CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

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From 2011 to 2020, the VA Spent $78 Billion on Care for Veterans Enrolled in Medicare Advantage Plans

In a study published in JAMA, researchers based out of the Providence VA COIN and the Brown University School of Public Health characterized how much the VA spends on veterans dually enrolled with Medicare Advantage. Due to a prohibition of the VA from seeking reimbursement from MA plans, this may represent significant duplicate federal spending.

Summary of the Issue

Medicare Advantage plans are paid on a capitated basis, meaning they receive a fixed payment per enrollee, adjusted for the individual's health risk. These payments are made regardless of whether the enrollee seeks care through the MA plan or, as is often the case for Veterans, through the VHA. The federal government is therefore paying MA plans a full annual payment for care even when Veterans receive few services in that plan while also funding the VHA to deliver that care. Dually enrolled Veterans can still receive supplemental benefits from MA plans not available from the VA, but it is highly likely that MA plans are being paid significantly for the same care the VHA is generating expense for.

Key Findings

Rapid Growth in Dual Enrollment

Between 2011 and 2020, the number of VHA-MA dual enrollees using VHA services grew by 63%, from 1 million to 1.73 million, representing 26% of all Veterans enrolled in both Medicare and VHA by 2020. This growing proportion of dual enrollees in VHA and MA suggests that a substantial segment of Veterans rely on the VHA for healthcare services, even as MA plans receive payments to provide those same services.

VHA's Spending on Dual Enrollees

In 2020 alone, VHA spent $12.1 billion on healthcare services for Veterans enrolled in both VHA and MA, which accounted for nearly 12% of the VHA's total healthcare spending of $102.7 billion. Moreover, over the ten year period of 2011-2020, the VHA spent a total of $78 billion on dual enrollees, with spending growing significantly for community care (370%), outpatient care (220%), pharmacy services (200%), and inpatient care (140%).

Implications

The rising dual enrollment growth among Veterans, along with the increasing prevalence of MA affinity plans targeting Veterans, points to a systemic inefficiency. By enrolling Veterans who rely on the VHA for most or all of their care, MA plans can collect substantial federal payments, creating a significant risk of duplicative spending. While the exact magnitude of duplicate payments remains uncertain due to the lack of detailed data on MA plan services, this study underscores the need for legislative and policy changes to close this loophole, to ensure more efficient use of federal resources while enabling the VHA to recoup payments from MA insurers.

Legislative Reforms

As the VA is facing increasing cost pressures as a result of spending growth in Community Care among other sources, there may be opportunity to eliminate the risk of duplicative spending.

Currently, if a beneficiary is eligible for both Medicare and VHA benefits, under Medicare Secondary Payer laws, the VA is the primary payer for VHA-authorized services, and Medicare does not and cannot pay. Medicare is statutorily prohibited from making payments to a federal health care program legally obligated to render the services, including the VHA (42 U.S.C. §§1395f(c), 1395n(d)). Further, the VA is statutorily prohibited from seeking payment from Medicare for VA-authorized services provided to veterans with Medicare coverage (42 U.S.C. § 1395f(c) and 38 U.S.C. §1729(i)(1)(B)(i)). Put differently, the VA's ability to recover payment for VHA-covered services from a veteran's third-party source of coverage excludes Medicare (38 U.S.C. § 1729). For veterans with Traditional (fee-for-service) Medicare, Medicare does not pay for VA-authorized services, so there

would be no issue of double-payment. However, for veterans with Medicare Advantage coverage, Medicare pays the MA plan a capitated rate for each beneficiary regardless of what other sources of coverage or care the beneficiary may receive. The prohibition on the VA seeking recoupment from Medicare results in double-payment for VHA-covered services rendered to beneficiaries with both VHA and Medicare Advantage coverage.

Policymakers could consider several reforms to address potentially duplicative federal spending among dual VHA-MA enrollees.

1. **The VHA could be authorized to collect reimbursements for care provided to MA enrollees, similar to the VHA's ability to collect such reimbursements from other private insurers.** This would require amendments to the Medicare statutory provisions that prohibit Medicare payment for services covered by the VHA (42 U.S.C. §§1395f(c), 1395n(d)) as well as the statutory prohibition on the VA from seeking payment from Medicare (38 U.S.C. § 1729). These changes could be accomplished by creating an exception for Medicare Advantage plans, while leaving the Medicare secondary payer rules intact for Traditional Medicare.
2. **The Medicare program could consider reducing payments to MA plans on behalf of Veterans who exclusively or nearly exclusively receive VHA care.** A similar carve-out approach is used in other contexts such as when a MA beneficiary enrolls in hospice benefits.

Conclusion

From 2011 to 2020, VHA paid over $78 billion in health services for VHA/MA dual enrollees as the number of these dual enrollees increased by 63%. These findings highlight a substantial risk of government overpayment, however there are straightforward solutions to address these challenges to ensure that Veterans are adequately cared for.
