Order Code RL32975

Veterans' Medical Care: FY2006 Appropriations

Updated August 2, 2005

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Veterans' Medical Care: FY2006 Appropriations

Summary

The Department of Veterans Affairs (VA) provides benefits to veterans who meet certain eligibility rules. Benefits to veterans range from disability compensation and pensions to hospital and medical care. VA provides these benefits to veterans through three major operating units: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA). VHA is primarily a direct service provider of primary care, specialized care, and related medical and social support services to veterans through an integrated health care system. Veterans are enrolled in priority groups that determine payments for service and non-service connected medical conditions.

The President's budget requested approximately $32.3 billion for VHA for FY2006. The Administration's request includes $22 billion for medical services, $4.5 billion for medical administration, $3.3 billion for medical facilities, $393 million for medical and prosthetic research, and $2.1 billion in collections (copays and third-party insurance payments).

On May 26, 2005, the House passed H.R. 2528 making appropriations for Military Quality of Life and Veterans Affairs and Related Agencies for FY2006 (MIL-QUAL appropriations bill). Among other things, H.R. 2528 provides $21 billion for medical services, $4.1 billion for medical administration, $3.3 billion for medical facilities, and $393 million for medical and prosthetic research. Under H.R. 2528, the total amount appropriated for veterans' health programs is $31 billion, including $2.1 billion in collections. On July 21, 2005, the Senate Appropriations Committee reported its version of H.R. 2528 making appropriations for Military Construction and Veterans Affairs and Related Agencies for FY2006 (MIL-CON appropriations bill). This bill would provide a total of $33.5 billion VHA programs. This is $1.1 billion more than the Administration's request for FY2006 and $2.5 billion more than the House-passed version of this bill

On June 23, 2005, VA announced a more than $1 billion shortfall from its FY2005 enacted budget for veterans' health programs. On July 26, 2005, the conferees of the Department of the Interior, Environment, and Related Agencies appropriations bill, 2006 (H.R. 2361, H.Rept. 109-188) provided $1.5 billion in supplemental appropriations for veterans medical services for FY2005, with carryover authority for FY2006 as well. The conference report has passed both the House and Senate and awaits the President's signature.

In its FY2006 budget submission to Congress, the Administration proposed several legislative and regulatory changes to increase certain copayments and other cost-sharing charges for veterans in lower-priority categories. The House and Senate Committees on Appropriations did not accept any of the Administration's cost-sharing proposals for VHA.

This report will be updated as legislative and budgetary activity occurs.

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Most Recent Developments

On July 26, 2005, the conferees of the Department of the Interior, Environment, and Related Agencies appropriations bill, 2006 (H.R. 2361, H.Rept. 109-188) provided $1.5 billion in supplemental appropriations for veterans medical services for FY2005, with carryover authority for FY2006 as well. This action was taken by Congress in response to the FY2005 budget shortfall of more than $1 billion announced by the Administration.[1] None of the supplemental appropriations would be contingent upon an emergency declaration.[2] The House adopted the conference agreement on July 28, 2005 and the Senate adopted the conference agreement a day later.

On July 21, 2005, the Senate Committee on Appropriations reported its version of H.R. 2528 (S.Rept. 109-105) making appropriations for Military Construction and Veterans Affairs and Related Agencies for FY2006 (MIL-CON appropriations bill). Among other things, this bill would provide $33.5 billion, including collections (copays and third-party insurance payments), for the Veterans Health Administration (VHA) programs. This is $1.1 billion more than the Administration's request for FY2006 and $2.5 billion more than the House-passed version of this bill. The MIL-CON appropriations bill would provide $23.3 billion for medical services, $2.9 billion for medical administration, $3.3 billion for medical facilities, $412 million for medical and prosthetic research, and $1.5 billion for information technology programs. It should be noted that the Committee has included bill language creating a separate account for information technology. Prior to this restructuring expenses for information technology was included in the medical administration account. The Committee **did not** recommend any of the fee increases proposed by the President.

On May 26, 2005, the House passed its version of H.R. 2528 (H.Rept. 109-95) making appropriations for Military Quality of Life and Veterans Affairs and Related Agencies for FY2006 (MIL-QUAL appropriations bill). Among other things, H.R. 2528 provided $21 billion for medical services, $4.1 billion for medical administration, $3.3 billion for medical facilities, and $393 million for medical and prosthetic research. Under H.R. 2528, the total amount appropriated for veterans'

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[1] On June 23, 2005, at a hearing of the House Veterans' Affairs Committee, the Administration announced that the increased medical care cost for FY2005 was about $1 billion more than the FY2005 enacted amount.

[2] By not designating funding as an emergency requirement the bill would exceed the funding levels agreed by the House and Senate in the FY2005 Budget Resolution (H.Con.Res. 95, H.Rept.108-498).

health programs is $31 billion including $2.1 billion in collections (copays and third-party insurance payments). The MIL-QUAL appropriations bill **did not** authorize any of the fee increases proposed by the President.

Background

The Department of Veterans Affairs (VA) provides benefits to veterans who meet certain eligibility rules. Benefits to veterans range from disability compensation and pensions, education, training and rehabilitation services, hospital and medical care, and other benefits, such as home loan guarantees and death benefits that cover burial expenses. VA carries out its programs nationwide through three administrations and the Board of Veterans Appeals (BVA). The Veterans Health Administration (VHA) is responsible for health care programs. The Veterans Benefits Administration (VBA) is responsible for providing compensation, pensions, and education assistance among other things. The National Cemetery Administration (NCA) is responsible for maintaining national veterans cemeteries.

VA's budget includes both mandatory and discretionary spending accounts. Mandatory funding supports disability compensation, pension benefits, vocational rehabilitation, and life insurance, among other benefits and services. Discretionary funding supports a broad array of benefits and services, including medical care. In FY2005, discretionary budget authority accounted for approximately 47% of the total VA budget authority, with most of this discretionary funding going toward supporting VA medical care.

VHA operates the largest direct health care delivery system in the nation.[3] In FY2004, VHA operated 157 hospitals, 134 nursing homes, 42 residential rehabilitation treatment centers, and 862 ambulatory care and community-based outpatient clinics. VHA also pays for care provided to veterans by independent providers and practitioners on a fee basis under certain circumstances. In addition, VHA provides grants for construction of state-owned nursing homes and domiciliary facilities, and collaborates with the Department of Defense (DOD) in sharing health care resources and services.

During FY2004, VHA provided medical services to an estimated 4.7 million unique veteran patients, a caseload that is expected to reach approximately 4.8 million in FY2005. According to VHA, this number will decrease to approximately 4.7 million by the end of FY2006.[4] The total number of outpatient visits reached 49.9 million during FY2004, and is projected to increase to 52.8 million in FY2005 and 55.8 million in FY2006. In FY2004, VHA spent approximately 56% of its medical care obligations on outpatient care.

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[3] Established in 1946 as the Department of Medicine and Surgery, succeeded in 1989 by the Veterans Health Services and Research Administration, renamed the Veterans Health Administration in 1991.

[4] These are unduplicated veteran patients; this number and projections exclude Readjustment Counseling, State Home, Civilian Health and Medical Program of VA (CHAMPVA), Spina Bifida, Foreign Medical Program and non-veterans. Data provided by VA.

In addition, VHA manages the largest medical education and health professions training program in the United States. Veterans' health care facilities are affiliated with 107 medical schools, 55 dental schools and more than 1,000 other schools offering students allied and associated education degrees or certificates in 40 health profession disciplines. In FY2004, over 84,000 health care professionals received training in VA medical centers.[5]

This report provides: (1) a basic overview of the federal appropriation process; (2) a brief overview of VHA's enrollment process and its enrollment priority groups; (3) a brief summary of funding levels for VHA for FY2005; (4) a discussion of the FY2005 and FY2006 budget shortfall; and (5) a discussion of the Administration's budget proposals for FY2006 and the amounts passed by the House and recommended by the Senate Appropriations Committee. This report will be updated to show the funding levels passed by the Senate and ultimately enacted by Congress and signed into law by the President.[6]

The Federal Budget

In general, the federal budget process begins with the submission of the President's budget request to Congress. Following this submission, the Budget Committees of the House and Senate develop the annual budget resolution, which sets forth aggregate spending and revenue levels, by functional levels of spending, for the upcoming fiscal year and at least the following four fiscal years.[7] The budget resolution is not binding and does not allocate funds among specific programs or accounts, but the major program assumptions underlying the functional amounts are often discussed in the accompanying report.[8] The House and Senate Appropriations Committees subdivide their allocations among their respective subcommittees, which are each responsible for one of the regular appropriations acts. Authorizing committees for certain programs may also consider legislation that will affect spending under their programs. A committee has the discretion to decide on the legislative changes to be recommended. It is not bound by the program changes recommended or assumed by the Budget Committees in the reports accompanying the budget resolution.

Changes in Appropriation Committee Jurisdictions. At the beginning of the 109th Congress, both the House and Senate Appropriations Committees reorganized their respective subcommittees. The House Committee on Appropriations reduced its number of subcommittees to ten from the original thirteen subcommittees. The Senate Committee on Appropriations reduced its number of subcommittees to twelve from the original thirteen subcommittees. The House Subcommittee on Military Quality of Life and Veterans Affairs and Related Agencies

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[5] For a detailed description of veterans' health care issues, see CRS Report RL32961, *Veterans' Health Care Issues in the 109th Congress*, by Sidath Viranga Panangala.

[6] VHA and VA will be used interchangeably throughout this report to refer to VHA.

[7] Specifically, budget function 700 includes funding for VA benefits and services.

[8] For more information on the formulation of the budget resolution, see CRS Report 98-512, *Formulation and Content of the Budget Resolution*, by Bill Heniff, Jr.

received jurisdiction over funding for VA programs, among other things. Similarly, the Senate Subcommittee on Military Construction and Veterans Affairs received jurisdiction over appropriations for VA programs among other things. Prior to this restructuring, appropriations legislation for VA programs was the responsibility of the House and Senate Veterans Affairs, Housing and Urban Development, and Independent Agencies Subcommittees.

VHA Health Care Enrollment

To understand VA's medical care appropriations and the Administration's major policy proposals discussed later in this report, it is important to understand VA's enrollment process and its enrollment priority groups. The Veterans' Health Care Eligibility Reform Act of 1996, P.L. 104-262 required the establishment of a national enrollment system to manage the delivery of inpatient and outpatient medical care. The new eligibility standard was instituted by Congress to "ensure that medical judgment rather than legal criteria will determine when care will be provided and the level at which care will be furnished."[9]

For most veterans, entry into the veterans' health care system begins with application for enrollment.[10] A veteran may apply for enrollment at any time during the year. Eligibility for VA health care is primarily based on "veteran's status" resulting from military service. "Veteran's status" is established by active-duty status in the military, naval, or air service and a honorable discharge or release from active military service.

After "veterans' status" has been established ,VA next places applicants into one of two categories. The first group in general is composed of veterans with service-connected disabilities or with lower incomes. These veterans are regarded by VA as "high priority" veterans, and they are enrolled in Priority Groups 1-6 (see **Appendix 1**). Veterans enrolled in Priority Groups 1-6 include:

- veterans in need of care for a service-connected disability;[11]
- veterans who have a compensable service-connected condition;

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[9] H.Rept. 104-690.

[10] Veterans do not need to apply for enrollment in VA's health care system if they fall into one of the following categories: veterans with a service-connected disability rated 50% or more (percentage ratings represent the average impairment in earning capacity resulting from diseases and injuries encountered as a result of or incident to military service; those with a rating of 50% or more are placed in Priority Group 1); less than one year has passed since the veteran was discharged from military service for a disability that the military determined was incurred or aggravated in the line of duty, but the VA has not yet rated; or the veteran is seeking care from VA for only a service-connected disability (even if the rating is only 10%).

[11] The term "service-connected" means, with respect to disability, that such disability was incurred or aggravated in line of duty in the active military, naval, or air service. VA determines whether veterans have service-connected disabilities, and for those with such disabilities, assigns ratings from 0 to 100 based on the severity of the disability.

- veterans whose discharge or release from active military, naval or air service was for a compensable disability that was incurred or aggravated in the line of duty;
- veterans who are former prisoner of wars (POWs);
- veterans awarded the purple heart;
- veterans who have been determined by VA to be catastrophically disabled;
- veterans of World War I;
- veterans who were exposed to hazardous agents (such as Agent Orange in Vietnam) while on active duty; and
- veterans who have annual income and net worth below a VA-established means test threshold.

VA also looks at applicants' income and net worth to determine their specific priority category and whether they have to pay copayments for nonservice-connected care. In addition, veterans are asked to provide VA with information on any health insurance coverage they have — including coverage through employment or through a spouse. VA may bill these payers for treatment of conditions that are not a result of injuries or illnesses incurred or aggravated during military service. **Appendix 2** provides information on what categories of veterans pay for which services.

The second group is composed of veterans who don't fall into one of the first six priority groups. These veterans are primarily those with nonservice-connected conditions and with incomes and net worth above the VA established means test threshold, and in general these veterans are enrolled in Priority Group 7 or 8.

Funding for VHA

VHA is funded through multiple appropriations accounts that are supplemented by other sources of revenue. Although the appropriations account structure has been subject to change from year to year, traditionally the appropriation accounts used to support VHA include medical care, medical and prosthetic research, and medical administration. In addition, Congress also appropriates funds for construction of medical facilities through a larger appropriations account for construction for all VA facilities. Furthermore, the Committees on Appropriations include medical care cost recovery collections when considering the amount of resources needed to provide funding for VHA. VHA is authorized to bill some veterans and most health care insurers for nonservice-connected care provided to veterans enrolled in the VA health care system, to help defray the cost of delivering medical services to veterans. The Balanced Budget Act of 1997 (P.L. 105-33) gave VHA the authority to retain these funds in the Medical Care Collections Fund (MCCF). Instead of returning these funds to the Treasury, VA can use this for medical services for veterans without fiscal year limitations.[12]

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[12] For a detailed history of funding for VHA from FY1995 to FY2004, see CRS Report RL32732, *Veterans' Medical Care Funding FY1995-FY2004*, by Sidath Viranga Panangala.

FY2005 Budget Summary

The Consolidated Appropriations Act, 2005 (P.L. 108-447)[13,14] provided $30.1 billion in FY2005 for VHA — an increase of $1.2 billion over the FY2005 Administration's request, and $1.9 billion over FY2004. As shown in **Table 1**, P.L. 108-447 provided $19.3 billion to finance medical services. Furthermore, it appropriated $4.7 billion for medical administration, $3.7 billion for medical facilities, and $402 million for medical and prosthetic research. Funding for VHA included $1.9 billion in the MCCF. The Consolidated Appropriations Act, 2005, also included $370 million from the construction major account and $182 million from the construction minor account for Capital Asset Realignment for Enhanced Services (CARES)-related activities. It should be noted that these amounts are not included in the total VHA budget since construction major and construction minor accounts are funded through separate construction accounts. The Consolidated Appropriations Act, 2005, did not approve the Administration's proposal to fund VHA through an alternative account structure, and **did not** include any copayment changes that were proposed in the President's budget request.[15]

On October 13, 2004, the Military Construction Appropriations and Emergency Hurricane Supplemental Appropriations Act, 2005 (P.L. 108-324, H.Rept. 108-773) was signed into law. As enumerated in **Table 1** this bill provided an additional $87 million for VHA for FY2005. On July 26, 2005, the conferees of the Department of the Interior, Environment, and Related Agencies appropriations bill, 2006 (H.R. 2361, H.Rept. 109-188) provided $1.5 billion in supplemental appropriations for veterans medical services for FY2005, with carryover authority for FY2006 as well. This action was taken by Congress in response to the FY2005 budget shortfall of more than $1 billion announced by the Administration(**Table 1**).

FY2006 VHA Budget

President's FY2006 Budget

The President's budget request for FY2006 was submitted to Congress on February 7, 2005. The President's budget requested approximately $30.4 billion for VHA. This is an increase of $199 million over the FY2005 enacted amount. The Administration's request includes $20 billion for medical services, $4.5 billion for medical administration, $3.3 billion for medical facilities, $393 million for medical and prosthetic research. The budget request also included $2.17 billion in medical

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[13] U.S. Congress, Conference Committees, *Consolidated Appropriations Act, 2005*, conference report to accompany H.R. 4818, 108th Cong., 2nd sess., H.Rept. 108-792.

[14] The Consolidated Appropriations Act, 2005, was signed into law on Dec. 8, 2004.

[15] For a detailed description of the FY2005 appropriations for VHA, see CRS Report RL32548, *Veterans' Medical Care Appropriations and Funding Process*, by Sidath Viranga Panangala.

care cost collections (a description of each of these accounts is given **Appendix 3**).[16] It should be noted here that the funding levels described above excludes the President's budget amendment submitted on July 14,2005 (see description under FY2005 and FY2006 budget shortfall).

House and Senate Budget Resolutions

On March 17, 2005 the House passed H.Con.Res. 95 (H.Rept. 109-17), providing $31.7 billion for VA's discretionary programs and $37.1 billion for mandatory programs. The Senate approved its bill, S.Con.Res. 18, on the same day and provided $68.9 billion for both discretionary and mandatory programs.[17] The House-passed budget resolution included a directive to the House Committee on Veterans' Affairs to reduce the level of direct spending on veterans' programs by $155 million for FY2006, but the Senate version did not.

On April 28, 2005, House and Senate conferees concluded negotiations on H.Con.Res. 95 (H.Rept 109-62), the FY2006 budget resolution. The conference agreement includes $31.8 billion in budget authority for VA discretionary programs including veterans' health care. This amount included $410 million over the President's recommended level of $31.4 billion for VA's discretionary programs. The conference agreement **did not** include any language directing the House and Senate Committees on Veterans' Affairs to reduce direct spending for veterans programs.

FY2006 House Appropriations Bill

On May 23, 2005, the House Committee on Appropriations reported H.R. 2528, (H.Rept. 109-95) making appropriations for Military Quality of Life and Veterans Affairs and Related Agencies for FY2006 (MIL-QUAL appropriations bill). The House passed H.R. 2528 on May 26, 2005. The MIL-QUAL appropriations bill provided $30.9 billion for VHA, an increase of $617 million over the FY2006 President's request, and $815 million over FY2005.

H.R. 2528 provided $21 billion for medical services. This is an increase of $1 billion over the President's FY2006 request, and $1.6 billion above the FY2005 enacted level (see **Table 1**). The Committee designated $2.2 billion of this recommended amount for speciality mental health care. According to the committee report, the Committee took the unusual step of fencing off these funds for one category of treatment because the Committee recognizes the need to dedicate resources for this treatment, and wants to be assured that funding for mental health care will not be used for other purposes.[18]

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[16] The terms "President's budget request" and the "Administration's budget request" will be used interchangeably throughout this report to refer to the same document.

[17] There is no Senate report to accompany S.Con.Res. 18.

[18] U.S. Congress, House Committee on Appropriations, *Military Quality of Life and Veterans Affairs and Related Agencies Appropriations Bill, 2006*, report to accompany H.R.

(continued...)

The MIL-QUAL appropriations bill also provided $4.1 billion for medical administration, a $534 million decrease from the FY2005 enacted level and $383 million less than the Administration's request. Most of this reduction is from VHA's information technology programs including the Health*e*Vet-VistA project.[19] The House Appropriations Committee recommended $3.3 billion for medical facilities, a decrease of $464 million from FY2005 and the same as the President's request. Furthermore, the committee recommended $393 million for medical and prosthetic research, the same as the Administration's request and $9.3 million less than the FY2005 enacted level (see **Table 1**). The committee report language stated that VA should dedicate at least 20% of its research budget towards mental health research programs. Furthermore, H.R. 2528 appropriated $607 million for construction major projects and $209 million for construction minor projects, the same as the President's request for these accounts. The MIL-QUAL appropriations bill provided $25 million for Grants for Construction of State Extended Care Facilities. This is $79 million less than the FY2005 enacted amount. The Administration's budget did not request any funding for this program (see discussion below). It should be noted that these amounts are not included in the total VHA budget since construction major, construction minor, and grants for construction of state extended care facilities accounts are funded through separate construction accounts.

FY2005 and FY2006 Budget Shortfall

On June 23, 2005, at a hearing of the House Veterans Affairs Committee the Administration announced that the increased medical care cost for FY2005 was about $1 billion more than the FY2005 enacted amount. At a hearing before the House Appropriations Subcommittee on Military Quality of Life and Veteran Affairs on June 28, 2005, the Secretary testified that for FY2006 veterans' health care programs would need $1.1 to $1.6 billion more than the FY2006 President's request. On June 29, 2005 the Senate passed H.R. 2361 (H.Rept. 109-80) making appropriations for the Department of the Interior, Environment and Related Agencies for FY2006. Included in this bill was $1.5 billion in "emergency appropriations" for veterans' medical services for FY2005.

On June 30, 2005, the Administration submitted a supplemental appropriations request to Congress requesting an additional $975 million for medical services for FY2005. This amount includes $273 million for increased workload due to new veterans returning from Iraq and Afghanistan. When developing its budget for FY2005 VA did not forecast the impact of the extended operations in Iraq and Afghanistan. The FY2005 budget assumed that only 23,533 veteran patients from and Iraq and Afghanistan would be entering the VA health care system; VA now estimates this number to be 103,000. Furthermore, the total requested amount includes $226 million for veterans long-term care, $200 million for increased workload in Priority Groups 1-6 veterans, $58 million for reducing the backlog of

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[18] (...continued)
2528, 109th Congress, 1st session, H.Rept. 109-95, p. 53.

[19] Health*e*Vet-VistA is a next generation computerized outpatient and inpatient information system based on VA's current Veterans Health Information Systems and Technology Architecture (VistA). In general, VistA is an electronic medical record.

veterans on waiting lists, $39 million for health care needs of dependents of 100% service-connected veterans, $84 million for purchase of emergency medical equipment, and $95 million for increased fuel and utility costs. Soon after the Administration presented its budget request, the House passed H.R. 3130 providing $975 million in supplemental FY 2005 appropriations for veterans medical services, equal to the administration's request. Although the bill does not specifically direct how the money should be spent, it is expected that the $975 million would be distributed as recommended by the administration.

On July 14, 2005, the Administration submitted a budget amendment for FY2006 requesting an additional $1.97 billion for VA medical services. This amount includes $276 million for increased workload due to returning veterans from Iraq and Afghanistan and $600 million for veterans long-term care services. When developing its FY2006 budget request the Administration underestimated the demand for long-term care services. The budget assumed that the average daily census level for long-term care would be 9,795; VA now estimates that this level should be 11,500.[20] Moreover, the budget amendment includes $152 million for reducing the backlog of veterans on waiting lists for medical appointments, $249 million to address increases in the number of patients, $400 million to address increases in utilization of services by veterans already receiving care from VA, and $300 million to replenish the carryover funds from FY2005. When developing its FY2006 budget request the Administration believed that it could carryover about $300 million from FY2005 into FY2006. It should be also noted that this budget amendment assumes the fee increases proposed in the President's FY2006 budget request.[21]

In response to the FY2005 budget shortfall for VA medical services, on July 26, 2005 the conferees of the Department of the Interior, Environment and Related Agencies, Appropriations bill, 2006 (H.R. 2361, H.Rept. 109-188) provided $1.5 billion in supplemental appropriations for VA medical services for FY2005. The bill included language that would allow VA to carryover any unused funds into FY2006. The House passed H.R. 2361 on July 28, 2005, and the Senate passed the measure a day later. It is unlikely that the Senate will consider H.R. 3130 because H.R. 2361 provides the additional funding needed for FY2005.

FY2006 Senate Appropriations Bill

On July 21, 2005, the Senate Committee on Appropriations reported out of committee H.R. 2528 (S.Rept. 109-105) making appropriations for Military Construction and Veterans Affairs and Related Agencies for FY2006 (MIL-CON appropriations bill). This bill would provide approximately $33.5 billion for VHA, including collections (**Table 1**). This is $1.2 billion above the Presidents request and

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[20] Average daily census is the average number of people served on an inpatient basis on a single day during the reporting period.

[21] At a House Veterans Affairs Committee Hearing on July 21, 2005, the Under Secretary for Health, Department of Veterans Affairs testified that "the total monetary effect of those — or appropriation effect of the fee increases — was approximately $1 billion. And, in absence of that, in addition to the $1.977 billion that we've come forward with the presidential budget amendment request for, an additional $1 billion would be necessary."

$2.5 billion above the House-passed amount. The total amount recommended for VHA is composed of $23.3 billion for medical services including $1.97 billion in "emergency appropriations" as requested by the President's budget amendment,[22] $2.9 billion for medical administration, $3.3 billion for medical facilities, $412 million for medical and prosthetic research, $1.5 billion for information technology and $2.2 billion in medical care collections. It should be noted here that the Committee has included bill language creating a separate account for information technology for the entire VA and not specifically for VHA. This would separate information technology from the medical administration account. According to the committee report this new account structure will help VA to better organize its entire information technology program and more accurately display and report VA's information technology efforts.

The MIL-CON appropriations bill has recommended $607 million for construction major projects and $209 million for construction minor projects, the same as the President's request and the House-passed funding levels for these accounts. Moreover, the MIL-CON appropriations bill provides $104 million for grants for construction of state extended care facilities. This amount is the same as the FY2005 enacted level and $79 million above the House-passed amount. The Administration's budget did not request any funding for this program (see discussion below). It should be noted that these amounts are not included in the total VHA budget because construction major, construction minor, and grants for construction of state extended care facilities accounts are funded through separate construction accounts.

Furthermore, the Committee **did not** approve any of the Administration's fee proposals. According to the committee report:

> The Committee is not supportive of these new proposals which would force hundreds of thousands of needy veterans to leave the VA system. To this end, the Committee recommendation reflects the real fiscal needs of the VA without charging the veteran population to make up the shortfall and has included direct appropriations to cover the differences. In future budget submissions, the VA should request a funding level that adequately represents the real needs of the veterans in the VA system without devising new fees. Therefore, the Committee directs that the VA not implement any of the new policy proposals, as submitted in the budget request, without concurrence from the Committees on Appropriations in both Houses of Congress.[23]

It is likely that the Senate will vote on the MIL-CON Appropriations bill after the August recess.

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[22] By designating funding as an emergency requirement it is not subject to enforcement procedures under the congressional budget process.

[23] U.S. Congress, Senate Committee on Appropriations, *Military Construction and Veterans Affairs and Related Agencies Appropriations Bill, 2006*, report to accompany H.R. 2528, 109th Cong., 1st sess., S.Rept. 109-105, p. 48.

Table 1. VHA Appropriations FY2004,FY2005, and FY2006 Request, and Amounts Recommended

($ in thousands)

Program	FY2004 enacted	FY2005 request	FY2005 House	FY2005 Senate	FY2005 enacted	FY2006 request	FY2006 House	FY2006 Senate Appropriations Committee
Medical services	$17,762,054	—	$19,498,600	$19,498,600[a]	$19,316,995	$19,995,141	$20,995,141	$21,331,011
Supplemental appropriations (P.L. 108-324)	—	$38,283	—	—	38,283	—	—	—
Supplemental appropriations	—	975,000[b]	975,000[c]	1,500,000[d]	1,500,000[e]	—	—	—
Emergency appropriations	—	—	—	—	—	1,977,000[f]	—	1,977,000[g]
Subtotal medical services	***17,762,054***	***1,013,283***	***20,473,600***	***20,998,600***	***20,855,278***	***21,972,141***	***20,995,141***	***23,308,011***
Medical administration	4,970,500	—	4,705,000	4,705,000	4,667,360	4,517,874	4,134,874	2,858,442
Supplemental appropriations (P.L. 108-324)	—	1,940	—	—	1,940	—	—	—
Subtotal medical administration	***4,970,500***	***1,940***	***4,705,000***	***4,705,000***	***4,669,300***	***4,517,874***	***4,134,874***	***2,858,442***
Medical facilities	3,976,400	—	3,745,000	3,745,000	3,715,040	3,297,669	3,297,669	3,297,669
Supplemental appropriations (P.L. 108-324)	—	46,909	—	—	46,909	—	—	—
Subtotal medical facilities	***3,976,400***	***46,909***	***3,745,000***	***3,745,000***	***3,761,949***	***3,297,669***	***3,297,669***	***3,297,669***
Medical and prosthetic research	405,593	384,770	384,770	405,593	402,348	393,000	393,000	412,000
Information technology	—	—	—	—	—	—	—	1,456,821
Medical care[h]	—	26,748,600	—	—	—	—	—	—
rescission	-270,000	—	—	—	—	—	—	—
Total VHA appropriations (without collections)	**26,844,547**	**28,195,502**	**28,308,370**	**28,854,193**	**29,688,875**	**30,180,684**	**28,820,684**	**31,332,943**
Medical care cost collection (MCCF)[i]	1,554,772	2,002,000	2,002,000	2,002,000	1,985,984	2,170,000	2,170,000	2,170,000
Total: VHA (appropriations and collections)	**$28,399,319**	**$30,197,502**	**$31,310,370**	**$30,856,193**	**$31,674,859**	**$32,350,684**	**$30,990,684**	**$33,502,943**

Source: Table prepared by the Congressional Research Service based on H.Rept. 108-674; S.Rept. 108-353; H.Rept. 109-95; and S.Rept. 109-105.

Note: Appropriation amounts for FY2005 adjusted to account for the 0.8% across-the-board reduction in most discretionary accounts as called for in Division J, Section 122 (a)(1) of P.L. 108-447. Supplemental appropriations for FY2005 are not subject to the 0.8% across-the-board reductions.

a. This amount includes $1.2 billion designated as an emergency requirement.
b. On June 30, 2005, the Administration requested an additional $975 million for medical services for FY2005.
c. On June 30, 2005, the House passed H.R. 3130.
d. On June 29, 2005, the Senate passed an amendment to H.R. 2361, the Department of the Interior, Environment, and Related Agencies Appropriations bill, 2006 to add $1.5 billion in emergency funds for medical services.
e. On July 26, 2005, the conference committee on H.R. 2361 reported the measure favorably out of committee (H.Rept. 109-188).
f. On July 14, 2005, the Administration requested an additional $1.977 billion for medical services for FY2006.
g. On July 21, 2005, the Senate Committee on Appropriations reported H.R. 2528 favorably out of committee (S.Rept. 109-105), and designated this amount as an emergency appropriation.
h. This amount includes funding for medical services, medical administration, and medical facilities.
i. Medical Care Cost Collection Fund (MCCF) receipts are restored to VHA as an indefinite budget authority equal to the revenue collected, estimated to be $1.985 billion in FY2005 and $2.17 billion in FY2006.

Key Budget Issues

In its FY2006 budget proposal the Administration is recommending a set of legislative and regulatory proposals. The Administration asserts that these proposals will refocus the veterans' health care system to better meet the needs of high priority core veterans — those with service-connected conditions, those with lower incomes, and veterans with special care needs. Some of these proposals were proposed in FY2004 and FY2005 as well, and were rejected by Congress.[24]

Changes in Cost-Sharing for Health Services

- Assess an annual enrollment fee of $250 for all Priority 7 and 8 veterans;
- Increase the veterans' share of pharmaceutical copayments from $7 to $15 (for each 30-day prescription) for all enrolled veterans in Priority Groups 7 and 8;
- Eliminate copayments for hospice care; and
- Authorize VA to pay for emergency care for enrolled veterans in non-VA medical facilities.

Changes in Long-Term Care Services

- Revise eligibility criteria for VA sponsored long-term care and restrict per-diem payments to state veterans nursing homes;
- Place a one year moratorium on grants for state extended care facilities;
- Exempt former POWs from long-term care copayments; and
- Eliminate mandatory long-term care daily census requirements.

A detailed description of the above legislative proposals follows:

Legislative Proposals to Change the Cost-Sharing Structure

Assess an Annual Enrollment Fee

The Administration proposes to establish an annual enrollment fee of $250 beginning October 1, 2005, for all Priority 7 and 8 veterans. Priority Group 7 veterans have incomes above $25,843 for a single veteran and below the Department of Housing and Urban Development (HUD) geographic means test level.[25] Priority

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[24] See CRS Report RL32548, *Veterans' Medical Care Appropriations and Funding Process*, by Sidath Viranga Panangala.

[25] The means test tables are available at [http://www.huduser.org/Datasets/IL/IL04/]. Also note that when determining if the veterans should be placed in Priority Group 7 or Priority (continued...)

Group 8 veterans are those with incomes above $25,843 for a single veteran and above the HUD geographic means test. The HUD geographic means test is established at a local level such as county or city. For instance, a veteran with no dependents residing in Cleveland County, Arkansas, whose annual income in 2004 was $26,149 will be placed in Priority Group 7, since the veteran's annual income is above VA's means test threshold and below the geographic means test threshold for FY2004 of $26,150. Similarly, a veteran with no dependents living in Trenton, New Jersey, whose annual income in 2004 was $40,249 will be placed in Priority Group 7, since the veteran's annual income is above VA's means test threshold and below the geographic means test threshold for FY2004 of $40,250. It should noted that there is wide variation in annual incomes of veterans placed in Priority Groups 7 and 8.

In its FY2004 and FY2005 budget submissions, the President requested authority from Congress to levy an annual enrollment fee on all Priority 7 and Priority 8 veterans. However, Congress did not approve imposing such a fee.

The House Committee on Appropriations **did not** include any language that would impose an annual enrollment fee beginning in FY2006. The MIL-QUAL appropriations bill passed by the House **does not** contain any provision that would impose an enrollment fee. Likewise, the Senate Appropriations Committee **did not** approve an annual enrollment fee.

Although the House Appropriations Committee did not approve imposing an annual enrollment fee, the House Veterans Affairs Committee (majority members) in its FY2006 views and estimates letter to the House Budget Committee recommended a $230 enrollment fee for Priority Group 7 veterans, and a four tired enrollment fee for Priority Group 8 veterans based on their income above the HUD geographic means test. According to the Committee the fees would be: Tier 1 — $230; Tier 2 — $250; Tier 3 — $350; Tier 4 — $500. The Committee's views and estimates letter further states that these enrollment fees would apply to both veterans who are currently enrolled and new enrollees.

Similarly, the majority members of the Senate Veterans Affairs Committee in its FY2006 views and estimates letter to the Senate Budget Committee did agree to approve a $250 a year enrollment fee for higher income veterans who have no service-connected injuries. It should be noted that at this time both the House and Senate Veterans Affairs Committees **have not** introduced any measures that will give VA the authority to implement this proposal.

Increase Pharmacy Copayments

The Administration proposes to increase the pharmacy copayments from $7 to $15 for all enrolled Priority Group 7 and Priority Group 8 veterans whenever they

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[25] (...continued)
Group 8 based on income, the veteran's income from the previous year is compared with the appropriate geographic means test threshold for the previous fiscal year. For example, annual income for 2004 is compared to the geographic means test threshold for FY2004.

obtain medication from VA on an outpatient basis for the treatment of a nonservice-connected disability. At present, veterans in Priority Groups 2-8 pay $7 for a 30-day supply of medication including over-the-counter medications.[26] The Administration put forward this proposal in its FY2004 and FY2005 budget requests as well, but did not receive any approval from Congress.

Similar to the enrollment fee proposal, the House Committee on Appropriations **did not** include any language that would increase the pharmacy copayment from $7 to $15. The MIL-QUAL appropriations bill passed by the House **does not** contain any provision that would authorize such an increase in pharmacy copayments. The Senate Appropriations Committee **did not** recommend increasing the pharmacy copayment from $7 to $15.

The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) authorized VA to charge most veterans $2 for each 30-day supply of medication furnished on a outpatient basis for treatment of a nonservice-connected condition. The Veterans Millennium Health Care and Benefits Act of 1999 (P.L. 106-117) authorized VA to increase the medication copayment amount and to establish annual caps on the medication copayment amount.[27] An annual cap was established to eliminate financial hardship for veterans enrolled in Priority Groups 2-6. When veterans reach the annual cap, they continue to receive medications without making a copayment. For calendar year 2005, the cap is $840. There is currently no cap for veterans in Priority Groups 7 and 8 (see **Appendix 2**).

Impact of the Annual Enrollment Fee and Increase in Pharmacy Copayments. According to actuarial projections done by VA, the $250 annual enrollment fee and the increase in prescription drug copayments would reduce the number of unique veteran patients in FY2006 by approximately 213,000, and 1.1 million veteran enrollees. The enrollment fees and increased copayments would generate about $454 million in revenue and save VA an additional $202 million due to reduced demand.

Exempt Copayments for Hospice Care

The Administration is proposing to exempt hospice care provided in all settings from inpatient and outpatient copayments. Under current law, veterans receiving hospice care may be subject to copayment obligations depending upon the type of VA facility or setting in which they receive care. Veterans are subject to inpatient copayments if they seek inpatient hospice care at facilities without nursing home

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[26] Veterans receiving a pension for a nonservice-connected disability from VA, veterans with incomes below $10,162 (if no dependents), and $13,309 (with one dependent plus $1,734 for each additional dependent), veterans receiving care for conditions such as Agent Orange, Military Sexual Trauma and combat veterans within two years of discharge, and veterans who are former POW's are exempt from paying copayments.

[27] This law allowed VA to increase the copayment amount for each 30-day or less supply of medication provided on an outpatient basis (other than medication administered during treatment) for treatment of a nonservice-connected condition. Accordingly VA increased the copayment amount from $2 to $7.

beds, or if the hospice care must be provided in an acute care setting as a result of clinical complexity. Moreover, veterans choosing to remain at home for their hospice care are subject to outpatient primary care copayments.

The Veterans Health Programs Improvement Act of 2004 (P.L. 108-422), among other things, exempted veterans receiving hospice care at a nursing home from extended care copayments.

The Veterans Health Care Act of 2005 (S. 1182) if enacted, among other things, would authorize VA to exempt veterans receiving hospice care from any VA facility or setting from copayment obligations.

Authorize VA to Pay for Emergency Care for Insured Veterans

The Administration is proposing to reimburse out-of-pocket expenses for emergency care treatment provided to certain insured veterans in non-VA facilities. Under current law, VA is authorized to reimburse all veterans for emergency treatment furnished in non-VA facilities for nonservice-connected conditions if they meet the following criteria: (1) they have enrolled in VA's health care system; (2) they have received care from VA within the 24-month period preceding the provision of such emergency treatment; and (3) they are financially liable to the provider for the emergency treatment. Veterans who have health insurance coverage for emergency care, or are entitled to other federal benefits care (i.e., under Medicare or Medicaid), or have other contractual or legal recourse are not eligible for reimbursement. [28] Currently, VA does not reimburse the veteran's out-of-pocket expenses associated with nonservice-connected care.[29]

The Administration's proposal would give VA the authority to pay for insured veteran patients' out-of-pocket expenses for emergency care services if emergency care is obtained outside of the VA health care system for a nonservice-connected condition. VA would be a secondary payer to private insurance or Medicare for emergency care services. VA would cover the out-of-pocket expenses, that is the amount of the co-payment the veteran would have been required to pay if the veteran had received the care from VA for a nonservice-connected condition. A similar proposal was included in the FY2005 budget request as well, however, there was no legislative action on this proposal.

The Veterans Health Care Act of 2005 (S. 1182) if enacted, would authorize VA to reimburse an eligible veteran for expenses resulting from emergency treatment furnished in a non-VA facility for which the veteran remains personally liable.

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[28] Veterans Millennium Health Care and Benefits Act (P.L. 106-117).

[29] VA fully reimburses veterans for emergency treatment obtained in non-VA medical facilities for service-connected disabilities (38 U.S.C. § 1728).

Legislative Proposals to Change Long-Term Care Services

Revise Eligibility Criteria for Long-Term Care and Per-Diem Payments

VA's long-term care program includes a continuum of services for the delivery of care to veterans needing assistance due to chronic illness or physical or mental disability. Long-term care services are provided in a variety of settings, including institutional care in nursing homes, or home and community-based noninstitutional care, and respite care services that temporarily relieves a caregiver from the burden of caring for a chronically ill and disabled veteran in the home.

Nursing home care is provided through VA-operated nursing homes, VA contracted community nursing homes, and state veterans nursing homes owned and operated by individual states. VA pays a portion of the daily cost of care of veterans residing in these homes, paying a per-diem ($59.36 in FY2005) for each eligible veteran. VA does not directly place patients in state veterans homes as it does in contracted community nursing homes; veterans must apply to the homes for admission, and eligibility and admission requirements vary by each state.

In general, under current law any veteran who has a service-connected disability rated at 70% or more qualifies for nursing home care. Veterans whose service-connected disability is clinically determined to require nursing home care also qualify. VA may provide nursing home care to other veterans if space and resources are available. Veterans who have a service-connected disability are given first priority for nursing home care.

In its FY2006 budget proposal the Administration proposes to revise VHA's eligibility criteria for long-term care services provided in VA, community, and state nursing homes. Under the President's proposal state veterans nursing homes would receive per diem payments for Priority Groups 1-3 veterans and Priority Group 4 veterans who have catastrophic disabilities and who need short-term care (less than 90 days), or hospice or respite care.[30] For Priority Group 4 veterans who are not catastrophically disabled, and for Priority Groups 5-8 veterans, state veterans nursing homes would be reimbursed only for short- term care subsequent to a hospital stay. VA asserts that this proposal would save the department $294 million in FY2006. The number of veterans in state nursing homes on whose behalf VA pays per-diem payments would decrease from 17,328 in FY2004 to 7,217 in FY2006.

The House Committee on Appropriations rejected the Administration's proposal to restrict per diem payments to state veterans nursing homes. The committee report

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[30] Veterans are considered to be catastrophically disabled if they have a permanent severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living (ADL) such as eating, dressing, bathing, to such a degree that the individual requires personal or mechanical assistance to leave home or bed or requires constant supervision to avoid physical harm to self or others.

states that "VA should with the National Association of State Veterans Homes and other stakeholders develop and implement solutions that will give veterans the best options for quality long-term care."[31] According to the committee report, the amount of funding provided under the medical services account is sufficient for providing long-term care services in state veterans nursing homes without revising current eligibility criteria for long-term care services.

Place a One-Year Moratorium on Grants for State Extended Care Facilities

VA provides grants to states to acquire or construct extended care facilities, and to expand, remodel, or alter existing buildings. A grant may not exceed 65% of the total cost of the project.

In its FY2006 budget proposal, the Administration is proposing a one-year moratorium on grants to state extended care facilities. During this one-year period VA intends to complete a review of its long-term care infrastructure, comparing projected demand against capacity. As a result of this proposed study, VA has not requested any funding for FY2006 for grants for state extended care facilities. This is a decrease of $104 million from FY2005.

The House Committee on Appropriations recommended $25 million for the grant program. According to the committee report language, funds will be used for safety improvements in existing state home facilities. Furthermore, the committee directs VA to undertake an extensive analysis of veterans' long-term care needs.

The Senate Appropriations Committee recommended $104 million for the grant program. According to the committee report:

> The Committee was disappointed that VA did not request any funding for this program, nor did it provide any explanation for the action. The Committee believes the VA decision to "suspend" this program was done solely to reduce the budget request and has no substantive merit. Therefore, the Committee recommendation includes a funding level that is equal to the fiscal year 2005 enacted level. To do any less could potentially jeopardize projects currently awaiting funding as well as the welfare of deserving veterans[32]

Exempt Former Prisoners of War (POWs) from Long-Term Care Copayments

The Administration is proposing to exempt former POWs from paying copayments for long-term care services. The Veterans Health Care, Capital Asset,

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[31] U.S. Congress, House Committee on Appropriations, *Military Quality of Life and Veterans Affairs and Related Agencies Appropriations Bill, 2006*, report to accompany H.R. 2528, 109th Congress, 1st session, H.Rept. 109-95, p. 52.

[32] U.S. Congress, Senate Committee on Appropriations, *Military Construction and Veterans Affairs and Related Agencies Appropriations Bill, 2006*, report to accompany H.R. 2528, 109th Cong., 1st sess., S.Rept. 109-105, p. 65.

and Business Improvement Act of 2003 (P.L. 108-170) provided VA with the authority to exempt former POWs from medication copayments. At present, former POWs have no copayment obligations for hospital and medical services, except for long-term care services. This proposal would effectively end any remaining copayment obligations on part of a former POW. It should be noted that the Administration put forth a similar proposal in its FY2005 budget request as well, however, there was no legislative action on this proposal.

The Veterans Health Care Act of 2005 (S. 1182) was introduced on June 7, 2005 by Senator Craig, Chairman of the Committee on Veterans Affairs. If enacted it would eliminate copayment obligations on part of former POWs for long-term care services. The Committee held a hearing on this measure on June 9, 2005.

Eliminate Mandatory Long-Term Care Daily Census Requirements

The Administration is requesting Congress to repeal the mandatory staffing and level of extended care service requirements under current law. The Veterans Millennium Health Care and Benefits Act of 1999 (P.L. 106-117) required VA to maintain its inpatient long-term care bed capacity at the 1998 level of 13,391. The law specifically states:

> The Secretary shall ensure that the staffing and level of extended care services provided by the Secretary nationally in facilities of the Department during any fiscal year is not less than the staffing and level of such services provided nationally in facilities of the Department during fiscal year 1998.[33]

VA asserts that it seeks to provide long-term care services in the least restrictive setting that is compatible with the veterans medical condition and personal circumstances. VA believes that by repealing the mandatory staffing requirements and requirements concerning the number of long-term care beds, it will be able to provide veterans with home and community- based services (HCBS), while reserving nursing home care for situations in which the veteran can no longer be cared for in a home and community-based setting. According to VA, this proposal would reduce the average daily census of veterans residing in VA nursing homes from 12,354 at the end of FY2004 to 9,795 in FY2006 and save $202 million in FY2006. VA is projecting an increase in both work load and funding for HCBS programs. The number of veterans in HCBS programs is projected to increase from 25,523 in FY2004 to 35,540 in FY2006. During this same period funding is projected to increase from $287 million to $400 million. VA believes that projected increase in HCBS programs will serve to offset some of the reductions in nursing home care.[34]

Section 3 of the Veterans Health Care Act of 2005 (S. 1182) contains a provision that would repeal the mandatory staffing and level of extended care requirements under current law.

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[33] P.L. 106-117, 113 STAT. 1548.

[34] U.S. Department of Veterans Affairs, *FY2006 Budget Submissions, Medical Programs*, vol. 2, pp. 8-18.

Appendix 1. Priority Groups and Their Eligibility Criteria

Priority Group 1 Veterans with service-connected disabilities rated 50% or more disabling
Priority Group 2 Veterans with service-connected disabilities rated 30% or 40% disabling
Priority Group 3 Veterans who are former POWs Veterans awarded the Purple Heart Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty Veterans with service-connected disabilities rated 10% or 20% disabling Veterans awarded special eligibility classification under Title 38, U.S. C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"
Priority Group 4 Veterans who are receiving aid and attendance or housebound benefits Veterans who have been determined by VA to be catastrophically disabled
Priority Group 5 Nonservice-connected disabled veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds Veterans receiving VA pension benefits Veterans eligible for Medicaid benefits
Priority Group 6 Compensable 0% service-connected disabled veterans World War I veterans Mexican Border War veterans Veterans solely seeking care for disorders associated with — exposure to herbicides while serving in Vietnam; or — ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or — for disorders associated with service in the Gulf War; or — for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.
Priority Group 7 Veterans who agree to pay specified copayments who have income and/or net worth *above* the VA Means Test threshold and income *below* the HUD geographic index — Subpriority a: Noncompensable 0% service-connected disabled veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date — Subpriority c: Nonservice-connected disabled veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date. — Subpriority e: Noncompensable 0% service-connected disabled veterans not included in Subpriority a above — Subpriority g: Nonservice-connected disabled veterans not included in Subpriority c above
Priority Group 8 Veterans who agree to pay specified copayments with income and/or net worth *above* the VA Means Test threshold and the HUD geographic index — Subpriority a: Noncompensable 0% service-connected disabled veterans enrolled as of January 16, 2003 and who have remained enrolled since that date — Subpriority c: Nonservice-connected disabled veterans enrolled as of January 16, 2003 and who have remained enrolled since that date — Subpriority e: Noncompensable 0% service-connected disabled veterans applying for enrollment after January 16, 2003

Source: Department of Veterans Affairs.

Note: Service-connected disability means with respect to disability, that such disability was incurred or aggravated in the line of duty in the active military, naval or air service.

Appendix 2. Veterans' Payments for Health Care Services

	Copayments			Insurance billing
	Inpatient	Outpatient	Medication[a]	
Priority Group 1	No	No	No	Yes, but only if care was for nonservice-connected condition
Priority Groups 2, 3,[b] 4[c]	No	No	Yes, but only for veterans with less than 50% service connected disability and medication is for nonservice-connected condition	Yes, but only if care was for nonservice-connected condition
Priority Group 5	No	No	Yes	Yes, but only if care was for nonservice-connected condition
Priority Group 6 (WWI, and 0% service-connected compensable)	No	No	Yes	Yes, but only if care was for nonservice-connected condition
Priority Group 6 (Veterans receiving care for exposure or experience[d])	No[d]	No[d]	No[d]	Yes, but only if care was for nonservice-connected condition
Priority Group 7[e]	Yes	Yes	Yes	Yes, but only if care was for nonservice-connected condition
Priority Group 8[f]	Yes	Yes	Yes	Yes, but only if care was for nonservice-connected condition

Source: *President's Task Force to Improve Health Care Delivery for Our Nation's Veterans*

Note: Veterans receiving a pension for a nonservice-connected disability from VA, veterans with incomes below $10,162 (if no dependents), and $13,309 (with one dependent plus $1,734 for each additional dependent), veterans receiving care for conditions such as Agent Orange, Military Sexual Trauma and combat veterans within two years of discharge, and veterans who are former POWs are exempt from paying outpatient prescription copayments for nonservice-connected conditions.

a. An annual medication copayment cap has been established for veterans enrolled in priority groups 2-6. Medication will continue to be dispensed after copayment cap is met. An annual copayment cap has not been established for veterans enrolled in Priority Groups 7 or 8.
b. Veterans in receipt of a Purple Heart are in Priority Group 3. This change occurred with the enactment of the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) on Nov. 30, 1999.

c. Priority Group 7 veterans who are determined to be catastrophically disabled and who are placed in Priority Group 4 for treatment are still subject to the copayment requirements as a Priority Group 7 veteran.
d. Priority Group 6 — health insurance and all applicable copayments will be billed when care is for conditions not related to the veteran's experience or exposure. Veterans in this priority group could be subject to full medical care copayments or reduced inpatient copayments under means-test criteria for nonservice-connected conditions. Combat veterans receiving care for a potential service related condition within two years of discharge from the military are in Priority Group 6.
e. Priority Group 7 veterans — For inpatient copayments only, veterans enrolled in this priority group are responsible for 20% of the inpatient copayment (in traditional insurance this is known as a deductible) and 20% of the inpatient per diem copayment. The means-tested copayment reduction does not apply to outpatient and medication copayments and veterans will be assessed the full applicable copayment charges for nonservice-connected care.
f. Priority Group 8 veterans — For inpatient copayments only, veterans enrolled in this priority group are responsible for the full inpatient copayment (in traditional insurance this is known as a deductible) and the inpatient per diem copayment. Veterans in this priority group are also responsible for the full outpatient and medication copayments for nonservice-connected care. There is no means-tested copayment reduction.

Appendix 3. VHA's New Account Structure

Medical Services. This account provides funds for treatment of veterans and eligible beneficiaries in VA medical centers, nursing homes, outpatient clinic facilities, and contract hospitals. Hospital and out patient care is also provided by the private sector for certain dependents and survivors of veterans under the Civilian Health and Medical Program of VA (CHAMPVA). Funds are also used to train medical residents, interns, and other professional, paramedical and administrative personnel in health science fields to support VA's medical programs. Overhead costs associated with medical and prosthetic research are also funded by this account.

Medical Administration. This account provides funds for the management and administration of VA's health care system. Funds are used for the costs associated with the operation of VA medical centers, other facilities, VHA headquarters, costs of Veterans Integrated Service Network (VISN) offices, billing and coding activities, and procurement.

Medical Facilities. This account provides funds for the operation and maintenance of VHA's infrastructure. Funds are used for costs associated with utilities, engineering, capital planning, leases, laundry, food services, groundskeeping, garbage disposal, facility repair, and selling and buying of property.

Medical and Prosthetic Research. This account provides funds for medical, rehabilitative, and health services research. The medical and prosthetic research program is an intermural program. In addition to funds from this appropriation, reimbursements from the Department of Defense (DOD), grants from the National Institutes of Health (NIH), and private sources supports VA researches. Medical research supports basic and clinical studies that advances knowledge so that efficient, and rational interventions can be made to prevent, care or alleviate disease. The prosthetic research program is involved in the development of prosthetic, orthopedic and sensory aids to improve the lives of disabled veterans. The health services research program focuses on improving the outcome effectiveness and cost efficiency of health care delivery for the veterans population. Overhead costs associated with medical and prosthetic research are also funded by the medical services account.

Medical Care Collections Fund (MCCF). VA deposits copayments collected from veterans obligated to make such payments for either medical services or inpatient pharmacy benefits for outpatient medication, and third-party insurance payments from service-connected veterans for nonservice-connected conditions into MCCF.

Previously copayments, third-party insurance payments, and fees for services other than medical services or inpatient pharmacy benefits were deposited in several medical collections accounts. In FY2004, the Administration's budget requested consolidating several medical collections accounts into MCCF. The conferees of the Consolidated Appropriations Act of 2004 (H.Rept. 108-401) recommended that collections that would otherwise be deposited in the Health Services Improvement Fund (former name), Veterans Extended Care Revolving Fund (former name),

Special Therapeutic and Rehabilitation Activities Fund (former name), Medical Facilities Revolving Fund (former name), and the Parking Revolving Fund (former name) should be deposited in MCCF.[35] The Consolidated Appropriations Act of 2005, (P.L. 108-447, H.Rept. 108-792) provided VA with permanent authority to deposit funds from these accounts into MCCF. The funds deposited in MCCF would be available for medical services for veterans. These collected funds do not have to be spent in any particular fiscal year and are available until expended.

[35] For a detailed description of these former accounts, see CRS Report RL32548, *Veterans' Medical Care Appropriations and Funding Process*, by Sidath Viranga Panangala.