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Report to Congressional Requesters

July 1993

VA HEALTH CARE

Comparison of VA Benefits With Other Public and Private Programs

GAO/HRD-93-94

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-253718

July 29, 1993

The Honorable Frank H. Murkowski
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

Dear Senator Murkowski:

Because of the growth of public and private health insurance programs, most veterans now have coverage under multiple health care programs. These programs, however, differ in terms of the criteria used to establish eligibility, the services covered, the limits placed on the availability of those services, and the cost sharing between the program and its participants.

In response to your request, we (1) compared the health care benefits available under major public and private programs, and (2) analyzed the potential effects of existing benefit differences on veterans' use of the Department of Veterans Affairs' (VA) health care system. Such information should assist policymakers in evaluating the likely impact of health care financing reform proposals on the VA system and in restructuring veterans' health benefits to supplement rather than duplicate benefits adequately covered under other programs.

To meet our objectives, we compared VA benefits with those available under other public programs—Department of Defense (DOD) health care facilities, Medicare, Medicaid, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)—and private health insurance—including the Federal Employees Health Benefits Program (FEHBP).[1] We compared the health benefits available under the various programs in terms of (1) eligibility, (2) covered services, (3) coverage limits, and (4) cost sharing. The information in this report reflects benefits during calendar or fiscal year 1991, except as noted. Our scope and methodology are discussed in appendix I.

You also asked for information on (1) the number of veterans having coverage under other public or private health care programs and (2) the costs of veterans' health care funded under VA and other public programs. We will report separately this summer on our work in response to these questions.

[1]For ease of presentation, this report uses the term "program" to describe both public health benefits programs and private health insurance.

Background

VA provides health care services through a "direct care" system of 171 hospitals, 240 outpatient clinics, 126 nursing homes, and 32 domiciliaries.[2] Similarly, DOD provides health care to active and retired members of the uniformed services[3] and their dependents through about 700 medical treatment facilities worldwide, ranging in size from small clinics to large hospitals.[4]

When these direct care systems were established, there were neither public nor private health insurance programs to assist veterans, military personnel, and the dependents of active duty and retired military personnel in paying for needed health care services. Private health insurance, which typically pays for services provided by physicians and health care facilities on a fee-for-service basis,[5] began to emerge in the 1930s with the establishment of Blue Cross and Blue Shield and commercial plans. The industry expanded rapidly during the 1950s, and in 1959, the Federal Employees Health Benefits Act authorized the federal government to provide health care benefits to millions of federal employees and retirees and their dependents through private health insurance. By 1990, over 185 million Americans were covered by private health insurance.

In 1965, the Congress enacted legislation establishing the two largest public health insurance programs—Medicare, serving elderly and disabled Americans, and Medicaid, a jointly funded federal-state program serving low-income Americans.[6] The following year, the Congress established CHAMPUS to enable military retirees and the dependents of active duty and

[2]Direct care means the agency owns, staffs, and operates the hospitals, clinics, and other medical facilities. Direct care is sometimes referred to as "direct delivery" of health care.

[3]The uniformed services consist of the Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration. In this report, the term "military" refers to all of the uniformed services.

[4]The number of DOD medical facilities is declining because of base closures and reductions in the size of the active duty forces.

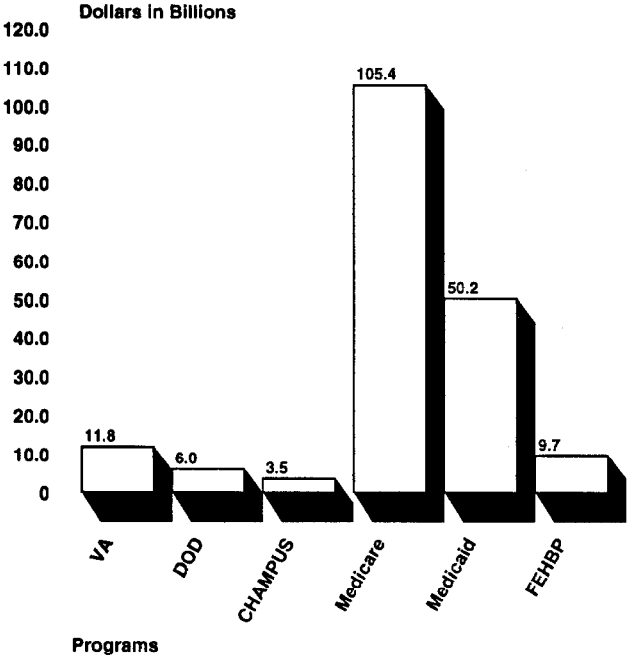
[5]Fee-for-service refers to an arrangement in which providers render services and are paid for each medically necessary service provided to a covered beneficiary.

[6]Medicare and Medicaid are administered at the federal level by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS). Medicaid programs are primarily state-administered, and there is considerable variation in the benefits covered.

retired military personnel to obtain health care in the private sector when services were not available or not accessible in DOD facilities.[7]

Fiscal year 1991 federal expenditures under the programs ranged from $3.5 billion under CHAMPUS to $105.4 billion under Medicare (see fig. 1). VA expenditures were $11.8 billion.

Figure 1: Federal Expenditures Under Major Health Programs (Fiscal Year 1991)



Although each of the major public and private programs has a different target population, overlaps between target populations result in many Americans having coverage under multiple programs. Table 1 describes potential overlaps in populations served by the VA health care system and the other health care programs discussed in this report. Appendix II contains a more detailed description of each program and the population served.

[7]The Dependents' Medical Care Act, effective on December 7, 1956, previously authorized care from civilian sources for spouses and children of active duty military members. Coverage was extended to retired members and their dependents and to dependents of deceased service members through the Military Medical Benefits Amendments of 1966. The program became known as CHAMPUS at that time.

Table 1: Overlapping Populations Served by Major Health Programs (1991)

Program	Target population		Major overlaps with VA
	Description	Size	
VA	Veterans	26,600,000	N/A
DOD direct care			
	Active duty military	2,000,000	None
	Military retirees	1,700,000	1,700,000 military retirees
	Dependents of active duty and retired military personnel	5,300,000	None
DOD-CHAMPUS			
	Military retirees under age 65	1,200,000	1,200,000 military retirees
	Dependents of active and retired military	4,800,000	None
Medicare	Elderly, disabled, and persons with end-stage renal disease	34,900,000	7,400,000 Medicare-eligible veterans[a]
Medicaid	Low-income	32,200,000	400,000 Medicaid-eligible veterans[a]
FEHBP			
	Active federal employees	2,400,000	745,000 active federal employees
	Retired federal employees	1,700,000	754,000 retired federal employees
	Dependents of active and retired employees	5,300,000	None
Private insurance	General public	185,000,000[a]	22,900,000 veterans[a]

[a]Estimate based on "Survey of Income and Program Participation," using 1990 data.

Results in Brief

VA's complex eligibility and entitlement provisions place more restrictions on the availability of services than do other programs. All veterans are eligible for at least some VA health care services, but the specific services covered and entitlement to those services depend on factors such as (1) the presence and seriousness of service-connected disabilities,[8] (2) income, and (3) the need for hospital care. Because of these restrictions, about two-thirds of veterans eligible to obtain care from VA facilities can do so only to the extent that space and resources are

[8]A service-connected disability is one that results from an injury or disease or other physical or mental impairment incurred or aggravated during military service.

available after VA meets the needs of service-connected and other veterans with higher priorities for care. By contrast, other public and private health care programs essentially guarantee payment for covered services to all eligible participants. Although DOD, like VA, limits the availability of services in its facilities based on available resources, CHAMPUS serves as a backup to help pay for services from private providers when DOD facilities are unable to provide needed services to retirees and dependents (other than those who are aged 65 or over and Medicare-eligible).

Once in the VA system, however, veterans are generally offered a more extensive array of services, fewer limitations in terms of the duration and number of visits or services covered, and less cost sharing than are available under most public and private health benefit programs. Participants under other major public and private health programs are more likely to be liable for significant out-of-pocket costs than are those under VA, DOD's direct care system, and state Medicaid programs for the poor.

Veterans' Entitlement to Health Care Services Varies

Other health benefits programs define a set of covered services and entitle everyone to the full range of covered services. VA has a broader range of covered services but no veteran is currently entitled to the full range of VA services. For example, veterans with service-connected disabilities rated at 50 percent or higher are entitled to inpatient hospital care and comprehensive outpatient care, but medically necessary nursing home care is available only to the extent that space and resources are available. Those veterans with service-connected disabilities rated at less than 50 percent are also entitled to inpatient hospital care but their entitlement to outpatient care is more limited; most are entitled only to treatment of their service-connected disability, and other outpatient services can be provided only if space and resources are available.

The availability of services for veterans without service-connected disabilities is even more complex. VA uses veterans' incomes and assets to determine which nonservice-connected veterans are (1) entitled to inpatient hospital care and (2) required to make copayments for both inpatient and outpatient services. Those veterans with incomes below designated amounts are placed in the mandatory-care category together with service-connected veterans, former prisoners of war, and certain other veterans (see pp. 28 to 30). Those not entitled to inpatient hospital care are placed in the discretionary-care category but can still obtain care if space and resources are available and they agree to make copayments.

Medicaid uses income and asset limits to determine eligibility. Those whose incomes and assets are above state-set limits are not eligible for Medicaid benefits. Moreover, significantly higher income and asset limits apply to VA care than are applied under Medicaid. For example, in 1991, a nonservice-connected veteran with two dependents would be placed in VA's mandatory-care category for inpatient hospital care if he or she had an income below $23,018. By contrast, the highest income the veteran could have and qualify for Medicaid was $11,208 (see app. III).[9]

In addition, the entitlement of veterans' with nonservice-connected disabilities to many VA health care services is dependent on the need for hospital care. For example, outpatient medical care is available to veterans with nonservice-connected disabilities only to obviate the need for hospital care or as a follow-up to hospital care. Similarly, dental care is available to veterans with nonservice-connected disabilities only if the veteran was examined, and had treatment started, while an inpatient. By contrast, under most health benefits programs the beneficiary can go directly to a physician or dentist for most care, and coverage is not limited to services that would obviate the need for hospital care.

VA is currently developing legislative proposals to reform VA eligibility. These proposals would address many of the complexities cited above.

VA Covers More Services With Fewer Limits

Although all of the major health benefits programs cover basic services like hospital and outpatient medical care, VA offers some health-related services not generally covered by other programs and places fewer limits on the number or duration of benefits. For example, VA operates domiciliaries to provide a structured living environment for veterans no longer capable of living independently but not needing the level of care required in a nursing home. This includes the recent establishment of domiciliaries specifically to serve homeless veterans. None of the other programs covers this level of care.

Similarly, VA and Medicaid provide the most extensive long-term institutional care. Other programs generally limit nursing home coverage to skilled nursing care following a hospitalization. There is, however, an expanding market for private long-term care insurance.

[9]Pregnant veterans with incomes of up to 133 percent (or up to 185 percent at states' option) of the federal poverty level must be provided Medicaid coverage of their pregnancies. The same income level would apply to the veterans' children up to 6 years of age.

VA also offers more comprehensive coverage of alcohol and substance abuse treatment, mental health services, prescription and over-the-counter drugs, and eyeglasses than Medicare and many state Medicaid programs. For example, VA operates special programs to help Vietnam veterans, and others, overcome war-related stress.

One area in which the availability of care is more limited in the VA and DOD direct care systems than under other programs is home health care. Although VA has a hospital-based home care program, it is available at fewer than half of the VA hospitals. Because there is no cost sharing for beneficiaries under the Medicare home health benefit,[10] however, that program appears adequate to meet the post-acute home care needs of elderly veterans. Similarly, although DOD's direct delivery system does not cover home health care, such care is available to DOD beneficiaries under CHAMPUS and, for those beneficiaries over age 65, under Medicare.

In addition to offering services not typically covered under other health programs, VA places fewer limits on the number or duration of covered services. For example, there is no limit on the number of days of care in VA-operated hospitals or nursing homes or on the number of outpatient visits or prescription drugs. Other programs frequently place limits on such benefits. For example, 21 states have per admission or annual limits on the number of days of hospital care covered under their Medicaid programs, and Medicare limits coverage of hospital care to 90 days per benefit period,[11] with a lifetime reserve of 60 additional days of hospital care. DOD, like VA, places few limits on the number or duration of benefits in its facilities. Such limits were, however, recently established for mental health benefits under CHAMPUS (see app. IV).

Out-of-Pocket Costs Generally Lower for Care Provided by VA

Veterans with dual health care eligibility will generally incur lower out-of-pocket costs if they obtain their care from VA. First, veterans who are able to access the VA system are less likely to incur expenses for noncovered services. This is because VA generally provides a wider array of services with fewer limits than other programs. The complex VA entitlement provisions could, however, have the opposite effect on veterans with nonservice-connected disabilities relying on VA as their sole

[10]While Medicare beneficiaries pay nothing for most home health services, cost sharing is required for durable medical equipment such as wheelchairs.

[11]A benefit period begins with admission to a hospital and ends when the beneficiary has been out of the hospital or other facility providing skilled nursing or rehabilitation services for 60 consecutive days.

source of health care. This is because outpatient services, other than those needed to obviate the need for inpatient care, or as a follow-up to inpatient care, are noncovered services.

Second, provider charges that exceed the amount the program considers reasonable are an important source of out-of-pocket costs, particularly for veterans eligible for Medicare and CHAMPUS. For example, Medicare enrollees were liable for nearly $2 billion in provider charges exceeding Medicare payment limits in fiscal year 1991.[12] By contrast, VA and DOD direct care patients are not liable for charges above approved rates. This creates an incentive for veterans with dual eligibility to use the direct care programs rather than Medicare or CHAMPUS for outpatient services.

A third source of out-of-pocket costs is insurance premiums. Premiums generally apply only to private insurance (all FEHBP plans charge enrollee premiums) and Medicare part B. This might provide a financial incentive for single veterans to rely on VA to avoid health insurance premiums. Those with dependents, however, would likely enroll in private health insurance plans to obtain coverage for their families. In addition, there may be some incentive among elderly veterans to rely on VA for their outpatient services to avoid the part B premium.

Fourth, beneficiaries are liable for costs that exceed the maximum benefit payment allowable under their private insurance. Such limits could affect the use of VA services by those veterans with catastrophic illnesses.

The final major sources of out-of-pocket costs are deductibles and copayments.[13] Medicare, CHAMPUS, FEHBP, and private insurance generally have higher copayments and deductibles than VA. Medicaid and the DOD direct care system, like VA, generally have minimal copayments and deductibles.

VA hospital care is generally free. Only those veterans with no service-connected disabilities and incomes over designated amounts ($18,171 in fiscal year 1991 for single veterans with no dependents) are required to contribute toward the cost of care. For stays of 90 days or less,

[12]The Omnibus Budget Reconciliation Act of 1989 set limits on physicians' charges above Medicare-approved charges. After 1992, physicians can charge Medicare beneficiaries no more than 15 percent above the Medicare-approved charges. In addition, physicians cannot bill Medicaid-eligible beneficiaries for the balance owed.

[13]Deductibles refer to amounts of approved charges a participant must pay before the health program pays any benefits. Copayments refer to the amount or share of approved charges that the program participant is required to pay once deductibles are satisfied.

those veterans required to contribute toward the cost of their care pay an amount equal to the Medicare hospital deductible ($628 in 1991) plus $10 a day.[14] There are no copayments for physician services.

Hospital copayment requirements vary significantly across the other programs. For example,

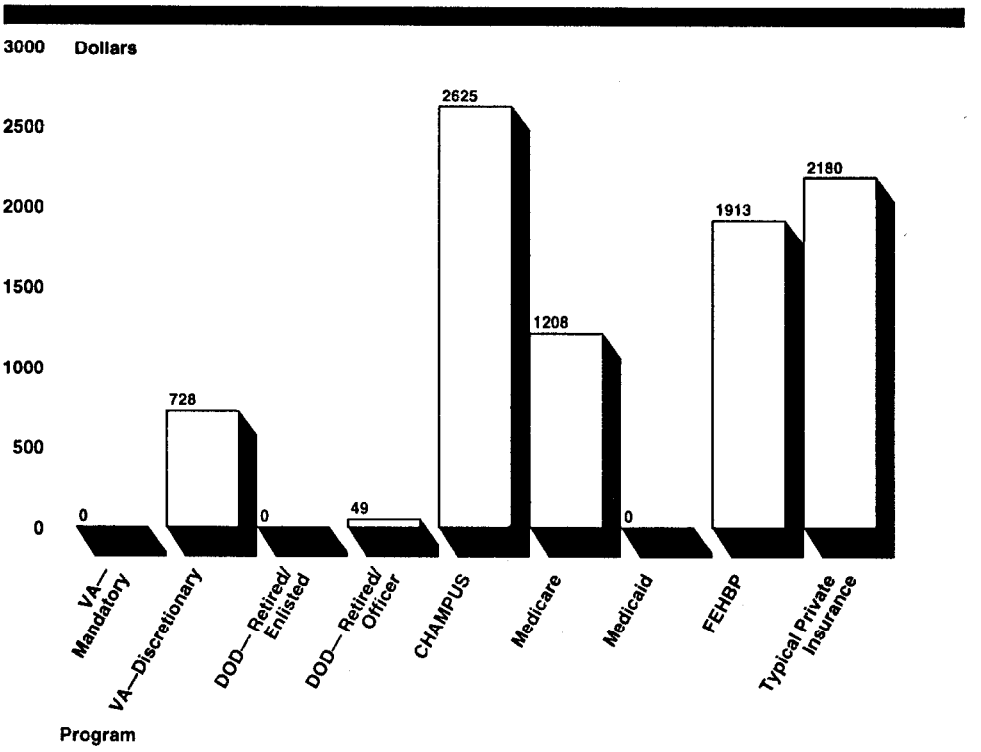
- CHAMPUS requires military retirees and their dependents to make copayments of up to 25 percent for both hospital charges and physician services.
- Medicare has a deductible, but no copayment for up to 60 days, for inpatient hospital care and has a deductible and 20 percent copayment for physician services.
- Most state Medicaid agencies impose no, or minimal, cost sharing for covered services.
- Most private health insurance participants have no deductible per hospital admission but have a deductible (most commonly $100) and copayments (most commonly 20 percent) for physician services.

The example below compares the out-of-pocket costs for a veteran receiving care under the various programs for a hypothetical inpatient hospital episode of care.

- Veteran A has major surgery requiring a 10-day hospital stay. The total cost of the surgery is $10,500 (includes $8,000 for room, board, and ancillary services and $2,500 in surgeon's fee). Assuming the veteran had no prior health care expenses, i.e., the veteran's calendar year deductible had not been satisfied earlier, veteran A's out-of-pocket costs would range from $0 (if a mandatory-care veteran obtaining care in a VA hospital or retired enlisted member obtaining care in a DOD hospital) to $2,625 (if a military retiree obtaining care under CHAMPUS). Even if veteran A is in VA's discretionary-care category, his or her out-of-pocket cost ($728) would be less than it would be under any program other than the DOD direct care program (see fig. 2). A veteran in the discretionary-care category would not be eligible for Medicaid.

[14]For each additional 90 days of care, the veteran must pay an amount equal to one-half of the Medicare hospital deductible plus $10 a day.

Figure 2: Veteran A's Cost for Inpatient Care Under Major Health Care Programs (1991)



Note: Medicaid recipients may be responsible for a minimal copayment.

The differences in cost sharing are more pronounced for nursing home care. Medicare beneficiaries are entitled to 20 days of free nursing home care during a benefit period. For days 21 through 100, however, they are required to pay $78.50 per day. The beneficiary pays all costs for stays beyond 100 days. For example, a single veteran obtaining nursing home care under Medicare would pay $6,280 for a 100-day nursing home stay. The same veteran, if his or her income was below $18,171, would incur no out-of-pocket costs if he or she obtained care in a VA nursing home or VA-supported community nursing home. He or she would incur out-of-pocket costs of $1,756 if his or her income was above $18,171.

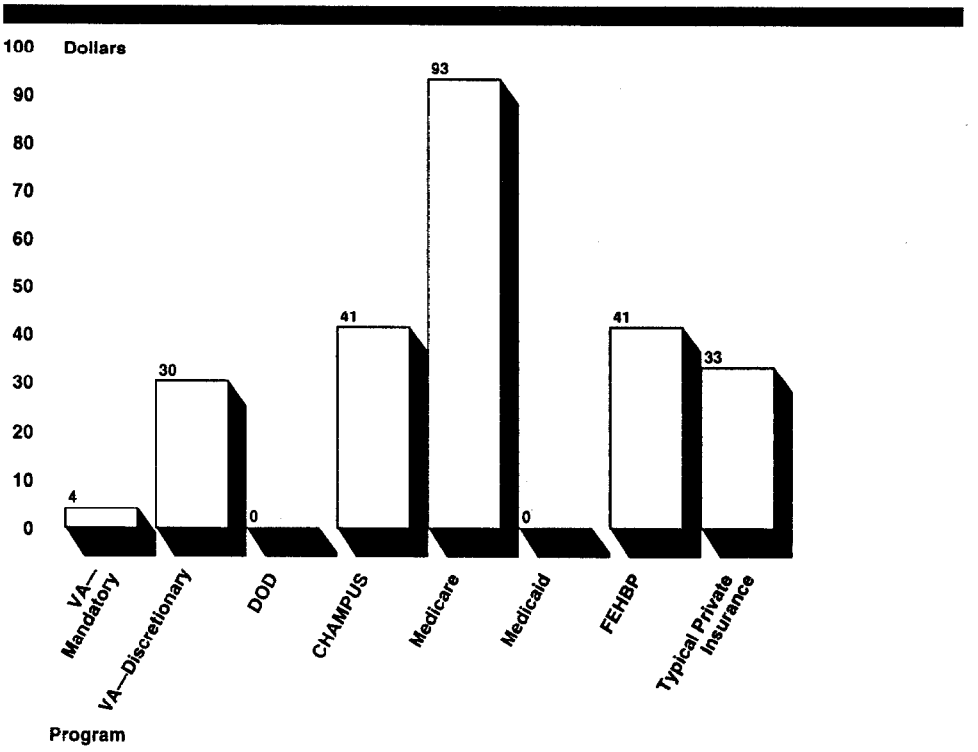
Nursing home cost sharing under the Medicaid program is even greater. Medicaid beneficiaries must spend most of their income and assets on medical care before becoming Medicaid-eligible and then contribute all but a small personal needs allowance toward the cost of their care on a

continuing basis. Special provisions apply to those Medicaid beneficiaries with spouses still living in the community to prevent their impoverishment.

Cost-sharing requirements also vary widely for outpatient care. Veterans in VA's mandatory-care category, DOD direct care patients, and most Medicaid recipients are exempt from copayment requirements for outpatient care. Veterans in VA's discretionary-care category pay $26 per visit plus $2 for each outpatient prescription; Medicare beneficiaries, 20 percent of outpatient charges and the full cost of prescription drugs; and CHAMPUS beneficiaries, 20 percent (for dependents of certain active duty members) or 25 percent (for all others) of approved charges. Medicare beneficiaries have a $100 annual deductible, while CHAMPUS beneficiaries are responsible for a deductible of $50 or $150 per year. The following example compares the out-of-pocket costs for a veteran under the various programs for a hypothetical outpatient episode of care.

- Veteran B has minor surgery in a physician's office requiring an approved office visit and surgical fee totaling $90, and two outpatient prescription medications totaling $75. Assuming this veteran had prior health expenditures that satisfied applicable annual deductibles, veteran B's out-of-pocket costs would range from $0 (if receiving care from a DOD outpatient clinic or under many Medicaid programs) to $93 (if obtaining care under Medicare). A veteran in VA's mandatory-care category may have a $4 copayment for the prescription drugs but no copayment for the outpatient surgery (see fig. 3).

Figure 3: Veteran B's Cost for Outpatient Care Under Major Health Care Programs (1991)



Notes: Some veterans in the mandatory-care category (service-connected veterans rated at 50 percent or more) are exempt from the prescription drug copayment and would receive this care cost-free.

Medicare does not cover outpatient prescription drugs.

Medicaid recipients may have a nominal copayment for outpatient care.

Although cost sharing under the Medicare program is significantly higher than under VA, the Medicare Catastrophic Coverage Act of 1988 requires state Medicaid programs to pay the part A and part B premiums and all deductibles and coinsurance for most Medicare beneficiaries with incomes below 100 percent of the federal poverty level ($6,620 for an individual in 1991).[15] Thus, veterans with incomes below the federal poverty level can now obtain first-dollar coverage of most of their health care needs through combined Medicare/Medicaid coverage (see app. V).

[15]Under the Omnibus Budget Reconciliation Act of 1990, this requirement was made effective January 1, 1991. The act also required state Medicaid programs to begin paying by 1995 the part B premiums of Medicare beneficiaries with incomes of up to 120 percent of the federal poverty level.

Conclusions

As health care reform unfolds, there will undoubtedly be a significant effect on the VA health care system.[16] The effect depends on many factors, including the types of basic services offered, access to these services, and costs to the recipient of the services. For example, demand for VA nursing home care is unlikely to decline significantly under a universal health care program if that program either does not cover nursing home care or imposes significantly higher cost-sharing requirements than the VA system imposes.

By offering veterans who have multiple health benefits coverage services with lower copayments, VA, in effect, is competing with those programs to attract patients. For example, elderly veterans can avoid Medicare copayments and deductibles if they are able to obtain care in VA facilities. Similarly, veterans with private health insurance can avoid copayments by obtaining care from VA.

VA provides a broad spectrum of health care services, even when such services are readily available from other sources. The advent of national health reform may give VA the opportunity to restructure its health benefits to focus its limited resources on those areas such as long-term psychiatric care, substance abuse treatment, and care for spinal cord injuries and war-related stress where veterans have few or no alternatives.

Agency Comments

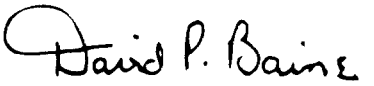
Officials from VA, DOD, HCFA, and the Office of Personnel Management reviewed a draft of this report; their comments are incorporated where appropriate.

We are sending copies of this report to the House and Senate Committees on Veterans' Affairs; the House and Senate Appropriations Committees; the Secretaries of Defense, Veterans Affairs, and Health and Human Services; the Director, Office of Personnel Management; and other interested parties.

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

If you have any questions, please call me on (202) 512-7101. Other major contributors to this report are listed in appendix VI.

Sincerely yours,



David P. Baine
Director, Federal Health Care
Delivery Issues

Contents

Abbreviations

AFDC	Aid to Families With Dependent Children
BLS	Bureau of Labor Statistics
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
DOD	Department of Defense
FEHBP	Federal Employees Health Benefits Program
HBHC	hospital-based home care
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
OPM	Office of Personnel Management
POW	prisoner of war
PTSD	post-traumatic stress disorder
SIPP	Survey of Income and Program Participation
SSI	Supplemental Security Income
VA	Department of Veterans Affairs

Scope and Methodology

To compare benefits under the major public health care programs—VA, DOD direct care, the Civilian Health and Medical Program of the Uniformed Services, Medicare, Medicaid, and the Federal Employees Health Benefits Program, we reviewed legislation, regulations, and other program documentation and supplemented that information through discussions with officials responsible for administering each program. We interviewed officials from VA, the Health Care Financing Administration, DOD and its office of CHAMPUS, and the Office of Personnel Management (OPM), which administers FEHBP.

For most comparisons to private sector health insurance benefits, we relied primarily on data contained in the Bureau of Labor Statistics (BLS) survey, Employee Benefits in Medium and Large Firms, 1989. The survey, which includes responses from 1,647 firms with a total of 6.5 million workers, is representative of the benefits available to 32.4 million full-time employees in private nonagricultural industries. We supplemented the BLS information with data from Foster Higgins' Health Care Benefits Survey, 1989 and Hay Management Consultants' Hay/Huggins Benefits Report, 1990.

The information in this report reflects the major health care program benefits, limits, and cost-sharing requirements existing during calendar or fiscal year 1991, except as noted. To facilitate our benefit comparisons, we used definitions of health care services commonly offered by most programs. Differences, where they exist, are highlighted in the text or in footnotes.

Methodology Used to Summarize Benefits Available to FEHBP Enrollees

To compare FEHBP health care benefits to other major health care programs, we analyzed the 1991 benefit structures of the 12 fee-for-service plans open to all federal employees. Together, these plans account for about 70 percent of all employees and annuitants enrolled in FEHBP. We excluded the other seven fee-for-service plans because enrollment was restricted to employees in certain occupational groups and/or agencies. The seven plans accounted for less than 3 percent of total FEHBP enrollment. Table I.1 provides the 1991 distribution of enrollments among the 12 fee-for-service plans open to all federal employees.

Table I.1: Distribution of Enrollments Among the 12 FEHBP Fee-For-Service Plans Open to All Federal Employees (1991)

Plan	Percent of enrollment
Blue Cross/Blue Shield Standard Option	51.4
Mail Handlers High Option	16.3
Government Employees Hospital Association	11.9
National Association of Letter Carriers	6.4
Blue Cross/Blue Shield High Option	5.5
American Postal Workers Union	4.9
Alliance Standard Option	1.1
Mail Handlers Standard Option	1.0
National Treasury Employees Union	0.6
Postmasters Standard Option	0.5
Postmasters High Option	0.3
Alliance High Option	0.1

We also excluded the 463 prepaid plans, more commonly known as health maintenance organizations (HMO). Although HMOs accounted for about 28 percent of all FEHBP enrollment in 1991, enrollment in these plans is restricted to residents of the limited geographic area each serves.

To determine the percentage of FEHBP enrollees having specific health care benefits and cost-sharing provisions, we (1) determined which plan(s) provided coverage, (2) totaled the number of employees and annuitants enrolled under the affected plan, (3) divided the number of enrollees affected by the provision by total enrollment under the 12 fee-for-service plans, and (4) multiplied by 100.

Methodology Used to Summarize Benefits Available to Medicaid Recipients

We made similar calculations for Medicaid recipients using data on (1) the number of Medicaid users for each state during fiscal year 1990, categorized by their basis for Medicaid eligibility (that is, categorically or medically needy);[1] (2) the health care services offered by each state Medicaid program as of October 1990; and (3) coverage limits and cost-sharing requirements collected for the Congressional Research Service by the National Governors' Association in January 1991.

[1]HCFA does not maintain similar counts of the number of state residents eligible for, but not using, Medicaid services.

Methodology Used to Estimate the Number of Veterans Eligible for Cost-Free Medical Care From VA

To estimate the number of veterans in VA's mandatory- and discretionary-care categories in 1991, we used data from the Census Bureau's 1990 Survey of Income and Program Participation (SIPP), supplemented by data from VA. SIPP is a nationwide longitudinal survey based on a statistical sample of about 22,000 noninstitutional living quarters and covers such areas as income, assets, employment, health insurance coverage, veteran status, and eligibility for participation in various government programs.

Using the 1990 SIPP data, we identified veterans in the sample and divided them into VA's mandatory and discretionary-care categories. We placed veterans in the mandatory category if they (1) reported having a service-connected disability or (2) had nonservice-connected disabilities but reported having incomes below the cutoff for inclusion in the mandatory-care category. The remaining veterans were presumed to be in the discretionary-care category.

Limitations of SIPP Analysis

The SIPP data did not enable us to identify all veterans who should be in the mandatory-care category. Specifically, it did not enable us to identify (1) former prisoners of war (POW), (2) veterans of World War I, and (3) veterans who may have been exposed to toxic substances or radiation. We do not consider this limitation significant and have not attempted to adjust the SIPP data based on other sources. For example, former POWs numbered fewer than 69,000[2] in 1991, including an estimated 110 who were World War I veterans. To the extent that some portion of those 69,000 POWs have service-connected disabilities or have incomes below the threshold, our methodology counts them in the mandatory-care category. Because of their small numbers, we made no attempt to identify the higher income POWs with nonservice-connected disabilities who may be included in our discretionary-care counts.

Likewise, the number of veterans with nonservice-connected disabilities who served during World War I is small, also numbering only about 69,000 in 1991. Some number of these veterans are also below the income threshold and are already included in the mandatory-care count. Again, we made no attempt to identify the small remaining number of higher income World War I veterans with nonservice-connected disabilities who may be included in our discretionary-care counts.

Finally, we did not attempt to estimate the number of veterans who need treatment for conditions related to exposure to radiation or toxic

[2]Based on information provided by the National Headquarters of the American Ex-Prisoners of War.

substances and who are not already included in our service-connected or low-income mandatory-care counts. These veterans are subject to the means test unless they are seeking care for specific conditions that may have been caused by such exposure. We recently reported on problems in application of the exemption procedures as they relate to Agent Orange.[3]

We did our work between August 1991 and January 1993 in accordance with generally accepted government auditing standards.

[3]VA Health Care: Copayment Exemption Procedures Should Be Improved (GAO/HRD-92-77, June 24, 1992).

Descriptions of Major Health Programs

This appendix contains brief descriptions of the major health care programs. It also includes the basic legislative authority for the program, the number of people covered, and the program expenditures in fiscal year 1991.

VA

Authorized under Title 38 of the U.S. Code, VA operates a nationwide health care delivery system that includes 171 hospitals, 240 outpatient clinics, 126 nursing homes, and 32 domiciliaries. In addition to providing care through these facilities, VA obtains health care services from other providers through sharing agreements, contracts, grants, and various fee-for-service arrangements. For example, VA-operated nursing home and domiciliary care is augmented by contracts with some 3,400 community nursing homes and by per diem payments for veterans receiving care in over 100 state-run homes for veterans. Also, VA pays private sector physicians and other health care providers to provide care to certain veterans when the care they need is unavailable within VA or they live too far from a VA facility.

Although VA does not generally provide health care to veterans' dependents, it administers a health benefits program called CHAMPVA—Civilian Health and Medical Program of the Department of Veterans Affairs—for dependents of veterans who are permanently and totally disabled because of a disease, injury, or other physical or mental impairment incurred or aggravated during military service (referred to as a service-connected disability).[1] CHAMPVA, authorized by the Veterans Health Care Expansion Act of 1973 (P.L. 93-82), is patterned after CHAMPUS (see the following section) and functions much like a health insurance plan using private sector physicians, hospitals, and other providers. The program is administered by CHAMPVA Center, which processes and pays claims for covered services.

In fiscal year 1991, VA spent about $11.8 billion (excluding construction) providing medical care to about 10 percent of the nation's estimated 26.6 million eligible veterans. Costs of care in VA facilities, including the costs of medical education and research, amounted to about $11.1 billion, while hospital and community nursing home contracts totaled more than $440 million, and grants to states for hospital, nursing home, and domiciliary care provided in state veterans' homes amounted to over $106

[1]CHAMPVA also serves dependent survivors of deceased veterans who had been permanently and totally disabled, dependent survivors of veterans who died as a result of a service-connected disability, and dependents of military personnel who died in active service in the line of duty.

million. In addition, in 1991, program costs for CHAMPVA were nearly $100 million.

DOD

DOD's health care system provides medical care to active duty members of the uniformed services, their dependents, retired members and their dependents, and survivors of deceased retired and active duty members. Authorized under title 10 of the U.S. Code, the system is composed of two parts: a direct care system using uniformed services health care facilities and medical personnel and a health benefits program called CHAMPUS that uses civilian physicians, hospitals, and other health care providers.

Direct Care

Within DOD, the Army, Navy, and Air Force operate about 700 health care facilities worldwide, ranging in size from small clinics with limited capabilities to large hospitals with extensive teaching programs. The Assistant Secretary of Defense (Health Affairs) is responsible for overall supervision and policy guidance for DOD medical care activities. The Coast Guard operates 32 U.S.-based health care clinics that complement the DOD direct care system. The Coast Guard's medical activities are under the overall supervision of its Office of Health and Safety. Finally, DOD contracts with 10 civilian-owned former Public Health Service hospitals and clinics, called Uniformed Services Treatment Facilities, that are also a part of the direct care system.[2]

In 1991, over 9 million active duty uniformed services members and other beneficiaries were eligible for medical care in the direct care system—about 2 million active duty members, over 3 million dependents of active duty members, and almost 4 million retirees and their dependents and survivors of deceased retired and active duty members. Federal costs for the direct care system that year totaled nearly $6 billion.

CHAMPUS

CHAMPUS, authorized by the Military Medical Benefits Amendments of 1966 (P.L. 89-614), was initially designed to be similar to comprehensive health insurance plans then available to civilian federal employees under FEHBP (see p. 27). It is administered by the Office of CHAMPUS, within the Office of the Assistant Secretary of Defense (Health Affairs). The Office operates the program with assistance from contracted organizations, referred to as fiscal intermediaries, that process and pay claims for covered services.

[2]DOD officials told us that about 1 million DOD beneficiaries live in the geographic areas served by the Uniformed Services Treatment Facilities.

In 1991, about 6 million dependents of active duty members and retirees and their dependents and survivors were eligible for CHAMPUS. Federal costs for CHAMPUS that year totaled over $3.5 billion.

Medicare

Medicare is a federal health insurance program covering almost all Americans aged 65 and older and certain individuals under 65 who are disabled or have chronic kidney disease. Authorized by title XVIII of the Social Security Act, which was added by the Social Security Amendments of 1965 (P. L. 89-97), Medicare is administered by HCFA, within HHS. HCFA operates the program with assistance from contracting insurance companies that process and pay claims for covered Medicare services.

The Medicare program is composed of two parts—Hospital Insurance, called part A, and Supplementary Medical Insurance, called part B. Part A helps pay for inpatient hospital care, post-hospital care in skilled nursing facilities, post-hospital home health services, and hospice care and is financed primarily by Social Security payroll tax contributions paid by employers, employees, and the self-employed. Part B supplements part A by helping pay for doctors' services, outpatient hospital services, and a number of other medical services and supplies. Participation in part B is voluntary; the program is financed by a combination of enrollee premiums and federal general revenues. Most Americans who are entitled to part A coverage also participate in part B.

In 1991, Medicare costs totaled over $117.7 billion. Part A insured about 34 million elderly and disabled persons and had total costs of $70.7 billion. Part B insured about 33 million at a total cost of $47.0 billion. The federal government's contribution to 1991 part B costs amounted to $34.7 billion.

Medicaid

Medicaid is a jointly funded federal-state program that pays for health care services provided to low-income individuals who are elderly, blind or otherwise disabled, members of families with dependent children, and certain other children and pregnant women. Authorized by title XIX of the Social Security Act, which was added by the Social Security Amendments of 1965 (P.L. 89-97), Medicaid is operated by states under the general oversight of HCFA. HCFA is responsible for developing program policies, setting standards, and ensuring compliance with Medicaid legislation and regulations. But each state has considerable flexibility in determining who will receive Medicaid assistance, what services will be provided them, and what limits will be placed on those services.

By law, the federal portion of state Medicaid payments cannot be lower than 50 percent or more than 83 percent and is based on each state's per capita income. States with lower per capita incomes receive higher rates of federal matching. State Medicaid administrative costs are generally shared equally. In fiscal year 1991, over 32 million low-income people were eligible for Medicaid; program expenditures totaled over $90 billion. The federal share of Medicaid expenditures was about $50.2 billion.

FEHBP

FEHBP is a jointly financed government-employee program providing voluntary health insurance coverage to civilian federal employees, retirees, and their dependents and survivors. Authorized by the Federal Employees Health Benefits Act of 1959, P.L. 86-382, FEHBP is administered by OPM. OPM contracts annually with insurance carriers and approves their health benefit plans for participation in the program. The employing agencies supervise most health insurance activities for their employees, withholding the employees' contribution toward the premium from salaries and paying the relevant government contribution from agency funds. OPM conducts those activities for retirees, withholding premiums from their monthly annuity checks and paying the government's share from OPM funds appropriated for that purpose.

In 1991, FEHBP plans insured some 9.4 million individuals—2.4 million employees, 1.7 million annuitants, and an estimated 5.3 million dependents. The federal government paid about $9.7 billion of the $12.6 billion in 1991 premiums.

Eligibility Requirements for Major Health Programs

This appendix describes the eligibility requirements for the major public health benefits programs. It also describes eligibility for enrollment in FEHBP.

VA

Any person who served on active duty in the uniformed services for the minimum amount of time specified by law and who was discharged, released, or retired under "other than dishonorable conditions" is eligible for VA medical care benefits. The amount of required active duty service varies depending on when the person entered the military, and an eligible veteran's entitlement to medical care offered by VA depends on such factors as the presence and extent of a service-connected disability, income, and period or conditions of military service.

Prior to the early 1980s, there was no required length of active duty service for a person to be eligible for VA medical care benefits. However, persons enlisting in one of the armed forces after September 7, 1980, and officers commissioned or who began active duty in one of the uniformed services after October 16, 1981, must have completed 2 years active duty or the full period of their initial service obligation to be eligible for benefits. Veterans discharged at any time because of service-connected disabilities and those discharged for disabilities unrelated to their military service or because of personal hardship near the end of their service obligation are not held to this provision. Also eligible are members of the armed forces' reserve components who were called or ordered to active duty and served the length of time for which they were activated.

Although all veterans meeting the above requirements are "eligible" for VA medical care, VA uses a complex priority system based on such factors as the presence and extent of any service-connected disability, the incomes of veterans with nonservice-connected disabilities, and the type and purpose of care needed, to determine which veterans receive care within available resources. In general, VA provides cost-free priority medical care to veterans (1) who have service-connected disabilities, (2) who have a special status, such as former prisoners of war or World War I veterans, or (3) whose incomes are below a specified level. If space and resources are available after caring for these veterans, VA provides care to other veterans, i.e., those veterans with nonservice-connected disabilities and incomes above the specified level.

VA Hospital and Nursing Home Care

Priority for receiving VA hospital and nursing home care is divided into two categories—mandatory and discretionary. VA must provide hospital care

and, if space and resources are available, may provide cost-free nursing home care to veterans in the mandatory category. VA may provide hospital and nursing home care to those in the discretionary category if space and resources are available in VA facilities. However, veterans in the discretionary category must pay part of the cost of the care they receive.

Included in the mandatory category are veterans who

- have service-connected disabilities;
- are former prisoners of war;
- served during the Mexican border period or World War I;
- were exposed to certain toxic substances or radiation and need treatment for related conditions;
- have nonservice-connected disabilities and are unable to defray the cost of care. Veterans eligible for Medicaid, receiving a VA pension, or having financial resources below a prescribed level are considered unable to defray the cost of necessary care.

In 1991, veterans whose incomes were $18,171 or less if single (or with no dependents), or $21,805 or less if married (or single with one dependent), plus $1,213 for each additional dependent were considered unable to defray costs and placed in the mandatory category.[1] Veterans with incomes above those levels were placed in the discretionary category. About two-thirds of eligible veterans are in the discretionary category, based on our analysis of data from the 1990 Survey of Income and Program Participation.

VA Outpatient Care

VA provides three levels of outpatient care:

- Comprehensive care, which includes all services needed to treat any medical condition.
- Service-connected care, which is limited to those services needed for the treatment of a condition or conditions related to a service-connected disability.
- Hospital-related care, which provides only the outpatient services needed to (1) prepare for a hospital admission, (2) obviate the need for a hospital admission, or (3) complete treatment begun during a hospital stay.

VA must furnish comprehensive outpatient medical services to veterans who have service-connected disabilities rated at 50 percent or more.

[1]If a veteran's income is below the prescribed threshold but the sum of the veteran's income and net worth exceeds $50,000, VA may place the veteran in the discretionary-care category and require copayments.

Comprehensive outpatient care may be provided to veterans who (1) are former prisoners of war, (2) served during World War I or the Mexican border period, (3) are housebound or in need of aid and attendance, or (4) are participants in VA-approved vocational rehabilitation programs.[2]

VA must furnish all outpatient services needed for the treatment of conditions related to any veteran's service-connected disability regardless of the veteran's disability rating. VA must also provide all outpatient services needed to treat medical conditions related to an injury a veteran suffered as a result of a VA hospitalization or while participating in a VA-approved vocational rehabilitation program.

VA must furnish hospital-related outpatient care to veterans (1) with service-connected disabilities rated at 30 or 40 percent and (2) whose annual incomes do not exceed VA's pension rate for veterans in need of regular aid and attendance.[3] VA may, to the extent resources permit, furnish hospital-related outpatient care to all veterans not otherwise entitled to outpatient care.

DOD

All active duty members of the uniformed services, their dependents, retired members and their dependents, and survivors of deceased retired and active duty members are eligible for medical care in DOD's health care system.[4]

Direct Care System

Active duty members have the highest priority for medical services in the direct care system, and their care is comprehensive and guaranteed. If a DOD health care facility cannot provide the needed medical care, the active duty member will be transferred to another DOD facility, a VA facility, or a private sector facility and all required medical care will be provided at DOD expense. Dependents of active duty members and other beneficiaries may use the direct care system when space, staff, and other resources are available.

[2]Rehabilitation programs under 38 U.S.C. Chapter 31.

[3]In 1991, $11,409 or less if single or with no dependents, or $13,620 or less if married or single with one dependent, plus $1,213 for each additional dependent.

[4]Eligible dependents include the active duty, deceased, or retired member's (1) spouse and, under certain conditions, unremarried former spouse; (2) unremarried widow or widower; (3) unmarried children, including an adopted child or stepchild up to age 21, or up to age 23 if enrolled in a full-time course of study in an institution of higher learning, or age 21 and over if incapable of self-support because of a mental or physical handicap that existed before the child's 21st birthday; and (4) parent or parent-in-law who is, or was at the time of the member's or former member's death, dependent for support and residing with him or her.

CHAMPUS

CHAMPUS supplements the direct care system for dependents of active duty members and other beneficiaries by paying for a substantial portion of medical care obtained from civilian providers when DOD facilities are not accessible or lack the capability to provide required care. Dependents of active duty members,[5] retired members and their dependents, and survivors of retirees and of members who died while on active duty are eligible for CHAMPUS. Retirees, survivors, or family members of retirees who become eligible for Medicare (see the following section) lose their CHAMPUS coverage but continue to be eligible for space-available medical care in the direct care system.

Medicare

People age 65 and over receive premium-free Medicare Hospital Insurance (part A) benefits if (1) they are entitled to cash benefits under the Social Security or Railroad Retirement System or (2) they or their spouses held employment in federal, state, or local government service that was subject to the hospital insurance portion of the tax imposed by the Federal Insurance Contributions Act, called Medicare-qualified government employment.[6] Also eligible for premium-free part A coverage, after a 2-year waiting period, are persons with disabilities who are under age 65 and are entitled to monthly Social Security or Railroad Retirement benefits or are Medicare-qualified government employees. Finally, premium-free Medicare part A benefits are available to persons of any age who need maintenance dialysis or a kidney transplant because of permanent kidney failure if they (or their spouse or a parent on whom they are dependent) have sufficient covered work experience to qualify for Social Security or Railroad Retirement benefits or are Medicare-qualified government employees. Most persons age 65 and over who are ineligible for premium-free part A coverage may enroll voluntarily by paying monthly premiums ($177 in 1991).

Persons entitled to benefits under part A, regardless of age, and most other persons age 65 and over may voluntarily enroll in Medicare's Supplementary Medical Insurance program (part B) and receive those benefits by paying a monthly premium ($29.90 in 1991). State governments may also enroll and pay Medicare premiums for eligible aged and disabled

[5]Dependent parents and parents-in-law are treated in the direct care system only and are not entitled to CHAMPUS benefits.

[6]Federal employment became Medicare-qualified beginning in 1983. With few exceptions, only those state and local employees hired after March 31, 1986, pay the hospital insurance portion of the Federal Insurance Contributions Act tax.

individuals who are also covered by the Medicaid program (see the following section).

Medicaid

Traditionally, eligibility for Medicaid has been linked to actual or potential receipt of cash assistance under the Aid to Families with Dependent Children (AFDC)[7] or Supplemental Security Income (SSI) programs.[8] Thus, to be eligible for Medicaid, persons generally had to meet both the (1) resource limits imposed by those programs and (2) other eligibility requirements based on such things as age, disability, and family structure. This means, for example, that persons who meet the resource requirements for AFDC would not generally qualify for Medicaid if they are single with no dependent children.

State Medicaid programs must, at a minimum, cover all categorically needy persons: those receiving AFDC assistance and most receiving SSI. Nearly three-fourths of all Medicaid recipients are eligible for Medicaid because of their AFDC-related status. On average across the states, the annual income of a family of three in January 1991 had to fall below 45 percent of the federal poverty level to qualify for AFDC.[9] The AFDC income limits for a family of three ranged from a low of $1,488 (13 percent of the poverty level) in Alabama to a high of $10,692 (77 percent of the poverty level) in Alaska.[10]

Individuals and couples can qualify for SSI payments if their countable income (which includes certain disregards such as the first $20 of Social Security benefits, but not need-tested income such as veterans' pensions) does not exceed uniform federal eligibility requirements. In 1991, the monthly federal benefit rate was $407 for an individual and $610 for a couple. Eligible individuals and couples must also have countable

[7]AFDC provides assistance to families where one parent is absent from the home continuously, incapacitated, or dead. AFDC can also provide assistance to two-parent families with children where the principal wage earner is unemployed.

[8]The SSI program provides monthly cash payments in accordance with uniform nationwide eligibility requirements, to needy persons who are age 65 or older, blind, or disabled. The blind are defined as individuals with 20/200 vision or less with the use of a correcting lens in the person's better eye, or those with tunnel vision of 20 degrees or less. Disabled persons are defined as those unable to engage in any substantial gainful activity by reason of a medically determined physical or mental impairment expected to result in death or that has lasted, or can be expected to last, for a continuous period of at least 12 months.

[9]As of January 1991, the federal poverty level was $11,140.

[10]The poverty level in Alaska differs from that in other states. For a family of three in Alaska, the poverty level in January 1991 was $13,930.

resources less than a specified amount. In 1991, the limit on resources was $2,000 for an individual and $3,000 for a couple.

In addition to the categorically needy, states can cover the medically needy under Medicaid. As of October 1991, 41 states had medically needy programs financed by both the state and federal governments. These programs must, at a minimum, cover pregnant women and children; however, most states also cover additional categories of individuals. The medically needy are persons who meet all the criteria for cash assistance, except that their income and assets are in excess of the standards for such coverage but below a state-established standard for the medically needy. Persons become medically needy only after they have incurred medical expenses significant enough to reduce their income and resources to the medically needy levels. Qualifying income limits for a family of three in January 1991 averaged $6,299 (56 percent of the federal poverty level for a family of three), representing a range from $3,096 (28 percent of the poverty level) in Louisiana to $11,208 (101 percent of the poverty level) in California (see table III.1).

Table III.1: Annualized Medicaid Eligibility Thresholds (January 1991)

State	AFDC family of three	Percent of poverty level	Medically needy family of three	Percent of poverty level	Pregnant women/ children family of three	Percent of poverty level
Alabama	$1,488	13.4	N/A	N/A	$14,816	133.0
Alaska[a]	10,692	76.8	N/A	N/A	18,527	133.0
Arizona	3,516	31.6	N/A	N/A	15,596	140.0
Arkansas	2,448	22.0	3,300	29.6	14,816	133.0
California	8,328	74.8	11,208	100.6	20,609	185.0
Colorado	5,052	45.4	N/A	N/A	14,816	133.0
Connecticut	6,972	62.6	9,276	83.3	20,609	185.0
Delaware	4,056	36.4	N/A	N/A	14,816	133.0
D.C.	5,136	46.1	6,540	58.7	20,609	185.0
Florida	3,528	31.7	3,528	31.7	16,710	150.0
Georgia	5,088	45.7	4,500	40.4	14,816	133.0
Hawaii[b]	7,584	59.2	7,584	59.2	23,699	185.0
Idaho	3,780	33.9	N/A	N/A	14,816	133.0
Illinois	4,404	39.5	5,904	53.0	14,816	133.0
Indiana	3,456	31.0	N/A	N/A	14,816	133.0
Iowa	5,112	45.9	6,792	61.0	20,609	185.0
Kansas	4,596	41.3	5,580	50.1	16,710	150.0
Kentucky	6,312	56.7	3,696	33.2	20,609	185.0

(continued)

State	AFDC family of three	Percent of poverty level	Medically needy family of three	Percent of poverty level	Pregnant women/ children family of three	Percent of poverty level
Louisiana	$2,280	20.5	$3,096	27.8	$14,816	133.0
Maine	7,824	70.2	7,296	65.5	20,609	185.0
Maryland	4,872	43.7	5,604	50.3	20,609	185.0
Massachusetts	6,948	62.4	9,300	83.5	20,609	185.0
Michigan	7,032	63.1	6,780	60.9	20,609	185.0
Minnesota	6,384	57.3	8,508	76.4	20,609	185.0
Mississippi	4,416	39.6	N/A	N/A	20,609	185.0
Missouri	3,504	31.5	N/A	N/A	14,816	133.0
Montana	4,440	39.9	5,076	45.6	14,816 1	33.0
Nebraska	4,368	39.2	5,904	53.0	14,816	133.0
Nevada	3,960	35.5	N/A	N/A	14,816	133.0
New Hampshire	6,192	55.6	7,392	66.4	14,816	133.0
New Jersey	5,088	45.7	6,792	61.0	14,816	133.0[b]
New Mexico	3,720	33.4	N/A	N/A	14,816	133.0
New York	6,924	62.2	8,700	78.1	20,609	185.0
North Carolina	3,324	29.8	4,404	39.5	20,609	185.0
North Dakota	4,812	43.2	5,220	46.9	14,816	133.0
Ohio	4,008	36.0	9,312	83.6	14,816	133.0
Oklahoma	5,652	50.7	5,508	49.4	14,816	133.0
Oregon	5,328	47.8	7,092	63.7	14,816	133.0
Pennsylvania	5,052	45.4	5,604	50.3	14,816	133.0
Rhode Island	6,648	59.7	8,892	79.8	20,609	185.0
South Carolina	5,280	47.4	3,396	30.5	20,609	185.0
South Dakota	4,620	41.5	N/A	N/A	14,816	133.0
Tennessee	4,944	44.4	3,204	28.8	16,710	150.0
Texas	2,208	19.8	3,204	28.8	14,816	133.0
Utah	6,444	57.8	6,432	57.7	14,816	133.0
Vermont	8,148	73.1	10,896	97.8	20,609	185.0
Virginia	3,492	31.3	4,296	38.6	14,816	133.0
Washington	6,372	57.2	7,800	70.0	20,609	185.0
West Virginia	2,988	26.8	3,480	31.2	16,710	150.0
Wisconsin	6,216	55.8	8,268	74.2	17,267	155.0
Wyoming	4,320	38.8	N/A	N/A	14,816	133.0
Average state	$ 5,085	45.1	$6,299	56.3	$17,206	153.3

(Table notes on next page)

Note: AFDC and Medically Needy thresholds are current through January 1991. Under AFDC, the term "threshold" refers to that income limit that truly drives program eligibility. In most states, this is the payment standard. In Colorado, Georgia, Kentucky, Maine, Michigan, Mississippi, Oklahoma, South Carolina, Tennessee, and Utah, the threshold is the state's need standard. Please note that in these 10 states, the threshold that appears on the table is not what the state pays to AFDC recipients. These states' payment standards are actually significantly lower than the eligibility threshold.

[a]Poverty levels for Hawaii and Alaska differ from those in other states: in Alaska, family of three = $13,930; in Hawaii, family of three = $12,810.

[b]Effective April 1, 1991.

Source: National Governors' Association, January 1991.

Since 1984, the Congress has passed a series of laws requiring or allowing states to provide Medicaid coverage to certain groups of individuals not meeting the requirements for cash assistance. For example, the Omnibus Budget Reconciliation Act of 1986 and the Omnibus Budget Reconciliation Act of 1987 (P.L. 99-509 and P.L. 100-203, respectively) allow states to offer Medicaid to low-income pregnant women, infants, and children in families with incomes above the AFDC qualifying level. States have the option to raise the income eligibility for pregnant women and infants to 185 percent of poverty and to continue phasing in coverage of children to age eight living below poverty.

The Omnibus Budget Reconciliation Act of 1989 required states, beginning April 1, 1990, to cover pregnant women and children up to age six at 133 percent of the federal poverty level.[11] Twenty-four states have expanded coverage of pregnant women and infants beyond the mandated 133 percent of poverty. By expanding Medicaid coverage under these laws, states are able to address the health care needs of these groups without also having to offer them AFDC payments, thus breaking the traditional link between the two programs for this population.

Similarly, the traditional link between Medicaid and SSI eligibility for the aged and disabled was broken through the Medicare Catastrophic Coverage Act of 1988 and the Omnibus Budget Reconciliation Act of 1990. Under the Medicare Catastrophic Coverage Act, state Medicaid programs are required to pay the part B and, if applicable, part A premiums and all deductibles and coinsurance for "qualified Medicare beneficiaries." These are aged and disabled persons who are receiving Medicare, whose family incomes are below 100 percent of the federal poverty level, and whose resources do not exceed twice the allowable amount under SSI. The

[11]Coverage for pregnant women is limited to services related to the pregnancy or complications of the pregnancy; children receive full Medicaid coverage.

Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) made the above requirement effective January 1, 1991, and required states to extend payment of Medicare part B premiums to qualified Medicare beneficiaries with incomes of up to 120 percent of the federal poverty level by 1995. In addition, states were given the option of providing full Medicaid benefits to qualified Medicare beneficiaries. As of January 1992, nine states were providing full Medicaid benefits to qualified Medicare beneficiaries.

Finally, the traditional link between the cash assistance programs and Medicaid eligibility was broken through expansion of Medicaid eligibility to specific groups. For example, newly legalized aliens and the homeless were given Medicaid eligibility even if they did not meet the requirements for cash assistance.[12]

FEHBP

Employees of the executive, legislative, or judicial branch of the U.S. government, including government-owned or -controlled corporations and Gallaudet College, are eligible to enroll in FEHBP if they are permanent employees with regularly scheduled tours of duty or temporary employees who have completed 1 year of current continuous employment.[13] Enrollment in FEHBP prepaid plans is limited to employees residing in the geographic area served by the plan. Also, only 12 of the 19 fee-for-service plans are governmentwide plans, that is, open to all employees; 7 plans limit enrollment to specific groups such as rural mail carriers or Panama Canal area employees.

Enrollment in FEHBP is voluntary, as is the employee's election to cover family members. Eligible family members include spouse; unmarried children under age 22, including adopted children, dependent stepchildren, and foster children who live with the employee in a regular parent-child relationship; and any unmarried children over age 22 who are incapable of self-support because of a mental or physical disability that existed before age 22. Under the family enrollment, dependents are eligible for the same benefits as employees.

An employee is eligible to continue enrollment into retirement if (1) he or she retired under a retirement system for civilian employees of the

[12]For additional information on Medicaid expansions, see Medicaid Expansions: Coverage Improves but State Fiscal Problems Jeopardize Continued Progress (GAO/HRD-91-78, June 25, 1991).

[13]Temporary employees enrolling in FEHBP must pay the total premium—both employee and federal share—for the plan they select. The District of Columbia withdrew from FEHBP effective October 1, 1987. However, employees of the District of Columbia who were employed and eligible for enrollment in FEHBP before October 1, 1987, can still participate in FEHBP.

government (federal or District of Columbia), (2) the retirement is on an immediate annuity, and (3) he or she was enrolled or covered as a family member in FEHBP for the 5 years of service immediately preceding retirement or for all service since the first opportunity to enroll in FEHBP if less than 5 years. Survivor annuitants who were covered under a family enrollment may continue their coverage after the death of the sponsoring employee or retiree. Retirees and survivor annuitants pay the same premiums and receive the same benefits as active permanent employees enrolled in the same plan except that FEHBP plans are required to waive their deductible and coinsurance amounts for retirees who also have Medicare coverage.

Benefits and Coverage Limitations Under Major Health Programs

The following analysis compares the benefits and coverage limitations for the major health programs. For each benefit, we present a definition, the results of our analysis, and our comments about the potential effects of differences in benefits and coverage limits on veterans' health care.

Inpatient Medical and Surgical Care

Definition

Inpatient medical and surgical care refers to treatment for illness or injury other than a mental health condition, which requires confinement as a patient in a hospital.

Results

All major health benefits programs provide inpatient medical and surgical care, generally without any restrictions on the days allowed for medically necessary care. Medicare, however, limits coverage of inpatient medical and surgical care to 90 days during any benefit period. For illnesses requiring more than 90 days of hospitalization, Medicare beneficiaries are allowed 60 extra hospital days, called reserve days. A beneficiary may use all or some of the reserve days during a benefit period, but the reserve days are not renewable. Medicare will not cover any additional days of hospitalization during a benefit period. (See table IV.1.)

Table IV.1: Length of Stay Limits on Inpatient Medical and Surgical Care (1991)

Program	Limits on length of stay
VA	None
DOD direct care	None
CHAMPUS	None
Medicare	90 days per benefit period, plus 60 reserve days
Medicaid	67% of recipients have no limits, 13% have limits of 14 to 30 days an admission, 11% have limits of 14 to 60 days a year, and 10% have other restrictions[a]
FEHBP	None[b]
Private insurance	98% of participants have no limits[c]

Note: The BLS survey of private insurance used 1989 data. Comparable information for 1991 was not readily available.

[a]Other restrictions include limits based on the diagnosis, an average length-of-stay measure, or a requirement for pre-approval. In addition, 38% of Medicaid recipients have a limit on the number of physician visits allowed in an inpatient hospital setting—the most common limit is one visit a day (31% of recipients).

[b]Three plans (68.7 percent of enrollment) limit inpatient medical and surgical benefits for organ transplantation to a maximum dollar amount—17.3 percent limited to $300,000 and 51.4 percent to $100,000.

[c]Two percent of employees with inpatient hospital coverage have a limit on the length of stay—data on the most common limit were not available.

The only other major health benefits program frequently imposing restrictions on the days of care is Medicaid. In 1991, 21 state Medicaid programs, with almost 33 percent of recipients, had limits on hospital care.

Although VA's and DOD's direct care systems do not limit the days of care, both systems have restrictions on access to inpatient care for some beneficiaries. As discussed on page 28, VA provides hospital care to veterans in the discretionary-care category only to the extent space and resources exist after it has met the needs of veterans in the mandatory-care category. Those discretionary-care veterans unable to obtain care from VA must obtain care from the community through their own resources or another health benefits program. DOD's direct care system similarly limits care available to the dependents of active duty personnel and retirees and their dependents and survivors to space available after meeting the needs of active duty personnel. Unlike VA, however, those DOD beneficiaries unable to obtain inpatient care through the direct care system can obtain care through CHAMPUS unless they are Medicare-eligible.

Potential Effect on Demand for VA Services

The Medicare limits on days of inpatient hospital care could result in Medicare-eligible veterans with catastrophic illnesses seeking care from VA once their Medicare coverage has been exhausted. Similarly, Medicare-eligible military retirees and their dependents and survivors may seek care in DOD hospitals when Medicare coverage has been exhausted. Although there is no backup program to provide services to discretionary-care category veterans unable to obtain needed hospital care from a VA facility, the significance of this limitation is questionable because most veterans in the discretionary-care category have private health insurance. Also, those over 65 years old would normally have Medicare coverage.

Outpatient Medical and Surgical Care

Definition

Outpatient medical and surgical care refers to treatment for illness or injury other than a mental health condition on an ambulatory basis in the outpatient department of a hospital or in a clinic or other medical facility, including a physician's or other health practitioner's office.

Results

All programs offer outpatient medical and surgical care, generally with no limits on the number of visits. The only limits are those imposed by 16 states under their respective state Medicaid programs. Those states, with about 23 percent of Medicaid recipients, set limits on yearly, monthly, or daily visits; the most common (applying to 10.3 percent of Medicaid recipients) limits recipients to one clinic or physician visit per day. Four state Medicaid programs that impose limits allow additional visits under certain circumstances. (See table IV.2.)

Table IV.2: Limits on Outpatient Medical and Surgical Care (1991)

Program	Limits on the number of office visits and outpatient surgery
VA	None
DOD direct care	None
CHAMPUS	None[a]
Medicare	None
Medicaid	77% of recipients have no limits; 23% have a limit on outpatient clinic or physician visits—the most common limit is one visit a day
FEHBP	None
Private insurance	No discussion of limits on outpatient care

Note: The BLS survey of private insurance used 1989 data. Comparable information for 1991 was not readily available.

[a]CHAMPUS does not cover certain outpatient procedures if the procedures can be performed within the direct care system.

Although VA does not have limits on the number of outpatient visits, VA's eligibility and entitlement provisions (see p. 28) place significant limits on the availability of routine outpatient care. For most veterans, outpatient care is limited to services needed to prepare for or obviate the need for hospitalization or as a follow-up to hospitalization. Only those veterans with service-connected disabilities rated at 50 percent or higher—about 520,000 in 1991—are guaranteed comprehensive outpatient care for both service-connected and nonservice-connected conditions. Other veterans who can be provided comprehensive outpatient care are former prisoners of war, veterans of the Mexican border period and World War I, veterans who are housebound or in need of aid and attendance, and disabled veterans participating in VA-approved vocational rehabilitation programs. There were only about 185,000 veterans in these categories in 1991.

Potential Effect on Demand for VA Services

If tightly controlled, the "obviate the need" requirement could result in veterans forgoing needed medical care until their conditions deteriorate to the point where the alternative to outpatient treatment is hospitalization. VA has generally taken a broad view of the "obviate the need" requirement and provided treatment for conditions that, if left untreated, could deteriorate to the point where the veteran would require hospitalization. As a result, the effects of the limitation are not clear.

Institutional Long-Term Care

Definitions

Long-term care refers to a wide array of medical, social, personal, supportive, and specialized housing services needed by people who have lost some capacity for self-care as a result of chronic illness or physical conditions that result in both functional impairment and physical dependence on others for an extended period of time. Long-term care services can be provided in institutions or in the home and community.

Nursing homes are facilities that provide skilled nursing care and related medical care for convalescents or persons who are not acutely ill and not in need of hospital care. Nursing homes can be freestanding facilities or distinct parts of hospitals.

Domiciliaries are facilities that provide care on an ambulatory self-care basis to people disabled by age or disease who are not in need of acute hospitalization and who do not need the skilled nursing services provided in nursing homes.

Skilled care refers to services provided to patients who need physician-supervised skilled nursing or skilled rehabilitation on a daily basis. Skilled care is provided in nursing homes.

Intermediate care refers to care provided to nursing home patients who do not require daily skilled nursing or rehabilitation but require supervision, protection, or assistance and physician supervised services that include occasional skilled nursing or skilled rehabilitation. Intermediate care is provided in nursing homes.

Custodial care refers to care that is primarily for the purpose of helping the patient in meeting daily living or personal needs and can be provided by people without professional skills or training. Custodial care can be provided in nursing homes or domiciliaries.

Results

VA provides a wider range of institutional long-term care services than other major health benefits programs. VA is the only program that covers custodial care, and VA and Medicaid are the only programs that cover intermediate care. All of the other public programs limit coverage to

skilled care, and Medicare further limits the number of days of coverage. Less than 3 percent of federal employees have skilled nursing care coverage. (See table IV.3.)

Table IV.3: Coverage and Length-of-Stay Limits for Institutional Long-Term Care (1991)

Program	Type of care			Length-of-stay limits
	Skilled	Intermediate	Custodial	
VA				
Service-connected	Yes	Yes	Yes[a]	No limits
Nonservice-connected	Yes	Yes	Yes[a]	No limits[b]
DOD direct care	Yes	No	No	No limits
CHAMPUS	Yes	No	No	No limits
Medicare	Yes	No	No	100 days per benefit period
Medicaid	Yes	Yes	No	No limits
FEHBP[c]	No	No	No	Not applicable
Private insurance	Yes	No	No	No data on specific limits[d]

Note: The BLS survey of private insurance used 1989 data. Comparable information for 1991 was not readily available.

[a]Custodial care is provided in VA-operated domiciliaries and state veterans' homes.

[b]While there is no limitation on length of stay in a VA-operated nursing home for a veteran with a nonservice-connected disability, stays in community nursing homes are limited to 6 months, although a 45-day extension can be granted.

[c]Three percent of FEHBP enrollees have a skilled care benefit—2 percent with a 60-day limit on coverage and 1 percent with no limit.

[d]About 80 percent of private insurance participants have extended-care-facility coverage, but the BLS survey does not define that level of care or cite specific limitations.

There are three restrictions on the availability of institutional long-term care from VA. First, nonservice-connected veterans are limited to 6-month placements in community nursing homes under VA sponsorship, although a longer stay can be authorized on an exception basis. Second, only low-income veterans (those with incomes below the maximum annual rate for a VA pension) are eligible for domiciliary care, although the Secretary of Veterans Affairs can authorize domiciliary care for other veterans determined to have no adequate means of support. Finally, VA care is limited to available space and resources.

Although DOD's direct care system does not operate nursing homes, skilled nursing care is provided in DOD hospitals. There are no length-of-stay limits but, like VA, care is limited to space available. The effects of this limitation are reduced, however, because (1) active duty members needing prolonged nursing home care can obtain care in VA nursing homes and (2) other DOD beneficiaries, such as retirees and dependents of active duty and retired members, can obtain skilled nursing care without limitations through CHAMPUS.

State Medicaid programs are required to provide nursing home services. None of the states places limits on the length of nursing home coverage, but 25 states, representing 38 percent of recipients, limit the number of physician visits to nursing home residents.[1]

Medicare covers only those nursing home stays where the beneficiary

- requires daily skilled nursing or skilled rehabilitation services,
- was hospitalized for at least 3 consecutive days (not counting the day of discharge) before the nursing home admission,
- was admitted to the facility within a short time after discharge from the hospital (generally within 30 days),
- was being treated for a condition related to the hospital stay, or
- has a physician certify that he or she needs and receives skilled nursing or rehabilitation on a daily basis.

In addition, coverage is limited to 100 days during a benefit period.

Potential Effect on Demand for VA Services

The limited coverage of long-term care services under Medicare and private insurance and the extensive cost sharing required under Medicaid (see p. 76) make VA an attractive option for veterans in need of such services. Although CHAMPUS also provides nursing home coverage, CHAMPUS eligibility ends at age 65, before most veterans need nursing home care.

[1]The states use differing limits in terms of visits per year (12 to 36), visits per month (1 to 5), or visits per day (1 to 2).

Inpatient Mental Health Care

Definition

Inpatient mental health care refers to treatment for mental disorders that require confinement as a patient in a hospital or other medical facility. It includes both short-term, acute psychiatric care and long-term institutionalization in a psychiatric hospital.

Results

Although all major health programs cover inpatient mental health services, most are directed toward short-term, acute psychiatric care, setting limits on days of care or maximum payments. DOD's direct care system does not formally impose limits on inpatient mental health care but generally provides inpatient mental health care only through acute psychiatric wards in DOD hospitals. VA, on the other hand, provides both acute and long-term psychiatric care. (See table IV.4.)

Table IV.4: Limits on Inpatient Mental Health Care (1991)

Program	Days of care limits	Dollar maximum limits
VA	None	None
DOD direct care	None	None
CHAMPUS	60 days a year; waivers may be granted[a]	None
Medicare	90 days a benefit period, plus 60 reserve days, and 190 days in a psychiatric hospital per lifetime	None
Medicaid	Data not readily available	None
FEHBP	1% of enrollees have a 30 day a year limit	99% of enrollees have a lifetime maximum dollar benefit; the most common is $50,000
Private insurance	49% of participants have limits on days—most commonly per year[b]	38% of participants have a maximum dollar benefit most commonly per lifetime[b]

Note: The BLS survey of private insurance used 1989 data. Comparable information for 1991 was not readily available.

[a]Effective October 1, 1991, the National Defense Authorization Act for Fiscal Year 1991 (P.L. 101-510) limited CHAMPUS mental health benefits for inpatient acute care to 30 days a year for adults and 45 days a year for dependents under 19 years of age. Care in residential treatment centers is limited to 150 days a year.

[b]The BLS data do not show the specific limitations in terms of days or maximum dollar benefits.

State Medicaid programs may cover inpatient mental health services provided in acute care hospitals. Because each state is allowed to (1) set use and dollar limitations on the duration, scope, and dollar amount of Medicaid coverage and (2) decide whether to cover certain mental health services, there is considerable variation among the states in the nature and extent of inpatient mental health services.

For example, Georgia does not impose length-of-stay restrictions on inpatient medical or surgical care, but limits inpatient psychiatric treatment to 30 days per admission. Similarly, Connecticut's program does not limit inpatient physician visits, but has imposed a limit of 42 psychiatric visits per year in an inpatient hospital setting.

Medicaid specifically excludes federal reimbursement for the care of the mentally ill aged 22 through 64 in institutions for mental diseases. These are defined in Medicaid regulations as institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care (which includes medical attention, nursing care, and related services) for people with mental diseases. States are not required, but have the option, to provide institutional care for the mentally ill who are under 21 years of age and 65 years or older.

FEHBP plans generally limit mental health benefits by imposing lifetime dollar maximums rather than limiting days of care. Eleven of the 12 FEHBP plans (with 99.4 percent of enrollment) limit coverage to lifetime maximum plan payments ranging from $25,500 to $75,000 per person for mental health care. The most common lifetime limit, affecting about 71 percent of enrollment, is $50,000 per person. The remaining plan, with less than 1 percent of enrollment, limits inpatient mental health coverage to a maximum of 30 days and provides no enrollee catastrophic protection.

The Bureau of Labor Statistics (BLS) reports that in 1989, 98 percent of private health insurance enrollees had inpatient mental health care coverage—21 percent with the same coverage limits as inpatient medical and surgical care and 77 percent with separate limits for inpatient mental health care. For those enrollees in plans with separate mental health limits, 49 percent had a limit on days, usually per year, but sometimes per confinement or per lifetime. In addition, 38 percent had a maximum dollar benefit, usually per lifetime, but occasionally per year. Specific day and dollar limitations for inpatient mental health care were not available in the BLS survey. A survey by Foster Higgins, however, found that lifetime

maximum dollar limits of $50,000 or less and annual limits of 30 days are most common.[2]

CHAMPUS benefits for inpatient mental health care overall are greater than inpatient mental health benefits in federal employees' and private sector health plans.[3] The key features that make CHAMPUS inpatient benefits greater are (1) higher limits on the days of coverage per year for children, (2) the ability to waive the limits on days of care, (3) the absence of lifetime limits, and (4) the inclusion of coverage for care in residential treatment centers for children.

Medicare provides more extensive coverage of inpatient mental health care than either CHAMPUS or FEHBP. It covers 90 days of inpatient care in a hospital per benefit period (with 60 lifetime reserve days) but not more than 190 days in a psychiatric hospital per lifetime. The limits on care in a hospital, including the reserve days, apply to both inpatient medical and surgical care and inpatient mental health care.

VA provides both acute and long-term inpatient psychiatric care without limits on days of care or costs. In addition, VA operates specialized inpatient mental health programs for veterans with post-traumatic stress disorder (PTSD).[4] These units are designed to provide care for those veterans whose PTSD is too severe or complex to be treated in general psychiatry inpatient or outpatient programs.

Potential Effect on Demand for VA Services

VA provides the most extensive mental health benefits of any major health program, particularly for long-term psychiatric care. Although Medicaid also covers care in psychiatric hospitals, it does not cover those between the ages of 22 and 64 and coverage of those 65 and older is optional. These limitations could make it difficult for veterans to obtain needed long-term psychiatric care under Medicaid. Similarly, the lifetime maximum of 190 days in a psychiatric hospital under Medicare provides an incentive for veterans to turn to VA after exhausting their Medicare coverage. In addition, VA provides specialized treatment for service-connected mental health problems (e.g., PTSD) that may not be available in the private sector.

[2]Health Care Benefits Survey, Foster Higgins (1989).

[3]Defense Health Care: CHAMPUS Mental Health Benefits Greater Than Those Under Other Health Plans (GAO/HRD-92-20, Nov. 7, 1991).

[4]This refers to such symptoms as nightmares, intrusive recollections or memories, flashbacks, anxiety, or sudden reactions after exposure to traumatic conditions.

Outpatient Mental Health Care

Definition

Outpatient mental health care refers to treatment for mental disorders on an ambulatory basis in the outpatient department of a hospital or in a clinic or other medical facility, including a physician's or other health practitioner's office.

Results

Although all major health programs cover outpatient mental health care, VA, DOD's direct care system, and Medicare are the only programs with no limits on either the number of visits or maximum dollar coverage. (See table IV.5.)

Table IV.5: Limits on Outpatient Mental Health Care (1991)

Program	Limits on number of visits	Limits on maximum plan benefits
VA	None	None
DOD Direct Care	None	None
CHAMPUS	2 visits per week; 23 visits per year[a]	None
Medicare	None	None
Medicaid	[b]	[b]
FEHBP	87% of enrollees have a limit; the most common is 25 visits a year	31% of enrollees have a limit; the most common is $1,400 a year
Private Insurance	34% of participants have a limit on days per year[c]	66% of participants have a limit on dollar amount; the most common is per lifetime[c]

Note: The BLS survey of private insurance used 1989 data. Comparable information for 1991 was not readily available.

[a]Extensions are available.

[b]Information on limits is not readily available.

[c]The BLS data do not show the specific limitations in terms of days or maximum dollar benefits.

Although CHAMPUS does not set an absolute limit on the number of outpatient mental health visits, it allows no more than 2 visits per week and 23 visits per calendar year without prior approval of the treatment plan.

By contrast, the FEHBP plans have absolute limits on the number of visits (three plans, with 69 percent of enrollment), maximum plan payments for professional services (six plans, with 13 percent of enrollment), or both (three plans, with 18 percent of enrollment).

BLS reports that about 95 percent of enrollees in private insurance plans have an outpatient mental health care benefit; 34 percent of participants have a limit on the number of visits per year and 66 percent, a limit on the maximum dollar benefit, usually per year (29 percent of participants) or per lifetime (31 percent of participants). Although data on specific limits are not provided in the BLS survey, a study by Hay/Huggins found that the most common limits were 50 or fewer visits and $2,000 or less as a maximum annual benefit.[5]

State Medicaid programs are, at a minimum, required to cover outpatient hospital care for mental health problems, consultations with a physician, and clinic and laboratory services under their Medicaid programs. In addition, they can cover a wide range of optional mental health services, including case management, social worker services, rehabilitation, and drugs. Information on Medicaid outpatient options by state is published by the National Mental Health Association. However, little data are readily available on the nature and extent of limits placed on the availability of outpatient mental health services under Medicaid.

In addition to routine outpatient mental health services provided in VA hospital-based and VA freestanding outpatient clinics, VA operates readjustment counseling (vet centers) to provide outreach and counseling to help veterans resolve war-related psychological difficulties and to help them achieve a successful post-war readjustment to civilian life. The vet centers provide group, individual, and family counseling and help veterans find services from VA and non-VA sources as needed.

Potential Effect on Demand for VA Services

Veterans can generally obtain outpatient mental health care through either public or private benefit programs, although those veterans under age 65 and not military retirees are likely to have limits on either the number of visits or cost of care. Those veterans age 65 and over can obtain medically necessary outpatient mental health care without limits through VA or Medicare. Because outpatient mental health benefits are covered under Medicare part B, those veterans choosing not to enroll in part B would be more likely to depend on VA for such care. Veterans would also tend to

[5]Hay/Huggins Benefits Report, Hay Management Consultants, 1990.

depend on VA for assistance in meeting their readjustment counseling needs.

Substance Abuse Treatment

Definition

Inpatient substance abuse care refers to treatment for alcoholism and drug abuse as a patient in a hospital or other medical facility.

Outpatient substance abuse care refers to treatment for alcoholism and drug abuse on an ambulatory basis in the outpatient department of a hospital or in a clinic or other medical facility, including a physician's or other health practitioner's office.

Results

All major health programs cover inpatient and outpatient treatment for substance abuse, but only VA and the DOD's direct care system have no set limits on coverage for medically necessary care.[6] Medicare provides unlimited coverage for outpatient care but applies inpatient mental health limits to substance abuse treatment stays. FEHBP plans generally limit both inpatient and outpatient care. Finally, federal Medicaid requirements allow states to pay for substance abuse services under several benefits, but little information on actual coverage is available. (See table IV.6.)

[6]While there are no limits on the duration or number of episodes of substance abuse treatment under the DOD system, repeated substance abuse by active duty members would likely result in discharge from active duty.

Table IV.6: Limits on Substance Abuse Treatment (1991)

Program	Limits on inpatient treatment	Limits on outpatient treatment
VA	None	None
DOD direct care	None	None
CHAMPUS	Drug abuse: 60 days a year[a] Alcohol abuse: None for detoxification in an inpatient hospital facility; 7 days for detoxification in a rehabilitation facility; and 21 days of rehabilitation per treatment; 3 treatments per lifetime	Drug abuse: 23 visits per year; 2 visits per week Alcohol abuse: 60 visits per year
Medicare	Included under mental health limits	None
Medicaid	[b]	[b]
FEHBP	Drug & alcohol abuse: 65% of enrollees have a limit of one 28- to 30-day treatment per year or per lifetime; 35% have only a maximum dollar limit, most commonly $25,500 per lifetime	Drug & alcohol abuse: 86% of enrollees have a limit on the number of visits, most commonly 25 per year; 12% have only a maximum dollar limit, most commonly $1,500 per calendar year[c]
Private insurance	Drug abuse: 42% of participants have a day limit; 23% have a dollar limit Alcohol abuse: 46% of participants have a day limit; 23% have a dollar limit[d]	Drug abuse: 20% of participants have a day limit; 35% have a dollar limit Alcohol abuse: 22% of participants have a day limit; 36% have a dollar limit[d]

Note: The BLS survey of private insurance used 1989 data. Comparable information for 1991 was not readily available.

[a]Effective October 1, 1991, stays for inpatient drug abuse treatment and alcohol detoxification and rehabilitation are limited to 30 days per fiscal year or an admission for adults and to 45 days for children age 18 and under.

[b]Some Medicaid programs may limit inpatient or outpatient treatment of substance abuse; however, this information is not readily available.

[c]Two percent of FEHBP enrollees have no outpatient coverage.

[d]For inpatient and outpatient substance abuse treatment, limits on days most commonly apply per year. Dollar limits on inpatient care most commonly apply per lifetime, while dollar limits on outpatient care are usually per year. No data are provided on specific limitations.

Limits on Inpatient Treatment for Substance Abuse

CHAMPUS includes inpatient treatment for drug addiction under its inpatient mental health benefits; drug abuse treatment counts against the 30 days per year limit on inpatient mental health for adults and 45 days per year for children under age 19. CHAMPUS has separate limits for alcohol abuse, allowing up to 7 days for detoxification in a hospital or alcohol

rehabilitation facility, and up to 21 days per treatment for inpatient rehabilitation, with no more than three treatments per lifetime.

Medicare includes inpatient treatment for alcohol and drug abuse under its inpatient mental health care coverage—and does not have separate limits; alcohol and drug abuse treatment are applied against the 90-day limit on inpatient care during any benefit period and toward the total of 190 days in a psychiatric hospital (if treatment is provided in a psychiatric hospital).

Federal employee plans limit inpatient treatment for substance abuse by the number of treatment programs and/or by maximum plan payments per calendar year or per lifetime. Sixty-five percent of enrollees are allowed one 28- or 30-day treatment program, usually per lifetime. Thirty-five percent of enrollees are subject only to a maximum dollar benefit limit for substance abuse treatment programs. Those limits range from $3,500 per calendar year to $50,000 per lifetime, with the most common being $25,500 per lifetime (affecting about 17 percent of enrollees).

BLS reported that in 1989 almost all enrollees in private health insurance had drug and alcohol abuse treatment benefits. All had coverage of inpatient detoxification, but only 64 percent and 68 percent, respectively, had coverage of inpatient rehabilitation. For both drug and alcohol abuse treatment, most participants are subject to separate limits that apply only to this treatment.

Limits on Outpatient Treatment for Substance Abuse

Compared with FEHBP and private sector plans, the public health benefits programs have fewer limits on outpatient substance abuse and alcohol abuse services; VA, DOD's direct care system, and Medicare have no limits. CHAMPUS includes outpatient treatment for drug addiction under its limits for treatment of mental disorders—23 visits per year with a limit of 2 visits per week. Outpatient treatment for alcoholism is limited to 60 visits per year.

Three of the 12 FEHBP plans open to all employees (with about 2 percent of enrollment) do not cover outpatient treatment for substance abuse. The other nine plans cover outpatient treatment, but limit coverage either by the number of visits (five plans with 86 percent of enrollment) or maximum plan payments (four plans with 12 percent of enrollment). The most common limit on the number of outpatient visits is 25 per year, and the most common maximum plan benefit is $1,500 per year. Coverage of outpatient substance abuse treatment is even more limited under private sector health plans. Only 58 percent of participants are covered for

outpatient drug abuse treatment. Similarly, only 61 percent of participants are covered for outpatient alcohol abuse treatment. Most of the private sector plans have separate limits, based either on visits or costs, for their outpatient drug abuse and alcohol abuse benefits. The BLS survey does not identify the specific limits most commonly used.

Medicaid Coverage Poorly Defined

Medicaid laws and regulations do not specify substance abuse treatment as a covered service; however, states can provide substance abuse treatment for Medicaid-eligible persons if the treatment is performed under a Medicaid service category that qualifies for federal matching funds. For example, while Medicaid regulations do not list alcohol detoxification as a reimbursable service, if an individual receives inpatient treatment that includes alcohol detoxification, the detoxification would be covered under Medicaid. In addition, outpatient substance abuse treatment may be provided under such optional service categories as clinic services, rehabilitative services, or prescribed drugs.

HCFA does not maintain data on the type and amount of substance abuse services provided by the states. However, some states restrict the Medicaid services offered for substance abuse treatment.[7] For example, some states do not allow inpatient rehabilitation following detoxification, and some states either deny or limit inpatient hospital treatment for substance abuse.

Potential Effect on Demand for VA Services

Alcohol and drug abuse are among the most significant health problems for some veterans. Because of the coverage limitations in other health benefits programs, VA plays an important role in meeting these treatment needs.

Limits on coverage of substance abuse treatment under private health insurance could increase demands for VA-supported care even among privately insured veterans. For Medicare-eligible veterans, however, services are generally available under Medicare. Although there are limits on days of inpatient treatment under Medicare, the inpatient phase of substance abuse programs is generally well within those limits.

[7]Substance Abuse Treatment: Medicaid Allows Some Services but Generally Limits Coverage (GAO/HRD-91-92, June 13, 1991).

Outpatient Drugs

Definition

Outpatient drugs are those drugs and medical supplies intended for use on an outpatient or at-home basis.

Results

Medicare is the only major health benefits program that does not routinely cover outpatient drugs, including insulin. Medicare covers primarily drugs and medical supplies furnished while a beneficiary is receiving inpatient care and injections administered in a doctor's office.

CHAMPUS and FEHBP plans limit outpatient drug coverage to insulin and drugs that by law cannot be obtained without a prescription. In contrast, VA, the DOD's direct care system, and most Medicaid programs cover some over-the-counter drugs and medical supplies.

There are few restrictions on the number of prescriptions covered. As of July 1990, 12 state Medicaid programs limited the number of prescriptions a recipient was permitted to have filled during a given time period (generally ranging from 3 to 7 prescriptions per month). None of the other programs that provide outpatient drug coverage has such limits.

BLS reports that 95 percent of participants in private health insurance plans have outpatient prescription drug coverage, but information is not available on the extent or limits on this coverage.

Potential Effect on Demand for VA Services

Elderly veterans have a financial incentive to seek care from VA rather than, or in addition to, care in the community under Medicare, in order to obtain prescription drugs. The extent to which this phenomenon occurs may be limited, however, because of the restrictions on most veterans' access to VA health care services.

Dental Care

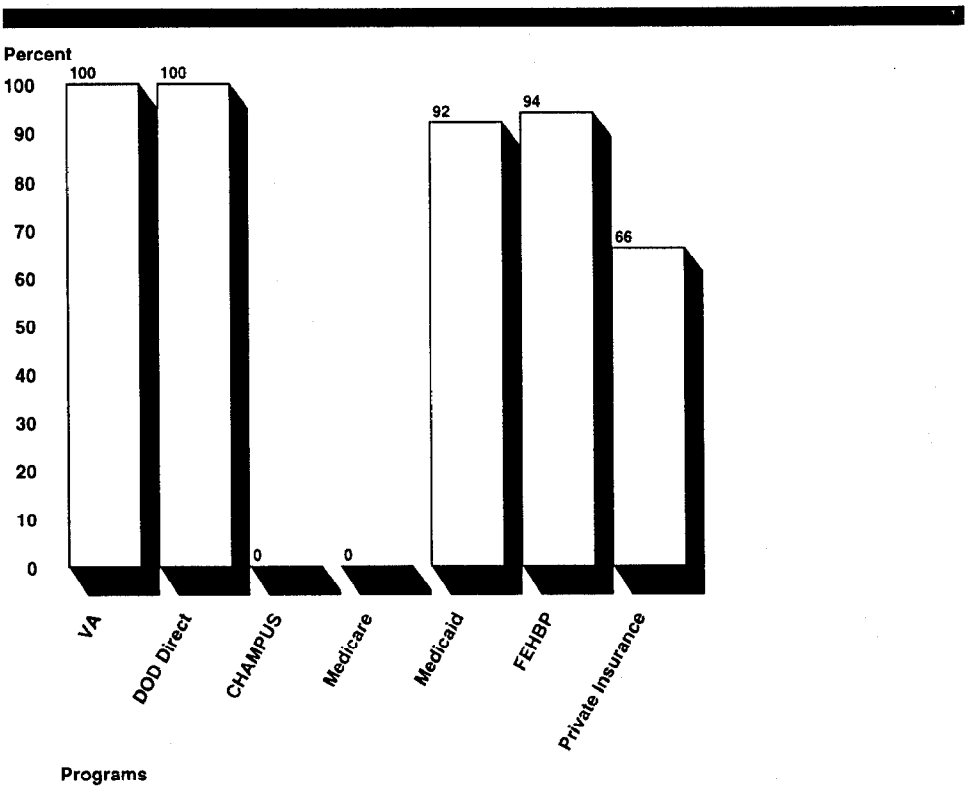
Definition

Dental care includes diagnostic and preventive services and may include restorative services, endodontics, periodontics, and other treatment services.

Results

All major health programs other than Medicare and CHAMPUS provide some dental coverage (see fig. IV.1). DOD's direct care system imposes no limits on the nature and extent of dental care, but services for dependents of active duty members and retirees and their dependents and survivors is on a space-and-resources-available basis. However, DOD sponsors a separate dental health care plan—the Dependents Dental Plan—for dependents of active duty members. In exchange for a nominal premium, an active duty member's spouse and children receive basic preventive and restorative care from civilian dentists. DOD officials said nearly all active duty dependents—about one-third of the beneficiaries eligible for the direct care system—are enrolled in the plan.

Figure IV.1: Percent of Beneficiaries Eligible for Dental Care (1991)



Note: The BLS survey of private insurance used 1989 data. Comparable information for 1991 was not readily available.

VA provides comprehensive dental care including examinations, cleanings, and restorative services, but eligibility for dental care is governed by a complex set of rules. Dental care is available to veterans who (1) have service-connected disabilities rated at 100 percent or are receiving a 100-percent disability rating by reason of unemployability; (2) have service-connected compensable dental disabilities; (3) were prisoners of war for 90 days or more; (4) are participating in a VA-approved vocational rehabilitation program; or (5) are inpatients at VA hospitals, nursing homes, or domiciliaries.

VA limits outpatient dental care for veterans who have service-connected noncompensable dental conditions to service-connected outpatient care, that is, only that treatment necessary to correct the condition. Outpatient dental care for veterans whose dental conditions are aggravating their service-connected medical conditions is similarly limited to that treatment necessary to resolve the dental conditions producing the detrimental effect. Finally, outpatient dental care for veterans who are eligible for dental services while in VA hospitals, nursing homes, and domiciliaries is limited to hospital-related outpatient care, that is, the services reasonably necessary to complete treatment begun during inpatient care.

All state Medicaid programs cover dental services for at least some recipients. A total of 92 percent of Medicaid recipients have coverage for dental services. In addition, dentures are covered for about 87 percent of Medicaid recipients.

Ten of the 12 governmentwide FEHBP plans we reviewed (with 94 percent of enrollment) cover routine dental examinations, cleaning, and some restorative treatment. Eight plans (with 36 percent of enrollment) limit the number of preventive care visits—the most common limit is two visits per person per year.

Coverage of dental care is somewhat less common in private sector health plans. About 66 percent of participants in private health plans are covered by a dental care benefit. Eighty-two percent of private dental plan participants are subject to an annual maximum plan benefit, most commonly $1,000.

Potential Effect on Demand for VA Services

The lack of dental coverage under Medicare and the limited coverage under many private health insurance plans could cause veterans with dual eligibility to seek care from VA. The effect of the coverage differences is

hard to predict, however, because of the complex entitlement provisions under the VA dental benefit. For most veterans, dental care can only be provided if the veteran was examined and treatment started while an inpatient in a VA hospital.

Hospice Care

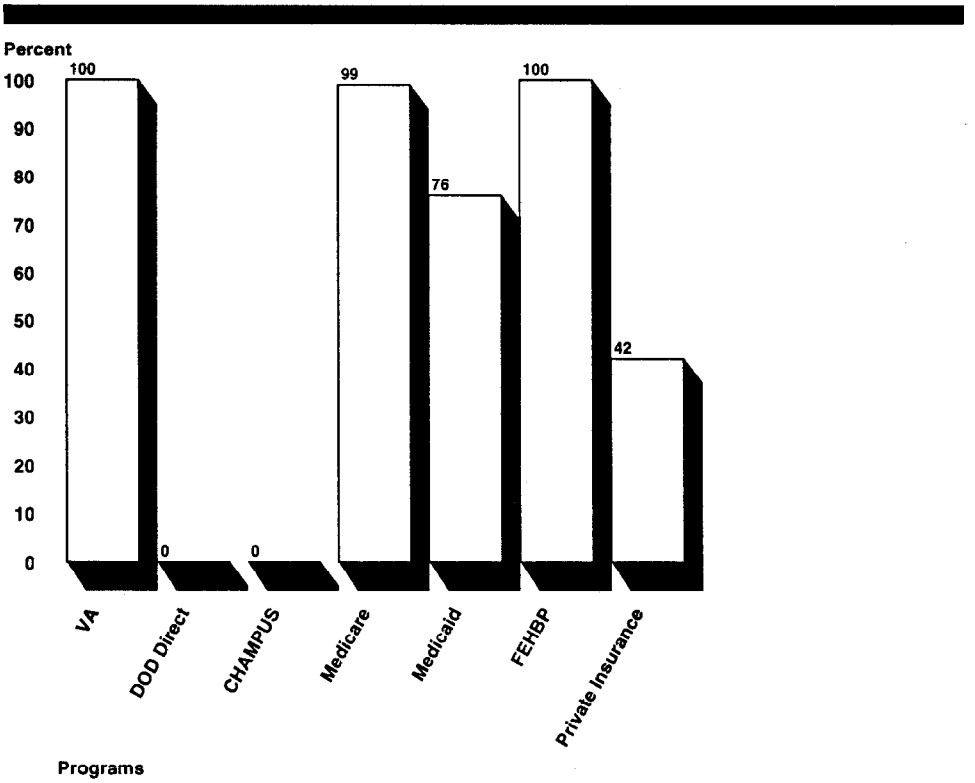
Definition

Hospice care involves a medically supervised program of home and/or inpatient palliative and supportive care for a terminally ill patient and the patient's family.

Results

Hospice care is available, to varying extents, under all major health benefits programs. Such care was recently added to CHAMPUS and DOD's direct care system. (See fig. IV.2.)

Figure IV.2: Percent of Beneficiaries Eligible for Hospice Care (1991)



Notes: The National Defense Authorization Act for Fiscal Years 1992 and 1993 authorized DOD and CHAMPUS to provide hospice care. The BLS survey of private insurance used 1989 data. Comparable information for 1991 was not readily available.

Medicare part A covers hospice services for beneficiaries who are terminally ill, but limits coverage to four periods of care—two 90-day periods, one 30-day period, and a final period of unlimited duration. Medicare provides incentives for hospices to provide care in the patient's home rather than in a facility.

The National Defense Authorization Act for Fiscal Years 1992 and 1993 (P.L. 102-190, enacted Dec. 5, 1991) authorizes the provision of hospice care in DOD facilities and under CHAMPUS. The hospice benefit, for which DOD is developing guidelines, will be patterned after the Medicare benefit.

All terminally ill veterans are eligible to receive hospice care from VA with no limits on the number of home visits or the length of time covered. VA's

Commission on the Future Structure of Veterans Health Care reported in November 1991 that only 45 VA medical centers had hospice programs as of October/November 1990.[8]

All enrollees under FEHBP plans have hospice coverage; 94 percent have both inpatient and in-home hospice. Two plans, Blue Cross High and Standard options, do not limit in-home care but limit inpatient coverage to 5 days per confinement.

Seventy-six percent of Medicaid recipients (32 state Medicaid programs) and 42 percent of private health insurance participants have a hospice care benefit. Information is not readily available on limits on Medicaid or private insurance hospice care.

Potential Effect on Demand for VA Services

Although VA places no limits on hospice benefits, the small number of medical centers offering inpatient hospice services makes them geographically inaccessible to most veterans. The availability of hospice care under Medicare, however, reduces the effect of this limitation. For those not Medicare-eligible, however, hospice coverage is more sporadic.

Home Health Care

Definitions

Home health care is medically supervised care and treatment provided in the patient's home. It includes such services as skilled nursing care, dressing changes, injections, monitoring of vital signs, physical therapy, prescription drugs and medications, nutrition services, medical social work, and medical appliances or equipment.

Results

Most private health insurance plans and all major federal health benefits programs other than DOD provide some home health coverage.[9] While most programs are oriented toward skilled care, VA, CHAMPUS, FEHBP, and Medicaid also offer home health care services to at least some additional patients. In addition, home care services may be available to the terminally ill under separate hospice benefits (see preceding section).

[8]Proceedings of the Commission on the Future Structure of Veterans Health Care (Nov. 1991). The Annual Report of the Secretary of Veterans Affairs, Fiscal Year 1992 indicates that all VA medical centers now provide hospice services and that 28 medical centers have inpatient hospice units.

[9]About 75 percent of participants in private health insurance plans have home health care coverage.

VA's hospital-based home care (HBHC) program delivers primary health care in the home through a hospital-based interdisciplinary team. Under the direction of a physician, an interdisciplinary team provides medical and nursing care, rehabilitation, social services, dietetic consultations, and psychological assessments. The interdisciplinary team is composed of such professionals as physicians, nurses, social workers, physical therapists, dietitians, and pharmacists.

The objectives of the HBHC program include

- providing primary health care services to patients confined in their homes in order to prevent institutionalization;
- creating a therapeutic and safe environment in the home;
- reducing the need for and providing an acceptable alternative to hospitalization, nursing home care, and emergency room and other outpatient visits; and
- promoting early discharge from the hospital or nursing home.

All veterans are eligible for participation in the HBHC program.

During fiscal year 1992, 75 VA medical centers operated HBHC programs. The programs had an average daily census of 5,136 patients.

Home health benefits covered by Medicare are oriented toward skilled care. To qualify for Medicare home health care, a person must be confined to his or her residence (homebound), be under a physician's care, and need intermittent skilled nursing care and/or physical or speech therapy. The services must be furnished under a plan of care prescribed and periodically reviewed by a physician. Individuals who need help with activities of daily living, such as eating or using the toilet, but who do not need skilled nursing care or physical or speech therapy, do not qualify for Medicare home health benefits.[10] In addition, Medicare beneficiaries who are not homebound but need part-time or intermittent skilled nursing care are ineligible for these benefits.

Home health care is a mandatory service for the categorically needy under state Medicaid programs. Medicaid home health services must be performed on a physician's orders as part of a written plan of care and are provided to any categorically needy individual entitled to skilled care in a nursing facility. These services must be provided at an individual's

[10]Persons qualifying for Medicare home health care may receive part-time or intermittent home health aide services, which include assisting patients with daily living needs such as bathing, grooming, getting into and out of bed, taking self-administered medications, and exercising.

residence and include three mandatory services (part-time nursing, home health aide, and medical supplies and equipment) and one optional service (physical therapy, occupational therapy, speech pathology, and audiology services). As of October 1, 1991, all 41 states with medically needy programs provided this service to all Medicaid recipients.

Since the passage of the Omnibus Budget Reconciliation Act of 1981, the Secretary of HHS has been authorized to waive statutory Medicaid requirements to permit states to provide a variety of services to individuals living in the community who would otherwise require Medicaid-financed nursing home care. Types of services that can be authorized under the waivers include case management, homemaker, personal care, habilitation, respite care, and adult day care.[11] As of December 1991, almost all states (with the exception of Alaska, Arizona, and the District of Columbia) were providing community-based services to populations at risk of institutionalization.

Home health care is not specifically defined under the CHAMPUS program. However, the program will pay for home nursing and, with certain limits on frequency and duration, for physical, speech, and occupational therapy in the home. In addition, CHAMPUS will pay for medical equipment and supplies. The program will not, however, pay for home health aides.

CHAMPUS is conducting two demonstration projects to test whether case management coupled with expanded home health care benefits could improve services to beneficiaries and help control health care costs. Expanded home care services under the first project, started in 1986, are available only to those dependents of active duty and deceased active duty military members who, in the absence of case-managed home health care, would be hospitalized. Each patient's home care must be cost effective when compared to the cost of hospital care.

The second project, started in 1988, differs from the first in that (1) eligibility was expanded to include military retirees and their dependents, (2) case-managed home care was no longer required to be cost effective on a case-by-case basis as long as the project showed savings in the aggregate, and (3) case-managed home care was no longer required to be in lieu of hospital care. The 1988 project is available in four geographic areas (Washington state; the Washington, D.C., area;

[11]Several of these services are not specifically included in the standard listing of optional services in Medicaid law and regulations. However, the Secretary of HHS has approved them as part of individual states' Medicaid plans under a general authority to cover "any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary."

Tidewater, Virginia; and the Fitzsimons medical region).[12] In October 1992, the Congress authorized DOD to establish a permanent program of case-managed home care for DOD beneficiaries with extraordinary medical or psychological disorders.

All of the 12 FEHBP fee-for-service plans open to all federal employees cover home health care for persons whose physician certifies that, without such care, confinement in a hospital or extended care facility would be required. Typically, care and treatment are provided in accordance with an approved home health care plan and must begin within a specified period of time after discharge from a hospital. However, FEHBP plans may offer benefit alternatives not ordinarily covered by the plans if such alternatives will result in more efficient medical treatment, such as home health care for patients whose condition may require long-term treatment.

Skilled nursing care in the home is offered to all enrollees in the 12 FEHBP fee-for-service plans. Other home health services can include physical, occupational, or speech therapy; social worker visits; and home health aides. The majority of FEHBP plans, however, limit home health coverage. For example, 65 percent of enrollees have a limit on the number of home health visits (ranging from 25 to 120 visits a year), 12 percent limit home health coverage to 90 days a year, and 1 percent have a $10,000 limit for home health payments.

Potential Effect on Demand for VA Services

Many elderly have unmet needs for assistance with their personal care needs (activities of daily living) or homemaker needs (instrumental activities of daily living).[13] Although the Medicaid home- and community-based services waivers could help reduce the number of elderly with unmet home care needs, the effect of the waivers is likely to be limited because of the income and asset limits applied to Medicaid beneficiaries. Similarly, because CHAMPUS eligibility ends at age 65, the new CHAMPUS home care demonstrations would have a limited effect on reducing the elderly's unmet home care needs. Finally, the limited number of VA medical centers providing home care services reduces VA's ability to meet the home care needs of veterans, despite the fact that VA has a broad

[12]The Washington, D.C., area includes Maryland and northern Virginia. The Fitzsimons medical region comprises Colorado, Wyoming, South Dakota, North Dakota, Utah, Nebraska, Missouri, and Kansas.

[13]See Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 2, 1986). Based on an analysis of data from the 1982 National Long-Term Care Survey, we reported that about 168,000 chronically ill elderly were not receiving all of the assistance they needed with activities of daily living and that an additional 1.1 million needed more assistance with instrumental activities of daily living.

home health care benefit. Because there is no cost sharing for beneficiaries under the Medicare home health benefit,[14] however, that program appears adequate to meet the post-acute home care needs of elderly veterans.

Vision Care

Definition

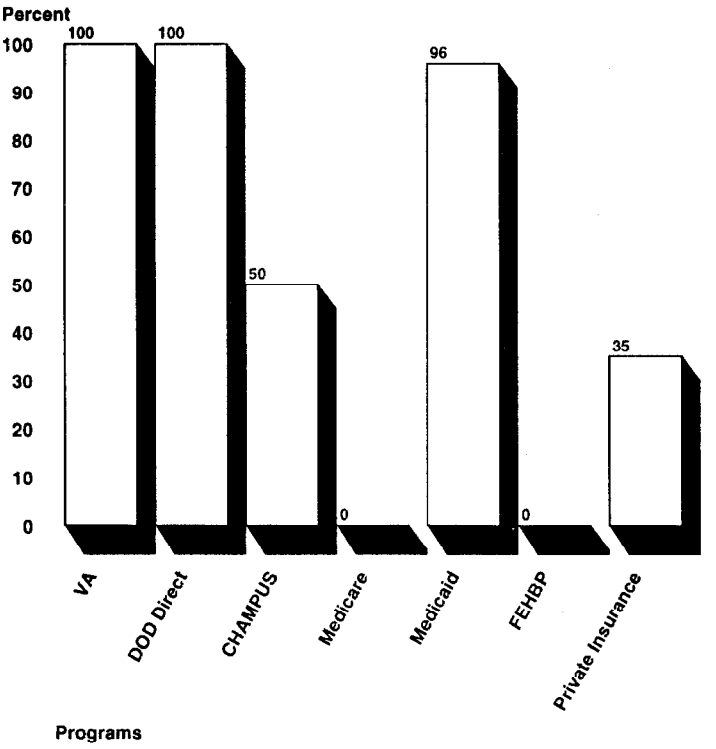
Vision care includes periodic eye examinations and may include eyeglasses or contact lenses.

Results

Coverage of vision care varies widely under major health benefits programs (see fig. IV.3). Medicare and federal employees health plans do not cover any vision care services, and CHAMPUS limits vision care to active duty family members, allowing only one eye examination per person per calendar year with no coverage for eyeglasses or contact lenses. DOD also limits vision care, allowing eye examinations for all beneficiaries but providing eyeglasses only to active duty and retired members. Contact lenses are generally not covered by DOD. But VA's direct care system provides a full range of services, including eyeglasses and contact lenses.

[14]While Medicare beneficiaries pay nothing for most home health services, cost sharing is required for durable medical equipment such as wheelchairs.

Figure IV.3: Percent of Beneficiaries Eligible for Vision Care (1991)



Note: The BLS survey of private insurance used 1989 data. Comparable information for 1991 was not readily available.

Medicaid also offers extensive vision care coverage. States are required to cover vision care for children and have the option of covering such services for adults. Almost all state Medicaid programs include adult vision care. As a result, 96 percent of Medicaid recipients have coverage for examinations and other optometrists' services and 94 percent have coverage for eyeglasses.

Overall, 35 percent of participants in private sector health plans have some coverage of vision care services. This includes 34 percent covered for examinations, 24 percent for eyeglasses, and 23 percent for contact lenses.

Potential Effect on Demand for VA Services

Veterans who normally rely on Medicare, CHAMPUS, or private health insurance to meet their health care needs may seek vision care services from VA because of the limited coverage under those programs.

Participants' Out-of-Pocket Expenses Under Major Health Programs

This appendix compares five major sources of participants' out-of-pocket expenses under major health programs: (1) noncovered services, (2) charges above health plan approved rates, (3) premiums, (4) maximum plan dollar benefits, and (5) copayments and deductibles.[1] For each source, we present a definition, the results of our analysis, and our comments on the potential effects of differences in out-of-pocket costs on demand for VA health care.

Noncovered Services

Definition

Noncovered services refers to medical care for which the program does not provide benefits. Programs define the benefit categories that are "covered" as well as the extent of covered care.

Results

Participants are liable for the full cost of medical care not covered by the program. And the fact that some or all of a needed medical service or procedure is not covered can have a significant financial impact on program participants. For example, with few exceptions,[2] Medicare beneficiaries must pay for all of their outpatient drugs, while other major health programs either offer attractive cost-sharing arrangements or provide them free (see p. 80). HCFA estimates that, during 1991, nearly 28 million Medicare enrollees spent an average of $538 each on outpatient prescription drugs; a total of over $15 billion in "out-of-pocket" expenses for a noncovered service.

Noncovered services also result from limits health programs place on the extent of benefits offered. For example, while all programs offer mental health care coverage, they often limit coverage to a fixed number of hospital days or outpatient visits, or to maximum dollar amounts. As discussed on page 46, 11 of the 12 FEHBP plans studied (with over 99 percent of enrollment) limit coverage of mental health conditions to lifetime maximum plan payments ranging from $25,500 to $75,000 per person. Medicare imposes a 190-day lifetime limit on the number of days in

[1]Our comparisons are based on cost-sharing provisions applicable under the various programs' permanent benefits. They exclude cost-sharing provisions under demonstration projects. Such projects frequently impose separate cost-sharing requirements. For example, DOD's managed care demonstration projects generally require more beneficiary cost sharing than is required under basic DOD and CHAMPUS benefits.

[2]Medicare helps pay for drugs used in immunosuppressive therapy for one year following a Medicare-covered organ transplant.

a psychiatric hospital. CHAMPUS also limits the number of days of inpatient mental health care.

As shown in appendix IV, VA generally offers more extensive benefits than other major health programs. As a result, veterans who are able to utilize the VA system are less likely to incur substantial out-of-pocket expenses for noncovered services. VA's complex eligibility/entitlement provisions, however, may limit many veterans' access to covered services. But most veterans having limited access to VA care have alternate public or private health insurance.

Potential Effect on Demand for VA Services

Because out-of-pocket costs for noncovered services can be substantial, veterans who have multiple health care coverage have an incentive to use the VA system to supplement their coverage under other programs. For example, Medicare-eligible veterans have an incentive to use VA for items not covered by Medicare, such as eyeglasses, dental care, and outpatient drugs. And, since many programs limit mental health care coverage, veterans may turn to VA for these services.

On the other hand, most veterans cannot rely solely on VA to meet their health care needs because of the complex entitlement provisions that may limit their access to routine outpatient care.

Charges Above Approved Rates

Definition

Charges above approved rates refers to the amount a medical provider charges for a service or procedure that exceeds the amount a medical program considers appropriate.

Results

Under most health insurance programs, participants are liable for any provider charges above the rates approved by the program. Under the direct delivery programs operated by VA and DOD, however, health care services are provided either cost-free or for fees established in law and regulation, and there are no charges above those rates. Therefore, VA and DOD direct care patients have no out-of-pocket expenses for charges above approved rates. In addition, VA fee-basis providers are required to accept

VA payments as payment-in-full and cannot bill veterans. Medicaid is the only other program that does not allow providers to collect from patients the difference between provider charges and approved payments.

Fee-for-service health insurance programs usually base the amount they pay on a combination of the provider's actual charge and charges of other providers in the community—sometimes called the usual, customary, and reasonable charge. And, some other programs use fee schedules with fixed dollar amounts assigned to covered medical services that may or may not relate to the amounts medical providers charge for the service. In either case, unless a medical provider agrees otherwise, the program participant is liable for all charges in excess of approved charges or rates.

To illustrate, Medicare gives physicians the option of accepting assignment (that is, accepting the Medicare-approved charge as full compensation for the services provided) or requiring patients to pay the difference between their actual charges and the Medicare-approved charges. In fiscal 1991, Medicare disallowed more than $22 billion[3] in medical care charges exceeding approved rates. Although most providers agree to accept the Medicare-approved amount as payment-in-full, Medicare enrollees were still liable for nearly $2 billion of those charges from providers not accepting assignment.[4]

In addition to restrictions on the ability of physicians to "balance bill" under Medicare, the private sector trend toward managed care and preferred provider arrangements that do not allow "balance billing" decreases the importance of charges above approved rates as a source of out-of-pocket health care costs.

Potential Effect on Demand for VA Services

Participants can face high out-of-pocket expenses resulting from physician charges that exceed approved rates. Veterans lacking protection from such charges under their alternate coverage may be more inclined to use VA facilities to limit their out-of-pocket expenses.

[3]Over 87 percent of Part B claims exceeded Medicare-approved charges by an average of over $56.

[4]The Omnibus Budget Reconciliation Act of 1989 set limits on physicians' charges above Medicare-approved charges. After 1992, physicians can charge Medicare beneficiaries no more than 15 percent above the Medicare-approved charges. In addition, physicians cannot balance bill Medicaid-eligible beneficiaries.

Premiums

Definition

Premiums refers to periodic payments some health programs require that enrollees pay as a condition of participating in the medical benefits offered.

Results

Most public health benefits programs, unlike private health insurance, do not charge premiums. Medicare is the only public health benefits program that charges premiums; premiums are charged for optional part B coverage and for those elderly not otherwise eligible for part A coverage. (See table V.1.)

Table V.1: Monthly Premium Cost of Program Coverage (1991)

Program	Monthly premium cost
VA	$0
DOD direct care	$0
CHAMPUS	$0
Medicare	Part A—$0[a] Part B—$29.90
Medicaid	$0[b]
FEHBP	The average for nonpostal and retired enrollees was $58.25 for individual and $90.20 for family coverage; postal employees paid $22.26 for individual and $30.50 for family coverage
Private insurance	The average for full-time enrollees in private insurance plans during 1991 was $27.00 for individual and $97.00 for family coverage

[a]Most elderly are eligible for premium-free coverage; however, the monthly premium was $177 for those buying into the program.

[b]States may impose an enrollment fee, premium, or similar charge on the medically needy, though states have generally not availed themselves of this option.

By contrast, since the inception of FEHBP, federal employees have shared in the cost of their health insurance. An increasing percentage of private sector employees also contribute toward the cost of their insurance coverage. In 1991, about half of private sector employees contributed toward the cost of health insurance for themselves and almost 70 percent paid premiums for family coverage.

Potential Effect on Demand for VA Services

Insurance premiums, other than for single veterans, would not appear to be a significant factor in use of VA facilities. This is because VA does not generally provide coverage for the spouse and dependents of veterans. Thus, veterans with dependents are likely to enroll in private health insurance plans in order to obtain coverage for their families. Because there are separate Medicare part B premiums for each beneficiary, there may be some incentive for elderly veterans to enroll their spouses in part B and rely on VA for their own care.

Maximum Plan Benefits

Definition

Maximum plan benefits refers to a lifetime or annual ceiling on health plan payments.

Results

Private health insurance plans frequently establish a ceiling on plan payments. None of the major health care programs has maximum plan benefits.

BLS reported that lifetime maximum plan benefits applied to 71 percent of participants in health insurance plans provided by medium and large firms during 1989; 42 percent with maximums of $1 million or more, 24 percent with maximums of $250,000 to $999,999, and 5 percent with maximums of less than $250,000. Another 8 percent of plan participants had annual or disability maximums or both lifetime and disability maximums. The remaining 21 percent of plan participants were in plans that did not impose maximum benefit limits.

Potential Effect on Demand for VA Services

Although most private health insurance plans set lifetime maximum dollar limits, these limits are not likely to affect most plan participants. The limits can, however, affect those participants with a catastrophic illness.

Deductibles, Copayments, and Catastrophic Protection

Definitions

Deductibles refers to amounts of approved charges a participant must pay before the health program pays any benefits. Typically, programs have a hospital deductible that must be paid for each hospital admission and a general or "annual" deductible that applies once a year to most other medical services.

Copayments or coinsurance payments refers to the amount or share of approved charges for covered services that the program participant is required to pay once deductibles are satisfied. The cost-sharing arrangement can be expressed as a flat fee (per service or visit or day) or as a percentage of approved charges. For programs that pay 80 percent of approved charges, the participant is liable for the remaining 20 percent.

Catastrophic protection or "out-of-pocket" maximum refers to a maximum amount a participant must pay in a year for covered medical services.

Results

Inpatient Care

VA requires less cost sharing for inpatient care than most major health benefits programs. In fact, free inpatient medical and surgical care, including hospital room and board, diagnostic tests and other hospital services, and physicians' and surgeons' services, is provided to veterans in the mandatory-care category, which represents over 95 percent of VA inpatients. DOD and Medicaid also provide free inpatient care to many beneficiaries. DOD provides free care to active duty and retired enlisted members, but charges active and retired officers $4.90 a day and all other beneficiaries $8.55 a day for their care. Over 80 percent of Medicaid recipients have no copayments for inpatient care; copayments for the remaining Medicaid recipients are typically nominal, ranging from $5 to $75 per admission. All other major health programs, however, typically require significant cost sharing for inpatient care, including professional charges and hospital expenses. (See table V.2.)

Table V.2: Cost Sharing for Inpatient Care (1991)

Program	Inpatient deductible	Copayments	
		Room & board and other expenses	Professional charges
VA			
Mandatory	$0	$0	$0
Discretionary	$0	Lesser of the cost of care or $628 plus $10 a day for the first 90 days of any 365-day period and $314 plus $10 a day for each additional 90 days	$0
DOD direct care			
Active & retired enlistees	$0	$0	$0
Active & retired officers	$0	$4.90 a day	$0
All others	$0	$8.55 a day	$0
CHAMPUS			
Active duty dependents	$0	Greater of $8.55 a day or $25 an admission	$0
All others	$0	Lesser of 25% of billed charges or $262 a day	25% of approved charges
Medicare			
	$628 each benefit period	$0 for the first 60 days; $157 a day for days 61-90; $314 a day for days 91-150; and 100% beyond day 150	20% of approved charges[a]
Medicaid[b]			
	$0	83% of recipients have no copayment; 6% have a $5-$50 copayment for each admission; 11% have a daily copayment, generally $3, with maximums of $21 to $75 per stay	87% have no copayment; 13% have a copayment of $.50 to $3
FEHBP[c]			
	83% of enrollees pay $50-$250 each admission; $100 is most common	No copayment for room & board; 24% of enrollees have a 15-20% copayment for other hospital expenses; 20% is most common	83% have a 10-25% copayment for surgical care and a 15-25% copayment for medical care; 25% is most common for both[a]
Private insurance[d]			
	90% of participants do not have a separate deductible[e]	72% of participants have a room & board copayment, 20% is most common	67% have copayment for surgical care; most range from 10% to 20%, and 20% is most common; no mention of nonsurgical care[a]

(Table notes on next page)

Note: Table includes information on acute inpatient medical, surgical, mental health, and substance abuse treatment. The BLS survey of private insurance used 1989 data. Comparable information for 1991 was not readily available.

[a]Participants in these programs must also satisfy an annual deductible before cost sharing for inpatient professional charges begins. See table V.3 for deductible amounts.

[b]The Medicaid information in this table pertains to inpatient hospital care. While some state Medicaid programs require a copayment for inpatient mental health care, inpatient substance abuse treatment, and related physician charges, complete information on copayments for these inpatient services is not readily available.

[c]The FEHBP information in this table pertains to inpatient medical and surgical care. About 25 percent of enrollees have a separate mental health care deductible, ranging from $500 to $1000, and 99 percent of enrollees have a copayment, the most common being 40 percent. Also, about 24 percent have a separate deductible for substance abuse treatment, ranging from $150 to $500, and 24 percent have a copayment requirement of 30 to 50 percent.

[d]The private insurance information in this table pertains to inpatient medical care. While some participants have similar coverage for inpatient mental health care and substance abuse treatment, others may be subject to different deductibles and copayment requirements, but data on amounts are not readily available.

[e]Deductible amounts not readily available for the 10 percent of participants with separate deductibles.

Even the nonservice-connected veterans in the discretionary care category required to make copayments will generally pay less at VA hospitals than they would in community hospitals under Medicare. While both programs require the same initial payment ($628 in 1991) for hospitalizations of 90 days or less, Medicare requires copayments of 20 percent for professional charges while discretionary care veterans pay VA only $10 per day. If professional charges average more than $50 per day, the out-of-pocket costs to beneficiaries would be higher under Medicare than under VA. Using a typical hospital stay of 7 days,[5] any professional charges exceeding $350 would result in lower out-of-pocket costs at VA. In 1991, the surgical fee for an appendectomy in New York City was about $1,900 and over $1,200 in Los Angeles. The charge for a triple coronary bypass operation was over $8,100 and $6,300, respectively.[6]

The financial advantages of VA over Medicare are more pronounced for longer stays. This is because Medicare imposes an additional copayment of $157 a day for stays of 61 to 90 days and $314 a day for stays of 91 to 150 days. VA, on the other hand, reduces the copayments for long stays, charging $314 plus $10 a day for stays of 91 to 180 days.

[5]Average length of stay in a community hospital in 1989 was 7.2 days. (Source Book of Health Insurance Data-1991, Health Insurance Association of America.)

[6]Source Book of Health Insurance Data-1991.

VA similarly offers veterans in the discretionary care category a financial advantage over most private health insurance. Like Medicare beneficiaries, most private health insurance participants (about two-thirds) have a coinsurance requirement for surgical care, and almost three-fourths require a copayment for room and board expenses, usually 20 percent. Thus, the out-of-pocket costs under private insurance can quickly exceed the copayments required of upper-income veterans.

Finally, VA offers even military retirees in VA's discretionary care category better benefits than CHAMPUS. CHAMPUS requires retirees and their dependents regardless of income to pay the lesser of 25 percent of billed charges or $262 a day plus 25 percent of approved charges for professional services. For any stay of 3 days or more, and for many shorter stays, the CHAMPUS copayments exceed the copayments that would be imposed by VA for veterans in the discretionary care category.

Although cost-sharing requirements are generally the same for inpatient medical, surgical, mental health, and substance abuse treatments, about 25 percent of FEHBP enrollees have a separate mental health care deductible, ranging from $500 to $1,000. Also, most FEHBP enrollees have copayments for mental health care of up to 50 percent. In addition, some FEHBP plans waive deductibles and copayments for inpatient substance abuse treatment.

Outpatient Care

Veterans in the mandatory-care category, persons treated in the DOD direct care system, and most Medicaid recipients receive free outpatient care. Other major public and private health benefits programs generally require participants to satisfy an annual deductible—ranging from $50 to $325 per person—and make copayments—most commonly 20 to 25 percent of approved outpatient charges. Although cost sharing is generally the same for medical, surgical, mental health, and substance abuse services, some private insurance plans and FEHBP plans set separate cost-sharing requirements for mental health and substance abuse services. For example, FEHBP plans generally set higher cost-sharing requirements for mental health and substance abuse treatment, e.g., FEHBP plans typically have a copayment requirement of 30 to 50 percent rather than the 15 to 25 percent for other outpatient care. (See table V.3.)

Table V.3: Cost Sharing for Outpatient Care (1991)

Program	Annual deductible	Limits on deductible	Copayments
VA			
Mandatory	$0	N/A	$0
Discretionary	$0	N/A	$26 per visit
DOD direct care			
	$0	N/A	$0
CHAMPUS			
Dependents of active enlisted E-4 or below	$50 a person	$100 a family	20% of approved charges, or $25 for outpatient surgery
All others	$150 a person	$300 a family	25% of approved charges
Medicare			
	$100 a person	N/A	20% of approved charges[a]
Medicaid[b]			
	$0	N/A	70% of recipients have no copayment, 30% have a copayment of $.50 to $3
FEHBP[c]			
	83% of enrollees pay $175-$325 a person; $250 is most common	63% pay 2 times the individual rate for a family; $500 is most common	over 82% have a 15-25% copayment for medical and 0-25% for surgical care; 25% is most common for both
Private Insurance[b]			
	95% of participants generally pay $50-$300 a person; $100 is most common	Most pay 2-3 times the individual rate for a family; $200 to $300 is most common	91% have a 10-20% copayment for medical care, 20% is most common; 20% have no copayment for surgical care

Notes: Table includes information on outpatient treatment for medical, surgical, mental health, and substance abuse. Excludes dental, vision, and hearing care. The BLS survey of private insurance used 1989 data. Comparable information for 1991 was not readily available.

[a]For outpatient treatment of mental illness and substance abuse, the beneficiary pays, in effect, 50 percent of approved charges.

[b]The Medicaid and private insurance information in this table pertains to outpatient medical care. While some participants in these programs have similar coverage for outpatient mental health care and substance abuse treatment, others may be subject to different deductibles and copayment requirements. Data on amounts are not readily available.

[c]The FEHBP information in this table pertains to outpatient medical and surgical care. About 11 percent of enrollees have a separate mental health care deductible, ranging from $150 to $500, and all enrollees have a copayment, the most common being 40 percent. Also, about 12 percent have a separate deductible for substance abuse treatment, ranging from $150 to $500, and 81 percent have a copayment requirement of 30 to 50 percent.

Unlike the major health benefits programs that impose copayments as a percentage of the cost of services provided, VA charges veterans in the discretionary-care category a flat fee ($26 per visit) regardless of the services provided. For a routine office visit costing less than $100, veterans in the discretionary-care category thus have higher copayments than participants in other programs. However, these veterans will have lower copayments than participants in other programs for visits involving x-rays, laboratory tests, or other services or supplies that increase the costs of the outpatient visit much beyond $100.

Nursing Home Care

Veterans in the mandatory-care category can obtain cost-free nursing home care on a space-available basis. Veterans in the discretionary-care category must make copayments, but they may be significantly less than the copayments many Medicaid recipients with lower incomes would have to make under Medicaid for long-term stays. For example, those veterans required to contribute toward the cost of their care in VA or community nursing homes paid an average rate equivalent to $11.98 a day for each 90-day stay in 1991. Also, during each 90-day stay, a single veteran in the discretionary-care category (with a minimum annual income of $18,171, or about $4,543 every 3 months) would earn a minimum of about $3,465 that would not be contributed toward the cost of VA nursing home care. (See table V.4.)

Table V.4: Cost Sharing for Nursing Home Care (1991)

Program	Individual deductibles	Copayment requirements
VA		
Mandatory	$0	$0
Discretionary	$0	The lesser of the cost of care or $628 for each 90 days of care during a 365-day period, plus $5 per day beginning with the first day of care
DOD direct care		
Active duty and retired enlistees	$0	$0
Active duty and retired officers	$0	$4.90 a day
All others	$0	$8.55 a day
CHAMPUS		
Active duty dependents	$0	The greater of $25 per admission or a daily fee of $8.55
All others	$0	The lesser of 25% of billed charges or $262 per day
Medicare		
	$0	$0 for the first 20 days; $78.50 per day for days 21 to 100; 100% beyond day 100
Medicaid		
	$0	Medicaid beneficiaries are required to spend all but a minimal amount (most commonly $30 per month) of their income for nursing home care
FEHBP[a]		
	Not covered	Not covered
Private insurance		
	Unknown[b]	Unknown[b]

Note: The BLS survey of private insurance used 1989 data. Comparable information for 1991 was not readily available.

[a]Three percent of FEHBP enrollees have a nursing home benefit. One percent have a per-admission deductible of $175 to $200, and 2 percent have a 10-percent copayment.

[b]While 80 percent of private insurance participants are covered by some extended care facility benefit, only 7 percent are covered in full, and 73 percent may be subject to a deductible or other copayment requirement.

By contrast, Medicaid beneficiaries without a spouse or minor children must contribute all but a minimal amount of their income, most commonly $30 per month, toward the cost of their nursing home care.[7] If necessary, Medicaid pays the difference between the approved charges and the recipient's contribution.

The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) established mandates to help protect a noninstitutionalized spouse from impoverishment while his or her spouse required nursing home care. The law provided that after an institutionalized individual had established eligibility for Medicaid, the state would be required to allow the noninstitutionalized spouse to receive a certain portion of the institutionalized spouse's income. As of January 1, 1991, the minimum protected income allowance for the noninstitutionalized spouse was $856 per month, or 122 percent of poverty. On July 1, 1992, the minimum protected income allowance increased to 150 percent of poverty.

The following example illustrates the difference in cost sharing between VA and Medicaid. A single nonservice-connected veteran with a monthly income of $1,514 (the lowest income at which a veteran is required to make copayments for VA care) is admitted to a community nursing home in Maine for a stay of 90 days. If the veteran obtained the care under Medicaid, he or she would have to contribute $4,422 for the 90 days toward the cost of his or her nursing home care (Maine allows Medicaid recipients to retain $40 a month for personal needs). But, if the veteran obtained nursing home care in the same community nursing home under VA auspices, the veteran would contribute about $1,078 toward the cost of care.

Home Health and Hospice Care

CHAMPUS and FEHBP require more cost sharing for home care services than other health benefits programs. CHAMPUS beneficiaries must make the same copayments they would for other outpatient care services—deductibles of $50 to $150 and copayments of 20 to 25 percent. Similarly, FEHBP enrollees generally have deductibles of $50 to $300 and copayments of from 15 to 25 percent. By contrast, there is no cost sharing under Medicare or for veterans receiving home health services from VA. About 12 percent of Medicaid recipients are subject to minimal copayments for home health care ranging from $.50 to $3. (See table V.5.)

[7]Veterans who receive VA pensions and Medicaid-covered nursing home care are allowed to keep $90 per month in VA pension money as their personal needs allowance.

Table V.5: Cost Sharing for Home Health and Hospice Care (1991)

Program	Home health	Hospice
VA	$0	$0
DOD direct care	Not covered	Not currently covered[a]
CHAMPUS	Deductible of $50 to $150; Copayment of 20 to 25%	Not currently covered[a]
Medicare	$0[b]	$0[c]
Medicaid	About 12% have nominal copayments[d]	$0
FEHBP	87% have annual deductible of $50-$300; 75% have copayment of 15-25%	83% have no copayment or deductible; 12% have annual deductible of $250; 17% pay daily charges in excess of $150
Private insurance	Unknown[e]	Unknown[f]

Note: The BLS survey of private insurance used 1989 data. Comparable information for 1991 was not readily available.

[a]The Defense Authorization Act for fiscal years 1992-93 authorizes the provision of hospice care in DOD facilities and under CHAMPUS. DOD is developing guidelines for the new benefit.

[b]Medicare beneficiaries pay 20 percent of the approved amount for durable medical equipment.

[c]There are no deductibles or copayments except (1) the lesser of $5 or 5 percent for approved charges on each prescription and (2) a 5-percent copayment for inpatient respite care (about $4 a day).

[d]About 9 percent have copayments for home health visits, 5 percent for durable medical equipment, and 2 percent for both visits and durable medical equipment. Copayments generally range from $.50 to $3.

[e]About 55 percent of participants may be subject to deductibles or copayments, but amounts are not readily available.

[f]About 33 percent of participants may be subject to deductibles or copayments, but amounts are not readily available.

Cost sharing for home health care is more prevalent in the private sector. About 55 percent of those covered under private health insurance plans may have deductibles or copayments and three-fourths or more of federal employees are subject to a deductible and/or copayment for in-home services under FEHBP.

There are few cost-sharing requirements for hospice care. Covered hospice services are free for VA and Medicaid beneficiaries. CHAMPUS and the DOD direct care system are in the process of establishing hospice benefits. However, Medicare beneficiaries must pay (1) the lesser of $5 or 5 percent of the approved charges for each prescription and (2) 5 percent

of the approved charges for inpatient respite care (about $4 a day) and 17 percent of FEHBP enrollees must pay all daily charges in excess of $150.

Outpatient Drugs

Most programs covering outpatient drugs require a copayment from some beneficiaries. While VA provides free outpatient drugs to veterans with service-connected disabilities rated 50 percent or more and free drugs to treat any service-connected condition, VA requires a $2 copayment for each 30-day supply of outpatient drugs intended to treat nonservice-connected conditions. About 33 percent of Medicaid recipients are subject to an outpatient drug copayment of $.50 to $1. And all CHAMPUS beneficiaries and most FEHBP enrollees are required to pay 20 percent to 25 percent of the costs of outpatient drugs. The DOD direct care system provides all drugs cost-free to all beneficiaries. Medicare does not cover outpatient drugs. (See table V.6.)

Table V.6: Cost Sharing for Outpatient Drugs (1991)

Program	Deductible	Copayment requirements
VA	$0	$0 for service-connected disabled veterans rated 50% or more; $0 for medications to treat any service-connected condition; $2 each 30-day or less supply for nonservice-connected conditions
DOD direct care	$0	$0
CHAMPUS		
Active duty dependents and retired enlistees	$50 per year	20% of approved charges
All others	$150 per year	25% of approved charges
Medicare[a]	N/A	N/A
Medicaid	$0	About 33% of recipients have a copayment requirement, ranging from $.50 to $1
FEHBP	82% of enrollees have a medical deductible of $175 to $325; 17% of enrollees have a separate prescription drug deductible of $300 to $600; 1% of enrollees have no deductible	82% of enrollees have a copayment of 20% to 25%; 17% of enrollees have a copayment of 50%; 1% of enrollees have a $3 copayment per prescription
Private insurance	Unknown[b]	Unknown[b]

Note: The BLS survey of private insurance used 1989 data. Comparable information for 1991 was not readily available.

[a]Medicare does not cover outpatient drugs.

[b]While 95 percent of private insurance participants have outpatient drug coverage, only 3 percent are covered in full, and 92 percent may be subject to a deductible and/or other copayment requirement.

Catastrophic Limits

CHAMPUS and most private health insurance plans have catastrophic limits on participants' out-of-pocket costs for deductibles and copayments. Medicare, Medicaid, VA, and DOD generally do not have catastrophic limits.

CHAMPUS limits out-of-pocket costs for the families of active duty members to $1,000 a year. The catastrophic limit for all other CHAMPUS-eligible families and CHAMPVA-eligible families is $10,000 a year.

All 12 of the FEHBP fee-for-service plans open to all federal employees have catastrophic limits for medical and surgical care beyond which cost sharing is suspended and the plan pays 100 percent of the costs of covered

services. Limits range from $1,000 per person/$3,000 per family to $2,500 per person/$5,000 per family. The most common limit is $2,500 per person/$2,500 per family (53 percent of enrollment).

About 83 percent of private insurance participants have a maximum on annual out-of-pocket expenses. The most common limits are $1,000 to $1,249 per individual (25 percent of participants) and $2,000 to $2,999 per family (14 percent of participants).

Potential Effect on Demand for VA Services

VA has lower cost sharing, particularly for nursing home care, than most other major health programs. This may result in veterans with coverage under multiple programs seeking care at VA to avoid high out-of-pocket costs.

The lower VA cost sharing may give an especially strong incentive for Medicare-eligible veterans to seek care from VA. Out-of-pocket costs for copayments and deductibles under Medicare can be significant. In 1991, HCFA estimates Medicare beneficiaries paid nearly $5 billion in hospital deductibles and over $2.7 billion in annual deductibles. In that same year, Medicare beneficiaries made copayments totaling more than $13 billion. The lack of catastrophic protection under Medicare could cause veterans with dual coverage to seek care from VA to avoid high out-of-pocket costs.

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