United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Health,
Committee on Ways and Means,
House of Representatives

For Release
on Delivery
Expected at
10:00 a.m. EDT
Tuesday,
August 11, 1992

HEALTH CARE

Demonstration Project Concerning Future Structure of Veterans' Health Program

Statement of David P. Baine, Director
Federal Health Care Delivery Issues
Human Resources Division

SUMMARY

At the request of Senator Frank Murkowski, GAO reported in June 1992 on the potential effects of employer-mandated health insurance and universal health insurance on the demand for Department of Veterans Affairs (VA)-supported health care. GAO has several ongoing reviews that also focus on the future structure of veterans' health benefits.

Demand for VA inpatient services, as measured by days-of-care provided to veterans, could drop by about 18 percent if employers nationwide were mandated to either provide health insurance coverage for their workers or pay a tax that would be used to obtain the coverage. Under a nationwide universal health plan, the impact could be even greater--demand for VA inpatient care could drop by about 47 percent.

H.R. 5263 would test one option for using the excess capacity in VA facilities that could be created by such health reforms. Under H.R. 5263, up to seven VA facilities with excess capacity would be authorized to treat the Medicare-eligible dependents and survivors of military retirees. In addition, Medicare-eligible veterans currently being denied care at the facilities would be allowed to participate in the demonstration. The facilities would be allowed to obtain and retain reimbursement for covered services provided to program participants from Medicare.

GAO agrees with the objective of the demonstration to test the cost-effectiveness of such interagency sharing, but identifies several factors that should be considered in designing the demonstrations:

-- The effects of the demonstration on health care costs, both to the individual agencies and to the government will be hard to determine.

-- It will be difficult to control the number and types of program participants.

-- The extent to which program participants are provided services not covered under Medicare will affect costs.

-- VA may be unable to recover any of its costs for program participants from Medigap insurers because Medicare cost sharing is waived.

-- The demonstrations could adversely affect the ability of facilities to meet their mandatory work load unless tightly controlled.

-- Participating medical centers may have limited capabilities to meet the privacy needs of an influx of women patients.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here to discuss our recent report on the potential effects of employer-mandated and universal health insurance proposals on demand for services under the Department of Veterans Affairs (VA) health care system.[1] In addition, we will briefly describe ongoing efforts to evaluate the future structure of veterans' health benefits. Finally, we will provide our preliminary views on factors that should be considered in designing demonstration projects to authorize VA facilities to recover a portion of their costs from Medicare.

BACKGROUND

Serving over 26 million veterans, VA administers the nation's largest health care network. VA operates 171 hospitals, 126 nursing homes, and hundreds of outpatient clinics.

When VA was established in 1930, private and public health insurance were virtually nonexistent. The first Blue Cross and Blue Shield plans emerged in the 1930s, followed by "commercial" health insurance in the 1940s. In 1956, the first public health benefit program, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), was established to provide health care coverage to military retirees and the dependents of active duty and retired military personnel. In 1965, the Congress established the two largest public health insurance programs--Medicare serving over 30 million elderly, blind, and disabled Americans and Medicaid serving about 25 million low-income Americans.

Because of the growth of public and private health benefits programs, many veterans now have coverage under multiple programs. In 1987, almost 80 percent of all veterans were covered by private health insurance. In fact, veterans were slightly more likely to have private health insurance than nonveterans. Similarly, about 30 percent of veterans are over age 65.[2] Almost all people over age 65 are eligible for Medicare.

VA currently recovers a portion of the costs it incurs in providing care to privately insured veterans from those veterans' insurance. This includes recoveries under Medicare supplemental insurance policies. The recovery authority was established based on our recommendation, and we continue to support VA recoveries from private health insurance.

---

[1]VA Health Care: Alternative Health Insurance Reduces Demand for VA Care (GAO/HRD-92-79, June 30, 1992).

[2]A 1987 VA survey found that over half of the veterans who used VA inpatient services in the past year were eligible for Medicare.

VA does not have similar authority to recover for services provided to veterans who are eligible for Medicare and Medicaid. H.R. 5263 would authorize the Secretary of Veterans Affairs to establish a demonstration project to determine the cost-effectiveness of (1) providing health care to Medicare-eligible veterans and Department of Defense (DOD) beneficiaries who are generally not able to gain access to care under VA and DOD health programs and (2) recovering the cost of such care from Medicare. In other words, the demonstration would test whether VA can provide care to Medicare-eligible people at less cost than community providers, thereby reducing government health care costs. Up to seven VA facilities that have excess capacity and are in the same geographic vicinity as DOD facilities that are scheduled for closure (or that have been closed) would participate in the demonstration.

ALTERNATE INSURANCE DECREASES DEMAND FOR VA SERVICES

As you know, many states have taken or are considering actions that could reduce the number of people without health insurance. And, at the national level, there are numerous proposals for nationwide employer mandates or universal health insurance.

Any program that would expand insurance coverage among veterans could substantially reduce demand for VA-sponsored care. For example, we estimate that demand for VA inpatient services, as measured by days-of-care provided to veterans, could drop by about 18 percent if employers nationwide were mandated to either provide health insurance coverage for their workers or pay a tax that would be used to obtain the coverage. Similarly, demand for VA outpatient services could drop by about 9 percent.

Our estimates are based on the premise that veterans obtaining alternate health insurance under employer mandates would, over time, reduce their use of VA health care to the lower rates that characterize veterans who now have private health insurance. For example, veterans without private coverage were eight times more likely to use VA inpatient care than veterans with private health insurance. Although several factors, such as the differences in the income of the employed-insured and employed-uninsured, could reduce the effect of employer mandates, we believe that there would be significant decreases in demand for VA care if employer mandates were implemented.

Under a nationwide universal coverage plan, we estimate that the effect could be even greater--demand for VA inpatient care could drop by about 47 percent. Likewise, use of VA outpatient care could drop by about 41 percent. Under a universal health insurance plan, veterans who would not be covered by employer mandates, including the unemployed, retired, and part-time workers would gain coverage.

Because veterans with private insurance tend to use VA care at a lower rate than veterans with public insurance--that is, Medicare or Medicaid--the decrease in demand for VA services might vary depending on whether the universal plan adopted resembled a private or public plan. In either case, we believe that the decrease would be substantial.

Even if future employer-mandated health insurance provides coverage for nursing home care, the mandates are not likely to have a significant effect on the demand for VA-sponsored nursing home care. This is because most VA nursing home care is provided to elderly veterans who are retired and would not be affected by employer mandates. In addition, the limited nature of nursing home coverage under most employer-mandated proposals means that many veterans needing such care would likely continue to seek it from VA.

Universal health coverage could, however, have a more significant effect on the demand for VA nursing home care to the extent that the universal plan provides coverage of long-term care services. Most of the major proposals have, however, focused on acute care rather than long-term care.

Under either employer health insurance mandates or some form of universal coverage, there would likely be a significant decline in demand for VA health care services. Such a decline could create significant excess capacity in VA facilities.

One option for utilizing any excess capacity in VA facilities that could result from health care reform would be to expand the patient population eligible to be served by the facilities. H.R. 5263 would test this option by authorizing VA to serve Medicare-eligible veterans and dependents and survivors of military retirees, who are currently unable to obtain care in VA or DOD facilities, in underutilized VA facilities.

ONGOING WORK RELATING TO STRUCTURE OF VETERANS' HEALTH BENEFITS

Before discussing the proposed demonstration, however, I would like to take a few moments to tell you about several ongoing GAO studies that could help VA in designing and evaluating the proposed demonstration.

First, we are comparing the health benefits under major health programs including VA, Medicare, DOD, Medicaid, and private insurance. We will be comparing the programs in terms of eligibility requirements, covered services and limitations on them, and cost sharing. Such information could be useful to VA in determining what services to cover under the demonstration project and the cost implications of various coverage options.

Second, we are developing data on the number of veterans eligible for care under major federal health programs and program expenditures on veterans health care under those programs. For example, we are matching VA records of eligible veterans with Medicare payment records. This will give us a better idea of the extent to which Medicare-eligible veterans rely on VA rather than community facilities for health care services.

Finally, we are studying veterans' concerns about gaining access to care at VA facilities. There are concerns that veterans in the mandatory-care category are unable to obtain care at some VA facilities while other facilities have adequate resources to provide services to their discretionary work load.[3] The results of this study could help in the selection of facilities to be included in the demonstration.

VIEWS ON H.R. 5263

I would like to turn now to H.R. 5263. As I mentioned earlier, the bill would authorize VA to recover from Medicare a portion of its costs of providing care to veterans and certain Medicare-eligible dependents and survivors of military retirees. The bill would, among other things,

-- limit participation in the demonstration to veterans and Medicare-eligible beneficiaries of military retirees generally unable to gain access to care at VA or DOD facilities;

-- authorize the Secretary of Veterans Affairs to determine what services would be provided to persons participating in the demonstration;

-- require the Secretary of Veterans Affairs to establish mechanisms to ensure that care is not provided in a manner inconsistent with VA priorities of care;

-- deem participating VA facilities to be Medicare providers;

---

[3]VA provides free hospital care to veterans in the mandatory-care category. Included in this category are veterans with service-connected disabilities, former prisoners of war, certain veterans exposed to toxic substances or radiation, veterans of the Mexican border period or World War I, veterans eligible for Medicaid or receiving a VA pension, and veterans with nonservice-connected disabilities and financial resources below a prescribed level. Veterans not meeting one of the above criteria are eligible for VA care but have the lowest priority for care. Providing care to such veterans is discretionary depending on the availability of staff and resources.

-- authorize VA facilities to obtain Medicare reimbursement for care and services provided to demonstration participants;

-- credit Medicare payments to the VA medical care appropriation and to the facility that provided the service;

-- base reimbursement on a methodology agreed upon by the Secretaries of Veterans Affairs and Health and Human Services;

-- waive Medicare copayments and deductibles for demonstration participants and authorize VA to waive, in whole or in part, VA cost-sharing requirements; and

-- require the Secretary of Veterans Affairs to establish mechanisms to evaluate the impact and cost-effectiveness of the demonstration.

We have long advocated sharing of medical resources between VA, DOD, and other health programs when such sharing is beneficial to the government. The proposed demonstration project would test the feasibility of increased coordination between VA, DOD, and Medicare with the aim of reducing overall government health care costs and utilizing government health care facilities to their maximum potential. In addition, by conducting the demonstration at VA facilities in the same geographic region affected by a DOD base closure, the effects of the base closures on the health care needs of military retirees and their Medicare-eligible dependents and survivors would be reduced.

While we agree with the objectives of the demonstration and identified no adverse risks to demonstration participants, I would like to discuss six factors that could limit the ability of the demonstration to achieve its intended objective.

Effects on Health Care Costs

First, the demonstration projects would essentially provide for a transfer of funds from one federal health care program to another. Basically, costs under one program will increase under the demonstration, but costs under the other program will decrease. If the costs of providing services to Medicare beneficiaries is less in VA facilities than in private sector facilities, then the overall effect will be a reduction in government health spending.

Evaluating the effects of the program on government health care costs is not as easy as it sounds, however. The bill recognizes this problem and directs the Secretary of Veterans Affairs, after consulting with the Secretary of Health and Human Services, to report, by March 1, 1993, to the Veterans' Affairs

committees on the methodology VA will use to evaluate the demonstrations. Let me explain the difficulty in attempting to measure the cost effects of the proposed demonstration and why this evaluation is so critical.

If the demonstration is limited to providing services to participants who, absent the demonstration, would have obtained health care in community facilities under Medicare, a computation of cost savings under Medicare is fairly straightforward. If Medicare pays VA less than it would have paid a community provider, Medicare savings will occur.

VA costs, however, might actually increase if, as intended, the demonstration is limited to providing services to veterans and Medicare-eligible dependents and survivors of retired military who currently obtain care in the community at no expense to VA. This would occur unless the agreed upon Medicare reimbursements cover VA's full cost of providing care and the costs of preparing and processing Medicare claims.

Determining the cost of providing care in the VA system has been a continuing problem. To determine the effects of the demonstration, the participating medical centers would need to develop sound cost data, including capital costs. If VA underestimates its actual cost of providing care, it will have to absorb the difference between the Medicare reimbursement and its costs. As I will explain in a moment, VA may be unable to recover the difference from Medigap insurance.

In addition, VA would have to pay for the administrative costs of seeking recoveries from Medicare, and pay for any services provided to participants that are not covered under Medicare. Because the participants, including the Medicare-eligible dependents and survivors of military retirees, were not previously using VA services, these would be new expenses and, without additional funding, could reduce funds available to provide care to VA's mandatory work load.

Even if the costs to Medicare are lower by providing services covered under Medicare in VA facilities rather than in private facilities, as I will discuss later, total government costs could increase if there is an increase in demand for services not covered by Medicare. VA would have to absorb such increased costs. Thus, it is important that the demonstration carefully define the package of services available to participants.

VA would stand to benefit if the demonstration serves people who previously obtained services from VA. This is because VA would be obtaining reimbursement from Medicare for costs it incurs. Even with the costs to prepare and process claims, VA would clearly benefit from Medicare recoveries for veterans it is currently serving. Because VA would be allowed to add the Medicare

recoveries to its appropriation, overall VA funding would increase. Medicare costs would also increase. Because the VA recoveries would not be returned to the Treasury and there would be increased administrative costs to operate the recovery program, overall government costs would probably increase.

Controlling the Number of Participants Would Be Difficult

The second factor I would like to discuss is the difficulty VA would face in limiting participation under the demonstration to veterans not currently being served by VA. Unlike other health programs, VA entitlement to care is done on a per episode basis. Thus, veterans in the discretionary category may be turned away from VA one day because adequate resources do not exist to provide the needed care, but admitted the next time they seek care. In addition, capacity may exist to provide certain services--but not others--to veterans in the discretionary category. In other words, it will be difficult to define a group of demonstration participants who generally did not have access to VA care in the past.

In addition, participating VA facilities will have a strong incentive to include under the demonstration, veterans currently obtaining services from the facility. This is because the facility gets to keep the Medicare payments for demonstration participants but not for Medicare-eligible veterans not participating in the demonstration.

Finally, VA may have trouble limiting the number of beneficiaries seeking services under the demonstration. Making cost-free care available to beneficiaries, especially those who do not have Medigap policies, who currently use private sector facilities could result in shifting more patients from private sector facilities to VA than the VA facilities can handle.

H.R. 5263 recognizes these potential problems and would require the Secretary of Veterans Affairs to establish mechanisms to ensure that care is not provided to participants in a manner inconsistent with the priorities for care established under the VA law. However, for the reasons I just described, it will be difficult for VA to develop such mechanisms.

Effects of Services Not Covered By Medicare

The third factor is one I alluded to earlier; that is, the services to be covered under the demonstration. In other words, would participants be limited to services covered by Medicare, or would they be eligible for the full range of VA services? To the extent the demonstration has its intended effect of bringing into the VA system, veterans and others previously unable to obtain

access to VA or DOD care any services provided beyond those reimbursed by Medicare would have to be paid by VA.

This is an especially important question for the Medicare-eligible dependents and survivors of military retirees because it is not clear from the bill whether DOD would have any obligation to pay for a portion of their care. Currently, Medicare-eligible dependents and survivors of military retirees are limited to whatever services are available at the DOD facilities where they seek care. However, available services vary widely in the DOD system, which ranges from small ambulatory care clinics to small hospitals with limited capabilities to large teaching hospitals offering extensive services. When they are unable to obtain services from a DOD facility, Medicare-eligible retirees and their dependents and survivors are required to seek care in the community under Medicare.[4] Providing participants who previously relied on DOD facilities with the full range of VA services would increase VA costs by shifting costs previously paid by DOD, private insurers, or the beneficiary to VA. On the other hand, authorizing DOD beneficiaries to use VA facilities could help reduce the effects of base closures on the Medicare-eligible dependents and survivors of military retirees who previously relied on DOD facilities for their medical care.

In addition, it is not clear from H.R. 5263 what obligation, if any, DOD has to pay for services not covered by Medicare, or for that matter, to compensate VA for any difference between VA's cost of providing care and the Medicare reimbursement. DOD currently has an obligation to pay for the care of Medicare-eligible retirees and their survivors and dependents only if they obtain services in its facilities. Because the demonstration is intended to serve DOD beneficiaries unable to obtain care from DOD facilities, DOD would appear to have no obligation to pay for their beneficiaries' health care in the community and, thus, no obligation to reimburse VA for any costs not paid by Medicare.

Effects on Third-Party Recoveries

The fourth factor to consider is the effect of the demonstration on third-party recoveries. VA currently attempts to recover a portion of the cost of care provided to Medicare-eligible veterans with Medicare supplemental policies (Medigap policies) from private insurers. Under the bill as currently drafted, VA may be unable to obtain recoveries from Medigap policies. This is because the legislation would waive copayments and deductibles under Medicare for participants in the demonstrations, thus relieving them of obligations that eyelid have been covered by Medigap policies. This waiver would likely have a significant effect because most Medicare beneficiaries have Medigap policies.

---

[4]Eligibility for CHAMPUS ends at age 65.

The inability to collect from Medigap policies could increase VA costs if the Medicare reimbursements for demonstration participants do not cover VA's full cost of providing care.

Effects on the Ability to Meet Needs of Mandatory VA Work Load

The fifth factor I would like to discuss is the potential effect on VA's ability to meet the needs of veterans in the mandatory-care category. Although the bill contains provisions intended to prevent the demonstration from adversely affecting care available to higher priority veterans, such provisions will, in our opinion, be hard to enforce. As I mentioned earlier, medical centers participating in the demonstrations will have a strong incentive to admit Medicare-eligible patients because they will be allowed to keep the Medicare reimbursements without an offset against their allotted funds.

As I mentioned before, if participants in the demonstration are limited to individuals not currently using VA services, VA might incur some costs in providing services to these new beneficiaries, including the dependents and survivors of military retirees, even with Medicare reimbursement. Without additional VA funding, this could reduce funds available to treat higher priority veterans.

Ability to Care for Women

The final factor I would like to discuss is the ability of VA medical centers to accommodate a sudden influx of women patients. Most VA medical centers currently have limited capabilities for providing care to women.[5] The Medicare-eligible dependents and survivors of military retirees are overwhelmingly women. This could create problems for VA medical centers in ensuring adequate privacy to women patients. On the other hand, an increased number of women patients could enable VA to expand services and help improve the availability of services to both veterans and the Medicare-eligible dependents and survivors of military retirees.

In summary, if the Congress decides to authorize the demonstration project, we believe it is important that VA proceed with caution in implementing the project to ensure that the objectives of the demonstration can be achieved.

- - - -

[5]VA Health Care for Women: Despite Progress, Improvements Needed (GAO/HRD-92-23, Jan. 1992).

This concludes my prepared statement. We will be happy to answer any questions that you or the other Members of the Subcommittee may have.