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Briefing Report to the Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate

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VETERANS' HEALTH CARE

Most Care Provided Through Non-VA Programs

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April 25, 1994

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

Dear Senator Murkowski:

When the Department of Veterans Affairs' (VA) health care system was established in 1930, neither public nor private health insurance programs were available to meet the health care needs of America's veterans. But with the subsequent growth of public and private health insurance programs, most veterans now have one or more alternatives to VA health care. Reforms of the nation's health financing system such as those currently being considered could further reduce the number of veterans without health insurance.

When veterans have multiple health care options, changes in one program can have unforeseen repercussions on other programs. For example, we reported in June 1992 that implementation of a universal care program could reduce demand for VA hospital care by almost 50 percent.[1] Similarly, significant changes in an existing program, such as adding benefits or increasing cost sharing, could affect future demand for services under other programs.

To help insure that the potential effect of fundamental changes in the availability of health coverage under other public or private programs on demand for VA services is considered in planning the future of the VA health care system, you asked that we

- assess how VA health benefits currently compare to those available under other health programs,
- determine how many veterans are receiving services under other federal health programs and the cost of providing those services, and
- determine how many veterans using VA services are eligible to receive care under other federal programs.

Your first question was addressed in our July 29, 1993, report Health Care: Comparison of VA Benefits With Other Public and Private Programs (GAO/HRD-93-94). We reported that VA's complex eligibility and entitlement

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

provisions place more restrictions on the availability of services than do other health care programs. 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 benefits programs.

This report addresses the two remaining questions and, as agreed with your staff, discusses the potential implications of the data presented on VA's role under a reformed health care system. It summarizes and expands on information provided in our April 15, 1994, briefing of your staff.

In summary, we found the following:

- Nine out of 10 veterans have non-VA health care coverage. Overall, about 81 percent have private health insurance and almost 26 percent are Medicare-eligible. Over 20 percent of veterans have both Medicare and private health insurance in addition to their VA coverage. (See section 1.)
- Veterans with Medicare coverage are unlikely to use VA services. Of Medicare-eligible veterans, almost 62 percent used Medicare but not VA services in 1990. By contrast, fewer than 7 percent of Medicare-eligible veterans used only VA services. Finally, fewer than 8 percent used both VA and Medicare services.[2] (See section 2.)
- Seven out of 10 federal dollars spent on veterans' health care come from non-VA programs. Because Medicare-eligible veterans tend to use their Medicare coverage rather than VA, Medicare accounted for about $20.6 billion of the $36 billion in federal expenditures we examined for veterans health care in 1990 compared with about $10.9 billion under VA. Other federal programs accounted for about $4.5 billion. (See section 3.)
- Expenditures on veterans' health care through private health insurance likely exceed those under VA. If veterans' use of private insurance is similar to that of the general population, then payments for veterans likely amounted to over $22 billion. (See section 3.)
- Veterans using VA services tend to have lower incomes and less private health insurance coverage than nonusers. Of the over 2.2 million veterans (about 8 percent of the nation's 28.2 million veterans) using VA services, over half reported having incomes under $10,000. More than 4 users in 10 had neither public nor private health insurance coverage. Still, Medicare-eligible veterans accounted for almost half of the VA use in 1990. (See section 4.)

[2]The remaining 24 percent did not use services under either program.

- Health reform could reduce VA's role as a safety net for acute-care services. Many VA users who have no public or private health insurance may leave the VA system if given a choice. In addition, proposed changes in Medicare benefits, such as adding prescription drug coverage and expanded long-term care services, might cause more veterans to rely on Medicare for most, if not all, of their health care. Without changes in the VA system, a significant portion of VA's acute-care work load may be lost. (See section 5.)
- President Clinton's proposed Health Security Act is the only major health reform proposal that would change the role of the VA health care system. The proposed act would (1) transform the VA system into a series of managed care plans to compete with private sector plans and (2) expand entitlement to free comprehensive acute-care services. Veterans enrolling in other health plans would be required to pay up to 20 percent of the cost of their insurance premiums and any copayments and deductibles.

  Currently, about 445,000 veterans with service-connected disabilities rated at 50 percent or higher are entitled to free comprehensive care at VA facilities.[3] Millions of other veterans are eligible for free care, but are entitled to only selected services, such as inpatient hospital care or outpatient treatment for their service-connected disabilities. Under the proposed Health Security Act, about 9 million veterans would be entitled to free comprehensive care if they enrolled in a VA health plan. Many factors could affect the number of veterans choosing VA plans, including the extent of covered services. To the extent the VA plan offers free coverage for services not generally covered under competing plans, such as long-term nursing home care, the number of veterans choosing VA plans, and the government's cost to operate those plans, will increase. (See section 5.)
- Several other options exist for restructuring the VA health care system. These include (1) maintaining a smaller direct-delivery system strictly for veterans; (2) opening the VA system to other federal beneficiaries (such as dependents of military personnel) to maintain work loads; (3) converting some existing facilities to other uses such as long-term care; (4) merging the VA system with one or more of the other federal health care systems, such as that of the Department of Defense; (5) eliminating the separate VA health care system and meeting the nation's commitment to veterans by supplementing the coverage available under a universal care program; and (6) contracting to provide hospital services to private sector managed care plans. VA officials said that all of these options were considered in developing the proposed Health Security Act. They said that the act would

[3]Excluding nursing home care, which is optional for all veterans, and care for a routine pregnancy.

give VA the flexibility to adopt any of the options other than (1) merging the VA system with another federal health care delivery system or (2) eliminating the separate VA system and supplementing coverage available under a universal care program. (See section 5.)

In summary, VA plays a small but nevertheless important role in meeting the health care needs of America's veterans. VA's role in meeting the needs of service-connected veterans would not be affected by any health reform proposal but its role as a safety-net provider for uninsured veterans would be reduced if any of the major health reform proposals is adopted. As a result, VA is likely to face a significant decline in the use of its acute care services unless there are changes either in veterans' health benefits or in the VA health care system. The challenge facing the Congress and VA is to identify the most appropriate role for the VA under a reformed health care system.

Data on veterans' health care coverages under public and private programs were obtained through analysis of the Survey of Income and Program Participation (SIPP).[4] Information on veterans' utilization of health care services under federal health care programs and expenditures on those services was developed through computer matches of eligibility and payment records from those programs. For most programs, this report reflects actual federal expenditures on veterans' health care in 1990. We used 1990 as a base year for our analyses because it was the most recent year for which data were available for all of the federal health programs studied. Because VA does not have a complete database of veterans, and Medicare records do not contain a veteran identifier, we obtained actual expenditures for about 60 percent of the Medicare-eligible veterans and projected total Medicare expenditures. We supplemented the demographic data available through these computer matches with data from VA's Survey of Medical System Users (see p. 53). Section 6 of this briefing report provides detailed information on the scope and methodology of our analyses.

[4]SIPP is a nationwide longitudinal survey based on a statistical sample of residents of about 22,000 noninstitutional living quarters. It covers such areas as income, assets, employment, health insurance coverage, veteran status, and eligibility for participation in various government programs. The SIPP estimate results in a 95-percent confidence interval of 26.9 to 29.5 million veterans in 1990.

VA uses a lower estimate of 26.9 million veterans in 1990 based on its projections of 1980 census data. We use the SIPP figure throughout this report because some of the analyses of alternate coverage are derived from SIPP.

We did not obtain formal agency comments on this briefing report; however, we did discuss a draft of the briefing report with responsible VA officials and have included their comments where appropriate.

As agreed with your office, we are providing copies of this briefing report to the Chairman, Senate Committee on Veterans' Affairs; the Chairmen and Ranking Minority Members of the House Committee on Veterans' Affairs and the Senate and House Committees on Appropriations; the Secretary of Veterans Affairs; and other interested parties. Copies will be available to others upon request. Please call me at (202) 512-7101 if you or your staff have any questions. Major contributors to this briefing report are listed in appendix I.

Sincerely yours,

David P. Baine

David P. Baine
Director, Federal Health Care
Delivery Issues

Contents

Abbreviations

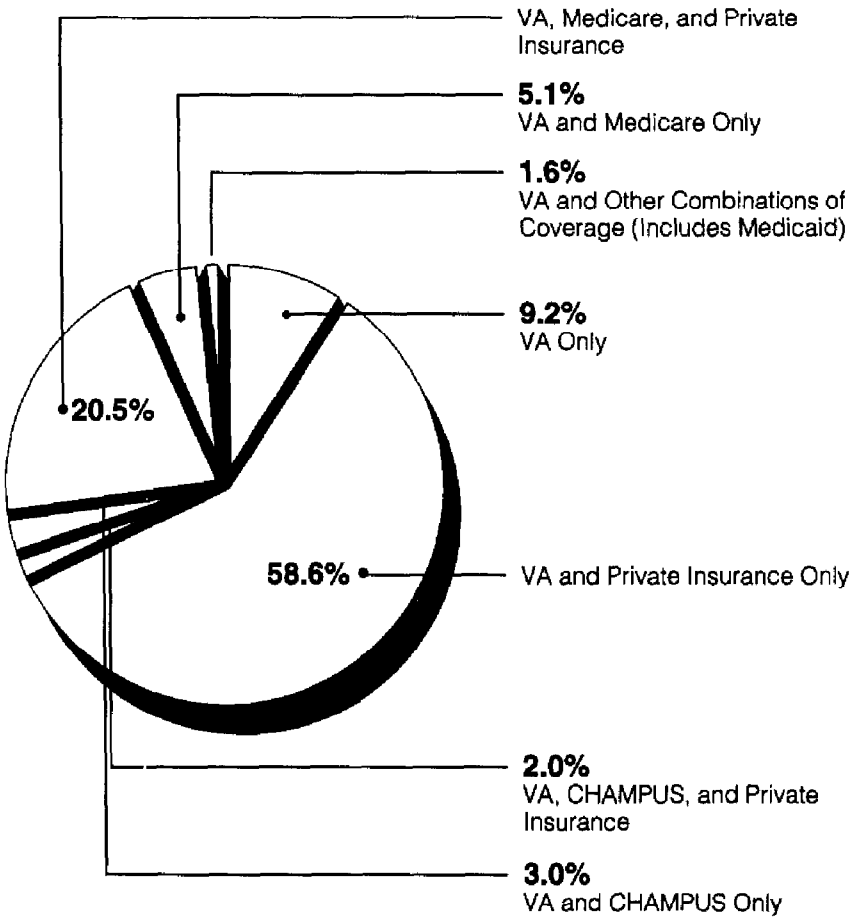
BIRLS	Beneficiary Identification and Records Locator Subsystem
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CPDF	current personnel data file
DEERS	Defense Enrollment Eligibility Reporting System
DOD	Department of Defense
FEHBP	Federal Employees Health Benefits Program
HCFA	Health Care Financing Administration
HISKEW	Health Insurance Skeleton Eligibility Writeoff File
MADRS	Medicare Automated Data Retrieval System
OPC	outpatient clinic system
OPM	Office of Personnel Management
PTF	patient treatment file
SC	service-connected
SIPP	Survey of Income and Program Participation
SSN	social security number
VA	Department of Veterans Affairs

Most Veterans Have Multiple Health Care Coverage

With the creation and expansion of public and private health benefits programs, about 25.6 million of the nation's estimated 28.2 million veterans (almost 91 percent) had public and/or private health care coverage in 1990 in addition to their VA coverage (see figure 1.1). Over 81 percent of veterans (22.9 million) had private health insurance; 26 percent (7.4 million) had Medicare coverage; 5.1 percent (1.4 million) had coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and 1.6 percent (0.4 million) had Medicaid coverage.

Over 22 percent of veterans had coverage under more than one other health benefits program. Such veterans were primarily Medicare-eligible veterans who also had private health insurance, most likely Medicare supplemental policies (commonly referred to as Medigap policies). Nearly 79 percent of the Medicare-eligible veterans also had private health insurance coverage.

Figure 1.1: Veterans' Sources of Health Care Coverage (1990)



Note: Veterans covered by CHAMPUS are also eligible for care in DOD health care facilities on a space available basis. Veterans losing CHAMPUS coverage upon becoming Medicare-eligible can still use DOD facilities on a space-available basis.

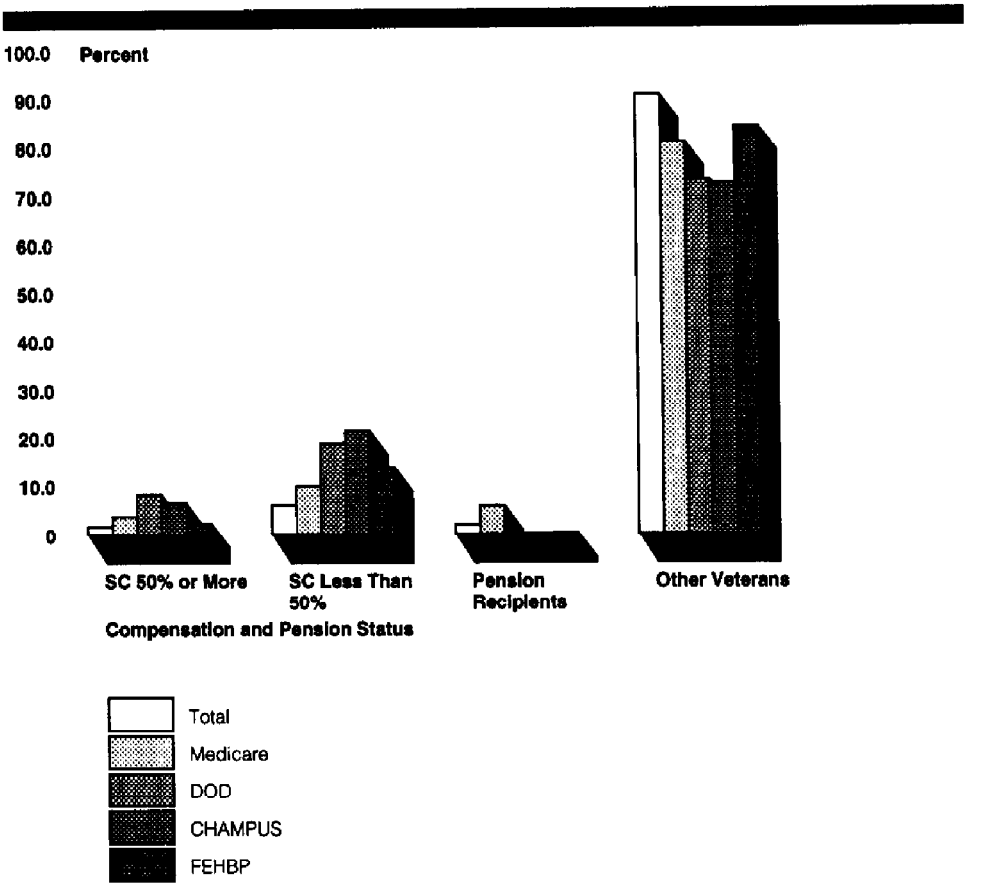
Compensation and Pension Status of Veterans

Veterans eligible for health benefits under Medicare, the Department of Defense (DOD), CHAMPUS, or the Federal Employees Health Benefits Program (FEHBP) are more likely to have service-connected disabilities than other veterans. Although fewer than 8 percent of the overall veteran population have compensable service-connected disabilities, over 26 percent of military retirees have such disabilities. Similarly, over 13

percent of Medicare-eligible veterans and 16 percent of those covered under FEHBP have compensable service-connected disabilities.[1]

Although 2 percent of veterans receive VA pensions, few veterans eligible for DOD/CHAMPUS and FEHBP receive VA pensions. On the other hand, almost 6 percent of Medicare-eligible veterans receive VA pensions. (See fig. 1.2.)

Figure 1.2: Compensation and Pension Status of Veterans, by Federal Health Program Eligibility (1990)



Note: SC = service-connected.

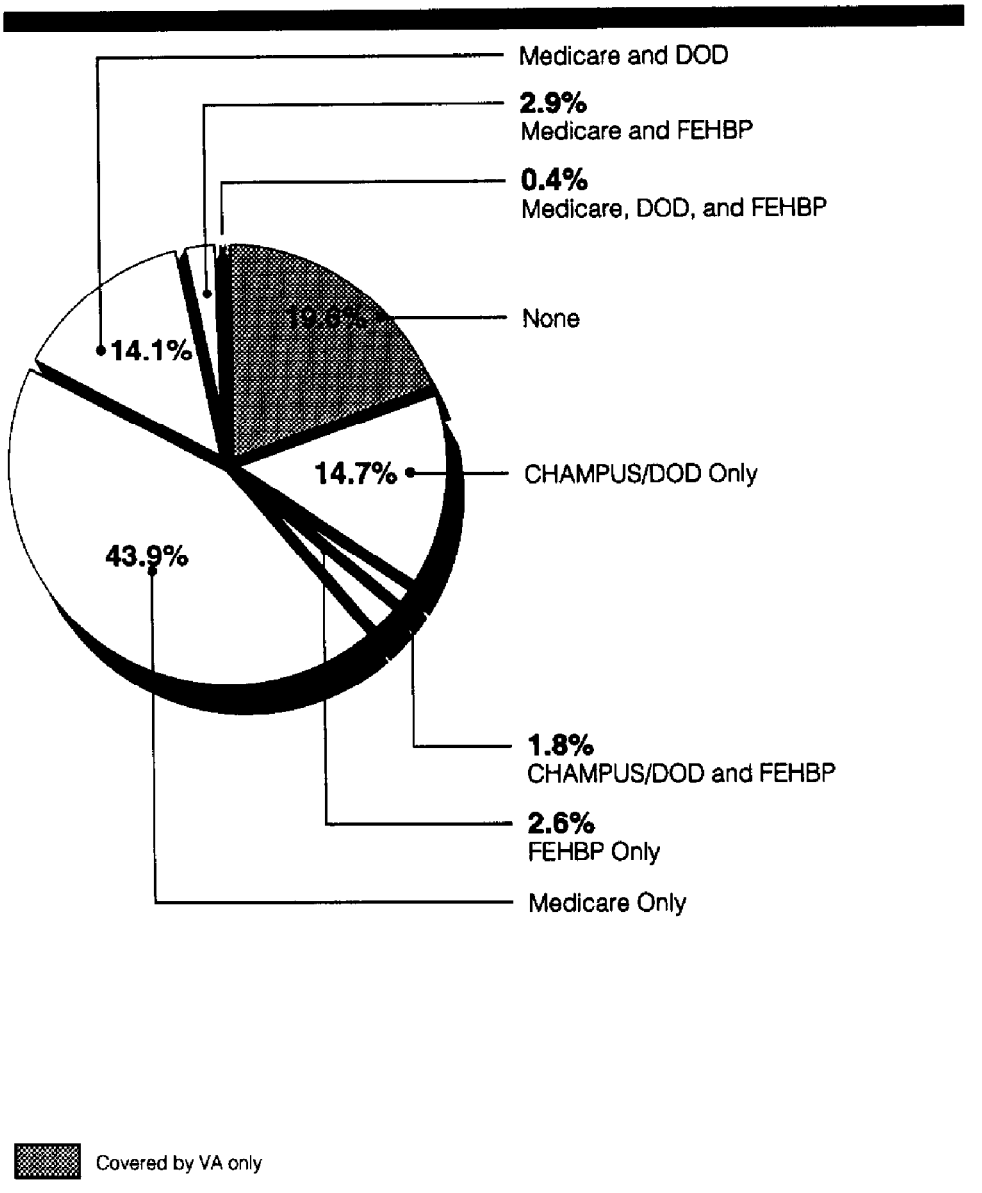
[1]Additional veterans have noncompensable "0" percent service-connected disabilities. VA does not, however, maintain a database of such veterans. VA estimates that about 1.6 million veterans have "0" percent service-connected disabilities. Throughout this report, we show only those veterans with compensable service-connected disabilities.

Veterans With Service-Connected Disabilities or Low Incomes More Likely to Have Other Federal Coverage

Veterans with service-connected disabilities rated at 50 percent or higher and low-income veterans receiving VA pensions are significantly more likely to have health care coverage under other federal programs than are other veterans with incomes above the pension level. Of veterans with disabilities rated at 50 percent or higher, 80 percent have coverage under other federal health care programs, such as Medicare or CHAMPUS; over 40 percent of those have multiple coverages under federal health programs. Similarly, over three-fourths of VA pension recipients are eligible for Medicare; few, however, have multiple program eligibilities. By contrast, only 3 out of 10 nonservice-connected veterans with incomes above the pension level are covered under other federal health programs, primarily Medicare.

Figures 1.3 through 1.6 provide additional information on the federal health care coverages of veterans by category.

Figure 1.3: Additional Federally Sponsored Health Coverages of Veterans With Service-Connected Disabilities Rated at 50 Percent or Higher (1990)

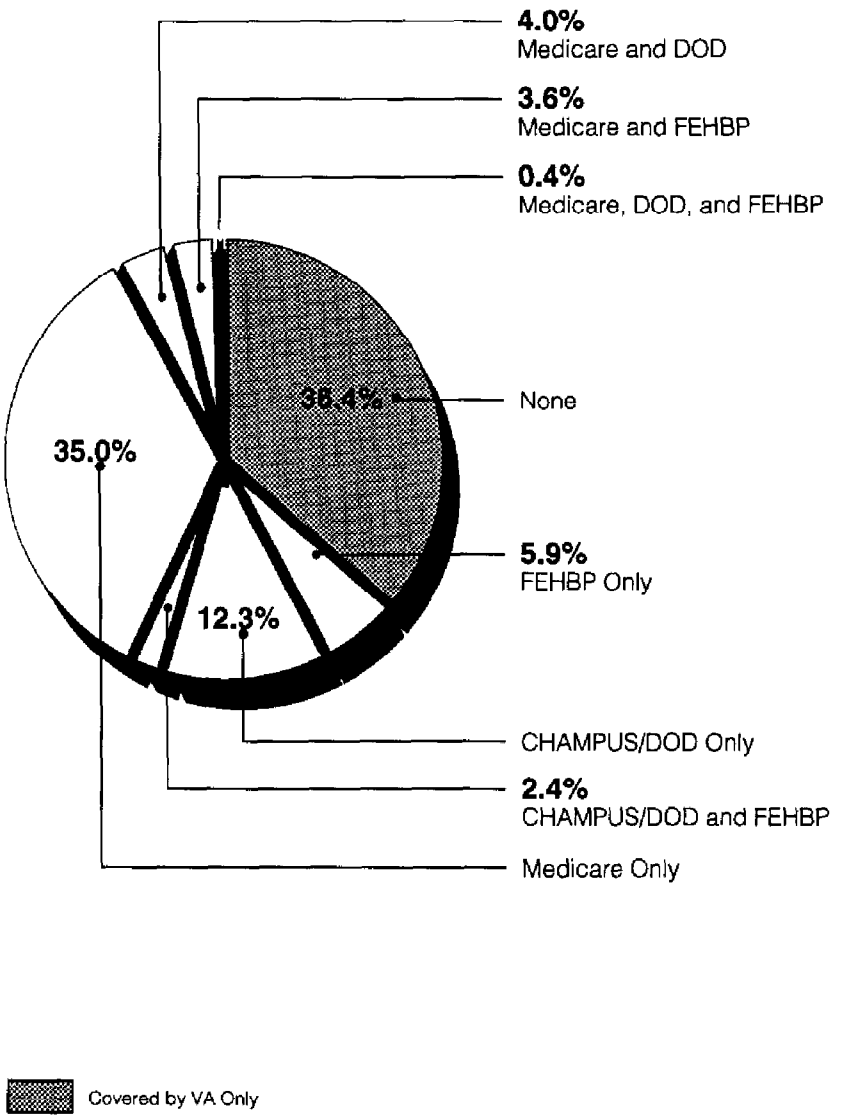


Notes: Of the 443,338 service-connected veterans with disabilities rated at 50 percent or higher, 271,433 were Medicare-eligible. Of these, 62,491 also had DOD but not FEHBP coverage, 12,731 also had FEHBP but not DOD coverage, and 1,591 also had both DOD and FEHBP coverage.

Of the 171,905 service-connected veterans who were not Medicare-eligible, 11,771 had FEHBP coverage, 65,096 had DOD/CHAMPUS coverage, and 7,903 had both FEHBP and DOD/CHAMPUS coverage.

Figure does not include information on coverage under Medicaid or the Indian Health Service.

Figure 1.4: Additional Federally Sponsored Health Coverages for Veterans With Service-Connected Disabilities Rated at Lower Than 50 Percent (1990)

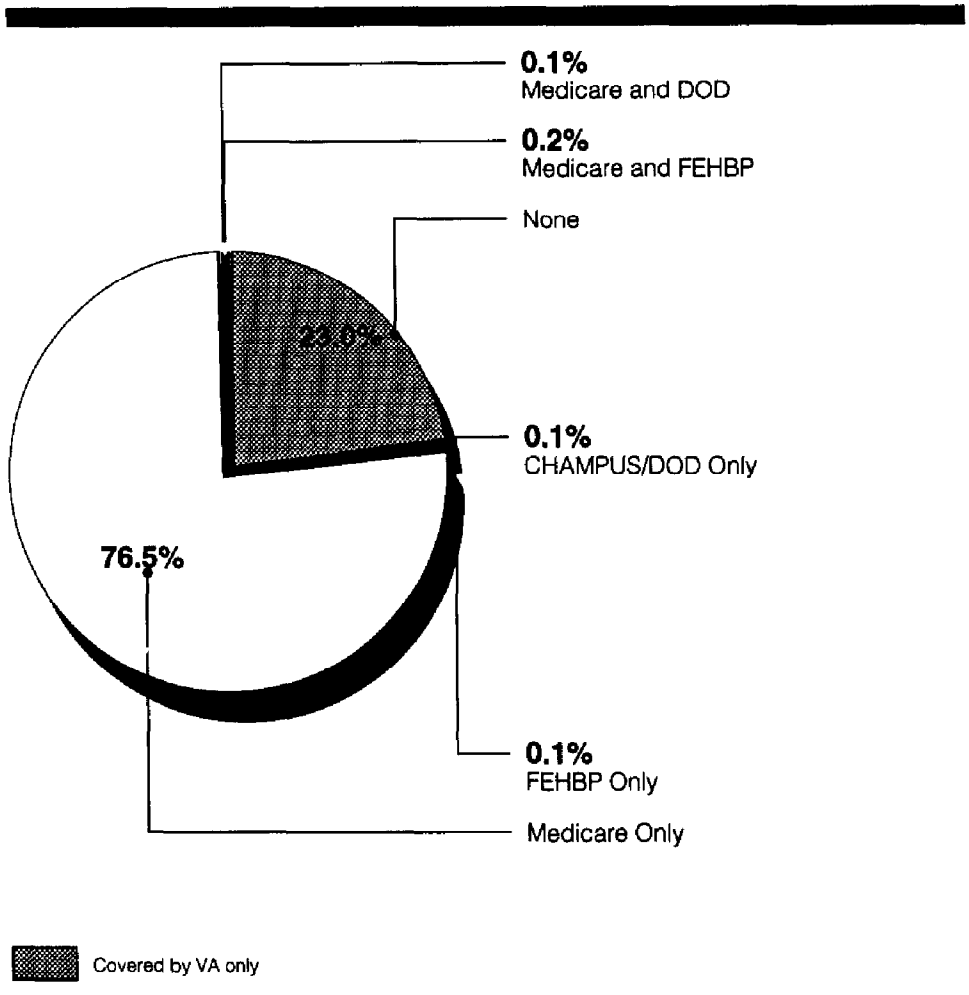


Notes: Of the 1,665,359 service-connected veterans with disabilities rated at lower than 50 percent, 715,748 were Medicare-eligible. Of these, 65,861 also had DOD (but not FEHBP) coverage, 59,973 had FEHBP (but not DOD) coverage, and 6,261 had both DOD and FEHBP coverage.

Of the 949,611 veterans not Medicare-eligible, 98,148 had FEHBP (but not DOD/CHAMPUS) coverage, 204,816 had DOD/CHAMPUS (but not FEHBP) coverage, and 39,892 had both DOD/CHAMPUS and FEHBP coverage.

Figure does not include information on coverage under Medicaid or the Indian Health Service.

Figure 1.5: Additional Federally Sponsored Health Coverages of Veterans Receiving VA Pensions (1990)

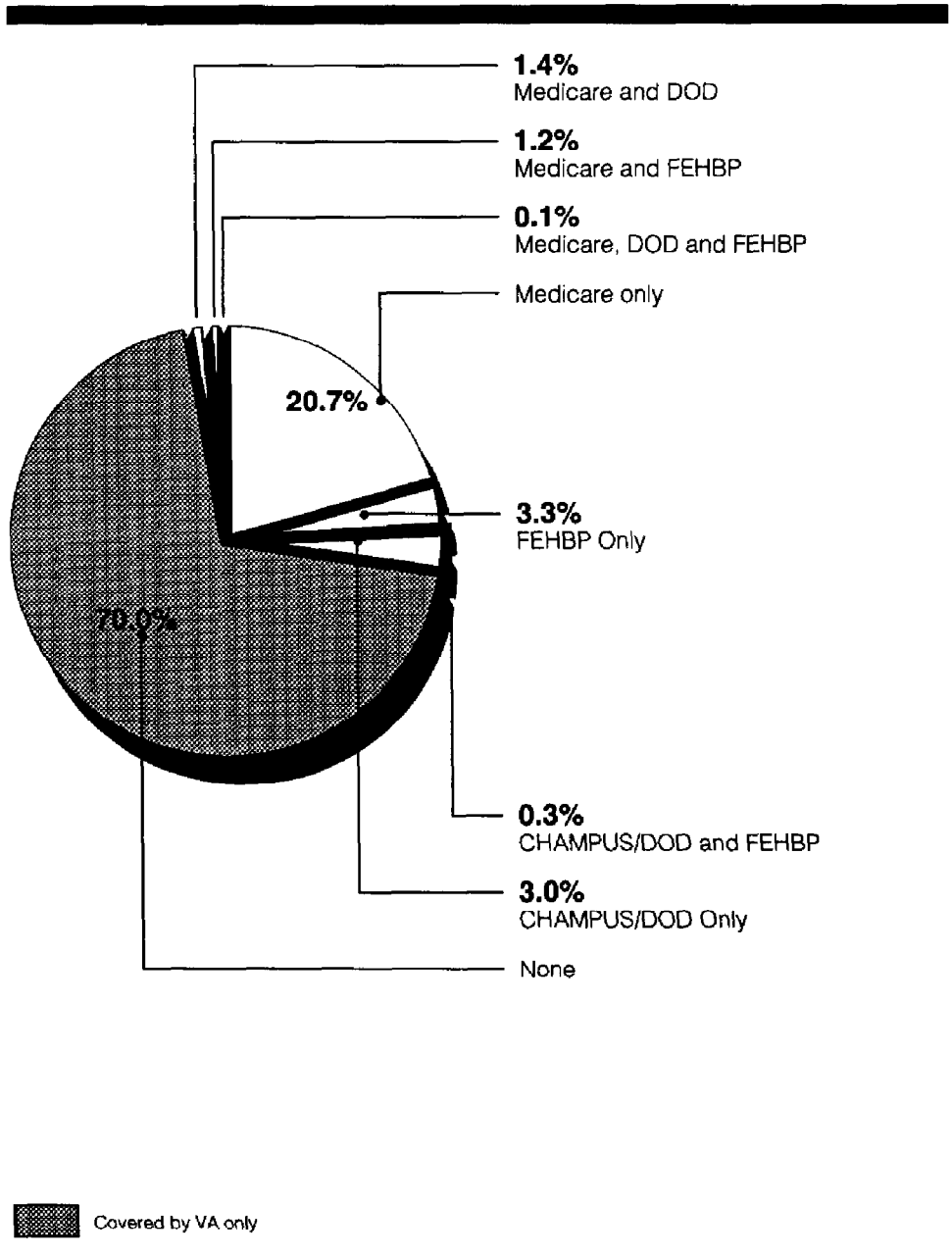


Notes: Of the 555,839 VA pension recipients, 426,823 were Medicare-eligible, including 761 who also had DOD coverage, 924 who also had FEHBP coverage, and 15 who had both DOD and FEHBP coverage.

Of the remaining 129,016 pension recipients, 742 had FEHBP (but not DOD/CHAMPUS) coverage and 432 had DOD coverage; 10 veterans had both DOD/CHAMPUS and FEHBP coverage.

Figure does not include information on coverage under Medicaid or the Indian Health Service.

Figure 1.6: Additional Federally Sponsored Health Coverages of Veterans Not Receiving VA Compensation or Pension Payments (1990)



(Figure notes on next page)

Notes: Of the 25,527,883 veterans not receiving VA compensation or pension payments, 5,985,827 were Medicare-eligible. Of these, 367,191 also had DOD (but not FEHBP) coverage; 310,499 had FEHBP (but not DOD) coverage; and 36,567 had both DOD and FEHBP coverage.

Of the remaining 19,542,056 veterans, 837,765 had FEHBP (but not DOD/CHAMPUS) coverage, 758,491 had DOD/CHAMPUS (but not FEHBP) coverage, and 73,799 had both FEHBP and DOD/CHAMPUS coverage.

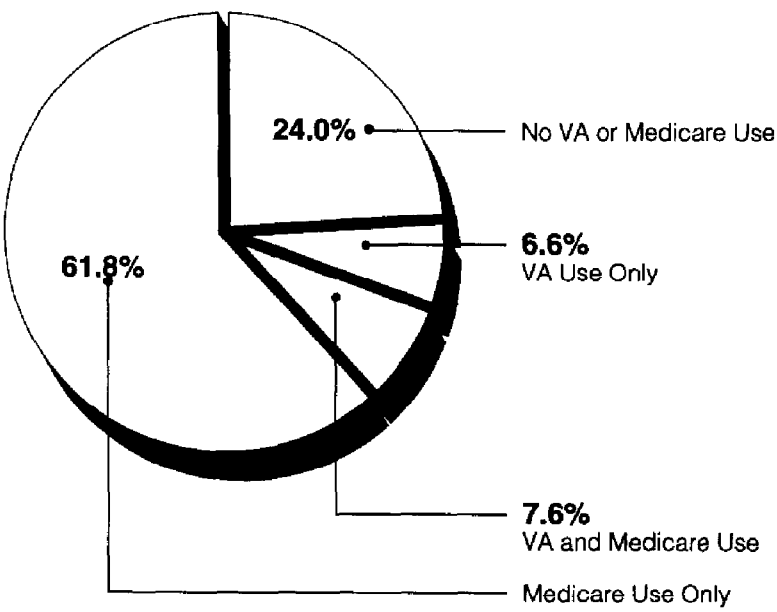
Figure does not include information on coverage under Medicaid or the Indian Health Service.

Most Medicare-Eligible Veterans Rely on Medicare

Most Medicare-eligible veterans rely on Medicare rather than VA to meet their health care needs. However, veterans are more likely to seek certain types of care from VA, such as inpatient psychiatric care where there is only limited coverage under Medicare. Like those individuals without Medicare coverage, veterans with service-connected disabilities rated at 50 percent or higher or receiving VA pensions are more likely to seek care from VA than are other groups of Medicare-eligible veterans.

Almost 62 percent of the 7.4 million Medicare-eligible veterans used Medicare but no VA services during 1990. By contrast, fewer than 7 percent used VA but no Medicare services. Finally, fewer than 8 percent used both Medicare and VA services during 1990 (fig. 2.1).[1]

Figure 2.1: Use of VA and Medicare Services by Medicare-Eligible Veterans (1990)



Note: A total of about 7.4 million veterans were Medicare-eligible in 1990.

[1]The remaining 24 percent used neither Medicare nor VA services during 1990.

Medicare-Eligible Veterans With Service-Connected Disabilities Most Likely to Use VA

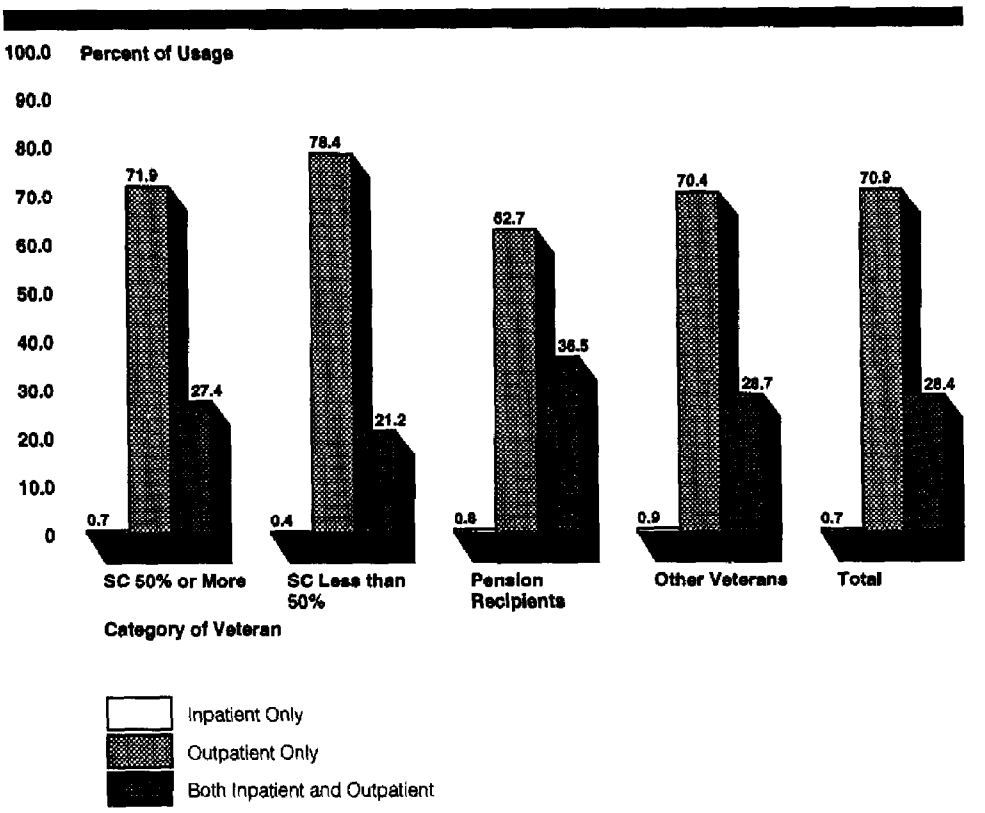
Medicare-eligible veterans with service-connected disabilities rated at 50 percent or higher were the most likely to use VA health care services. Veterans with service-connected disabilities rated at 50 percent or higher used VA at a greater rate than they used Medicare—about 34 percent used VA but no Medicare services, 30 percent used both VA and Medicare services; and 24 percent used Medicare but no VA services during 1990.[2]

Medicare-eligible veterans receiving VA pensions were also more likely to use VA services than those nonservice-connected veterans with incomes above the pension level. One possible explanation of this higher usage by VA pension recipients may be the lack of Medigap insurance or other resources to help pay the copayments and deductibles under Medicare. While data were not generally available on veterans' Medigap coverage, we found that VA usage by Medicare-eligible veterans with private health insurance coverage under FEHBP was much lower than that of comparable veterans without FEHBP coverage.

Figure 2.2 provides additional information on the use of VA inpatient and outpatient services by Medicare-eligible veterans. Figures 2.3 through 2.6 break down the use of VA and Medicare by category of veteran (that is, service-connected disabilities rated 50 percent or higher, service-connected disabilities rated lower than 50 percent, VA pension recipients, or veterans not receiving compensation or pension payments.).

[2]About 11 percent did not use either VA or Medicare services during 1990.

Figure 2.2: Types of VA Services Used by Medicare-Eligible Veterans, by Veteran Category (1990)



Notes: Percentages may not add due to rounding.

Figure 2.3: Use of VA and Medicare Services by Service-Connected Veterans With Disabilities Rated at 50 Percent or Higher (1990)

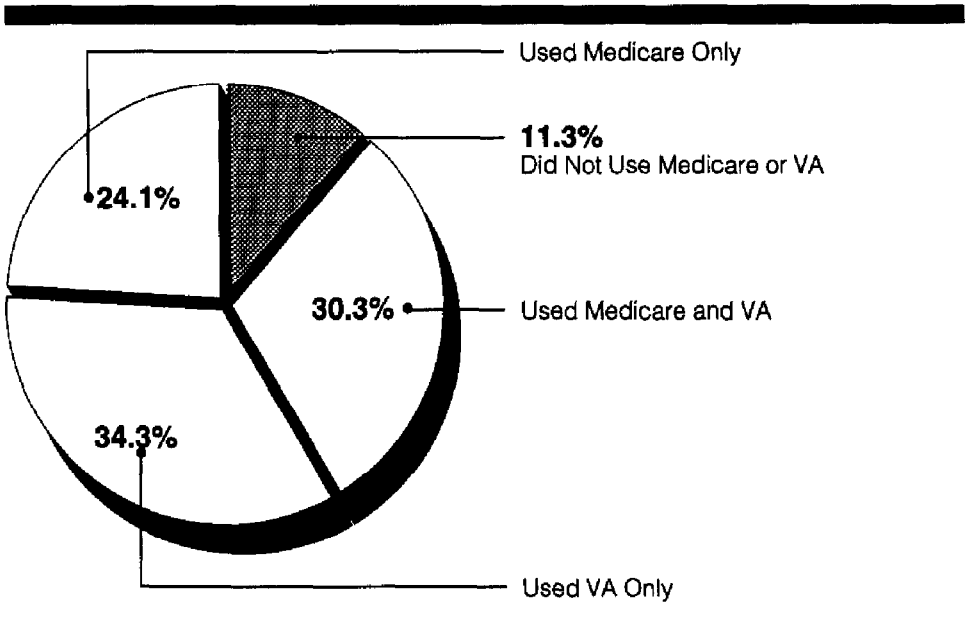


Figure 2.4: Use of VA and Medicare Services by Veterans With Service-Connected Disabilities Rated at Lower Than 50 Percent (1990)

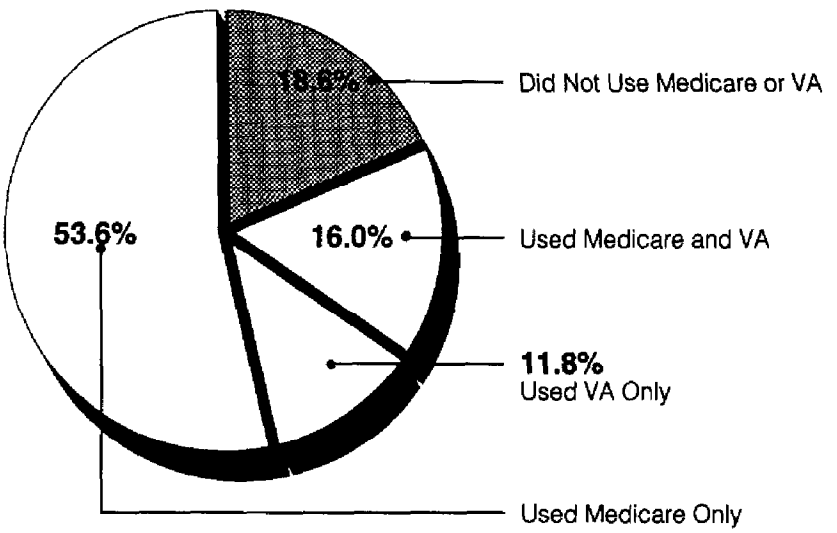


Figure 2.5: Use of VA and Medicare Services by VA Pension Recipients (1990)

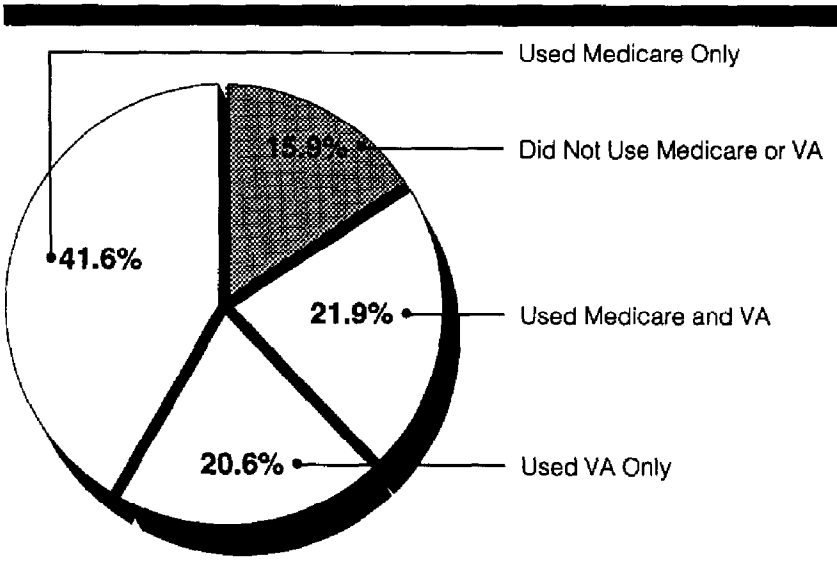
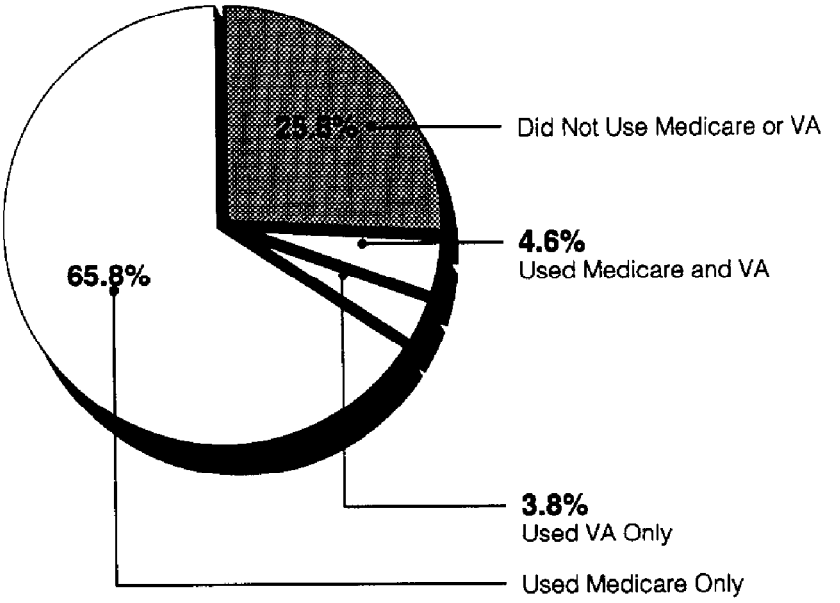


Figure 2.6: Use of VA and Medicare Services by Veterans Not Receiving VA Compensation or Pension Payments (1990)



Use of Selected Inpatient Services by Medicare-Eligible Veterans, by Source of Care

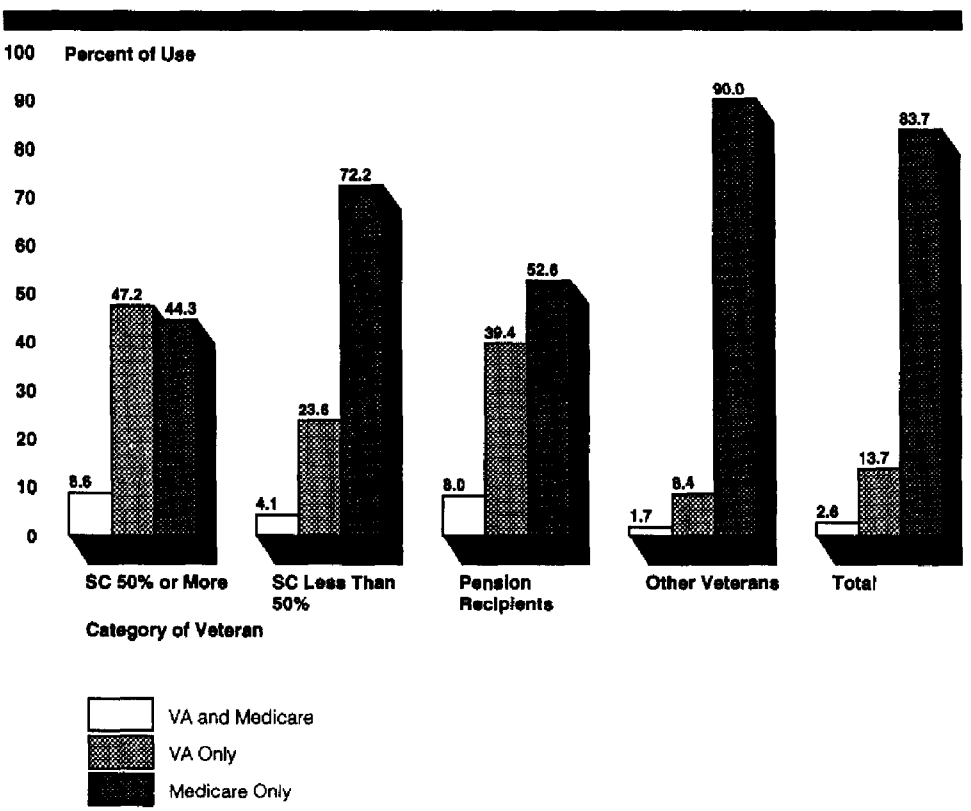
Medicare-eligible veterans were generally more likely to use VA for inpatient psychiatric care than for inpatient medical/surgical care and nursing home care. Service-connected veterans with disabilities rated at 50 percent or higher were the only category of veterans more likely to use VA than Medicare for inpatient medical/surgical care and nursing home care. By contrast, all categories of veterans, except those not receiving compensation or pension benefits, were more likely to use VA than Medicare for inpatient psychiatric care.

The greater reliance of severely disabled service-connected veterans on VA even when Medicare coverage is fairly extensive is clearly demonstrated through examination of inpatient medical/surgical care. Of veterans hospitalized for medical/surgical care during 1990, about 90 percent of those who were Medicare-eligible nonservice-connected veterans with incomes above the pension level relied on Medicare and not VA to pay their bills. By contrast, about 47 percent of service-connected veterans with

disabilities rated at over 50 percent relied on VA to provide their inpatient medical/surgical care.

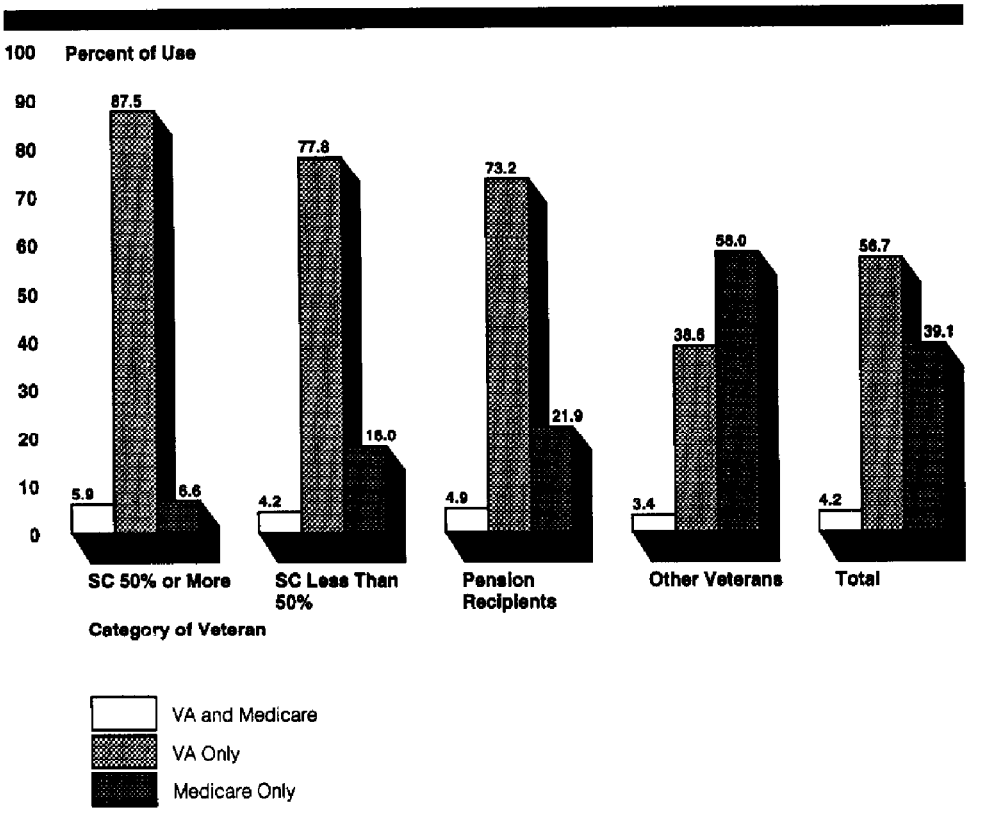
Figures 2.7 through 2.9 provide additional information on the use of VA and Medicare inpatient services by Medicare-eligible veterans.

Figure 2.7: Inpatient Medical/Surgical Care of Medicare-Eligible Veterans, by Source of Care (1990)



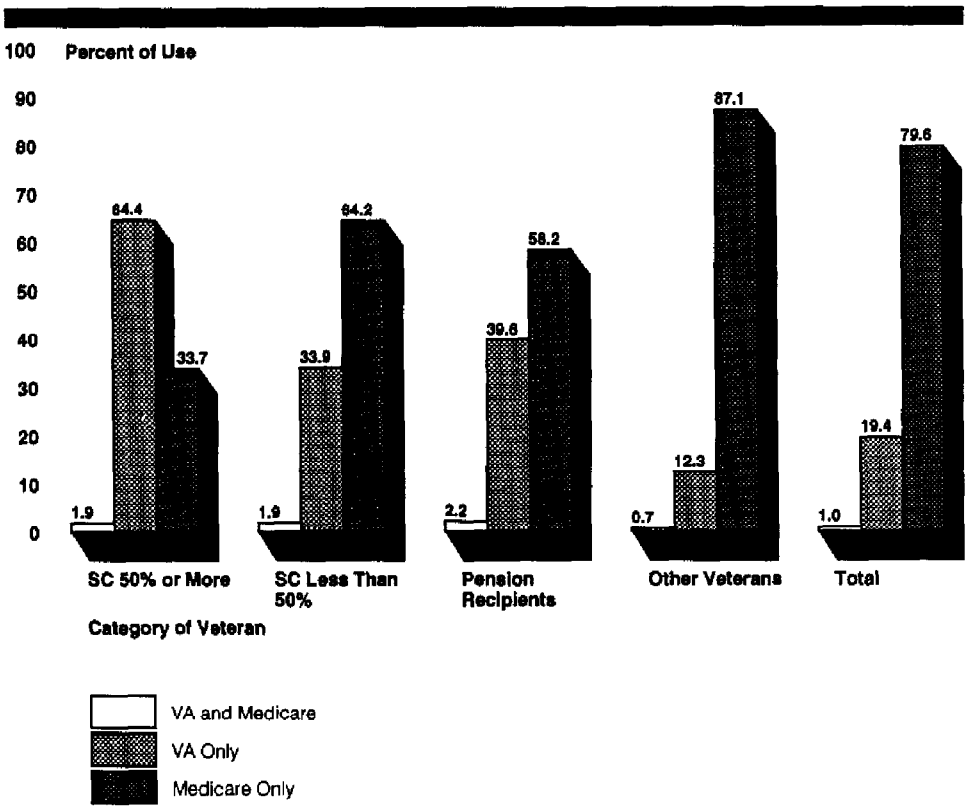
Note: SC = Service-connected disability.

Figure 2.8: Psychiatric Hospital Use by Medicare-Eligible Veterans, by Source of Care (1990)



Note: SC = Service-connected disability.

Figure 2.9: Nursing Home Use by Medicare-Eligible Veterans, by Source of Care (1990)



Note: SC = Service-connected disability.

VA Eligibility Does Not Appear to Reduce Medicare Use/Expenditures

Eligibility for VA health care does not appear to reduce Medicare utilization or expenditures. We found no significant differences in (1) the percentage of beneficiaries using Medicare services during 1990 or (2) the Medicare expenditures per beneficiary for Medicare-eligible male veterans and all Medicare-eligible males age 65 and over.[3] Additional details of this comparison are contained on page 52 in Section 6.

[3]We compared veterans to the general male Medicare-eligible population age 65 and over because about 95 percent of veterans over the age of 65 are males.

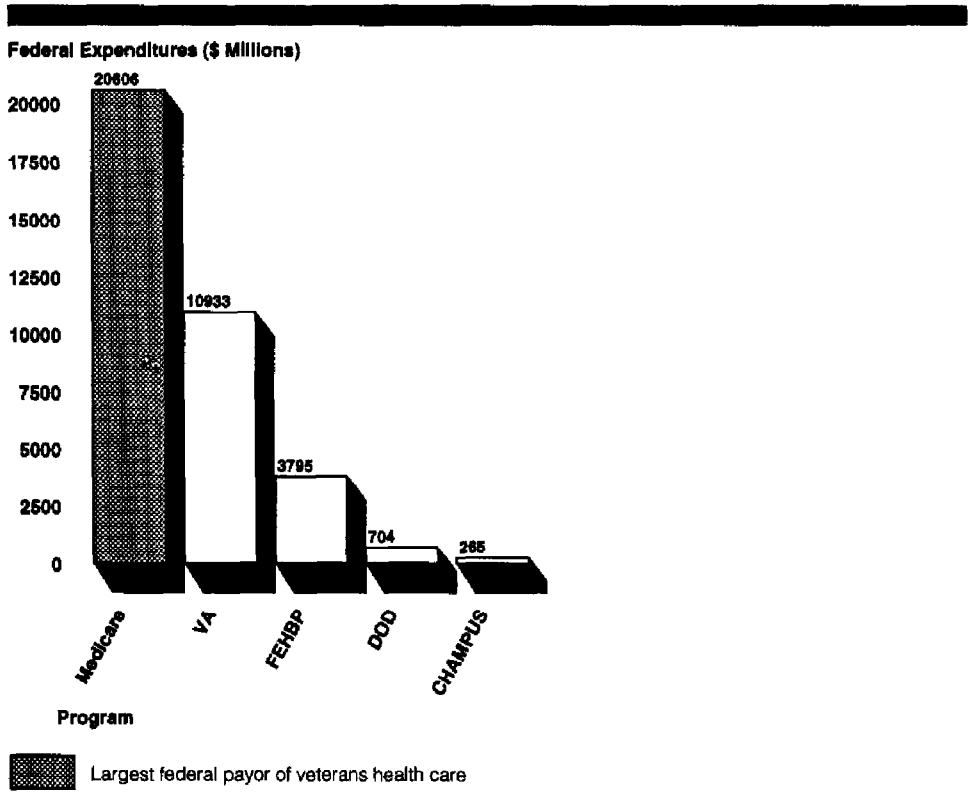
Most Veterans' Health Care Financed Under Federal Programs Other Than VA

About 70 percent of the more than $36 billion in federal expenditures on veterans' health care in 1990 was paid through programs other than VA.[1] Private health insurance and state and local government programs also play important roles in meeting the health care needs of veterans, but expenditures on veterans' health care under these programs were not readily available.

Medicare accounted for about 57 percent ($20.6 billion) of the federal expenditures for veterans' health care in 1990 compared with VA's approximately 30 percent (about $10.9 billion). Other federal programs accounted for the remaining 13 percent of federal expenditures (see fig. 3.1).

[1]This is a conservative estimate—we could not readily determine federal expenditures on veterans' health care provided through Medicaid and the Indian Health Service.

Figure 3.1: Federal Expenditures on Veterans' Health Care, by Source of Payment (1990)



Notes: Medicaid and Indian Health Service expenditures could not be readily determined.

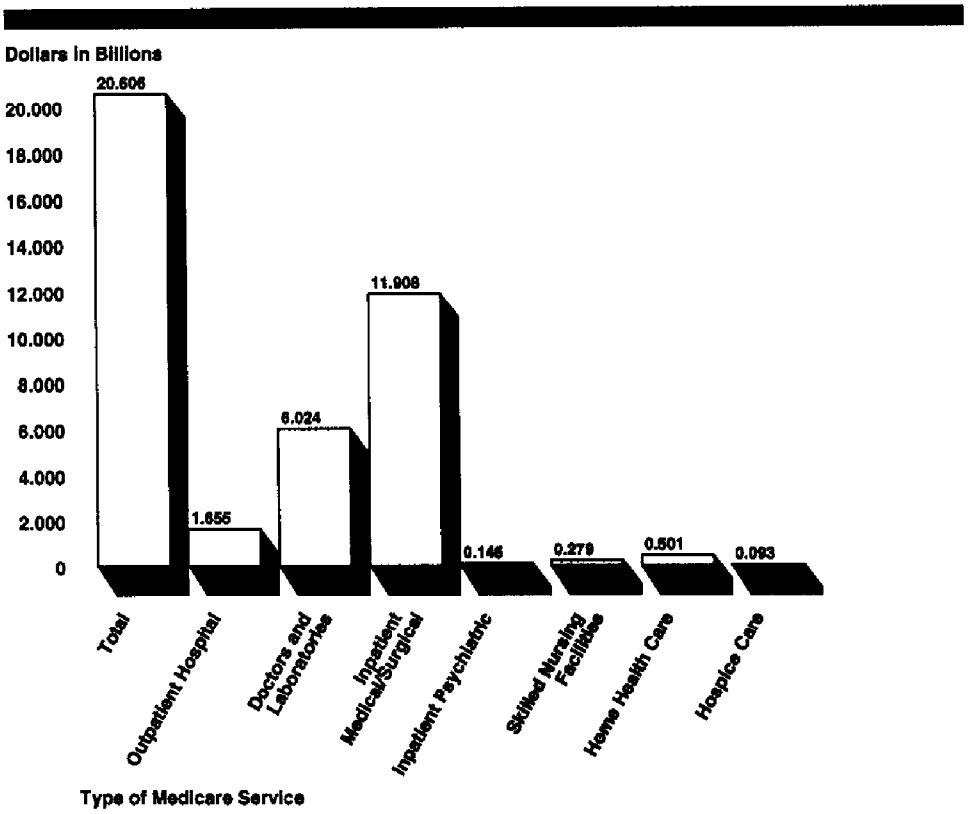
FEHBP expenditures are based on the government's share of premiums.

Identifiable federal expenditures for veterans' health care totaled over $36 billion in 1990.

Medicare Reimbursements for Veterans' Health Care

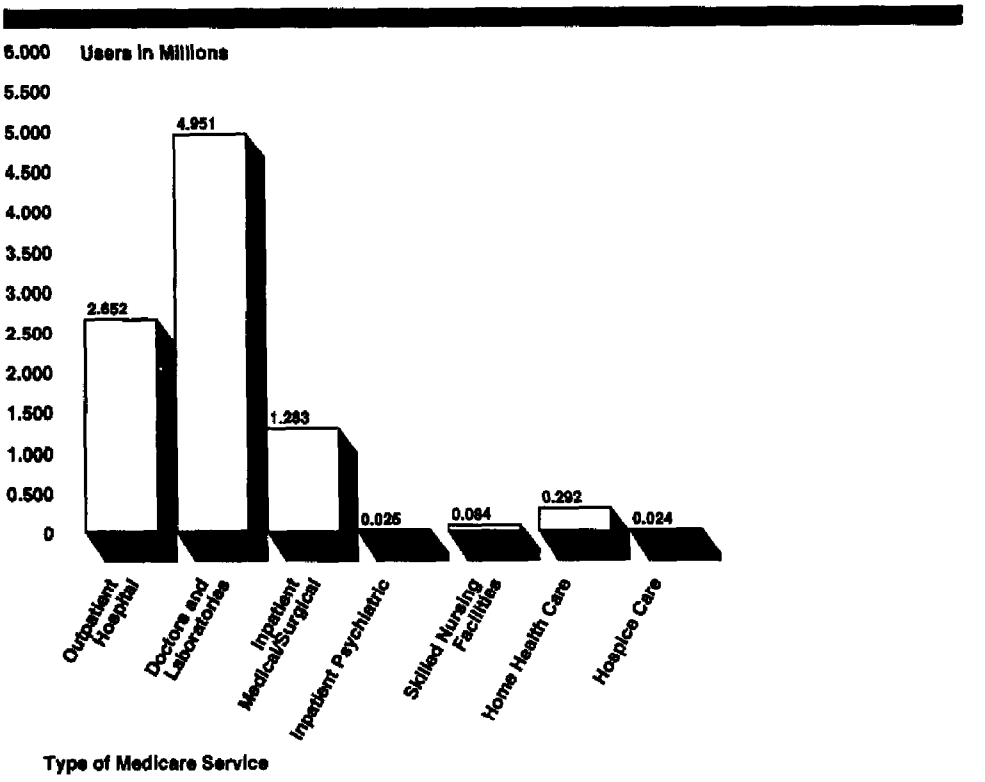
Over half of the $20.6 billion spent on veterans' health care through the Medicare program was spent on inpatient medical and surgical care. Another $1.7 billion was spent on outpatient hospital care and $6.0 billion for physicians and laboratories. (See fig. 3.2.)

Figure 3.2: Medicare Reimbursements for Veterans' Health Care, by Type of Care (1990)



Almost four times as many Medicare-eligible veterans used physician and laboratory services, and twice as many used outpatient hospital services as inpatient medical and surgical care. (See figure 3.3.)

Figure 3.3: Number of Veterans Using Medicare Services, by Type of Service (1990)



Figures 3.4 and 3.5 provide information on the average Medicare expenditures per veteran user and per Medicare-eligible veteran, respectively.

Figure 3.4: Average Medicare Reimbursements Per Veteran User, by Type of Service (1990)

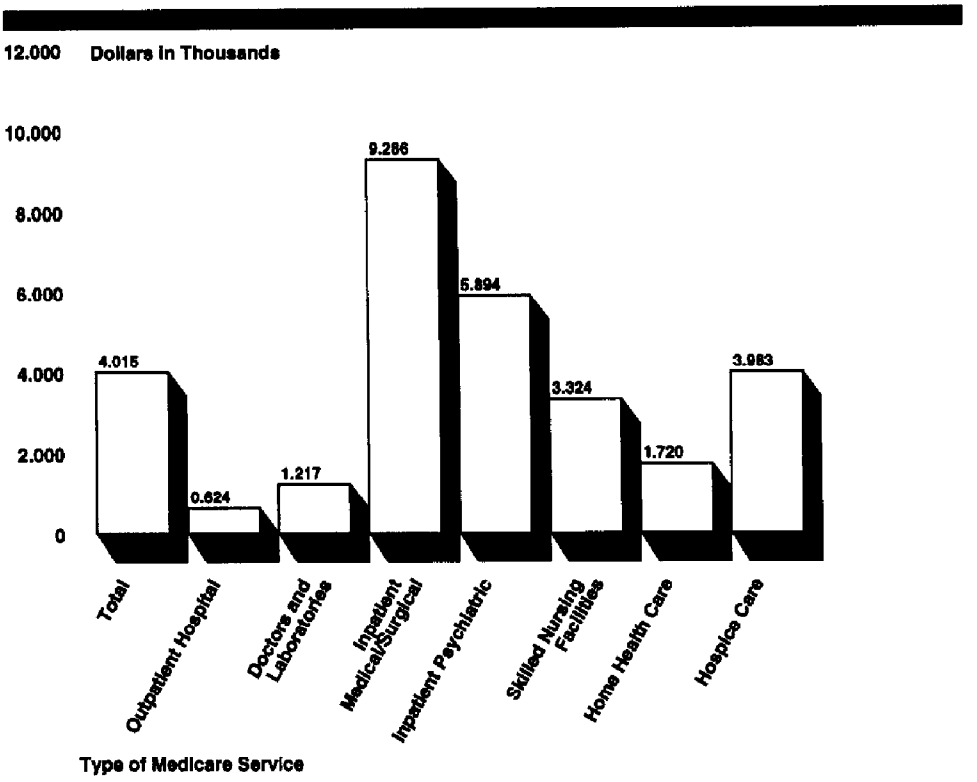
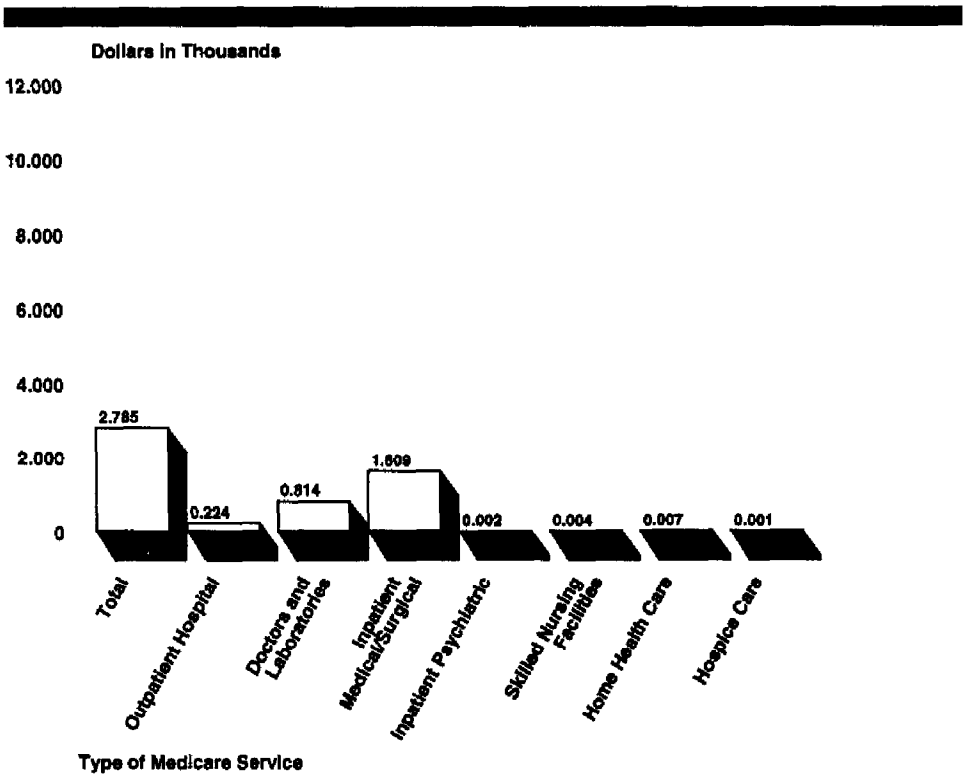


Figure 3.5: Average Medicare Reimbursements Per Medicare-Eligible Veteran, by Type of Service (1990)



Expenditures Under Private Insurance Likely to Exceed VA Expenditures

Although expenditures on veterans' health care through private health insurance are not readily available, they likely exceed those under VA. Data published by the Health Insurance Association of America, an industry trade association, indicate that private health insurance paid claims of about $980 per insured person in 1989.[2] If veterans' use of private insurance is similar to that of the general population, then private health insurance payments for veterans likely amounted to over $22 billion.

State and Local Programs Also Pay for Services for Veterans

Finally, state and local programs likely play a significant role in meeting the health care needs of veterans. Fewer than half of the veterans with no health insurance coverage have ever used a VA hospital. VA officials believe many of those veterans may be unable to use VA services because of geographic inaccessibility on VA's complex eligibility and entitlement provisions. It is not clear to what extent such veterans are obtaining care

[2]The Association's 1991 Source Book of Health Insurance Data reports that 189 million people were covered by private health insurance in 1989 and claim payments totaled $185.3 billion ($980 per insured).

from other sources but public hospitals and clinics are likely providing services to many uninsured veterans.

VA Provides a Safety Net for Some Veterans but Most VA Users Have Other Coverage

VA continues to play a critical role in meeting the health care needs of some veterans by serving as a safety net for veterans with limited health care options. Veterans who use VA facilities tend to have lower incomes and less private health insurance coverage than the overall veteran population.[1] For example, only about 33 percent of veterans using VA hospitals have private health insurance compared with 81 percent of the overall veteran population identified through our Survey of Income and Program Participation analysis. Similarly, over half of VA users had incomes of lower than $10,000. More than 4 users in 10 were found to be medically indigent in VA's Survey of Medical System Users, having neither private nor public insurance that would enable them to pay their health care bills.

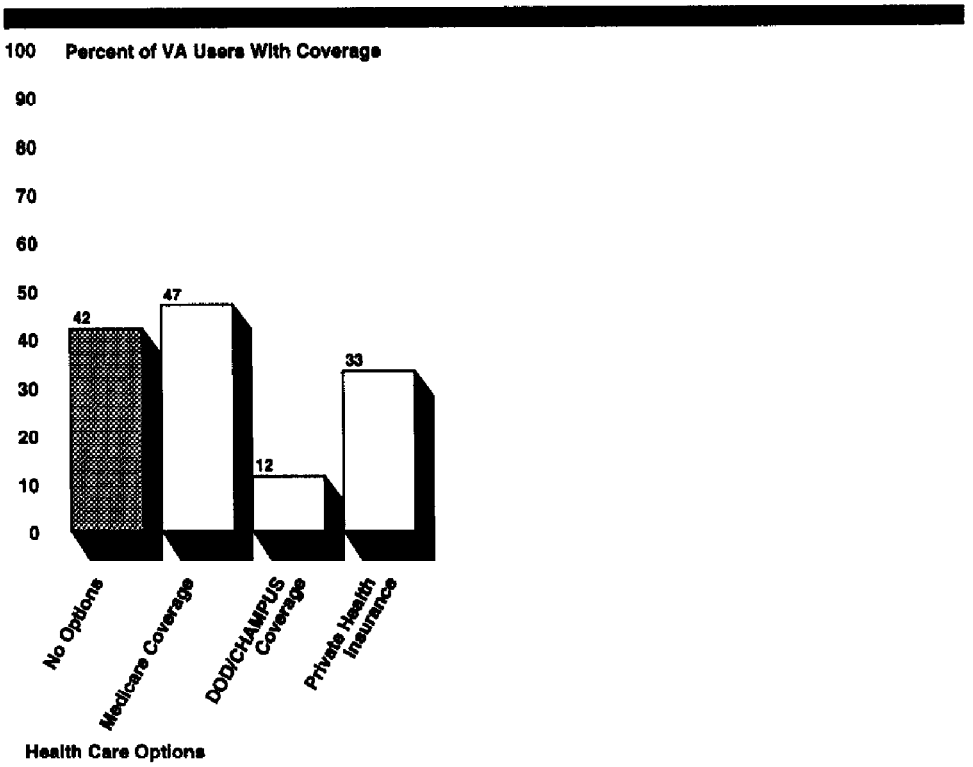
Our analyses confirm that veterans with low incomes (that is, those receiving VA pensions) are more likely to use VA services than are higher-income veterans. For example, among non-Medicare-eligible veterans, about 23 percent of those receiving VA pensions used VA hospital services during 1990 compared with about 8 percent of nonservice-connected veterans not receiving VA pensions.

Still, over 56 percent of the veterans who used VA health care services in 1990 had other federal health care coverage. In fact, veterans using VA health services are more likely to have other federal health care coverage than those veterans who do not use VA. For example, 47 percent of the veterans who used the VA system in 1990 were Medicare-eligible, even though only 26 percent of all veterans were Medicare-eligible. One possible explanation for this is that VA users tend to be older, have lower incomes, and have less private insurance coverage than the overall veteran population.

Figures 4.1 through 4.6 contain additional information on VA health care users, including their compensation and pension status, Medicare eligibility, and use of services by veterans not Medicare-eligible.

[1]Based on VA's Survey of Medical System Users, conducted between August 1988 and May 1989. VA surveyed 2,865 veterans who had been inpatients in a VA medical center during fiscal year 1987. The survey developed a sociodemographic profile of VA medical system users including age, income, and insurance coverage.

Figure 4.1: Health Care Options of Veterans Using VA Health Care During 1990



Notes: Percents do not add to 100 because some veterans have multiple coverages.

Data on private health insurance coverage and the percentage of veterans with no health care options are from the VA Survey of Medical System Users.

Data on Medicaid and the Indian Health Service were not readily available.

Figure 4.2: VA Users, by Category of Veteran (1990)

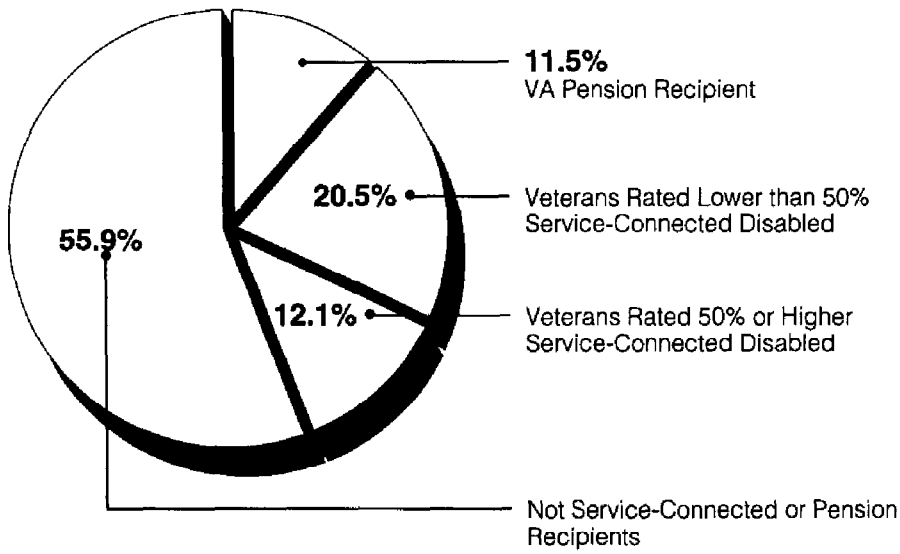
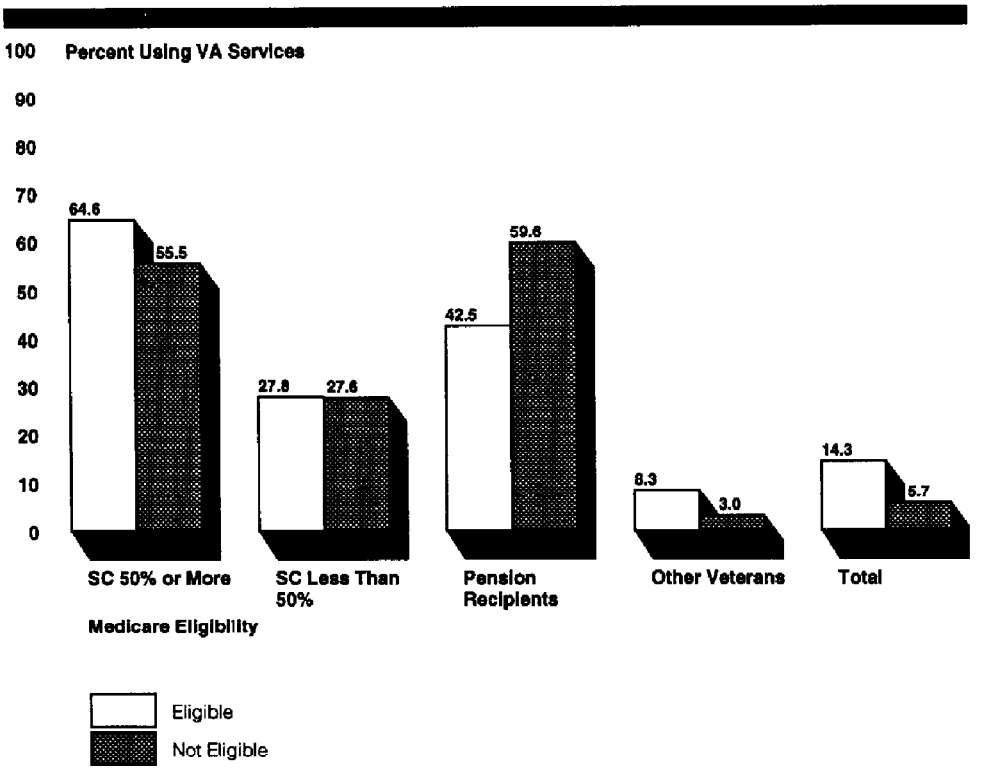
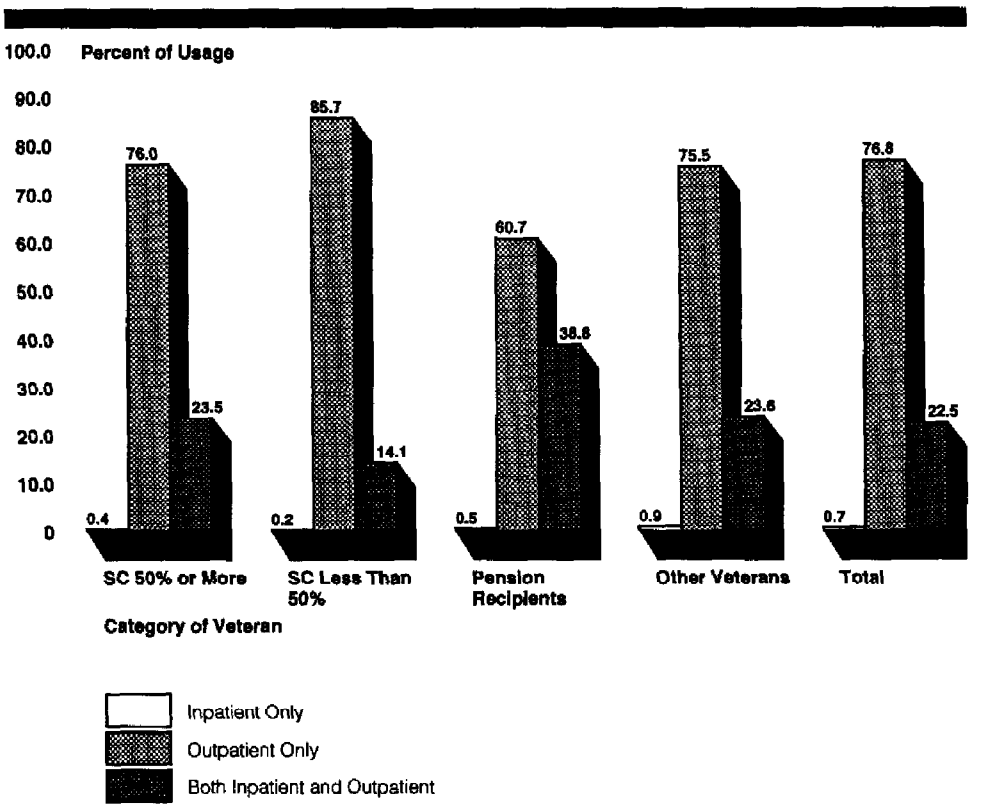


Figure 4.3: Percentage of Veterans Using VA Health Care Services, by Medicare and VA Status (1990)



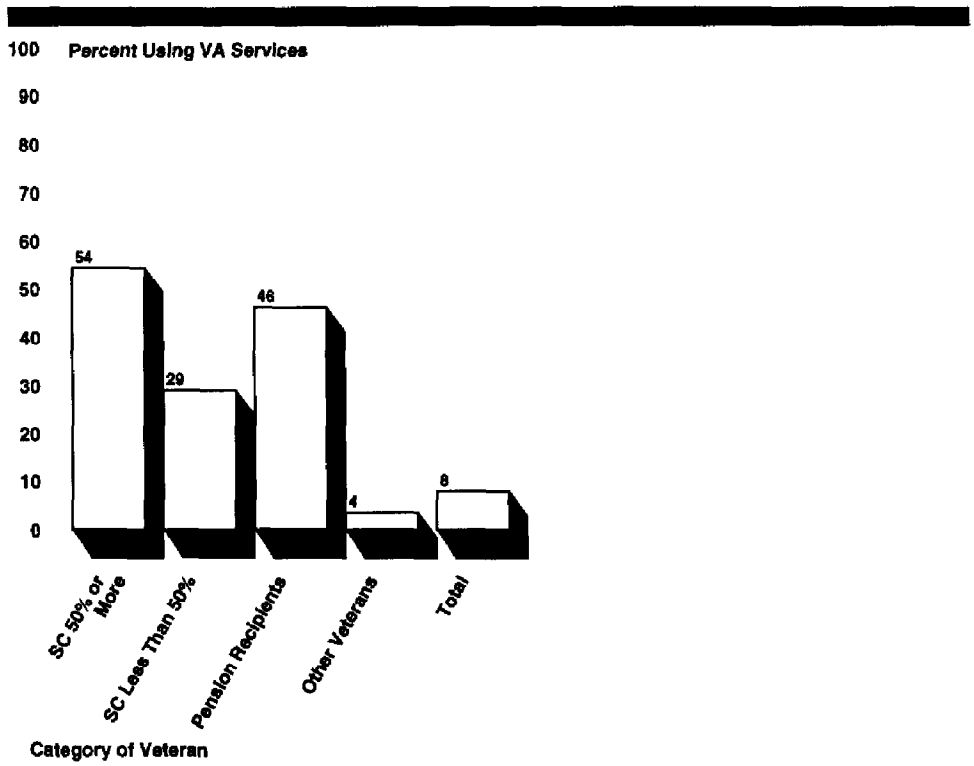
Note: SC = Service-connected disability.

Figure 4.4: Types of VA Services Used by Veterans Not Eligible for Medicare, by Category of Veteran (1990)



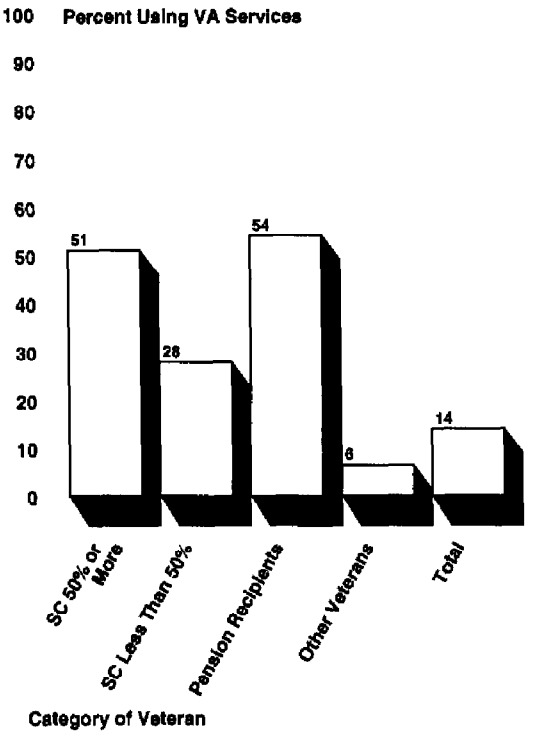
Note: SC = Service-connected disability.

Figure 4.5: Use of VA Services by Veterans With FEHBP but Not Medicare Coverage, by Category of Veteran (1990)



Note: SC = Service-connected disability.

Figure 4.6: Use of VA Services by Veterans Eligible for CHAMPUS but Not Medicare, by Category of Veteran (1990)



Note: SC = Service-connected disability.

Implications of Health Reform for the VA Health Care System

Health Reform Could Further Reduce VA Role as a Safety Net

Reform of the nations' health financing system to reduce the number of Americans who lack coverage of basic acute health care services could further reduce VA's role as a safety net for low-income and uninsured veterans. Similarly, expansion of Medicare benefits could result in decreased demand for those types of VA services. Without fundamental changes in the structure of the veterans' health care system, VA could lose much of its current acute care work load as a result of health reform. Health reform is, however, unlikely to affect demand for those types of services, such as long-term psychiatric care, that are not extensively covered under other public and private insurance and would not change VA's obligation to meet the health care needs of service-connected veterans.

Although 7 out of 10 federal dollars spent on veterans' health care in 1990 came from Medicare and other non-VA programs, VA continues to serve as a safety net for veterans without alternative coverage or without the resources to pay for copayments and deductibles. About 40 percent of veterans using VA have neither public nor private insurance to help pay for their care in private sector facilities. We previously reported that many of these veterans, given health insurance, would likely choose to obtain much of their future care from private sector facilities.[1]

But given that over 56 percent of VA users do have other federal health care coverage, it is also important to explore the factors that contribute to their decisions to use VA care. Cost-sharing appears to be an important determinant of VA use as 21 percent of Medicare-eligible VA pension recipients (a proxy for low-income) used VA but no Medicare services (and another 22 percent used both VA and Medicare services) whereas only 4 percent of nonservice-connected veterans not receiving VA pensions used VA but no Medicare services (and another 5 percent used a combination of VA and Medicare services).

A second major determinant appears to be covered services. Virtually all public and private health insurance provides coverage of acute inpatient medical/surgical care. Not surprisingly then, most Medicare-eligible veterans relied on Medicare to meet such acute care needs. Those most likely to use VA were severely disabled veterans and VA pension recipients who may be unable to afford Medicare copayments and deductibles.

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

By contrast, all categories of Medicare-eligible veterans, except those not receiving compensation or pension payments, tended to use VA for psychiatric care, presumably because of the limited coverage of inpatient psychiatric care under Medicare. Another area where higher-income Medicare-eligible veterans made significant use of VA was for nursing home care. While such veterans relied primarily on Medicare, which has a very limited nursing home program with high cost sharing, about 12 percent relied on VA.

Thus, the extent to which veterans gaining health insurance coverage through health reforms reduce their use of the VA system will, in large measure, depend on the services covered and the out-of-pocket costs that would be incurred. In other words, if low-income veterans are given health insurance through health reform, but would be required to pay significant copayments or deductibles to obtain care from private sector facilities, many might choose to stay with the VA system. Others will likely stay with VA for specific services not covered by their insurance.

Just as many veterans gaining health insurance through health reform might reduce their use of VA care, those VA users with health insurance might reduce their use of VA services if their insurance coverage is improved or cost sharing reduced. For example, the 8 percent of Medicare-eligible veterans who used both VA and Medicare services might shift more toward Medicare usage if the Medicare program adds prescription drug coverage or expanded long-term care services.

Similar to the fact that veterans with private insurance tend to use private sector providers rather than VA, our current work shows that Medicare-eligible veterans generally choose to use those benefits to pay for health care services from private sector facilities rather than obtaining care from VA. Fewer than 7 percent of Medicare-eligible veterans used VA but no Medicare services during 1990.

Clearly, without fundamental changes in the VA health care system, VA could face significant decreases in its acute care work load.

Health Security Act Only Major Health Reform Proposal That Would Change the Role of the VA System

Although many veterans would likely continue to seek treatment at VA facilities under a universal health care system, the magnitude of the likely decline in demand for VA-sponsored care suggests that plans for restructuring the VA health care system be developed as part of a national health care reform initiative. Of the major health reform bills that have been introduced, however, only one—the President's Health Security Act—contains plans for restructuring the VA health care system.

The proposed Health Security Act would (1) transform VA facilities into a series of managed care plans to compete with private sector plans and (2) expand entitlement to free comprehensive acute care services for veterans choosing the VA plan. Additional VA services not covered under the comprehensive benefits plan would continue to be offered to all veterans under existing eligibility and entitlement provisions, subject in most cases to the availability of resources. VA would also be given the authority to provide services to the veterans' dependents.

Currently, about 445,000 veterans with service-connected disabilities rated at 50 percent or higher are entitled to free comprehensive health care services from VA.[2] Millions of other veterans are eligible for free care, but entitled only to certain services, such as inpatient hospital care or outpatient treatment for their service-connected disabilities. Under the proposed Health Security Act, about 9 million veterans would be entitled to free comprehensive care if they enrolled in a VA health plan. Veterans enrolling in other health plans would be required to pay up to 20 percent of the cost of their insurance premiums and any copayments and deductibles.

In transforming the VA system into a series of managed care plans, VA expects to build or lease hundreds of additional outpatient facilities and to contract for services for the dependents of veterans.

Other provisions of the proposed Health Security Act might limit the effectiveness of the VA provisions in attracting veterans. First, low-income individuals would obtain subsidies regardless of which health plan they choose. This could largely negate the incentive for low-income veterans to enroll in the VA plan. Second, Medicare would be expanded to offer a prescription drug benefit and expanded long-term care benefits. This could reduce the use of such VA services by Medicare-eligible veterans.

[2]The provision of nursing home care is an optional benefit for all veterans.

Under the proposed system, all veterans, including those currently without public or private insurance, would have comprehensive acute care services with or without a VA managed care plan. Those with low incomes would receive subsidies to help pay for their insurance coverage. But veterans have other health care needs, such as substance abuse treatment, vision care, dental care, long-term psychiatric care, and long-term nursing home care, that would not be extensively covered under the managed care plans. Implementation of a universal coverage program would give VA the opportunity to shift resources and programs from basic acute care services to meeting veterans' remaining health care needs.

Other Options Exist for Restructuring the VA Health Care System

Converting VA facilities into managed care plans is but one option for preserving veterans' health care benefits. As we pointed out in our December 1992 report, Veterans Affairs Issues (GAO/OGC-93-21TR), other options that could be considered include

- maintaining a smaller direct delivery system strictly for veterans, but focusing on those services, such as treatment of spinal cord injuries and service-connected disabilities, that may not be adequately covered under a reformed national health care system;
- maintaining the current direct delivery system but opening the system to other federal beneficiaries to maintain work loads;
- converting some existing facilities to other uses, such as long-term psychiatric care, nursing home care, housing for homeless veterans, or AIDS treatment facilities;
- merging the VA system with one or more of the other federal health care systems, such as the DOD health care system; or
- eliminating the separate VA health care system and meeting the nation's commitment to veterans by supplementing the coverage available under a national health care reform initiative.

Another option under a managed care approach such as the one proposed by the Health Security Act would be to preserve VA facilities by contracting to provide services to private sector health plans. Such an option might enable VA to preserve or expand its inpatient work load without undertaking a costly expansion of VA facilities. Such contracts could be restricted to treatment of veterans or be expanded to other federal beneficiaries.

VA officials said that all of the above options were considered in developing the proposed Health Security Act. They said that the act would

give VA the flexibility to adopt any of the options other than (1) merging the VA system with another federal health care delivery system or (2) eliminating the separate VA system and supplementing coverage available under a universal care program.

Scope and Methodology

Determining the Number of Veterans With Insurance Coverage

To estimate the number of veterans covered by federal and private health benefits programs, we analyzed data contained in the Census Bureau's 1990 Survey of Income and Program Participation (SIPP).[1] SIPP is a nationwide longitudinal survey based on a statistical sample of about 22,000 noninstitutional households and covers such areas as health insurance coverage, income, assets, veteran status, and eligibility for participation in various government programs.

Because a statistical sample rather than the entire population was surveyed, each estimate from the survey has a standard error associated with it. By using each estimate and its standard error, we calculated a 95-percent confidence interval around each estimate. This means there is a 95-percent chance that the actual population total of interest falls within that interval.

Estimating the Veteran Population

We extracted the records for each rotational group with the reference month equal to January 1990. We estimated the veteran population on the basis of the number of people who responded "yes" to the question "Did this person ever serve on active duty in the U.S. Armed Forces?" and "no" to the question "Is this person currently in the Armed Forces?" There were 6,080 such respondents. On that basis, we estimated that the total veteran population was 28,192,419. The 95-percent confidence interval around this estimate is 26,865,627 to 29,519,211.

Estimating Medicare Coverage

We estimated the number of veterans covered by Medicare on the basis of the number of veterans in the sample who responded "yes" to the question "Is this person covered by Medicare?" to estimate the number of veterans covered by Medicare. There were 1,592 such veterans. On that basis, we estimated that the total Medicare-eligible veteran population was 7,399,831. The 95-percent confidence interval around this estimate is 6,762,565 to 8,037,097.

Estimating Medicaid Coverage

We estimated the number of veterans covered by Medicaid on the basis of the number of veterans in the sample who responded "yes" to the question

[1]We used the Panel Wave 1 Rectangular Core File. The Wave 1 SIPP survey consists of four rotational groups, each interviewed in a different month from February through May 1990. For each group, the reference period for reporting is the four calendar months preceding the interview month and, thus, one of the reference months in each rotational group overlaps. The common month for Wave 1—the month occurring in all the reference periods—is January. We chose January as the reference month for our analysis because this ensured only one record for each sampled person and provided the largest population.

"Was this person covered by Medicaid for the month?" There were 95 such veterans. On that basis, we estimated that the total Medicaid-eligible veteran population was 439,446. The 95-percent confidence interval around this estimate is 280,863 to 598,029.

Estimating CHAMPUS Coverage

We estimated the number of veterans covered by CHAMPUS on the basis of the number of veterans in the sample who responded "yes" to the question "CHAMPUS/CHAMPVA coverage?" Because CHAMPUS coverage ends at age 65, we eliminated those veterans over 65 from our determination of CHAMPUS coverage. In addition, CHAMPVA coverage was naturally eliminated because it covers dependents of veterans not veterans. There were 283 veterans who met the above criteria. On that basis, we estimated that the total CHAMPUS-eligible veteran population was 1,432,796. The 95-percent confidence interval around this estimate is 1,147,286 to 1,718,306.

Estimating Private Health Insurance Coverage

We estimated the number of veterans covered by private insurance on the basis of the number of veterans in the sample who responded "yes" to the question "Did this person have health insurance coverage this month?" There were 4,972 such veterans. On that basis, we estimated that the total privately insured veteran population was 22,924,828. The 95-percent confidence interval around this estimate is 21,712,928 to 24,136,728.

Estimating the Number of Veterans Without Public or Private Health Insurance

We estimated the number of veterans without private or public health insurance on the basis of the number of veterans in the sample who did not answer "yes" to any of the above questions. There were 549 such veterans. On that basis, we estimated that the total uninsured veteran population was 2,600,145. The 95-percent confidence interval around this estimate is 2,172,502 to 3,027,788.

In addition to the above estimates, we developed estimates of multiple coverages following the same techniques.

Estimating Expenditures on Veterans' Health Care Under Federal Health Programs and Analyzing VA and Medicare Utilization

To determine federal expenditures for veterans' health care under VA and other federal health programs and analyze veterans' utilization of health services under VA and Medicare, we obtained and analyzed fiscal year 1990 (1) Medicare eligibility and payment data from the Health Care Financing Administration, which administers Medicare; (2) cost and eligibility data from the Department of Defense and its Office of CHAMPUS, which administer the DOD health care system and CHAMPUS, respectively; (3) employee and annuitant records from the Office of Personnel Management, which administers the Federal Employees Health Benefits Program;[2] and (4) cost and utilization data from VA.

While the statistical and financial reporting systems of DOD, CHAMPUS, and VA contained sufficient program eligibility and cost information to enable us to estimate how much was spent on veterans' health care under those programs, HCFA and OPM information systems did not. For example, Medicare's eligibility records did not contain a veteran indicator.

As a result, we developed a database of veterans (hereafter referred to as "LIVEVETS") and performed a series of computerized tape matches to arrive at Medicare and FEHBP expenditures for veterans' health care in 1990. The database was also used to analyze the number of veterans who used VA health care services in 1990 who also had coverage under other public health benefits programs and use of Medicare and VA health care services by Medicare-eligible veterans that same year.

Creation of LIVEVETS

We created LIVEVETS because no complete database of veterans exists. VA officials told us that VA's Beneficiary Identification and Records Locator Subsystem (BIRLS) was the most complete database of veterans. Even so, over 11 million of the veteran records had no social security number (SSN)—about 40 percent of over 29 million records in the file. In addition, the database did not reflect all veteran deaths.

We did some preliminary comparisons of the numbers of usable records (that is, those with SSNs) in BIRLS with VA and SIPP projections of the number of veterans by age group. BIRLS appears to be a fairly complete database for younger veterans (VA now receives copies of military discharge papers and creates a BIRLS record) but an incomplete database for older veterans. There were SSNs for only about 49 percent of the estimated number of veterans aged 65 or older.

[2]FEHBP data on active postal workers was obtained from the United States Postal Service.

In order to develop the LIVEVETS file, we obtained information from the following databases (some are extracts and some are complete databases):

- BIRLS;
- Social Security Death Master File to identify veterans who were deceased before 1990;
- patient treatment file (PTF) to identify inpatients at VA medical facilities;
- outpatient clinic system (OPC) to identify patients treated on an outpatient basis at VA facilities;
- Active Employee Reference File from the United States Postal Service to identify active postal service employees who are veterans and their participation in FEHBP;
- Current Personnel Data File (CPDF) from OPM to identify all other active federal employees and their FEHBP coverage;
- Annuity Roll from OPM to identify all retired federal and postal employees who are veterans and their FEHBP coverage;
- Defense Enrollment Eligibility Reporting System (DEERS) from DOD to identify retired military personnel (veterans) eligible for treatment in the DOD direct care system or through CHAMPUS; and
- Health Insurance Skeleton Eligibility Writeoff File (HISKEW) from HCFA to identify veterans eligible for Medicare part A and/or part B.

First, we eliminated those BIRLS records with no SSNs. This reduced the size of the file from 29,401,503 records to 18,141,393 records.

Second, we matched the remaining records against the Social Security Death Master File and eliminated 354,227 deceased veterans. This further reduced the LIVEVETS file to 17,787,166 records.

Third, to enhance the LIVEVETS file and determine how many veterans were eligible for health care under the various federal health care programs, we conducted matches of the LIVEVETS file to the other files mentioned above, adding veterans that were not originally on BIRLS and noting which veterans were eligible for health care services from each program during 1990. This process resulted in the addition of 1,332,129 additional SSNs to the LIVEVETS file as follows:

- PTF (574,282 records already in LIVEVETS; 9,239 veterans added),

- OPC (1,310,444 records already in LIVEVETS; 343,477 veterans added),[3]
- USPS (200,227 records already in LIVEVETS; 90,656 records added),
- CPDF (433,001 records already in LIVEVETS; 203,870 records added),
- Annuity (465,523 records already in LIVEVETS; 437,686 records added, and
- DEERS (1,443,976 records already in LIVEVETS; 247,201 records added).

Fourth, the resulting 19,119,295 veteran SSNs in the LIVEVETS file were matched against Medicare's HISKEW file, yielding 4,411,558 Medicare-eligible veterans.

Fifth, we matched the Medicare-eligible veterans against the Medicare Automated Data Retrieval System (MADRS) to obtain the number of veterans receiving Medicare covered services and the cost of those services. The match yielded 3,059,855 Medicare users.

Finally, to enable us to analyze differences in VA and Medicare utilization based on the existence and extent of service-connected disabilities and receipt of a VA pension, we matched the LIVEVETS file against the Compensation and Pension Minimaster file to mark all pension recipients and veterans with a service-connected disability including the percentage rating of that disability.

We matched LIVEVETS against the Compensation and Pension Minimaster file because of concern about the accuracy of the compensation and pension indicators in BIRLS, OPC, and PTF. Because the compensation and pension file is a payment file and likely to be more accurate than the information contained in the other databases, we used the compensation and pension indicators from the Compensation and Pension Minimaster file.

The match identified 2,664,536 compensation and pension recipients—443,338 with service-connected disabilities rated at 50 percent or higher, 1,665,359 with service-connected disabilities rated at lower than 50 percent, and 555,839 pension recipients. However, the match also identified 50,495 veterans not on our LIVEVETS file. Because these veterans were identified after LIVEVETS had been matched against Medicare records and account for fewer than 2 percent of veterans contained in the

[3]Approximately 600,000 veteran SSNs were initially omitted from the match because of an unnoticed change in coding of the veteran indicator field in the OPC. We subsequently matched these records against LIVEVETS and identified about 30,000 veteran SSNs that should have been added to LIVEVETS during the initial match or add processing. Because this error was not identified until after LIVEVETS had been matched against Medicare records, and accounted for fewer than 1.4 percent of VA users (30,000 out of 2.2 million) we excluded the 30,000 SSNs from our analysis.

compensation and pension file, we excluded these veterans from our analysis.

The final LIVEVETS file contains 19,119,295 veteran records or about 68 percent of the estimated 28.2 million veterans living in 1990. The database also contains about 60 percent of all veterans eligible for Medicare that same year (based on projections of the Medicare-eligible veteran population from SIPP). The database contains all veterans who (1) used VA outpatient clinics or obtained inpatient care under VA auspices (with the exception of the approximately 30,000 VA outpatient users discussed in footnote 3), (2) were retired from the uniformed services, and (3) were either current or retired federal or postal employees.

Estimating Medicare Expenditures for Veterans' Health Care

We identified 4,411,558 (60 percent) of the estimated 7,399,831 veterans eligible for Medicare in 1990 through our match of LIVEVETS to HCFA's HISKEW files.[4] This is consistent with our earlier finding that most of the BIRLS records with missing SSNs were for older veterans.

We compared our Medicare-eligible veteran population to the overall population of Medicare-eligible males over the age of 65 using three measures

- rate of use of Medicare services;
- expenditures per beneficiary; and
- expenditures per Medicare user.[5]

We found no significant differences between our veteran population and the overall Medicare population on any of the measures. The utilization rate of Medicare eligible beneficiaries (69.4 percent for our veteran population compared with 71.6 percent for the Medicare-eligible aged males); the amounts Medicare paid per user ($4,015 for our veteran population compared with $4,018 per Medicare-eligible aged male user) and the amounts paid per eligible beneficiary ($2,785 for Medicare eligible veterans compared with $2,876 per Medicare-eligible aged male) were all similar. This allows us to suggest that our 2,988,273 "unknown" Medicare-eligible veterans used Medicare at the same rate as our 4,411,558 known Medicare-eligible veterans.

[4]Based on 1990 SIPP data.

[5]We chose Medicare-eligible males over the age of 65 as our point of comparison because over 95 percent of all veterans are male and over 90 percent of Medicare-eligible veterans are over the age of 65.

Accordingly, we projected the amount of expenditures obtained through our tape matches to the remaining universe of veterans to arrive at the amount of Medicare expenditures on behalf of all Medicare-eligible veterans in 1990.

Estimating Federal Expenditures for FEHBP

Federal expenditures for FEHBP are the government's share of premiums paid various plans for covering participating employees. FEHBP participants have a wide choice of health plans and the government's share of premium payments varies among those plans. We identified 1,498,591 current and retired federal employees who were veterans participating in FEHBP by matching the LIVEVETS file to OPM and U.S. Postal Service tapes containing FEHBP plan enrollment data. Using a computerized table containing the government's share of premium payments for the various FEHBP plans, we then calculated the federal expenditures on behalf of veterans participating in FEHBP during calendar year 1990.

Developing Demographic Data on Veterans Who Used VA Facilities

Because LIVEVETS does not contain information on private health insurance coverage other than FEHBP and contains no data on veteran incomes, we supplemented the data in LIVEVETS with data from VA's Survey of Medical System Users. This survey covered 2,865 veterans who had been inpatients in a VA medical center during fiscal year 1987. Because it is based on veterans using inpatient services, it may or may not be representative of veterans who used only VA outpatient services.

We did our work between August 1991 and December 1993.

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Related GAO Products

VA Health Care: Comparison of VA Benefits With Other Public and Prvate Programs (GAO/HRD-93-94, July 29, 1993).

VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (GAO/HRD/93-68, July 27, 1993).

Veterans Affairs: Accessibility of Outpatient Care at VA Medical Centers (GAO/T-HRD-93-29, July 21, 1993).

VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 14, 1993).

VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (GAO/HRD-93-123, June 30, 1993).

Veterans' Health Care: Potential Effects of Health Care Reforms on VA's Major Construction Program (GAO/-T-HRD-93-19, May 6, 1993).

Veterans' Health Care: Potential Effects of Health Financing Reforms on Demand for VA Services (GAO/T-HRD-93-12, Mar. 31, 1993).

Veterans' Health Care: Potential Effects of Health Reforms on VA Construction (GAO/T-HRD-93-7, Mar. 3, 1993).

VA Health Care: Actions Needed to Control Major Construction Costs (GAO/HRD-93-75, Feb. 26, 1993).

Veterans' Affairs Issues (GAO/OCG-93-21TR, Dec. 1992).

VA Health Care: Offsetting Long-Term Care Costs by Adopting State Copayment Practices (GAO/HRD-92-96, Aug. 12, 1992).

VA Health Care: Demonstration Project Concerning Future Structure of Veterans' Health Reform (GAO/T-HRD-92-53, Aug. 11, 1992).

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

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