veterans who were housebound or had catastrophic non-service-connected disabilities (priority group 4). Contrary to public perception, the average cost to care for Gulf War II combat veterans is relatively low—less than one-half the average amount spent per enrollee—and it has not been a major driver in spending growth. That may change, however, as those veterans age and their health declines.

### Recent Trends in VA's Spending

Although the rate of VA's spending growth has slowed somewhat in recent years, annual growth is still substantial. Federal spending (net outlays) in 2017 for VA totaled \$180 billion in 2018 dollars, nearly 4 percent higher than the \$173 billion spent in 2016 (see Table 3). CBO estimates that VA spent about \$187 billion in 2018, about 4 percent more than in 2017, although that amount is based on preliminary data and could change.<sup>11</sup>

11. Spending in 2016 and 2018 is normalized to 12 monthly payments for recipients of disability compensation and pensions and for beneficiaries of education programs to enable comparison across years. Because 13 payments were made in 2016, total net outlays for VA were nearly \$8 billion higher than stated above. Fiscal year 2018 had only 11 payments; if they were not normalized, total net outlays for VA would be about \$8 billion less than the adjusted spending cited in the text.

Spending for disability compensation, VA's biggest expense in 2017, was \$73 billion, an increase of 6 percent from 2016. CBO estimates that net outlays for disability compensation totaled about \$78 billion in 2018, based on preliminary data, about 6 percent higher than net outlays in 2017.

Medical care, VA's second biggest expense in 2017, accounted for \$69 billion in net outlays, more than 6 percent higher than in the previous year. Of that total, about \$6 billion in discretionary spending was used to provide community care through its long-established programs and another \$5 billion in mandatory spending went to a newer, temporary program, the Veterans Choice Program. (Those figures reflect net outlays; VA spending was offset in part by \$3.5 billion in payments that it received for medical care from veterans and third parties.) CBO estimates that medical care accounted for \$72 billion of VA's spending in 2018.

After disability compensation and medical care, VA's third largest expenditures are for education and vocational programs. They accounted for \$14 billion of VA's spending in 2017, a decline of 4 percent compared with the amount in the previous year.<sup>12</sup> The vast majority of that spending, \$11 billion, goes for education benefits provided by the Post-9/11 GI Bill. VA spent less on those benefits in 2017, primarily because fewer people used the Post-9/11 GI Bill benefits. The remainder of VA's spending—which includes survivor benefits, pensions, housing programs, life insurance, information technology (IT) systems and administrative costs for VBA—totaled about \$24 billion, or 13 percent of the agency's spending in 2017.

### How Some Recent Legislative Changes Affect VA's Medical Spending

Since 2014, lawmakers have provided funding to expand veterans' access to community care—medical care provided by medical practitioners outside of VA facilities but paid for by VA. Those changes have increased VA's spending on medical care and will affect future spending.

12. In this report, spending on education and vocational programs includes VA's payments to beneficiaries including veterans, their family members, and some active-duty service members. Spending is net of offsets such as contributions from service members (\$150 million in 2017). However, it does not include intragovernmental transfers, nor does it include general operating costs and IT expenses associated with the program. (Spending has been normalized to 12 monthly payments for those programs.)

Table 3.

**VA's Spending for Major Programs, 2016 to 2018**

Billions of 2018 Dollars

	2016	2017	Estimated, 2018	Annual Rate of Growth (Percent)	
				2016–2017	2017–2018
Disability Compensation	69	73	78	6.0	6.1
Medical Care <sup>a</sup>					
Medical care and research accounts	62	64	67	2.8	5.0
Veterans Choice Program <sup>b</sup>	3	5	4	87.8	-18.2
Total	65	69	72	6.3	3.3
Education and Vocational Programs <sup>c</sup>	14	14	13	-4.3	-2.4
<b>Memorandum:</b>					
Total VA Spending <sup>d</sup>	173	180	187	3.8	4.1

Source: Congressional Budget Office.

Spending reflects net outlays and is adjusted for the number of monthly benefit payments (which can vary from 11 to 13) in a fiscal year. Because 13 payments were made in 2016, actual outlays were about \$8 billion more than shown above; 11 payments were made in 2018, and actual outlays were about \$8 billion less.

VA = Department of Veterans Affairs.

- a. Includes outlays from discretionary medical care accounts (medical support and compliance, medical services, medical facilities, and medical community care) and the medical and prosthetic research account. That spending is offset by reimbursements to VA from third parties for medical care, which totaled about \$3.5 billion in 2017. Also included are care for nonveterans, which cost VA about \$2 billion in 2017, and outlays from mandatory funding provided in the VA Choice Act and in subsequent legislation that extended the Veterans' Choice Program. Spending to build VA medical facilities is not included.
- b. Includes outlays for medical care from community providers as provided in the VA Choice Act of 2014 and subsequent legislation, including the VA MISSION Act of 2018.
- c. Includes payments to beneficiaries—veterans, their family members, and some active-duty service members. Also includes offsets to those accounts from contributions made by current service members (\$150 million in 2017), but not intragovernmental transfers, administrative costs, or information technology spending associated with the programs.
- d. Includes spending on other programs not listed here.

The Veterans Access, Choice, and Accountability Act of 2014 provided mandatory funding of \$5 billion to expand VA's in-house capacity and an additional \$10 billion to establish the Veterans Choice Program, a temporary program intended to improve veterans' access to community care for three years or until the funds were expended.<sup>13</sup> To be eligible for that program, veterans must have difficulty accessing care at VA facilities—for example, either the veteran's waiting time for an

appointment or the travel distance to a VA facility does not meet VA's standards. The Congress appropriated \$2.1 billion for the Veterans Choice Program in August 2017 and another \$2.1 billion in December 2017. (All amounts in this section are expressed in nominal, or non-inflation-adjusted, dollars.)

In June 2018, the VA MISSION Act was signed into law, further expanding veterans' access to community care. The MISSION Act requires VA to establish the Veterans Community Care Program (VCCP) and to provide community care in several situations: for instance, when VA facilities do not offer the medical care needed or when a veteran cannot get care in a manner that complies with VA's standards for timely access to treatment. VCCP replaces a long-established program

13. To provide medical care, VA relies primarily on discretionary funding—that is, funding the Congress provides through annual appropriation acts. However, funding for the Veterans Choice Program, which is provided through other legislation, is classified as mandatory. Mandatory spending is generally governed by statutory criteria and is not normally constrained by the annual appropriation process.

that authorized community care, usually in limited circumstances, to some groups of enrolled veterans, such as those who have service-connected disabilities. The new law both broadens the criteria for offering community care and extends eligibility to all enrolled veterans who meet the broader criteria. CBO estimates that implementing the new community care program will cost VA \$21.4 billion over the 2019–2023 period, assuming that the Congress appropriates the amounts necessary to fully implement the law.<sup>14</sup> The law also provides \$5.2 billion in mandatory funding to continue the temporary Veterans Choice program.

In addition to expanding access to community care, the MISSION Act expands a caregivers' stipend program. Under the previous program, enacted in 2010, family members and others who provided care for Gulf War II veterans who were severely injured while they were on active duty could receive stipends, health care, and other assistance. Under the new law, the program, phased in over two stages, will be open to caregivers for all veterans. CBO estimates that spending associated with the expansion will total \$2.5 billion in 2023, a fivefold increase over the previous program, which cost \$0.5 billion in 2017. (Several other provisions in the MISSION Act also affect veterans' health care or other VA programs, but their costs are less significant.)<sup>15</sup>

### Projected Spending for Veterans' Benefits From 2018 to 2028

Spending on VA programs is affected by many factors that cannot be projected with certainty. CBO therefore examined three scenarios to illustrate some possible paths for VA's projected spending over the next 10 years. The three scenarios capture some possible trajectories for VA's future spending—CBO's baseline projections (which

have been modified to reflect the effects on mandatory spending of recent legislation) and two scenarios that could result in more spending. (VA's spending could also be less than projected in the modified baseline; however, because of Congressional concern about budgetary risks, this report focuses on possible higher spending paths.) The scenarios focus on VA's largest programs: disability compensation for veterans with service-connected disabilities and medical care.

The first scenario, which is based on CBO's baseline projection, generates the lowest projected outlays, because it is based on current appropriations and does not reflect VA's recent history of rising costs. The other two scenarios would result in higher spending. For the second scenario, CBO again used its modified baseline projection for VA spending, with one exception: the cost of medical care. The assumption that medical care appropriations will grow at the rate of inflation, which is specified in the law governing CBO's baseline projections, does not accord with historical experience. Hence, in Scenario 2, CBO instead projects how spending would need to grow to extend current law (including the recently enacted VA MISSION Act) and VA's policies for medical care, and to reflect the projected rate of increase in spending on health care in the general economy. Because policies for both the disability compensation and medical care programs have changed over the years, CBO also constructed a third scenario. In Scenario 3, CBO projects both disability compensation and medical care differently than it does in the modified baseline. Using historical growth in spending as a guideline, it increases spending per beneficiary for disability compensation and medical care at rates similar to those experienced by VA in the past 10 years (see Table 4).

### CBO's Scenarios for VA's Spending

CBO's scenarios illustrate some possible paths for VA spending. Some of the factors underlying those scenarios are uncertain, however. They include the rate of inflation in the general economy and, for VA programs specifically, unexpected changes in the number of beneficiaries (for instance, because of increased disabilities resulting from deployments) and changes to VA's policies and benefits. This report does not predict future appropriations but rather illustrates what VA's spending would be if the Congress appropriated funding under various assumptions.

14. For a more detailed description of the legislation and projected spending, see Congressional Budget Office, cost estimate for H.R. 5674, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (enacted as S. 2372), May 2018, [www.cbo.gov/publication/53871](http://www.cbo.gov/publication/53871).

15. The law also allows VA to enter into Veterans Care Agreements with local health care providers, which are not subject to competition or other requirements that normally apply to federal contracts. CBO estimates that giving VA the legal authority to continue to provide some existing community care through those agreements would cost \$15 billion over the 2019–2023 period. However, costs for such community care have been factored into VA's budget and previous appropriations. Consequently, for the purpose of this analysis, they are not included as an incremental cost to the MISSION Act.

Table 4.

**Assumptions Used to Project VA's Spending Paths Under Alternative Scenarios**

	<b>Scenario 1: Modified Baseline Projection</b>	<b>Scenario 2: Extend Current Policies</b>	<b>Scenario 3: Extend Past Growth</b>
<b>Beneficiaries</b>			
<b>Disability Compensation</b>	Eligibility and program parameters reflect current law	Same as Scenario 1	Same as Scenario 1
<b>Medical Care</b>	Not modeled; baseline projections extend the 2019 level of spending, adjusted for inflation	Existing policies are incorporated through the projection period (2028)	Same as Scenario 2
	Mandatory spending for the VA MISSION Act is incorporated	All projected spending for the VA MISSION Act is incorporated	Same as Scenario 2
	Veterans Choice Program is not renewed once funds are expended	Same as Scenario 1	Same as Scenario 1
<b>Education and Vocational Programs</b>	Eligibility and program parameters reflect current law	Same as Scenario 1	Same as Scenario 1
<b>Per Capita Growth in Spending</b>			
<b>Disability Compensation</b>	Eligibility and program parameters reflect current law; growth is about the same as expected for the consumer price index	Same as Scenario 1	Growth per beneficiary is about the same as VA experienced from 2008 to 2017
<b>Medical Care</b>	Not modeled; baseline projections extend the 2019 level of spending, adjusted for inflation	Rate of growth per enrollee in the medical care spending accounts is about the same as expected in the general economy	After 2023, rate of growth per enrollee is about the same as VA experienced from 2008 to 2017
	Mandatory spending for the VA MISSION Act is incorporated	All projected spending for the VA MISSION Act is incorporated	Same as Scenario 2
	Veterans Choice Program is not renewed once funds are expended	Same as Scenario 1	Same as Scenario 1
<b>Education and Vocational Programs</b>	Eligibility and program parameters reflect current law	Same as Scenario 1	Same as Scenario 1
	Rate of growth for education and housing expenses is about the same as expected in the general economy	Same as Scenario 1	Same as Scenario 1

Source: Congressional Budget Office.

CBO's modified baseline budget projection is based on the April 2018 baseline, adjusted to include appropriated spending for the VA MISSION Act of 2018. The baseline's starting point includes advance appropriations for 2019 for VA's discretionary medical care accounts and 2018 appropriations for VA's other discretionary accounts.

VA = Department of Veterans Affairs.

**Scenario 1: Modified Baseline Projection.** This scenario is based on CBO's April 2018 baseline budget projection, updated to include an additional \$5.2 billion provided for the Veterans Choice Program as part of the MISSION Act. VA's budget includes both mandatory funding (generally determined by eligibility rules, benefit formulas and other parameters that are set in law) and discretionary funding (which is controlled by annual appropriation acts). CBO's baseline budget projection is prepared following rules specified in law for each type of funding, primarily the Balanced Budget and Emergency Deficit Control Act of 1985, and with guidance from the budget committees. In constructing its baseline, CBO generally assumes that existing laws and policies will remain unchanged.<sup>16</sup>

*Mandatory Spending.* Many of VA's programs, including its disability compensation program and education and vocational rehabilitation benefits, are mandatory programs. To project spending for those programs in the baseline, CBO estimates the future veterans population, applies the programs' eligibility parameters and estimates payment growth. For the disability compensation program, CBO projects its growth in Scenario 1 by estimating the number of beneficiaries over the projection period, incorporating actual caseload and estimated mortality rates from the most recent fiscal year. It projects the number of new beneficiaries over the next decade on the basis of the number of service members leaving the military, the estimated total number of veterans over the projection period, and the rate at which it is estimated veterans will apply for disability benefits. Finally, CBO estimates the average net payment per beneficiary, incorporating a cost-of-living increase as represented by the consumer price index (CPI). The projection builds in adjustments to account for changes that have been made in law or policy that would substantially affect the number of beneficiaries or average payments.

*Discretionary Spending.* Most of VA's medical care programs are discretionary, which means that their funding is controlled by annual appropriation acts. In constructing its baseline for discretionary programs, following the rules specified in law, CBO assumes that the most recent

year's appropriation is continued in each subsequent year, with adjustments each year for projected economy-wide inflation.<sup>17</sup> The inflation rate used in the baseline is a weighted average of the gross domestic product (GDP) price index and the employment cost index (ECI) for wages and salaries, with the weights reflecting the shares of personnel costs and other costs in that portion of the budget. For Scenario 1, CBO follows the rules for constructing baselines for discretionary programs and applies the inflation rate to VA's total budget for medical care rather than estimating it per enrollee. The baseline does not reflect changes in the number of enrollees, the characteristics of those enrollees, or their use of services. Moreover, it does not reflect the projected growth in spending that is specific to the U.S. health care sector. It simply extrapolates the growth from the most recent appropriation using the general measure of inflation described above. The modified baseline projection for discretionary spending was not affected by the discretionary provisions of the MISSION Act because funding for those provisions had not been appropriated at the time the law was signed.

**Scenario 2: Extend Current Medical Care Policies.** For this scenario, CBO takes factors affecting VA medical spending that do not vary in the baseline and allows them to change. Unlike Scenario 1, this scenario also includes the anticipated discretionary spending required to implement the MISSION Act. Scenario 2 uses CBO's modified baseline projection from Scenario 1 for all other VA programs.

In Scenario 2, CBO projects what spending would be if the Congress appropriated the funding needed to pay the estimated costs of medical care under VA's current policies and to implement the MISSION Act. Other than the MISSION Act, Scenario 2 incorporates no other major changes in current policies, such as VA's eligibility rules and cost-sharing, and anticipates that VA would continue to provide essentially the same package of services.

The methodology CBO uses differs fundamentally from the baseline's methodology for projecting discretionary medical accounts. In this scenario, CBO allows the mix

16. CBO's baseline projection methodology is described in its February 2018 report, *How CBO Prepares Baseline Budget Projections*. The baseline projection that was used to construct Scenario 1 is summarized in Congressional Budget Office, *An Analysis of the President's 2019 Budget* (May 2018), [www.cbo.gov/publication/53884](http://www.cbo.gov/publication/53884).

17. The starting point for CBO's April 2018 baseline budget projection of spending for medical care is VA's advance appropriation for 2019 as enacted in 2018 for the discretionary medical community care, medical services, medical support and compliance, and medical facilities accounts.



of enrollees, the use of medical services per enrollee, and medical inflation to vary over the projection period. To project medical care spending (other than that required to implement the MISSION Act), CBO uses VA's projections of the future number of enrollees in each priority group. (VA's projections are based on assumptions similar to those that CBO used for this scenario.) Among other factors, the enrollment projections incorporate anticipated changes in the number and combat status of service members separating from military service and observed patterns in new enrollment.<sup>18</sup> In this scenario, CBO uses the most recent values for the veterans' rates of reliance on VA's care and the relative costs of caring for enrollees in each priority group throughout the projection period.<sup>19</sup> CBO estimates the future cost to the VA of providing that medical care per user, applying the anticipated growth in national health care spending per capita to the average cost of a user by priority group.<sup>20</sup>

In addition, Scenario 2 includes the effects of the MISSION Act on discretionary medical spending. From 2019 to 2023, the scenario incorporates the projected spending required to implement the law, as reported in CBO's cost estimate for the legislation, which estimated costs assuming a five-year implementation period that

18. CBO relied on data on enrollment, reliance, and relative cost by priority group provided by VA from its Enrollee Health Care Projection Model (with some adjustments). For a general description of some elements of the model, see *2015 VA Enrollee Health Care Projection Model* (August 19, 2015), Department of Veterans Affairs, and Government Accountability Office, *Veterans' Health Care: VA Uses a Projection Model to Develop Most of Its Health Care Budget Estimate to Inform the President's Budget Request*, GAO-11-205 (January 2011), [www.gao.gov/products/GAO-11-205](http://www.gao.gov/products/GAO-11-205).

19. As the health care delivery and insurance markets evolve over the next 10 years, it seems likely that reliance will change; however, the direction or magnitude of any future change is uncertain.

20. Using the data described above, CBO determined the number of full-time-equivalent users (a measure of veterans' use of VA's services) in each priority group for each year of the projection period. The annual cost for each such user was estimated from historical data by priority group. The costs per enrollee by priority group were inflated using increases in the rate of spending per capita in the general economy for each group as projected by the Centers for Medicare and Medicaid Services and adapted by CBO. Calculating full-time-equivalent users enables CBO to separately and easily adjust for future changes in reliance and total cost per user by priority group. For a fuller description of CBO's methodology, see Congressional Budget Office, *Potential Costs of Veterans' Health Care* (October 2010), [www.cbo.gov/publication/21773](http://www.cbo.gov/publication/21773).

ends in 2023. After 2023, the scenario incorporates the assumption that the spending required to implement the MISSION Act's community care provision grows at the same rate per enrollee as health care spending is anticipated to grow in the general economy. CBO projects that the expanded caregivers' benefits would grow as a measure of wage and salary growth, as represented by the ECI. Scenario 2 also incorporates the assumption that the VA Choice Program will expire once the funds that have already been appropriated for it are expended.

**Scenario 3: Extend the Past Rate of Growth.** This scenario reflects a future in which VA's per-recipient spending on disability compensation and medical care grows at the annual rates that VA has experienced over the past decade (2008 to 2017): 3.0 percent and 3.9 percent, respectively. (CBO uses the average growth rate over the past 10 years to reduce the effect of shorter-term variations in spending and to exclude the expenses associated with revamping VA's medical care program in the early 2000s.) For disability compensation, the historical growth rate is applied to each year of the projection period. For medical spending, Scenario 3 is the same as Scenario 2 for the first five years of the projection period as the MISSION Act is implemented. This scenario incorporates no additional growth over that period as VA focuses its resources on implementing the new community care program (for instance, developing standards for timely access to care, contracting with networks of private providers, informing enrollees about their benefits, and overseeing the initial rollout). For years after 2023, CBO applies the historical growth in spending per beneficiary. Finally, Scenario 3 uses the same number of beneficiaries as the previous scenario for both the disability compensation program and medical care.

Unlike CBO's modified baseline scenario, Scenario 3 does not incorporate the assumption that current law and policy will remain in effect. Instead, under Scenario 3, legislative or economic changes or a combination of factors may lead to further growth. Specifically, the scenario illustrates how costs would grow if actions by the Congress and the President, VA, or the courts increased VA spending at the same rate as they have in recent years. For example, the VA Secretary or the Congress could establish new presumptive conditions or expand eligibility for medical care to higher-income veterans without service-connected disabilities. In addition to changes in veterans' benefits, other factors that could affect spending are possible future deployments, changes

in the economy, or changes in the medical insurance market. As in Scenario 2, spending for programs other than disability compensation and medical care follows CBO's baseline projections.

### Possible Spending Paths

Applying the baseline's methods and price indexes would result in slower projected growth in total spending than in the other two scenarios. Under Scenario 1, VA's costs would increase by nearly 20 percent from 2017 to 2028.<sup>21</sup> By contrast, VA's costs would increase by about 33 percent under Scenario 2 and by just over 50 percent under Scenario 3.

**Projected Spending Increase Under Scenario 1 (Modified baseline projection).** Adjusted for inflation, VA's spending would grow from \$180 billion in 2017 to \$215 billion in 2028 (see Table 5). Growth would average 1.6 percent annually from 2017 to 2028, substantially less than the 5.5 percent average annual growth that occurred between 2010 and 2017.

Net outlays for disability compensation are projected to grow from \$73 billion in 2017 to \$92 billion in 2028, an average annual growth rate of 2.1 percent. That growth is primarily driven by new recipients (see Table 6). CBO estimates that the average number of recipients of disability compensation would grow by 24 percent, to 5.5 million, by 2028. Although CBO anticipates that the number of new beneficiaries in each year would be higher than it was in the early 2000s, it will be lower than in recent years for at least two reasons: Fewer service members are being deployed to combat regions, and most service members who were deployed in support of the recent conflicts have left active-duty military service. (Combat veterans are more likely both to receive disability compensation and to be awarded higher disability ratings than non-combat veterans.)

By contrast, VA's medical care spending shows less growth (from \$69 billion to \$78 billion from 2017 through 2028) in part because of the baseline rules CBO followed to project discretionary accounts. Increases in spending for education and vocational programs (from

\$14 billion in 2017 to \$17 billion in 2028) do not account for much of the total growth in VA's spending over the projection period; however, the growth in those programs' spending would exceed general inflation by 2.1 percent annually. The number of recipients is expected to flatten out but spending per recipient is anticipated to rise annually by 1.7 percent, driven by rates of inflation for housing and education that exceed general price increases in the economy.

**Projected Spending Increase Under Scenario 2 (Extend current medical care policies).** Adjusted for economy-wide inflation, spending under Scenario 2 would reach \$238 billion by 2028, about one-third higher than the level in 2017—an annual growth rate of 2.6 percent. That growth rate is roughly 60 percent higher than under Scenario 1 but a little less than half as rapid as VA's spending growth between 2010 and 2017.

In this scenario, more than half of the increase in VA's spending over the projection period is attributable to rising costs for the medical care program. Spending for that program increases to \$102 billion in 2028, an average annual growth rate from 2017 to 2028 of 3.5 percent.<sup>22</sup> About 9 percent of that \$102 billion would be for discretionary spending associated with the MISSION Act. Because CBO's baseline projection is the basis for all but the medical care portion of this projection, spending on disability compensation and all other programs remains the same under this scenario as in Scenario 1.

Under Scenario 2, enrollment in VA's medical care program would increase from 9.1 million in 2017 to 9.4 million by 2022 and then drop back to 9.2 million by 2028, stemming in part from an anticipated decline in the number of combat veterans leaving the military. At the same time, however, a greater share of enrollees will be veterans with service-connected disabilities because the number of veterans receiving disability compensation is expected to continue increasing. The vast majority of disability compensation recipients enroll in VA's medical care program. In 2018, roughly 50 percent of enrolled veterans are estimated to have

21. To compare the scenarios, CBO applied the gross domestic product (GDP) price index to convert the projections to 2018 dollars. Because CBO projects that wages and salaries will rise more rapidly than the GDP price index, the modified baseline projection (which incorporates projected increases in wages and salaries) increases in real terms through 2028.

22. That growth does not include increases to build new VA facilities. CBO did not estimate such increases partly because there is substantial uncertainty about how VA might increase its physical presence. Rather than build new facilities, VA could choose to extend its community care programs, extend hours of operation at its facilities, or reduce the average length of appointments, among other options.

Table 5.

**Spending by VA and for Major Programs in 2028 Under Alternative Scenarios,  
Compared With 2010 and 2017 Spending**

	Scenario 1: Modified Baseline Projection	Scenario 2: Extend Current Policies	Scenario 3: Extend Past Growth
<b>All of VA</b>			
Spending (Billions of 2018 dollars)			
2010	124	124	124
2017	180	180	180
2028	215	238	272
Increase, 2017–2028	35	59	92
Average Annual Growth (Percent)			
2010–2017	5.5	5.5	5.5
2017–2028	1.6	2.6	3.8
<b>Disability Compensation</b>			
Spending (Billions of 2018 dollars)			
2010	43	43	43
2017	73	73	73
2028	92	92	122
Increase, 2017–2028	19	19	49
Average Annual Growth (Percent)			
2010–2017	7.8	7.8	7.8
2017–2028	2.1	2.1	4.8
<b>Medical Care</b>			
Spending (Billions of 2018 dollars)			
2010	50	50	50
2017	69	69	69
2028	78	102	105
Increase, 2017–2028	9	32	35
Average Annual Growth (Percent)			
2010–2017	4.7	4.7	4.7
2017–2028	1.1	3.5	3.8
<b>Education and Vocational Programs</b>			
Spending (Billions of 2018 dollars)			
2010	10	10	10
2017	14	14	14
2028	17	17	17
Increase, 2017–2028	4	4	4
Average Annual Growth (Percent)			
2010–2017	4.8	4.8	4.8
2017–2028	2.1	2.1	2.1

Source: Congressional Budget Office.

CBO's modified baseline budget projection is based on the April 2018 baseline, adjusted to include appropriated spending for the VA MISSION Act of 2018. The baseline's starting point includes advance appropriations for 2019 for VA's discretionary medical care accounts and 2018 appropriations for VA's other discretionary accounts.

VA = Department of Veterans Affairs.

Table 6.

**VA's Spending per Recipient and by Major Program Under Alternative Scenarios**

	Actual, 2017	Scenario 1: Modified Baseline Projection		Scenario 2: Extend Current Policies		Scenario 3: Extend Past Growth	
		2028	Average Annual Rate of Growth, 2017–2028 (Percent)	2028	Average Annual Rate of Growth, 2017–2028 (Percent)	2028	Average Annual Rate of Growth, 2017–2028 (Percent)
<b>Disability Compensation</b>							
Total spending (Billions of 2018 dollars)	73	92	2.1	92	1.9	122	4.8
Recipients (Millions)	4.5	5.5	2.0	5.5	1.7	5.5	2.0
Spending per recipient (2018 dollars)	16,500	16,700	0.1	16,700	0.1	22,200	2.7
<b>Medical Care</b>							
Total spending (Billions of 2018 dollars)	69	78	1.1	102	3.5	105	3.8
Recipients (Millions)	9.1	n.a.	n.a.	9.2	0.1	9.2	0.1
Spending per recipient (2018 dollars)	7,600	n.a.	n.a.	11,000	3.4	11,400	3.7
<b>Education and Vocational Programs</b>							
Total spending (Billions of 2018 dollars)	14	17	2.1	17	2.1	17	2.1
Recipients (Millions)	1.1	1.1	0.4	1.1	0.4	1.1	0.4
Spending per recipient (2018 dollars)	12,600	15,100	1.7	15,100	1.7	15,100	1.7
<b>Memorandum:</b>							
Total VA Spending (Billions of 2018 dollars) <sup>a</sup>	180	215	1.6	238	2.6	272	3.8

Source: Congressional Budget Office.

CBO's modified baseline budget projection is based on the April 2018 baseline, adjusted to include appropriated spending for the VA MISSION Act of 2018. The baseline's starting point includes advance appropriations for 2019 for VA's discretionary medical care accounts and 2018 appropriations for VA's other discretionary accounts.

VA = Department of Veterans Affairs; n.a. = not applicable (CBO's baseline projection for medical care does not include estimates of the number of enrollees or spending per enrollee).

a. Includes spending on other programs not listed here.

service-connected disabilities; that share is expected to increase to about 60 percent by 2028. Because veterans with service-connected disabilities also generally cost more to care for than other veterans, their share of VA's medical spending (excluding the spending for the MISSION Act) would increase from about 60 percent to nearly 75 percent in 2028.

Besides the spending associated with the VA MISSION Act, spending growth for medical care under this scenario is largely driven by the assumption that medical expenditures per enrollee grow at about the same rate as CBO projects that they would in the general

population.<sup>23</sup> Aging of the veteran population will probably not contribute substantially to the growth in

23. CBO's findings are broadly consistent with other research. See Projesh Ghosh, Sebastian Negrusa and John Warner, "Health Insurance, Health Conditions, and Veteran Health Care Utilization," *Defence and Peace Economics*, vol. 29, no. 1 (July 2017), pp. 24–43, <https://doi.org/10.1080/10242694.2017.1349311>, in which the authors predict substantial increases in outpatient visits to the VA through the end of their projection period (2023). Also see Christine Eibner and others, *Current and Projected Characteristics and Unique Health Care Needs of the Patient Population Served by the Department of Veterans Affairs* (RAND Corporation, 2015), [www.rand.org/pubs/research\\_reports/RR1165z1.html](http://www.rand.org/pubs/research_reports/RR1165z1.html), which projects some increases in the number of patients treated by VA and a rise in the prevalence of several medical conditions among veterans through the end of RAND's projection period (2024).

spending because most Vietnam veterans are now over 65 and thus qualify for Medicare. (At that age, veterans' reliance on VA drops, and the costs to VA per veteran decline until veterans begin using long-term medical services, such as nursing home care, in substantial numbers.)

In 2028, the amount of medical care spending required in this scenario would be about \$24 billion, or more than 30 percent, higher than the modified baseline projection. That difference in spending would be more than the amount required to serve priority groups 6, 7, and 8 in that year under this scenario. Consequently, if lawmakers held VA's medical care funding to the amount in CBO's modified baseline projection (that is, Scenario 1), the projections under Scenario 2 indicate that the Secretary of Veterans Affairs would be required under current law to rescind enrollment for veterans in those priority groups so that VA could continue to provide care for the other groups. Even lower-income veterans (priority group 5) would face some limitation on enrollment or other restrictions in access by 2028 if VA were required to restrain its budgetary growth to the rate in CBO's modified baseline projections. Priority group 8 veterans, as the lowest in the statutory list, would be the first to be excluded from receiving services, potentially as early as 2021.

**Projected Spending Under Scenario 3 (Extend the past rate of growth).** Spending in this scenario would reach \$272 billion by 2028, adjusted for inflation, a little more

than 50 percent higher than in 2017—an annual average rate of growth of 3.8 percent (see Table 5 on page 17). That rate is nearly 2.5 times greater than under Scenario 1 but about 30 percent lower than the growth in VA's health care spending from 2010 to 2017.

In Scenario 3, the increase in spending on disability compensation dominates increases in other programs. Spending for that program would reach \$122 billion by 2028, an average annual increase of 4.8 percent. Unlike in the previous scenario, increases in the size of the disability payment per beneficiary would contribute more toward growth in that program than would increases in the number of recipients.

Spending for medical care would grow to \$105 billion in 2028, an annual average increase of 3.8 percent—slightly higher than in Scenario 2. The annual rate of growth per enrollee that is projected for 2017 to 2023 (the years over which the MISSION Act will be implemented) turns out to be similar to the annual rate of growth per enrollee over the 2008–2017 period (3.6 percent between 2017 and 2023 compared to 3.9 percent over that period). The rise in spending per enrollee would be the primary driver of the growth in medical spending. As in the previous scenario, if appropriations did not keep pace with the growth that CBO projects under this scenario (as in Scenario 1, for example), the Secretary of Veterans Affairs would have to rescind the enrollment of some veterans.







## Appendix: Possible Spending Paths for VA in Nominal Dollars

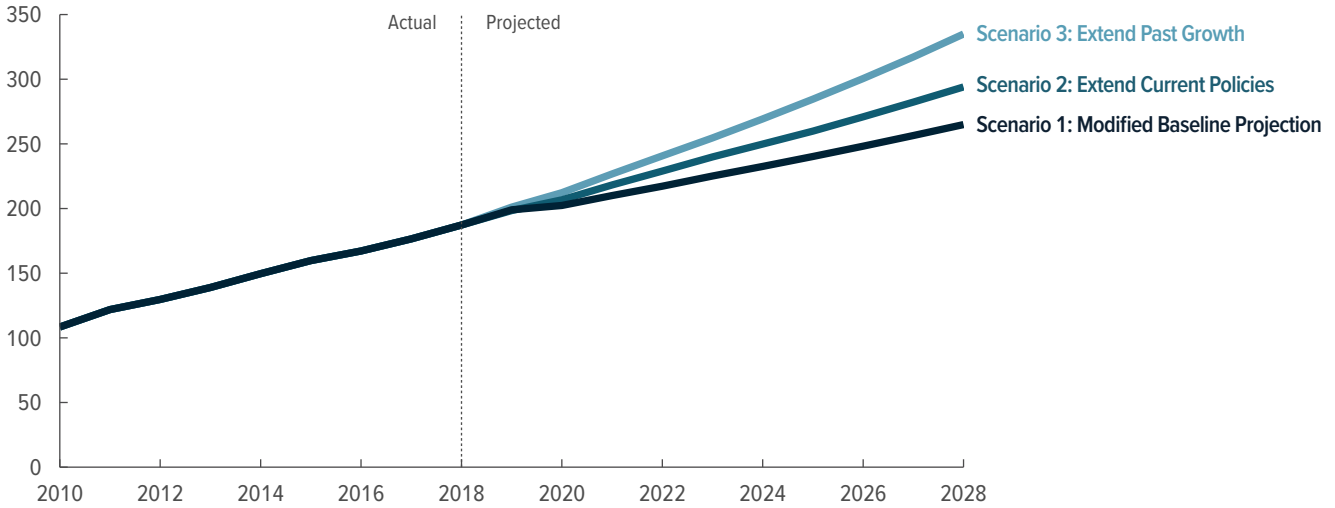
**T**he growth curves in Figure 1 (on page 3) and spending growth shown in Table 5 (on page 17) are adjusted to remove the effects of inflation using the gross domestic product price index, with values of that index for 2018 through 2028 projected by the Congressional Budget Office. In contrast, the growth curves and spending shown in Figure A-1 and Table A-1 are expressed in nominal dollars, meaning that they include the effects of inflation.

In nominal terms, VA's spending in the CBO modified baseline (Scenario 1) would total \$265 billion in 2028, an increase of about 50 percent above the 2017 amount. Under Scenario 2, spending would grow to \$294 billion by the end of the projection period (2028), about two-thirds more the 2017 amount. Finally, under Scenario 3, spending would grow to \$335 billion in 2028, about 90 percent higher than the 2017 amount.

Figure A-1.

**Some Possible Higher Spending Paths for VA Through 2028, in Nominal Dollars**

Billions of Nominal Dollars



Source: Congressional Budget Office.

Spending reflects net outlays and is adjusted for the number of monthly benefit payments (which can vary from 11 to 13) in a fiscal year. Because 11 payments were made in 2018, actual outlays for that year were about \$8 billion less than shown above.

CBO's modified baseline budget projection is based on the April 2018 baseline, adjusted to include appropriated spending for the VA MISSION Act of 2018. The baseline's starting point includes advance appropriations for 2019 for VA's discretionary medical care accounts and 2018 appropriations for VA's other discretionary accounts.

VA = Department of Veterans Affairs.

Table A-1.

**Spending by VA and for Major Programs in 2028 Under Alternative Scenarios,  
Compared With 2010 and 2017 Spending (in Nominal Dollars)**

	Scenario 1: Modified Baseline Projection	Scenario 2: Extend Current Policies	Scenario 3: Extend Past Growth
<b>All of VA</b>			
Spending (Billions of nominal dollars)			
2010	108	108	108
2017	177	177	177
2028	265	294	335
Increase, 2017–2028	88	109	150
Average Annual Growth (Percent)			
2010–2017	7.2	7.2	7.2
2017–2028	3.8	4.7	6.0
<b>Disability Compensation</b>			
Spending (Billions of nominal dollars)			
2010	38	38	38
2017	72	72	72
2028	114	114	151
Increase, 2017–2028	42	42	79
Average Annual Growth (Percent)			
2010–2017	9.6	9.6	9.6
2017–2028	4.2	4.2	7.0
<b>Medical Care</b>			
Spending (Billions of nominal dollars)			
2010	44	44	44
2017	68	68	68
2028	96	125	129
Increase, 2017–2028	28	57	61
Average Annual Growth (Percent)			
2010–2017	6.4	6.4	6.4
2017–2028	3.2	5.7	6.0
<b>Education and Vocational Programs</b>			
Spending (Billions of nominal dollars)			
2010	9	9	9
2017	13	13	13
2028	21	21	21
Increase, 2017–2028	8	8	8
Average Annual Growth (Percent)			
2010–2017	6.6	6.6	6.6
2017–2028	4.3	4.3	4.3

Source: Congressional Budget Office.

CBO's modified baseline budget projection is based on the April 2018 baseline, adjusted to include appropriated spending for the VA MISSION Act of 2018. The baseline's starting point includes advance appropriations for 2019 for VA's discretionary medical care accounts and 2018 appropriations for VA's other discretionary accounts.

VA = Department of Veterans Affairs.



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## About This Document

This Congressional Budget Office report was prepared at the request of the Chairman of the House Budget Committee. In accordance with CBO's mandate to provide objective, impartial analysis, the report makes no recommendations.

Heidi Golding prepared the report with guidance from David Mosher and Edward G. Keating. Elizabeth Bass, Terry Dinan, Ann Futrell, Sebastien Gay, Sarah Jennings (formerly of CBO), David Newman, Evelio Rubiella, Logan Smith, and David Weaver provided useful comments.

David Chu of the Institute for Defense Analyses and Sebastian Negrusa of the Lewin Group provided comments on the draft. (The assistance of external reviewers implies no responsibility for the final product, which rests solely with CBO.)

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CBO continually seeks feedback to make its work as useful as possible. Please send any feedback to [communications@cbo.gov](mailto:communications@cbo.gov).

Keith Hall  
Director  
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