



Introduction to Veterans Health Care

The federal government’s role in providing health care to the nation’s veterans can be traced back to World War I. The veterans’ health care system was first developed in 1919 with the enactment of P.L. 65-326, which authorized the Public Health Service to provide needed care to veterans injured or sick as a result of military service—having a disability that is incurred or aggravated during active military, naval, or air service (today known as a service-connected disability). In 1924, with the enactment of the World War Veterans Act (P.L. 68-242), veterans with no service-connected disability but who were “financially unable to pay” for care were also given access to Department of Veterans Affairs (VA) health care, thus creating a safety net mission. Congress has enlarged the scope of VA’s health care mission, and it has enacted legislation to create new programs and expand benefits and services. This In Focus briefly outlines the mission, eligibility and enrollment requirements, health care delivery system, and funding for veterans health care. Selected trends in enrollment and budget are provided as well.

Mission of the VA Health Care System

VA provides health care and health-related services through the Veterans Health Administration (VHA). VHA’s primary mission is to provide health care services to eligible veterans. It also provides health care to some family members through the Civilian Health Medical Program of the Department of Veterans Affairs (CHAMPVA). The VHA is statutorily required to conduct medical research, to train health care professionals, to serve as a contingency backup to the Department of Defense medical system during a national security emergency, to provide support to the National Disaster Medical System (NDMS), and to provide assistance to the federal emergency response efforts (also known as VHA’s “Fourth Mission”), as necessary (38 U.S.C. §§7301-7303; §8111A; §1785).

Eligibility and Enrollment for Care

Not all veterans are eligible to receive care, and not every eligible veteran is automatically entitled to medical care from the VHA. Eligibility for VA health care has evolved over time, and laws governing eligibility have been amended by Congress many times—ultimately creating two broad categories of eligibility. Two significant laws that have affected eligibility include the Health Care Eligibility Reform Act of 1996 (P.L. 104-262) and the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act; P.L. 117-168). The PACT Act, among other things, made several changes to veterans’ health care eligibility for veterans exposed to burn pits or other toxic substances during their military service (see CRS Report R47542, *Honoring Our PACT Act of 2022 (P.L. 117-168): Expansion of Health Care Eligibility and Toxic Exposure Screenings*).

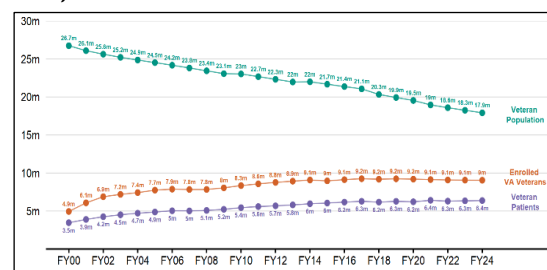
The first eligibility category includes veterans who *shall* be furnished care. This category comprises veterans with

service-connected disabilities; Medal of Honor recipients; Purple Heart recipients; former prisoners of war; World War II veterans; veterans exposed to toxic substances and environmental hazards, including burn pits; and veterans whose attributable income is not greater than an amount established by a “means test.” The second eligibility category includes veterans who *may* be eligible to receive care through VA to the extent resources permit. Once veterans are determined to be eligible for care in VHA, most eligible veterans are required to formally enroll in VA’s health care system to receive services (38 U.S.C. §1705). Once a veteran is enrolled, the veteran remains in the system and does not have to reapply for enrollment annually. Veterans are placed in one of eight priority enrollment groups. Veterans in some priority enrollment groups are required to pay co-payments for certain benefits. Enrolled veterans do not pay any premiums, deductibles, or coinsurance for their care. This is in contrast to major medical insurance plans, which typically have premiums, deductibles, coinsurance, and co-payments.

Trends in Enrollment

P.L. 104-262 required VHA to establish a patient enrollment system. Before the law was passed, VA medical centers used different methods to provide care to eligible veterans based on available resources. VHA started enrolling veterans in FY1999. **Figure 1** shows the trends in enrollment and the number of unique veteran patients from FY2000 to FY2024. In FY2000, the total veteran population was 26.75 million, 4.94 million veterans were enrolled in the VA health care system, and 3.46 million unique veteran patients received care. In FY2024, it is estimated that the total veteran population would be 17.91 million, an estimated 9.05 million would be enrolled, and an estimated 6.38 million veteran patients would receive care. In a given year, not all enrolled veterans receive their care from the VA, either because they do not need services or because they have other forms of health coverage, such as Medicare, Medicaid, or private health insurance.

Figure 1. Veteran Population, VA Enrollees, and VA Patients, FY2000-FY2024



Source: Chart prepared by CRS based on numbers VA budget justifications.

Note: FY2024 total veteran population projected as of September 30, 2022. FY2023 and FY2024 veteran enrollee and patient data are estimates.

VA Health Care System

Once veterans are eligible and enrolled, they receive their care directly through an integrated health care system (i.e., VHA). VHA is the largest public integrated direct health care delivery system in the United States, with over 1,200 sites of care, including hospitals, community living centers, health care centers, community-based outpatient clinics (CBOCs), other outpatient service sites, and dialysis centers. To administer this system, the VHA has divided the country into Veterans Integrated Service Networks (VISNs), based on geography. There are currently 18 VISNs, which vary regarding the types and number of facilities, and in geographic size. Each VISN has a VISN Director, who has oversight of the VA facilities within that VISN and who supervises the facility director at each facility. Although policies and guidelines are developed at VA headquarters for the VHA health care system as a whole, management authority for decisionmaking and budgetary responsibilities is delegated to the VISNs.

VHA operates under a different model from the predominant health care financing and delivery model in the United States, in which there is a payer for health care services (e.g., Medicare or private health insurance plan), a provider (e.g., hospital, physician), and a recipient of care (the patient). VHA is not a health insurance financing program that provides reimbursement to providers for all or a portion of a patient's health care costs. VHA is primarily a direct provider of care; VHA owns the hospitals and employs the clinicians. However, VHA does pay for care in the community under certain circumstances. The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act; P.L. 115-182) created the Veterans Community Care Program (VCCP), which applies eligibility for care in the community broadly to all enrolled veterans. For example, a veteran can seek care in the community if he or she needs a service that is unavailable at the VA, resides in a state with no full-service VA medical facility, meets certain access standards for drive- or wait-time, qualifies under standards for previous programs, or if it is in the best medical interest of the veteran. Under VCCP, third-party administrators (TPAs) administer a national Community Care Network (CCN) contract and provide eligible veterans access to medical care through a network of community providers as authorized by VHA.

Health Care Services

All enrolled veterans are eligible for a standard medical package, which includes a full range of health care, gender-specific medical services, prescription drugs, prosthetics and sensory aids, long-term care, and social support services. The medical package provides benefits generally not found in private health insurance plans, such as travel reimbursement for medical appointments, family caregiver stipends, homeless veterans programs, and dental care (38 C.F.R. §17.38). Under the Whole Health approach, veterans have access to acupuncture, mindfulness, tai chi, yoga, and other complementary and integrative health services.

Health Care Appropriations

Congress annually provides discretionary appropriations to fund VA health care and support services for enrolled veterans. In addition to annual discretionary appropriations, Congress has provided VHA the authority to bill some veterans and most health care insurers for nonservice-connected care provided to veterans to defray costs.

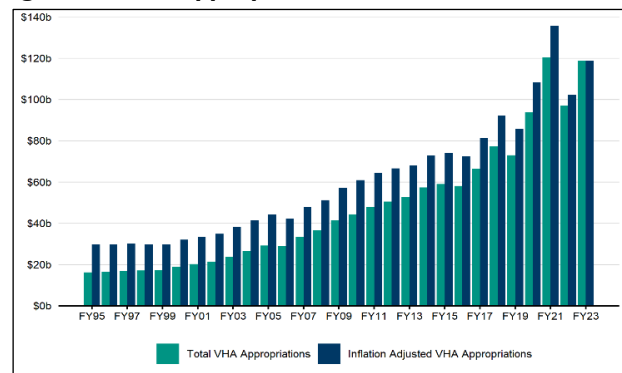
Toxic Exposure Fund (TEF)

The PACT Act established the Cost of War Toxic Exposure Fund (TEF) to be used for costs associated with the delivery of health care associated with environmental hazards during active military service. In addition, TEF funds may be used for costs associated with medical and other research related to environmental hazards, administrative expenses related to benefits (including information technology), benefit claims processing, and adjudicating appeals from veterans. TEF is considered “direct spending” and will be treated as an “appropriated entitlement.” (See TEF discussion in CRS Report R47423, *Department of Veterans Affairs FY2023 Appropriations*).

Trends in Appropriations

In FY2023 Congress provided \$118.75 billion for VHA, excluding medical research and collections. In FY1995 (the year prior to major reforms of 1996), this amount was \$16.22 billion (in nominal dollars). Between FY1995 and FY2023, VHA's appropriations grew in real terms by a compound annual growth rate of 5.06% (Figure 2).

Figure 2. VHA Appropriations, FY1995-FY2023



Source: Chart prepared by CRS based on appropriation figures provided by VA Office of Management, Office of Budget.

Notes: Chart excludes medical and prosthetic research funding, and medical care collections. Nominal (or current) dollar values are adjusted to real (constant) dollars using the Gross Domestic Product (GDP) Price Index Series deflator where 2023 (1st quarter) = 100.

CRS Products

CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*.

Sidath Viranga Panangala, Specialist in Veterans Policy
Jared S. Sussman, Analyst in Health Policy

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