Ensuring Value and Efficiency in Veterans' Health Care:

Addressing Overpayments and Strengthening Medicare-VHA Alignment

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CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health BROWN UNIVERSITY

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[1]The opinions and conclusions expressed in this testimony are the author's alone and do not necessarily reflect those of Brown University, the Brown University School of Public Health, or any of the research sponsors.
[2]The Center for Advancing Health Policy through Research (CAHPR) at the Brown University School of Public Health is dedicated to generating research that informs policies aimed at reducing costs, improving patient well-being, and driving meaningful transformations in U.S. health care delivery. Our work focuses on the design of insurance plans and their interactions within the health care market, employing a unique approach that integrates quantitative policy analysis with legal evaluation. This combined methodology helps identify the most effective legal and regulatory changes to create a significant impact. While this testimony is not a research publication, it is informed by relevant research conducted by CAHPR and its affiliates.

Chairman Bost, Ranking Member Takano, and distinguished members of the committee, thank you for the opportunity to submit testimony on this vital topic. My name is David Meyers. I am an associate professor and vice department chair of Health Policy at the Brown University School of Public Health and Associate Director of the Center for Advancing Health Policy through Research (CAHPR). My research focuses on the Medicare Advantage (MA) program, examining how payment policy and market dynamics impact federal spending and patient care. The testimony I submit is in my personal capacity as an expert on MA and U.S. health care payment systems, and are informed by recent studies conducted by my colleagues and me estimating duplicative spending among veterans dually enrolled in both MA and the Veterans Health Administration (VHA).

I will make three points in my testimony:

1. The current payment structure for dually enrolled veterans creates inefficiencies and unnecessary costs that may lead to over $20 billion in potentially duplicative spending each year.
2. Without reform, these inefficiencies will grow as MA enrollment continues to expand.
3. There are straightforward potential policy solutions that could improve alignment of payment, protect taxpayer resources, and strengthen the sustainability of veterans' health care.

How MA and the VHA Payment Leads to Duplication and Wasteful Spending

Veterans who are eligible for care from the VHA and who are also Medicare eligible due to age, disability, or having end-stage renal disease, may be dually covered for their healthcare needs by two different insurance and delivery systems. Depending on where they receive care, and whether they are enrolled in Traditional Medicare or Medicare Advantage, may lead to very different spending by the federal government.

Under the current system, when a veteran is only eligible for the VHA and not enrolled in Medicare, the VHA is the primary payer for all of their services. The VHA receives an appropriation from Congress that is used to cover the care needs of services that are provided to Veterans. Things become more complicated when Veterans are dually eligible for VHA and Medicare. When a Veteran is enrolled in both the VHA and traditional Medicare, only one program pays for a given service, which prevents duplicate federal payments for the same care. It is an entirely different scenario when a veteran is dually enrolled in the VHA and a Medicare Advantage plan.

In Medicare Advantage, private plans are paid by the Centers for Medicare and Medicaid Services (CMS) on a per capita rate each year to cover all required member needs. These capitation rates are based on historical traditional Medicare spending in a county, and are risk-adjusted based on the measured chronic conditions of beneficiaries in these plans.[3] Because capitation rates reflect the total cost of Medicare-covered services a beneficiary might receive in a year, they implicitly assume that the MA plan will cover all of those services.

[3] https://www.commonwealthfund.org/publications/explainer/2024/mar/how-government-updates-payment-rates-medicare-advantage-plans

Table 1: Who Pays for Services Based on Enrollment

Setting	VHA Alone	VHA / TM	VHA / MA
Care at a VHA Provider	VA pays	VA pays	VA pays
Care from a Community Care Provider	VA pays	VA or Medicare pays	VA or MA Plan pays
Prescriptions	VA pays	VA pays	VA or MA Plan pays
VA HCBS and Wraparound Services	VA pays	VA pays	VA pays
Medicare Suplemental Benefits	N/A	N/A	MA Plan Pays
Capitated Payments	N/A	N/A	Medicare Pays MA Plan

In the VA context, this is not the case. When a dual VA/MA beneficiary receives care from a VHA provider or through its community care program, the VHA pays. When they receive prescription medications through the VHA pharmacy benefit, the VHA also pays. The key difference is that the MA plans are still paid a full capitation rate under the assumption that they are providing services for beneficiaries, that, in all likelihood, they are not. The MA plan may pay for additional supplemental benefits that are not covered by the VHA, however for the most part, the VHA covers most healthcare, and yet the MA plan is also paid, leading to duplication. In the Table above, the higher the VHA payments and the plan capitation payments (highlighted in yellow), the greater the duplication.

What is the Current and Projected Impact of These Payment Inefficiencies

The duplication of payments by the VHA and to MA plans in their capitation payments is already of significant concern and has worsened as the MA program has grown.

In a study we published last year, we found that from 2011 to 2020, the number of MA / VHA dually enrolled beneficiaries who used VA services increased from 634,000 in 2011 to 1,033,000 in 2020.[4] These beneficiaries and their care accounted for $78 billion in VHA spending over the time period. In newer work, we find that From 2021 to 2023 there was an additional $59.4 billion in additional spending, with $22.7 billion in 2023 alone, representing nearly one-fifth of the VHA congressional appropriation in that year.

There are three factors that are potentially contributing to increasing VHA spending for MA enrollees . First, the overall number of VHA beneficiaries enrolling in MA is increasing substantially. Second, among those who have dual coverage, a greater share are becoming reliant on VHA services, which increases the duplicate payments if plans are not being charged. Third, this overall growth in spending is also being influenced by the growth of Community Care, which is more expensive than VHA provided care. Given this increased enrollment, we projected forward what would happen over the next ten years if this continues.[5] Under modest assumptions about this continuing growth rate and accounting for inflation, **we estimate from 2026 to 2035, a total of $357 billion in VHA will be paid by the VHA for beneficiaries that MA plans are also being paid to cover for the same services.** (Table 2).

[4] https://jamanetwork.com/journals/jama/fullarticle/2824364

[5] https://cahpr.sph.brown.edu/sites/default/files/documents/Public%20Comments/Response%20to%20Request%20to%20Estimate%20Spending%20Impact%20of%20Proposed%20VA_MA%20Legislation%20(1).pdf

Table: Spending projects based on historical growth rates

Year	Estimate of VHA/MA Beneficiaries Who Use Care	Estimate of Total Spend per Beneficiary	Total VHA Spend
2026	1,553,466	$20,159.13	$31,316,521,835.03
2027	1,535,103	$21,066.29	$32,338,920,553.95
2028	1,515,769	$22,014.28	$33,368,561,640.32
2029	1,494,608	$23,004.92	$34,383,340,116.93
2030	1,470,541	$24,040.14	$35,352,002,620.89
2031	1,444,775	$25,121.95	$36,295,552,750.28
2032	1,418,010	$26,252.44	$37,226,226,776.05
2033	1,391,426	$27,433.79	$38,172,078,259.70
2034	1,365,621	$28,668.32	$39,150,050,796.20
2035	1,340,902	$29,958.39	$40,171,256,230.06
Total			$357,774,511,579.40

The substantial growth in VHA / MA dual enrollment makes sense from the perspective of an MA plan. Plans are currently able to grow their member share of these dually enrolled Veterans and get paid substantial amounts for them in the capitation payments, while largely only being on the hook for paying for their own supplemental benefits. While these supplemental benefits may be attractive for many Veterans, there is currently limited evidence on their long term usefulness and value in addressing member health needs. This has not stopped MA plans from rapidly trying to grow their enrollment among Veterans, largely though the marketing of Veterans affinity plans, which may worsen these trends by pushing growth even higher.[6]

How Can These Challenges Be Addressed

Neither CMS nor the VA can fully address this issue without congressional action.[7] 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.[8] Further, the VA is statutorily prohibited from seeking payment from Medicare for VA-authorized services provided to veterans with Medicare coverage.[9] Put differently, the VA's ability to recover payment for VHA-covered services from a veteran's third-party source of coverage excludes Medicare.[10]

There are two potential strategies that could be used to address this issue. First, payments to MA plans could be reduced for all Veterans who are enrolled in the plan on a member-by-member basis. Plans could still be paid a rebate for covering supplemental benefit use, but would not receive full Part A/B premium-based capitation payments for their dually enrolled veterans. This would be analogous to the

[6] https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00302
[7] https://cahpr.sph.brown.edu/sites/default/files/documents/CAHPR_VHA-MA%20PolicyBrief.pdf
[8] 42 U.S.C. §§1395f(c), 1395n(d).
[9] 42 U.S.C. § 1395f(c) and 38 U.S.C. §1729(i)(1)(B)(i)
[10] 38 U.S.C. § 1729

current carve-out of hospice services in the MA program. However, this option would not permit VHA to recoup payment from MA plans for services provided to dually enrolled veterans. While this open would save taxpayers, it would do nothing to provide support to the VHA without additional appropriate by congress.

A second and potentially more comprehensive solution would be to authorize the VA to collect reimbursements for care provided to MA enrollees from plans, similar to the VHA's ability to collect such reimbursements from other private providers. It is my understanding that the Guarantee Utilization of All Reimbursements for Delivery of Veterans' Health Care Act or GUARD VA Act would make the necessary changes to the statute to allow for this recoupment of costs to occur.[11] While it is unlikely that the VA will be able to receive reimbursement for every instance of care provided to VHA / MA dual beneficiaries, given the enormous growth in spending in this space, such a law could potentially result in substantial savings for the VHA and federal spending overall by shifting the costs from the VHA to MA plans that are currently profiting from this arrangement.

Additional Considerations for the GUARD VA Act

The GUARD VA Act could address much of the current problem by tackling overpayments bringing reimbursements for VHA / MA dual beneficiaries more inline with the rest of the U.S. healthcare system. Still, there are three important considerations that are important to keep in mind.

First, by requiring MA plans to cover VHA costs, the Act would increase plan spending on veterans. This could make caring for veterans less profitable and raise concerns about cuts to benefits. However, several factors suggest these risks are limited. For one, prior research shows that payment changes in MA tends to have only modest effects on benefits.[12][13] Further, the MA market is competitive and if a plan reduces too many of its benefits it runs the risk of losing members to competitors which would ultimately be more costly to plans.[14] Aside from specific veterans affinity plans, veterans make up a relatively small percentage of most plans' overall enrollment, reducing the likelihood of major changes in benefit design.

Second, for plans where veterans make up a large share of their members, any changes that increase their spending could affect bidding behavior. If a plan anticipates higher costs, they may increase their bids, which could reduce rebate payments and increase Medicare spending. While this may in part offset some of the savings from this legislation, there is reason to believe that the impact may be muted. Most MA plans currently bid under or near the benchmark that is set based on historical traditional Medicare spending. In an analysis of MA bid data, we find that this is even true among plans with high VHA enrollment. Because these benchmarks serve as an upper limit on Medicare spending, any increases in bids are likely to be constrained and smaller than the savings generated through allowing reimbursement.

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[11] https://www.congress.gov/bill/119th-congress/house-bill/4077/text?s=2&r=1&q=%7B%22search%22%3A%22HR4077%22%7D

[12] https://hcp.hms.harvard.edu/sites/default/files/assets/users/Working%20Papers/Pricing_Pass-through_MA_1-12-23.pdf, https://www.aeaweb.org/articles?id=10.1257/aer.20151362, https://www.sciencedirect.com/science/article/pii/S0047272716300767?casa_token=u0zM69X2c3UAAAAA:uTIir-6_3Bgi6bgOOMqvYfi_2SIogq4Dvt1t76VddW3lDukIpvk3VxUZap3DWVsq3BkuCQIWEA

[13] https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01031

[14] https://www.aeaweb.org/conference/2025/program/paper/sKb9ikK8

Third, it is important to note that CMS already applies a VA and Department of Defense (DoD) adjustment factor in the calculation of MA plan benchmarks. Currently, CMS calculates an adjustment factor based by comparing the Traditional Medicare spending among beneficiaries who are eligible for VA/DoD healthcare compared to beneficiaries who are not. If CMS finds that Traditional Medicare spending in a county for VA/DoD beneficiaries is lower than average spending, then the adjustment factor leads to higher benchmarks in that county, and the reverse if the VA/DoD beneficiaries have higher spending than the average beneficiary. The reason CMS does this is because if Medicare / VHA beneficiaries are receiving most of their care from the VA, their spending is not being properly accounted for when setting payment rates for MA beneficiaries. In most cases, the adjustment factor leads to higher MA benchmarks, as VHA beneficiaries have lower Traditional Medicare spending because they rely on the VHA for some or most of their care. The existence of this policy does not negate the need for legislation such as the GUARD VA Act and may in fact make the situation worse. Under this current policy, if in certain counties, veterans are using VHA services at higher rates, this will lead to higher payments to MA plans. If in those same counties, VHA / MA dual beneficiaries are also reliant on the VHA for a greater share of their services, which is a reasonable assumption, it will make the duplicate payment problem worse, particularly for plans that have very high enrollment among veterans. Given the inefficiencies with this current policy, it may be better to directly include VHA spending into the calculation of benchmarks if the VHA will have the ability to bill MA plans as any other provider would.

In Conclusion

In summary, MA plans receive full capitation payments for veterans even when the VHA provides much of their care, leading to large and growing duplicate federal spending. Without legislative action, this problem will worsen over time. The VA Guard Act could make an important difference in reducing duplicate spending, and creating a more sensible care and financing system for our nation’s veterans.