CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

July 14, 2006

Honorable Larry E. Craig
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In response to your request, the Congressional Budget Office (CBO) has assessed the potential implications for future budgets if medical expenditures by the Department of Veterans Affairs (VA) continue to grow at the rates experienced over the past few years. Specifically, CBO formulated four scenarios for possible growth rates of VA's medical expenditures over the next 10 years. As you requested, the first scenario extrapolates the 11.5 percent increase between funding to date during fiscal year 2006 and VA's budget submission for fiscal year 2007, with the latter modified to exclude the increases in user fees proposed in the budget submission. The other three scenarios apply annual growth rates that reflect a combination of longer-run trends in VA's costs and some different assumptions regarding medical-care inflation and veterans' propensity to use VA for care.

The attachment describes the interim results developed by CBO's National Security Division. CBO expects to provide a complete report to the Committee by February 2007. If you would like further details, CBO would be pleased to provide them. The analysis was prepared by Allison Percy, who can be reached at (202) 226-2913, and Matthew Goldberg, who can be reached at (202) 226-2914.

Sincerely,

Donald B. Marron

Donald B. Marron
Acting Director

Attachment

cc: Honorable Daniel K. Akaka, Ranking Member
Senate Committee on Veterans' Affairs

Honorable Judd Gregg, Chairman
Honorable Kent Conrad, Ranking Member
Senate Committee on the Budget

Honorable Thad Cochran, Chairman
Honorable Robert C. Byrd, Ranking Member
Senate Committee on Appropriations

Honorable Kay Bailey Hutchison, Chairman
Honorable Dianne Feinstein, Ranking Member
Subcommittee on Military Construction and Veterans Affairs,
and Related Agencies
Senate Committee on Appropriations

Honorable Steve Buyer, Chairman
Honorable Lane Evans, Ranking Member
House Committee on Veterans' Affairs

Honorable Jim Nussle, Chairman
Honorable John Spratt, Ranking Member
House Committee on the Budget

Honorable Jerry Lewis, Chairman
Honorable David R. Obey, Ranking Member
House Committee on Appropriations

Honorable Jim Walsh, Chairman
Honorable Chet Edwards, Ranking Member
Subcommittee on Military Quality of Life and Veterans Affairs,
and Related Agencies
House Committee on Appropriations

Potential Growth Paths for Medical Spending by the Department of Veterans Affairs

July 14, 2006

The Congress of the United States ■ Congressional Budget Office

Summary

The Veterans Health Administration (VHA) within the Department of Veterans Affairs (VA) provides medical care and rehabilitation services to eligible veterans, conducts medical research, provides graduate medical education, and plays a role in national emergency management. Funding for VHA is discretionary; its budget authority (that is, the authority to obligate funds) is provided one year at a time through the appropriation process.[1] Thus, it is not possible to project definitively VHA's future appropriation levels because those levels depend on future acts of Congress. Nonetheless, the sometimes double-digit annual rates of increase in VHA's appropriations have prompted observers to question the potential effects on future budgets if those increases continue.[2]

Several approaches could be used to project future paths for VHA's spending. One approach would be to apply an assumed growth rate—derived from historical experience—to VHA's current overall funding under the assumption that future growth will be similar to that experienced in the recent past. Another approach would rely on underlying factors to project the individual components of VHA's future funding; such factors include the enrollment of veterans in VA's medical system, the utilization of VA medical-care services per enrollee, and the growth rate of cost per service provided by the VA system. That approach assumes that the Congress would choose to appropriate funding for VA medical care at a rate sufficient to satisfy demand (under VA's current policies on enrollment, access to care, and fees) and to accommodate inflation.

A third approach would project VHA's discretionary appropriations using the same rules that govern the Congressional Budget Office's (CBO's) annual baseline projections of the entire discretionary portion of the federal budget, as contained in CBO's January 2006 *Budget and Economic Outlook.* Under the Balanced Budget and Emergency Deficit Control Act of 1985, CBO must assume that the most recent year's discretionary budget authority is provided in each future year, adjusted using specific

1. When VHA provides care for veterans with non-service-connected conditions, it has the authority to collect copayments from certain categories of veterans and to bill those veterans' insurance companies or other third-party payers. Those payments are deposited into VA's Medical Care Collections Fund (MCCF) and are treated as offsets to discretionary spending. Spending from the MCCF is subject to appropriations.

2. VHA is not unique in facing rapid growth in its medical expenditures. Overall health care expenditures have risen notably faster than the rest of the economy. The Centers for Medicare and Medicaid Services (CMS) estimates that from 1980 to 2004, U.S. per capita health care spending grew at an average annual rate of 7.5 percent, while per capita gross domestic product (GDP) grew at 5.0 percent per year over that same period (see www.cms.hhs.gov/NationalHealthExpendData). Furthermore, CMS currently projects that per capita national health expenditures will rise at an annual rate of about 6 percent over the next 10 years, compared with a rate of about 4 percent per year for per capita GDP.

price indexes to offset projected inflation and to allow for factors such as the cost-of-living adjustment for federal workers.[3]

Using those three approaches, CBO developed four scenarios to project future appropriations for VA medical care.[4] The first two scenarios follow the first approach described above, deriving growth rates from historical experience. Scenario 1 assumes that appropriations would grow at a nominal (that is, without the effects of future inflation removed) annual rate of 11.5 percent between fiscal year (FY) 2006 and FY 2016. That rate reflects initial indications of the increase that the Congress will provide in appropriations for the next fiscal year (2007). It is nearly twice the 6.1 percent average annual increase in budget authority for VA medical care that occurred between 1992 and 2006. (In 12 of those 14 years, the annual increase was less than 10 percent.)

Scenario 2 assumes that appropriations would grow at a nominal annual rate of 8.3 percent, which was the average annual growth rate in VHA's funding for medical care between 1999 and 2006. That more-recent period represents higher growth than in the immediately preceding years, because expansion of eligibility, coupled with the opening of more geographically dispersed outpatient clinics, brought about a substantial increase in the number of veterans who turned to VA for medical care.[5]

Scenario 3 assumes that the Congress would choose to appropriate funding for VA medical care at a rate sufficient to keep pace with the demand for care by currently eligible veterans and to accommodate inflation. That scenario implies an average annual growth rate of 6.9 percent in VHA's appropriations.

Scenario 4 assumes that the Congress would choose to appropriate funding in a manner consistent with the rules that govern CBO's annual baseline projections of discretionary spending. That final scenario implies an average annual growth rate of 3.0 percent.

Under Scenario 1, VHA's current appropriation of $29 billion (net of collections) for medical care would grow to $86 billion by FY 2016 (see Summary Figure 1). Under Scenario 2, which applies a lower nominal growth rate of 8.3 percent to VHA's appropriations, CBO determined that VHA's appropriations for medical care would grow

3. CBO's baseline projection methodology is described in Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2007 to 2016* (January 2006), pp. 5-8.

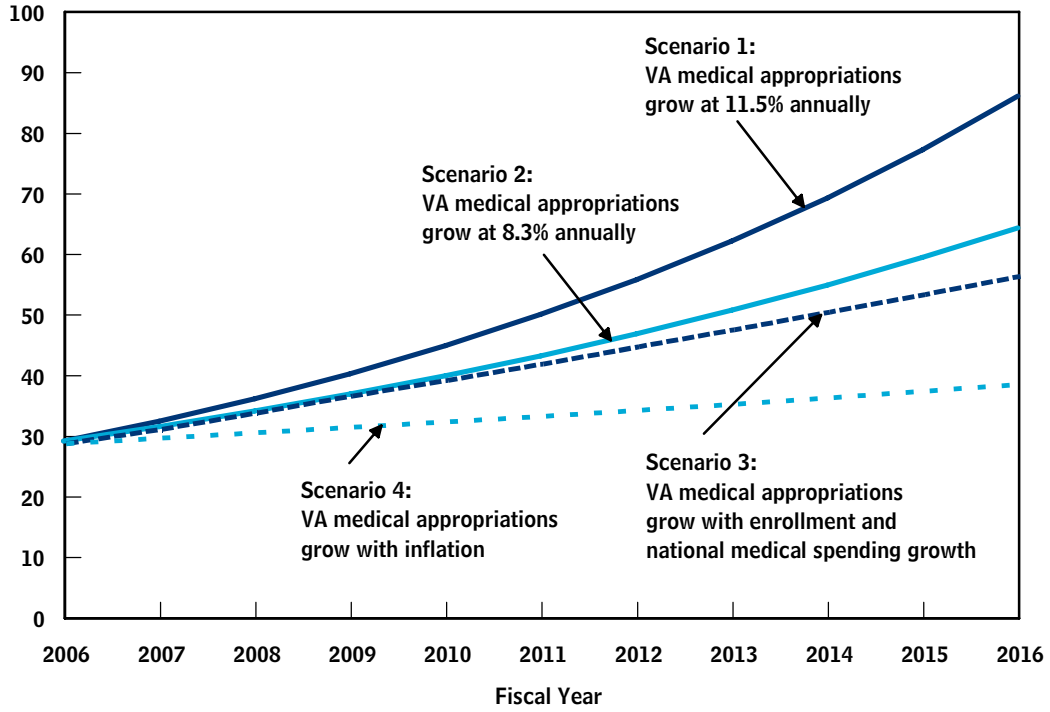
4. Throughout this analysis, VA medical care is defined to include medical services, medical administration, and medical facilities. Medical care excludes other activities undertaken by VHA, such as medical and prosthetic research, the VA information and technology fund, major and minor construction, and grants for state extended care.

5. The enrollment system and corresponding relaxation of eligibility requirements followed from the Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262). The number of veterans using the system increased from 2.9 million in 1995 to 5.3 million in 2005.

Summary Figure 1.

Projected Appropriations for VA Medical Care Under Four Scenarios, in Current Dollars

(Billions of dollars)



Source: Congressional Budget Office.

Note: VA = Department of Veterans Affairs.

to $64 billion by the end of the decade. Under Scenario 3 (VHA's appropriations grow with veterans' demand for medical care and inflation), funding for veterans' medical care would grow to $57 billion by 2016. Finally, under Scenario 4, those appropriations would grow from $29 billion to $39 billion over the decade.

The same information may be displayed in terms of the potential share that appropriations for VA medical care might constitute of total federal discretionary spending. The path of discretionary spending will be determined by future acts of Congress and is impossible to project definitively, but two alternative assumptions about future growth are illustrative. The first assumption is that total discretionary appropriations would keep pace with inflation over the next decade. The second assumption is that discretionary spending would grow at the same rate that CBO projects for gross domestic product (GDP). Because CBO currently projects that GDP growth will exceed

Summary Table 1.

Projected Appropriations for VA Medical Care as a Share of Total Federal Discretionary Spending, Fiscal Year 2016

(Percent)

Growth Rate Assumption for Total Federal Discretionary Spending, FY 2007 Through FY 2016	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Discretionary Spending Grows at the Same Rate as General Inflation	7.3	5.5	4.8	3.3
Discretionary Spending Grows at the Same Rate as the Gross Domestic Product	6.0	4.5	3.9	2.7

Source: Congressional Budget Office.

Notes: For FY 2006, VA's share of discretionary spending equals 3.2 percent.

VA = Department of Veterans Affairs; FY = fiscal year.

inflation by an average of 2.9 percent per year over the next decade, the second assumption implies faster-growing discretionary spending and a correspondingly slower-growing (or even declining) share for appropriations for VA medical care.

Under the first assumption for growth in overall discretionary spending, VA medical care as a share of the total might grow from its current level of 3.2 percent to 5.5 percent if appropriations increased at a nominal rate of 8.3 percent per year over the next decade (see Summary Table 1). That share could climb to 7.3 percent if VA medical appropriations grew at a nominal rate of 11.5 percent per year over the decade.

Under the second assumption—that discretionary spending will grow at the same rate as GDP—VA medical care as a share of the total could increase to 4.5 percent if appropriations grew at a nominal rate of 8.3 percent per year over the next decade and 6.0 percent if appropriations grew at a nominal rate of 11.5 percent per year over that period.

Background Information

The Veterans' Health Care Eligibility Reform Act of 1996 significantly expanded eligibility for health care services by Department of Veterans Affairs (VA) and directed that VA create an enrollment system for its health care programs. In most cases, veterans must enroll in order to use the VA medical system, although there is no enrollment fee. As part of the enrollment process, applicants must document their status as veterans and are assigned to one of eight priority groups on the basis of their service-connected disabilities (if any), income, assets, and other factors. Veterans in seven of the eight priority groups face no obstacles to enrollment; furthermore, those veterans may seek medical care and receive that care along a timeline determined by the Veterans Health Administration's (VHA's) available staffing and physical capacity.

Priority Group 8 consists of veterans who do not have service-connected disabilities and whose income and net worth exceed both the VA means test and the geographic index developed by the Department of Housing and Urban Development (HUD).[1] As of January 17, 2003, then-Secretary of Veterans Affairs Anthony Principi exercised his authority to freeze new enrollment among veterans in Priority Group 8, although veterans who had already enrolled by that time were "grandfathered" into the system and remain eligible for VA medical care. The freeze on Priority Group 8 enrollment remains in effect.[2]

Recent Budget History

VHA's budget authority for medical care increased at an average annual rate of 8.3 percent between fiscal year (FY) 1999 and FY 2006 (see Table 1). That increase was driven by several factors, including (1) increasing enrollment (notwithstanding the freeze on Priority Group 8 enrollment toward the end of that period), (2) increasing reliance of enrolled veterans on VA health care (as opposed to Medicare, employer-provided health insurance, or other sources of health care available to those veterans), and (3) medical inflation above the general rate of inflation.[3]

During the past two years, VHA's costs have exceeded the amounts initially requested or appropriated. In a hearing of the House Committee on Veterans Affairs on June 23, 2005, Secretary of Veterans Affairs Jim Nicholson stated that VA's costs for medical care for FY 2005 would exceed the amount already enacted for that year by

1. The income thresholds for the VA means test, which depend on family size, are updated each year for inflation. For fiscal year 2006, the threshold for a veteran with no dependents is $26,902 per year (see www.va.gov/healtheligibility/Resource/pubs/VAIncomeThresholds/VA2005.pdf). The HUD index takes into account differences in the cost of living from one geographic area to another.

2. The Secretary's authority to freeze enrollment was established in the Veterans Health Care Eligibility Reform Act of 1996 (Public Law 104-262).

3. The role of those factors in determining VA's costs for medical care is described in Congressional Budget Office, *The Potential Cost of Meeting Demand for Veterans' Health Care* (March 2005).

Table 1.

Budget Authority for VA Medical Care, Fiscal Years 1999 Through 2007

Fiscal Year	Budget Authority for VA Medical Care[a] (Millions of dollars)	Percentage Increase
1999 Actual	17,820	n.a.
2000 Actual	19,462	9.2
2001 Actual	20,951	7.7
2002 Actual	22,482	7.3
2003 Actual	25,337	12.7
2004 Actual	27,952	10.3
2005 Actual	29,910	7.0
2006 Actual (to date)	31,049	3.8
2007 Budget Estimate[b]	34,546	11.3 [c]
Average Percentage Increase, 1999-2006	n.a.	8.3

Source: Congressional Budget Office.

Note: VA = Department of Veterans Affairs; n.a. = not applicable; FY = fiscal year.

a. Figures include medical services, medical administration, and medical facilities; they exclude medical and prosthetic research, the VA information and technology fund, major and minor construction, and grants for state extended care. Figures include the spending of collections deposited into VA's Medical Care Collections Fund.

b. The 2007 budget estimate is from VA's *FY 2007 Budget Submission* (February 2006).

c. Percentage increase shown is gross of collections deposited into VA's Medical Care Collections Fund. The increase in the FY 2007 budget estimate, net of collections and deducting user fees proposed by the Administration but not enacted by the Congress, is 11.5 percent; see Table 2.

about $1 billion. At a hearing five days later of the Subcommittee on Military Quality of Life and Veterans Affairs, and Related Agencies, of the House Committee on Appropriations, Secretary Nicholson testified that VA would require between $1.1 billion and $1.6 billion more to administer its medical program in 2006 than had been requested in the FY 2006 President's budget submission. In response to the issues raised during those hearings, the Congress included $1.5 billion in supplemental appropriations for veterans' medical care in the FY 2006 Department of the Interior, Environment, and Related Agencies Appropriation Act (H.R. 2361, Public Law 109-54), which the President signed into law on August 2, 2005. In addition, the Congress included $1.225 billion in emergency funding in the FY 2006 Military Quality of Life, Military Construction, Veterans Affairs, and Related Agencies Appropriations

Act (H.R. 2528, Public Law 109-114), which the President signed on November 30, 2005.[4]

Budget Request for Fiscal Year 2007

The President's budget submission for 2007 included two proposed increases in the fees that veterans pay to use VA medical care and one change in third-party billing practices, which would also increase the share of costs paid by veterans. First, the budget proposed to establish an annual enrollment fee of $250 for all veterans in Priority Groups 7 and 8.[5] If the enrollment fee was implemented, then enrollment in VA medical care would decline. As a result, VA's spending on medical services and pharmaceuticals would fall. The enrollment fee would also increase VA's collections.[6]

In addition, the 2007 budget proposed to increase pharmaceutical copayments from $8 to $15 (for each 30-day prescription) for all enrolled veterans in Priority Groups 7 and 8. Savings would reflect a reduction in spending on pharmaceuticals as well as an increase in collections.

Finally, the 2007 budget proposed legislative language that would more clearly delineate the financial responsibilities of veterans who are treated for non-service-connected conditions and who have sources of third-party payments, such as health insurance, workers' compensation, victims' aid, or tort settlement. VA's current practice is that when a veteran owes a copayment but VA collects funds from third-party sources, those collections offset or reduce the veteran's first-party indebtedness. That practice has been criticized by the Government Accountability Office, among

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4. The legislative history is summarized in Sidath Viranga Panangala, *Veterans' Medical Care: FY2007 Appropriations*, CRS Report for Congress RL33409 (Congressional Research Service, updated May 31, 2006). Public Law 109-114 (Page 119, Stat. 2384) stipulated that the President designate the entire $1.225 billion as an emergency requirement. The President provided that designation on January 28, 2006.

5. Veterans in Priority Group 7 are those who do not have service-connected disabilities and whose net worth is above the VA means test but below HUD's geographic index.

6. The Department of Defense (DoD) budget request for 2007 also proposed to increase user fees for non-Medicare-eligible military retirees and their family members. Specifically, the proposal would institute annual enrollment fees for TRICARE Standard and Extra (the non-managed-care options), increase deductibles for TRICARE Standard and Extra, and index those fees to future inflation. The proposal would also boost the annual enrollment fee for TRICARE Prime (the managed-care option) and index that fee as well. Section 704 of the House version of the FY 2007 National Defense Authorization Act (NDAA) (H.R.5122, which passed on May 11, 2006) would prohibit DoD from increasing the premium, deductible, copayment, or other charges for TRICARE Prime or the charge for inpatient care under TRICARE Standard between April 1, 2006, and December 31, 2007. Section 705 of the Senate version of the FY 2007 NDAA (S.2766, which passed on June 22, 2006) would prohibit increases in enrollment fees for TRICARE Prime during FY 2007. Although the House and Senate agree on the basic principle of freezing TRICARE fees, they differ in the details. Those differences (among others) have not been resolved in conference as of this writing.

Table 2.

Proposed Appropriations for VA Medical Care, Fiscal Year 2007

(Millions of dollars)

Account	Fiscal Year 2006 to Date	Fiscal Year 2007 President's Request[a]	Fiscal Year 2007 H.R. 5385[b]
Medical Services			
General fund appropriations	22,707	25,511	25,412
Authority to spend collections	2,117	2,289	2,329
Medical Administration	2,927	3,177	3,277
Medical Facilities	3,298	3,569	3,594
Total Budget Authority (Gross)	31,049	34,546 [c]	34,612
Total Budget Authority (Net of collections)	28,932	32,257 [d]	32,283

Source: Congressional Budget Office.

Note: VA = Department of Veterans Affairs; FY = fiscal year.

a. CBO modified the dollar amounts in this column from the President's request by deducting user fees proposed by the Administation but not enacted by the Congress.

b. The FY 2007 Military Quality of Life, Military Construction, and Veterans Affairs Appropriations Act (discussed below).

c. Increase of 11.3 percent above FY 2006 gross appropriations.

d. Increase of 11.5 percent above FY 2006 net appropriations.

others.[7] Under the proposal, veterans would receive a bill for their copayment at the same time that VA bills their insurance company or another third-party payer, and any offsets would be eliminated.

CBO estimates that the proposed fees and copayments from the three initiatives would yield additional receipts to the government totaling $400 million to $500 million per year. They might also result in some reduction in utilization of VA medical services.

Excluding any estimated savings from the three initiatives and net of anticipated collections, the Administration requested $32.3 billion in appropriations for VA medical care in FY 2007 (see Table 2). That figure is 11.5 percent higher than the corresponding amount appropriated in FY 2006 to date.

Legislative Action to Date on FY 2007 Appropriations

The House of Representatives passed its version of the FY 2007 Military Quality of Life, Military Construction, and Veterans Affairs Appropriations Act (H.R. 5385) on

7. Government Accountability Office, *VA Health Care: Guidance Needed to Collect from Veterans and Private Health Insurers*, GAO-04-938 (July 2004).

May 19, 2006. That legislation contains no provisions authorizing VHA to increase veterans' fees as proposed in the President's budget submission. The legislation would set FY 2007 appropriations for VA medical care (net of anticipated collections) at $32.3 billion, or essentially the same amount requested by the Administration, excluding any estimated savings from the three initiatives (see Table 2).

The Senate Appropriations Committee has not yet taken up the FY 2007 appropriations for VA. However, the Senate discussed funding for VA medical care when it considered its budget resolution for FY 2007. On March 14, 2006, the Senate approved an amendment (number 2999) to its Concurrent Resolution on the Budget for FY 2007 (S. Con. Res. 83); the purpose of the amendment was "[t]o provide increased funding for veterans health programs, and to negate the need for enrollment fees and increase in pharmacy co-payments." The amendment added $823 million to the budget resolution's allocation of budget authority for budget function 700 (veterans' benefits and services). Of that amount, $795 million represents the Office of Management and Budget's estimate of the funding that would have to be added to the President's request in order to maintain service levels if the three legislative proposals were not enacted; the remainder would fund additional medical and prosthetic research.

Scenarios of Future Spending Growth

For purposes of this analysis, CBO analyzed four scenarios for the possible growth of VA's appropriations for medical care over the next 10 years.

Scenario 1

Under the first scenario, as specified by Senator Craig, appropriations for VA medical care grow at a nominal rate of 11.5 percent per year between FY 2006 and FY 2016.

Although VHA's funding for medical care may increase by as much as 11.5 percent between FY 2006 and FY 2007 (depending on the Congress's final disposition of the FY 2007 Military Quality of Life, Military Construction, and Veterans Affairs Appropriations Act), that rate is nearly twice the 6.1 percent average annual increase that occurred between 1992 and 2006. In 12 of those 14 years, the annual increase was less than 10 percent.

Scenario 2

Under the second scenario, appropriations for VA medical care grow at a nominal rate of 8.3 percent per year between FY 2006 and FY 2016. The second scenario assumes that funding grows at the average nominal rate of increase experienced between fiscal years 1999 and 2006 (see Table 1). That rate may be more indicative of the long-run trend.

Scenario 3

Under the third scenario, appropriations for VA medical care grow at an average rate of 6.9 percent per year—a rate sufficient to meet projected demand for services by currently eligible veterans and to accommodate projected growth in the cost per enrolled veteran. CBO assumes that VA's current policies on enrollment, access to care, and fee collections remain unchanged.

The third scenario builds up the potential budget by considering the underlying population of veterans (by priority group) and those veterans' propensities to enroll for VA medical care and to rely on VA (as opposed to alternative sources of care). That approach, which updates the projections reported in an earlier CBO paper, uses projections of veterans' enrollment and reliance rates provided by VA, as well as factors describing the relative annual medical expenditures on veterans as a function of their priority group.[8] The projections of enrollment and reliance do not incorporate the reductions in utilization that would be expected under the legislative proposals contained in the President's budget for 2007. In addition, CBO assumes that the freeze on Priority Group 8 enrollment remains in effect but that the freeze is not extended to any of the higher-priority groups. The approach also allows for medical inflation and other factors that lead to growth in the annual medical expenditures per enrolled veteran. CBO estimated the latter using projections of the growth in national per-capita medical expenditures developed by the Office of the Actuary, Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services.[9]

Scenario 4

As specified in the Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99-177), CBO projects discretionary spending by applying forecasts of the employment cost index (ECI) to the wages and salaries of federal personnel and the gross domestic product (GDP) price index to all other expenditures. CBO's most recent projection of discretionary spending, including the appropriations associated with VA medical care, is from its March 2006 *Analysis of the President's Budgetary Proposals for Fiscal Year 2007.*[10] Scenario 4 is CBO's baseline for VA's medical spending under those assumptions, reflecting an average rate of growth of 3.0 percent per year.

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8. Congressional Budget Office, *The Potential Cost of Meeting Demand for Veterans' Health Care*.

9. See "National Health Care Expenditures Projections: 2005-2015," available at www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2005.pdf. CMS projects annual increases in per capita expenditures ranging from 6 percent to 7 percent over the next decade.

10. See Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2007* (March 2006), which updates the projections in *The Budget and Economic Outlook: Fiscal Years 2007 to 2016* (January 2006). Using the rules specified for its baseline, CBO projects that budget authority for VA medical care (defined to include medical services, medical administration, and medical facilities) will grow by between 3 percent and 4 percent per year for most of the next decade. Note that, under the baseline rules, total discretionary spending will decline both as a share of the overall federal budget and relative to the size of the economy. See *The Budget and Economic Outlook: Fiscal Years 2007 to 2016*, Table 3-1 on p. 52.

Impact on Other Federal Programs

CBO did not estimate any reductions in demand for other federal programs (such as Medicare, Medicaid, TRICARE, or the Federal Employees Health Benefits program) that might offset the increases in funding for VA medical care. There is little empirical evidence that veterans will migrate entirely into VA medical care if increased funding improves their access to that care. For example, as of 2003, some 65 percent of enrolled veterans in Priority Groups 7 and 8 were also enrolled in Medicare Part A (hospital insurance), and 60 percent had purchased Medicare Part B (supplemental medical insurance); 88 percent had access to some source of medical coverage (including federal programs as well as various forms of private health insurance) outside of their VA eligibility. Enrolled veterans in those two groups relied on VA for about 20 percent of their total medical care, obtaining their care from various providers and funding sources.[11] Moreover, even if there were reductions in spending on those other federal programs as VA's spending rose, much of the funding involved would fall into the mandatory portion of the federal budget rather than the discretionary portion that is the subject of this analysis.

Projections of Future Appropriations

The four scenarios in this analysis span a wide range of potential outcomes for appropriations for VA medical care over the next 10 years. If growth occurred at a nominal rate of 11.5 percent per year over the next decade (Scenario 1), those appropriations would reach $86 billion by FY 2016 (see Figure 1). However, if VA's medical appropriations just kept pace with inflation, those appropriations would reach $39 billion by FY 2016 (Scenario 4).

The growth curves in Figure 1 incorporate general inflation, which affects all sectors of the economy, including health care delivery. By contrast, the growth curves in Figure 2 remove the effect of general inflation by normalizing for the projected trend in the GDP price index. In that figure, the slowest-growing curve, depicting Scenario 4, shows cumulative real growth of 12.1 percent over the entire next decade. That scenario generates real (inflation-adjusted) growth only to the extent that the federal pay raise—which is assumed to be equal to the annual percentage increase in the employment cost index—outpaces the GDP price index.[12]

If appropriations for VA medical care grew at a rate sufficient to meet veterans' projected demand for services and to accommodate projected real growth in the cost per enrolled veteran (Scenario 3), real appropriations could reach $47 billion by FY 2016, about 63 percent higher than the level in FY 2006. Under Scenario 2, appropriations

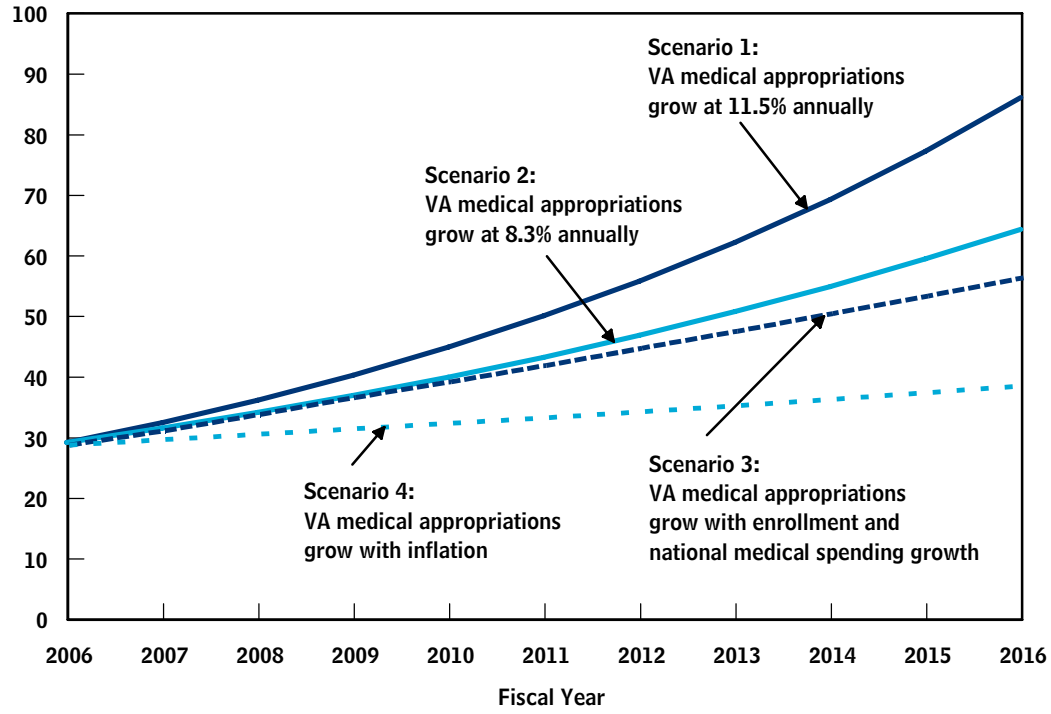
11. Congressional Budget Office, *The Potential Cost of Meeting Demand for Veterans' Health Care*, p. 8.

12. The ECI grew more rapidly than the GDP price index in each year of the 1981-2005 period, and CBO expects that pattern to continue between 2006 and 2016. Over the next decade, growth of the ECI will exceed growth of the GDP price index by an average of 1.5 percent per year, CBO projects.

Figure 1.

Projected Appropriations for VA Medical Care Under Four Scenarios, in Current Dollars

(Billions of dollars)



Source: Congressional Budget Office.

Note: VA = Department of Veterans Affairs.

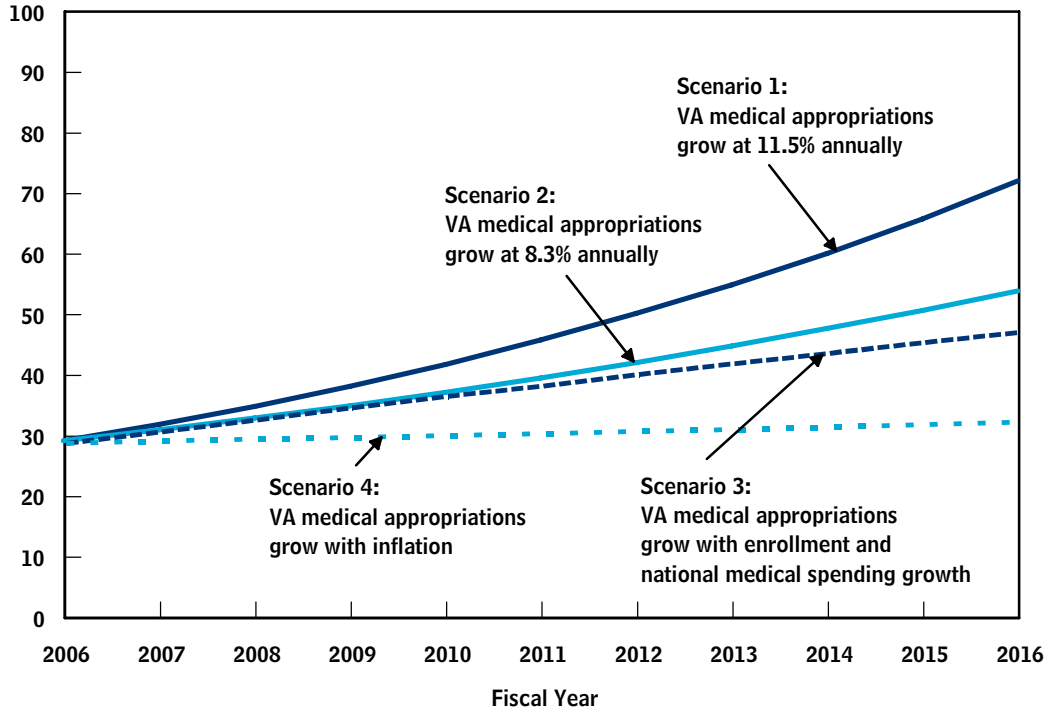
would grow at the seven-year average rate of 8.3 percent, or a real rate averaging 6.4 percent, over the next decade. Real appropriations would increase by 85 percent over the decade, reaching $54 billion by FY 2016. Finally, under Scenario 1, appropriations would grow at a nominal rate of 11.5 percent per year, or a real rate averaging 9.5 percent, over the next decade. Real appropriations would be two and a half times as large as the current value by the end of the decade, reaching $72 billion by FY 2016.

The same information may be displayed in terms of the potential share that VA's medical appropriations might constitute of total federal discretionary spending. The path of the discretionary spending will be determined by future acts of Congress and is impossible to project definitively, but two alternative assumptions about future growth are illustrative. The first assumption is that the total federal discretionary budget would keep pace with inflation over the next decade. The second assumption is that the discretionary budget would grow at the same rate that CBO projects for GDP. Because CBO currently projects that GDP growth will exceed inflation by an average of 2.9 percent per year over the next decade, the second assumption implies faster

Figure 2.

Projected Appropriations for VA Medical Care Under Four Scenarios, in Constant Dollars

(Billions of fiscal year 2006 dollars)



Source: Congressional Budget Office.

Notes: The effects of future inflation have been removed from these estimates using CBO's projection of the gross domestic product price index.

VA = Department of Veterans Affairs.

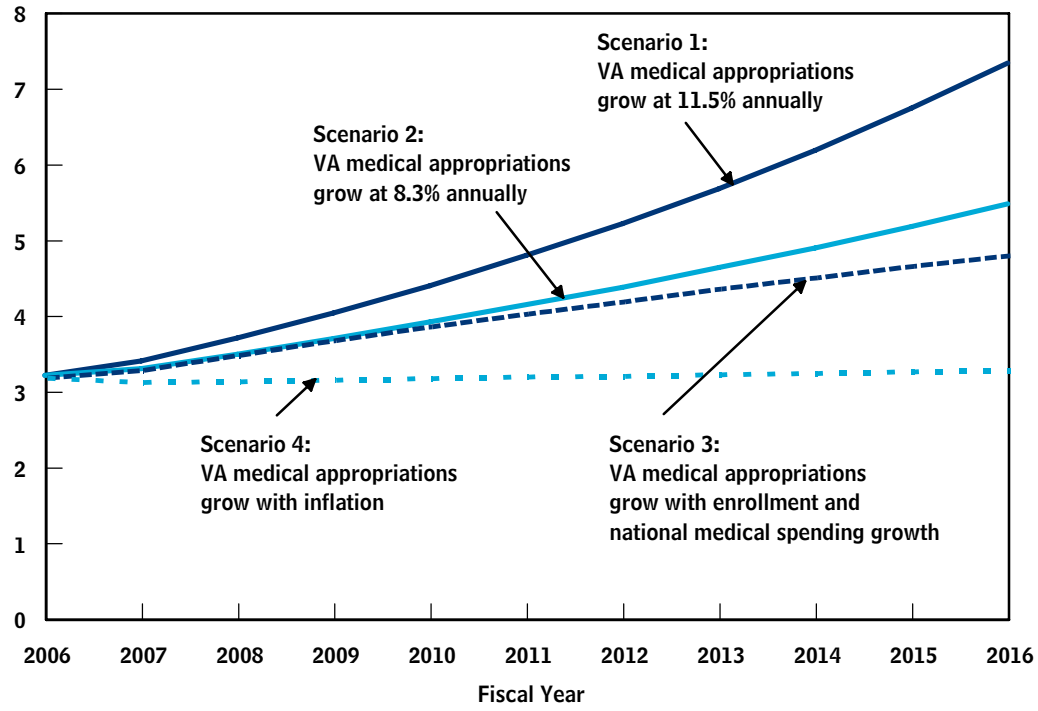
growth in overall discretionary spending and a correspondingly slower-growing (or even declining) share for VA medical appropriations.

Under the first assumption about growth in federal discretionary spending, VA's medical appropriations would grow only slightly faster than overall discretionary spending under Scenario 4, so VA's share would increase from 3.2 percent to 3.3 percent (see Figure 3). VA's share would climb to 4.8 percent under Scenario 3 (in which VA's medical appropriations grow with enrollment and national medical spending trends) and 5.5 percent under Scenario 2 (in which VA's medical appropriations grow at the average annual rate of the past seven years). The share of VA's medical appropriations would more than double—to 7.3 percent—under Scenario 1 (in which VA's medical appropriations grow at an 11.5 percent nominal rate for the next 10 years).

Figure 3.

Projected Appropriations for VA Medical Care as a Share of Total Federal Discretionary Spending, Under the Inflation-Only Growth Assumption

(Percent)



Source: Congressional Budget Office.

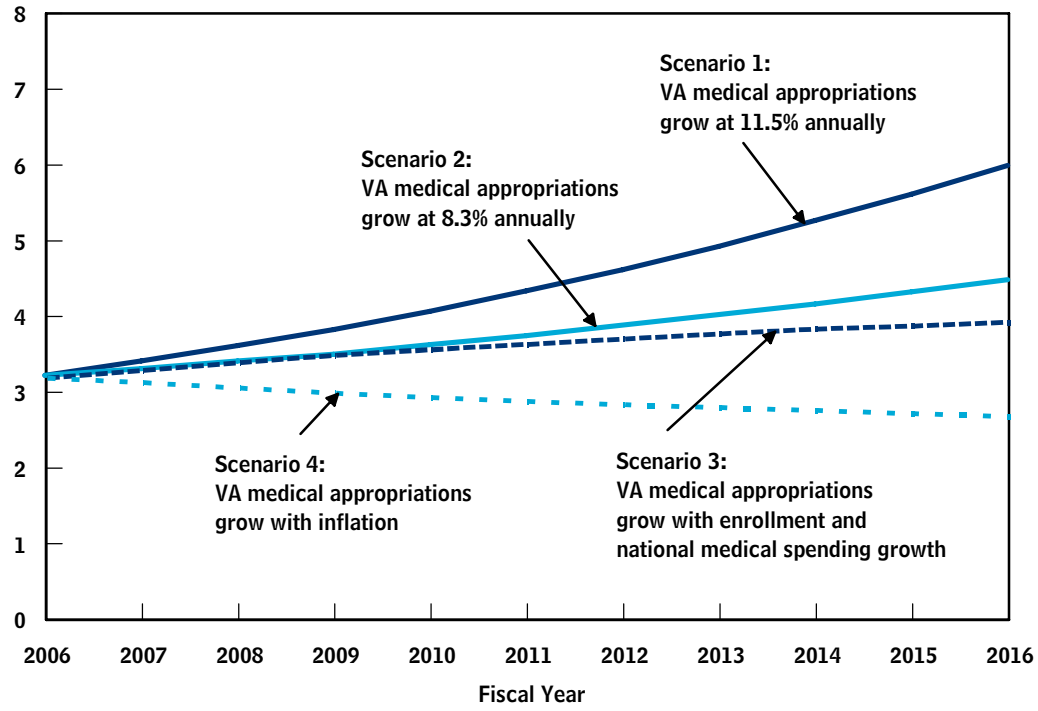
Note: VA = Department of Veterans Affairs.

Using the second assumption, federal discretionary spending would grow at the same rate that CBO projects for GDP. VA's share would decline under Scenario 4, falling from 3.2 percent to 2.7 percent by 2016, because VA's medical appropriations under that scenario would grow only as fast as inflation but not as fast as GDP (see Figure 4). VA's share would increase to 3.9 percent under Scenario 3 (medical appropriations grow with enrollment and national medical spending trends) and to 4.5 percent under Scenario 2 (medical appropriations grow at the average annual rate of the past seven years). The share of VA's medical appropriations would nearly double under Scenario 1 (in which the appropriations grow at an 11.5 percent nominal rate over the next decade), climbing from 3.2 percent to 6.0 percent by 2016.

Figure 4.

Projected Appropriations for VA Medical Care as a Share of Total Federal Discretionary Spending, Under the GDP Growth Assumption

(Percent)



Source: Congressional Budget Office.

Note: VA = Department of Veterans Affairs; GDP = gross domestic product.