Testimony of Brian J. Miller, M.D., M.B.A., M.P.H.

Associate Professor of Medicine and Business (Courtesy)
Johns Hopkins University

Nonresident Fellow
American Enterprise Institute

Before the

House Committee on Veterans' Affairs

On

"Legislative Hearing on: Discussion Draft: The Sharri Briley and Eric Edmundson Veterans Benefits Expansion Act of 2025, and H.R. 4077, GUARD Veterans' Health Care Act."

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Chairman Bost, Ranking Member Takano, and distinguished members of the Committee:

My name is Brian Miller, and I practice hospital medicine at the Johns Hopkins Hospital. As an academic health policy analyst, I serve as an Associate Professor of Medicine and Business (Courtesy) at the Johns Hopkins University School of Medicine and as a Nonresident Fellow at the American Enterprise Institute. My research focuses on how we can build a more competitive and vibrant health sector to make healthcare more efficient, flexible, and personalized for patients. This perspective is based upon my prior regulatory experience at four federal regulatory agencies. Through my current role as a faculty member, I regularly engage with regulators, policymakers, and businesses in search of solutions to help create a better healthcare system for all. Today I am here in my personal capacity, and the views expressed are my own and do not necessarily reflect those of the Johns Hopkins University or the Johns Hopkins Health System, the American Enterprise Institute, the North Carolina State Health Plan, or the Medicare Payment Advisory Commission (MedPAC).

The veterans population is changing. In FY2000, the overall veteran population was 26.75 million veterans with 4.94 million enrolled in the Veterans Health Administration (VHA) and 3.46 million unique veterans receiving care. In FY2024 these numbers shrank to 17.91 million veterans, grew to 9.05 million enrollees, and expanded to 6.38 million veterans receiving care.[1] Today's veteran population is older, more rural, has a greater burden of disabilities, and a comparably higher tobacco use rate and disease burden compared to non-veteran populations.[2] The VHA has simultaneously undergone a transformation, with 18 Veterans Integrated Service Networks (VISNs)[3] representing 170 Veterans Affairs (VA) medical centers and 1,193 outpatient clinics.[4] With a national mandate to serve every veteran, access has remained a geographic and operational challenge for a closed, vertically integrated healthcare financing and delivery system. The passage of the 2014 Veterans Access, Choice, and Accountability Act (CHOICE)[5] and 2018 VA Maintaining Systems and Strengthening Integrated Outside Networks (MISSION) Act[6] marked a recognition of the vast geographic spread of veterans across the US, demarcating a transition from a purely public to a public-private

[1] Panangala, Sidath Viranga, and Jared S. Sussman. "Introduction to Veterans Health Care." Congress.gov, June 28, 2023. https://www.congress.gov/crs-product/IF10555
[2] "Overview of VHA Patient, Veteran, and Non-Veteran Populations and Characteristics." Agency for Healthcare Research and Quality (US), 2020. https://www.ncbi.nlm.nih.gov/books/NBK578553/
[3] Veterans Health Administration. "Veterans Integrated Services Networks (VISNs) - Veterans Health Administration." www.va.gov, n.d. https://www.va.gov/HEALTH/visns.asp
[4] Veterans Health Administration. "About VHA." Va.gov, November 8, 2023. https://www.va.gov/health/aboutvha.asp
[5] Congress.gov. "H.R.3230 - 113th Congress (2013-2014): Veterans Access, Choice, and Accountability Act of 2014." Congress.gov, 2013. https://www.congress.gov/bill/113th-congress/house-bill/3230
[6] Congress.gov. "S.2372 - 115th Congress (2017-2018): VA MISSION Act of 2018." Congress.gov, 2017. https://www.congress.gov/bill/115th-congress/senate-bill/2372

delivery system wherein veterans who cannot access VHA-delivered services in a timely fashion can access equivalent care in the broader community care market.

In 2025, if a veteran has multiple sources of health benefits, veterans' health benefits can end up interacting with other publicly funded programs, such as Medicaid,[7,8] Medicare, and privately funded health benefits (employer-sponsored coverage, employer retiree health benefits). Unfortunately veterans' health benefits coordination remains an underdeveloped policy and operational arena.

As a first principle, veterans should be able to fully utilize all earned benefits. It is the role of policy to facilitate this, and as a matter of policy our country has not yet fully executed on this promise for veterans' health benefits. In my testimony today, I will focus on the challenge and opportunity of health benefits coordination for America's veterans, in addition to enumerating why H.R. 4077 does not represent an adequate or appropriate solution:

1. The Challenge of Veterans – Medicare health benefits coordination
2. Lessons from TRICARE and Employer-sponsored Insurance
3. Opportunities to Improve Benefits Coordination

1. The Challenge of Veterans – Medicare health benefits coordination

Both the Veterans' Health Administration and Medicare programs have significant challenges with regards to a wide scope of medical needs in their respective populations, with a range of beneficiaries needing distinct care delivery specialization and customization. The Medicare program has made significant progress in this arena, adapting to reflect variation of disease combinatorics in the Medicare population reflecting >1 million disease combinations.[9,10] Policymakers responded with the creation of Special Needs Plans (SNP) as part of the 2003 Medicare Modernization Act, with the SNP program undergoing reauthorization eight times and finally achieving statutory stability as part of the 2018 Bipartisan Budget Act. SNPs fall into three categories, including institutionalized beneficiaries (I-SNPs) who have distinct needs from the community-dwelling Medicare population, beneficiaries enrolled in Medicare and Medicaid or so-called dual eligibles (D-SNPs), and those with severe or disabling chronic conditions (C-SNPs). Policy experts including Sachin Jain, M.D., a physician with experience in both governmental and private health benefits operations, have even suggested specialized plans for homeless Medicare beneficiaries,[11] who likely have unique clinical and health-related social needs. In this sense, the Medicare program has continued to evolve in order to meet the needs of a wide range of beneficiaries through offering fee for service (FFS) Medicare, conventional Medicare Advantage (MA) plans, and SNPs.

The veteran population faces many similar challenges, yet more policy attention is needed. Veterans have a high prevalence of many chronic health conditions,[12] higher rates of some conditions,[13] and variance across age groups in disease combinations.[14] Yet, similar benefits customization and coordination has yet to be undertaken to better support veterans in achieving whole health and maintain independence. Veterans' health benefits eligibility is simple while

[7] Cervantes, Sammy, Jennifer Tolbert, Alice Burns, and Robin Rudowitz. "5 Key Facts about Medicaid and Veterans | KFF." KFF, June 30, 2025. https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-veterans/

[8] Yoon, Jean, Megan E. Vanneman, Sharon K. Dally, Amal N. Trivedi, and Ciaran S. Phibbs. "Use of Veterans Affairs and Medicaid Services for Dually Enrolled Veterans." Health Services Research 53, no. 3 (June 13, 2017): 1539–61. https://doi.org/10.1111/1475-6773.12727

[9] Sorace, James, Hui–Hsing Wong, Chris Worrall, Jeffrey Kelman, Shahin Saneinejad, and Thomas MaCurdy. "The Complexity of Disease Combinations in the Medicare Population." Population Health Management 14, no. 4 (August 2011): 161–66. https://doi.org/10.1089/pop.2010.0044

[10] Sorace, James, Michael Millman, Mallory Bounds, Michael Collier, Hui-Hsing Wong, Chris Worrall, Jeffrey Kelman, and Thomas MaCurdy. "Temporal Variation in Patterns of Comorbidities in the Medicare Population." Population Health Management 16, no. 2 (April 2013): 120–24. https://doi.org/10.1089/pop.2012.0045

[11] Jain, Sachin H., John Baackes, and James J. O'Connell. "Homeless Special Needs Plans for People Experiencing Homelessness." JAMA, February 13, 2020. https://doi.org/10.1001/jama.2019.22376

[12] Eibner, Christine, Heather Krull, Kristine M. Brown, Matthew Cefalu, Andrew W. Mulcahy, Michael S. Pollard, Kanaka Shetty, et al. "Current and Projected Characteristics and Unique Health Care Needs of the Patient Population Served by the Department of Veterans Affairs." www.rand.org, 2016. https://www.rand.org/pubs/periodicals/health-quarterly/issues/v5/n4/13.html

[13] Betancourt, José, Diane Dolezel, Ramalingam Shanmugam, Gerardo J Pacheco, Paula Stigler Granados, and Lawrence V Fulton. "The Health Status of the US Veterans: A Longitudinal Analysis of Surveillance Data prior to and during the COVID-19 Pandemic." Healthcare 11, no. 14 (July 17, 2023): 2049–49. https://doi.org/10.3390/healthcare11142049

[14] Steinman, Michael A., Sei J. Lee, W. John Boscardin, Yinghui Miao, Kathy Z. Fung, Kelly L. Moore, and Janice B. Schwartz. "Patterns of Multimorbidity in Elderly Veterans." Journal of the American Geriatrics Society 60, no. 10 (October 2012): 1872–80. https://doi.org/10.1111/j.1532-5415.2012.04158.x

enrollment and subsequent access is more complex.[15] Veterans face 3 basic criteria for eligibility: (1) meet statutory definition of a veteran, (2) meet statutory definition of active duty, and (3) served for a minimum of 24 months of continuous active duty. Enrollment qualification is based upon service-connected disability, income, and other factors (e.g. former POW, Medal of Honor recipient, Purple Heart recipient, etc.) with veterans placed into one of eight priority groups. Cost-sharing for services (if any) is determined via priority groups.[16] Thus, while eligibility is more transparent,[17] the enrollment process is more complex.

Benefits coordination is critical to ensuring that all patients receive integrated, coordinated care. In the Medicare marketplace, benefits coordination has been a long-term, bipartisan policy focus. For example, as part of the 2003 Medicare Modernization Act (MMA), policymakers created employer group waiver plan (EGWP) or group MA marketplace, functionally facilitating a mechanism for employers[18,19] to "buy up" from Medicare A/B benefits and deliver integrated retiree health benefits including affordable and rich Medigap and Part D prescription drug coverage through a customized MA plan. This facilitated retirees in being able to fully access both their earned Medicare and earned worker retiree health benefits, a model that today 5.7 million Americans[20] including millions of union members utilize. Medicare and Medicaid coordination has also been a bipartisan policy focus, as the dual eligibles are a population that is very expensive, with 19% of beneficiaries accounting for 35% of Medicare spending in CY2021,[21] significant impairments in functional status (limitations of 3-6 activities of daily living[22] are 24% of duals v. 6% of non-duals),[23] and complex multi-morbidity. As part of the 2003 MMA, policymakers created D-SNP plans to promote benefits coordination and customization, with the 2010 Patient Protection and Affordable Care Act[24] providing regulatory, policy, and oversight support via the creation of the so-called "Duals Office" or the Centers for Medicare and Medicaid Services' (CMS) Medicare-Medicaid Coordination Office.[25] Finally, policymakers have also worked to coordinate Medicare and earned TRICARE benefits, with the 2001 creation of TRICARE for Life (TFL) model, a Medicare wrap around plan substituting for Medigap coverage, thus allowing military retirees to fully access their Medicare and TRICARE benefits.

In contrast, in the arena of veterans' health affairs, lack of benefits coordination is a matter of policy, to the disadvantage of the veteran. Veterans' health benefits and Medicare do not coordinate or integrate as a matter of policy, with the VA own's web site noting that "*You'll need to choose which benefits to use each time you receive care*."[26] The VA does not directly bill Fee For Service (FFS) Medicare or MA plans, but may bill Medigap plans for services for non-service-connected conditions. This lack of coordination has real impacts, as of the 2023 VHA enrollees an estimated 4.15 million or 50.5% are enrolled in Medicare, with 39% or 3.2 million in FFS Medicare and 0.94 million or 11.4% in MA. Of those enrolled in FFS Medicare an estimated 1.07 million or 13.1% have Medigap

[15] Panangala, Sidath Viranga, and Jared S. Sussman. "Health Care for Veterans: Answers to Frequently Asked Questions." Congress.gov, 2025. https://www.congress.gov/crs-product/R42747#_Toc45808475
[16] U.S. Department of Veterans Affairs. "VA Priority Groups." Veterans Affairs, August 11, 2021. https://www.va.gov/health-care/eligibility/priority-groups/
[17] U.S. Department of Veterans Affairs. "Eligibility for VA Health Care." Veterans Affairs, October 11, 2019. https://www.va.gov/health-care/eligibility/
[18] Skopec, Laura, and Stephen Zuckerman. "Medicare Advantage Employer Group Waiver Plans a Primer," 2024. https://www.urban.org/sites/default/files/2024-01/Medicare%20Advantage%20Employer%20Group%20Waiver%20Plans.pdf
[19] CMS. "Employer Group Plans," 2024. https://www.cms.gov/files/document/slides-employer-group-plans-july-2024.pdf
[20] Ochieng, Nancy, Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman. "Medicare Advantage in 2025: Enrollment Update and Key Trends | KFF." KFF, July 28, 2025. https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/
[21] See Page 30 of "Beneficiaries Dually Eligible for Medicare and Medicaid Data Book." Jointly Produced by the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission Medicaid and CHIP Payment and Access Commission. January 2024. https://www.macpac.gov/wp-content/uploads/2024/01/Jan24_MedPAC_MACPAC_DualsDataBook-508.pdf
[22] Edemekong, Peter F, Deb L Bomgaars, and Shoshana B Levy. "Activities of Daily Living (ADLs)." NCBI. StatPearls Publishing, May 4, 2025. https://www.ncbi.nlm.nih.gov/books/NBK470404/
[23] See Page 36 of ""Beneficiaries Dually Eligible for Medicare and Medicaid Data Book." Jointly Produced by the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission Medicaid and CHIP Payment and Access Commission. January 2024. https://www.macpac.gov/wp-content/uploads/2024/01/Jan24_MedPAC_MACPAC_DualsDataBook-508.pdf
[24] Medicaid.gov. "Program History and Prior Initiatives | Medicaid." Medicaid.gov, 2022. https://www.medicaid.gov/about-us/program-history
[25] Cms.gov. "About the Medicare-Medicaid Coordination Office | CMS," 2024. https://www.cms.gov/medicare/medicaid-coordination/about
[26] Veterans Affairs. "VA Health Care and Other Insurance | Veterans Affairs," July 14, 2025. https://www.va.gov/resources/va-health-care-and-other-insurance/

while 2.3M or 28% have TRICARE.[27,28] Functionally, neither the VHA or Medicare will serve as a secondary coverage when the other program is primary payer.[29]

This has resulted in problems in both formulations of Medicare benefits – FFS Medicare and Medicare Advantage. In FFS Medicare, veterans may be paying out of pocket for both the Part B premium, Medigap coverage, and maybe even standalone Part D coverage instead of being able mix and match their earned veterans' health benefits and earned Medicare benefits. This primarily raises costs for veterans.

In MA, veterans may pay the Part B premium and CMS may pay MA plans for covering veterans who incur little or no Medicare-funded services, while VHA pays for VHA-delivered services. This primarily raises costs for taxpayers. Both outcomes are suboptimal and result from a lack of benefits coordination.

Prior research has delineated both of these policy challenges. VA-Medicare benefits coordination is lacking in the VA's interface with the MA marketplace. A 2012 *JAMA* paper by former VA Undersecretary for Health Kenneth Kizer, M.D., M.P.H.[30] denotes that of dual eligible (for VA and Medicare) veterans, 10% exclusively used the VA, 35% used MA, only 50% used both MA and the VA, and 4% received no services. More recent efforts by researchers from Harvard and Boston University in 2024 updated this work, denoting that CMS paid $1.32 billion to MA plans whose veterans did not use any Medicare services in 2020,[31] representing <0.5% of annual expenditures in the Medicare Advantage program. Further work by some of the same researchers attempted to define MA plans marketing to veterans,[32] labeled by researchers as Veterans Affinity MA plans.

The absence of VA-Medicare benefits coordination is also a longstanding problem on the FFS Medicare side of the table. As far back as 1979, the Government Accountability Office (GAO) issued a report describing duplicate payments for VA and Medicare-eligible veterans in Florida and California.[33] The introduction of VA Community Care has highlighted both CMS' and the VHA's lack of benefits coordination, with a 2023 Department of Health and Human Services (HHS) Office of Inspector General (OIG) report denoting duplicate Medicare FFS payments from CY2017-2021 for 298,527 claims representing $128 million in Part A and B items and services already paid for by VHA.[34] CMS has not fully acted on recommendations for regulatory improvement, and did not establish a long-term data-sharing agreement, an internal process to address duplicate payments made by Medicare for medical services authorized and paid for by the VA, or a variety of other HHS OIG recommendations.

Still other government reports have demonstrated that the lack of VA-Medicare benefits coordination is a very old and persistent problem on both the FFS Medicare and MA sides of the Medicare table. For example, a 1994 GAO report denoted use of VA services by Medicare-eligible veterans, with vets choosing VA for services then not available in Medicare (such as prescription drugs),[35] while a 2016 GAO report noted that the lack of data sharing between VA and CMS likely resulted in inaccurate, lower payments to MA plans due to decreases in the per capita county Medicare

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[27] Taylor, Erin A. "Veteran Access to Multiple Forms of Health Care Coverage: Veterans' Issues in Focus." Rand.org. RAND Corporation, August 19, 2025. https://www.rand.org/pubs/perspectives/PEA1363-15.html

[28] "2023 Survey of Veteran Enrollees' Health and Use of Health Care Contract Number: 36C10X21N0115," December 18, 2023. https://www.va.gov/VHASTRATEGY/SOE2023/2023_Survey_of_Veteran_Enrollees_Health_and_Use_of_Health_Care_Main_Results_Report.pdf

[29] Taylor, Erin A. "Veteran Access to Multiple Forms of Health Care Coverage: Veterans' Issues in Focus." Rand.org. RAND Corporation, August 19, 2025. https://www.rand.org/pubs/perspectives/PEA1363-15.html

[30] Trivedi, Amal N., Regina C. Grebla, Lan Jiang, Jean Yoon, Vincent Mor, and Kenneth W. Kizer. "Duplicate Federal Payments for Dual Enrollees in Medicare Advantage Plans and the Veterans Affairs Health Care System." JAMA 308, no. 1 (July 4, 2012). https://doi.org/10.1001/jama.2012.7115

[31] Ma, Yanlei, Jessica Phelan, Kathleen Yoojin Jeong, Thomas C Tsai, Austin B Frakt, Steven D Pizer, Melissa M Garrido, Allison Dorneo, and José F Figueroa. "Medicare Advantage Plans with High Numbers of Veterans: Enrollment, Utilization, and Potential Wasteful Spending." Health Affairs 43, no. 11 (November 1, 2024): 1508–17. https://doi.org/10.1377/hlthaff.2024.00302

[32] Dorneo, Allison, Yanlei Ma, Melissa M. Garrido, Steven D. Pizer, Paul R. Shafer, Thomas C. Tsai, Austin B. Frakt, and Jose F. Figueroa. "Characteristics and Benefit Design of Veteran Medicare Advantage Affinity Plans." JAMA Health Forum 6, no. 3 (March 28, 2025): e250159. https://doi.org/10.1001/jamahealthforum.2025.0159

[33] Gao.gov. "Duplicate Payments for Medical Services by VA and Medicare Programs," October 22, 1979. https://www.gao.gov/products/hrd-80-10

[34] Grimm, Christi. "Medicare Could Have Saved Up To $128 Million Over 5 Years If CMS Had Implemented Controls To Address Duplicate Payments For Services Provided To Individuals With Medicare and Veterans Health Administration Benefits." Department of Health and Human Services Office of Inspector General 2023. https://oig.hhs.gov/documents/audit/9651/A-09-22-03004-Complete%20Report.pdf

[35] United States General Accounting Office. "Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans." Gao.gov, October 1994. https://www.gao.gov/assets/hehs-95-13.pdf

FFS spending benchmark (spending at the VA would be excluded from the benchmark calculation), lower MA plan bids due to MA plans bidding lower based upon incomplete historical experience (VA spending is not included in their actuarial underwriting), and lower risk scores as VA-provided care related to any diagnoses would be excluded from the risk model and plans would not have access to diagnoses made by VA.[36]

When confronted with this problem, policymakers should stick to first principles: veterans who have earned veterans' health benefits and Medicare benefits should be able to use them together in order to realize their full value. To force veterans to choose between them is unjust and violates our society's social contract to care for those who have served.

The proposed H.R. 4077 GUARD Veterans' Health Care Act does not address the decades-old root causes of today's Veterans health benefits coordination challenges. Instead of promoting benefits coordination between the VA and Medicare, the proposed legislation transfers costs from the VA to the Medicare program for both VA and Medicare-associated health benefits while eliminating key fiscal guardrails, requiring payment by an MA plan if any item of service is covered by the MA plan regardless of whether the VA or Medicare program is actually responsible for incurring the cost. This would transfer billions of dollars of cost annually into the Medicare program without any fiscal boundaries or benefits coordination, worsening further insolvency which the Medicare Trustees expect the Hospital Insurance Trust Fund to breach in 2033.[37]

The proposed H.R. 4077 GUARD Veterans' Health Care Act also requires payment regardless of clinical appropriateness and disregards both VA or MA plan care guidelines.[38] Both the VA and MA plans use utilization review, albeit in different ways. For example, for prescription drugs the VA has a single national formulary[39,40] and aggressively implements step therapy, quantity limits,[41] or designates products as non-formulary.[42] In contrast, MA and standalone prescription drug plans (PDP) are generally more likely to use prior authorization than non-formulary designations. In some circumstances, such as the prescription of controlled substances (opioids, barbiturates, benzodiazepines, sedative-hypnotics, and THC products), prior authorization may serve a valid safety function. In other cases, prior authorization may redirect conversations and care towards more appropriate care choices, such as the American Board of Internal Medicine's Choosing Wisely Criteria. While it is known that in some circumstances that prior authorization can inappropriately impede access to care or drug therapy and there is a great need for process improvement, convenience, and significant patient- and clinician-facing improvements,[43,44] this does not obviate the need for some degree of oversight of federally-financed medical care.

The proposed H.R. 4077 GUARD Veterans' Health Care Act ignores existing policy levers to address duplicative payment in MA, notably the VA/DoD adjuster. In MA, CMS applies a VA/DoD adjuster to benchmark FFS per capita

[36] United States Government Accountability Office. "Medicare Advantage: Action Needed to Ensure Appropriate Payments for Veterans and Nonveterans." Gao.gov, April 2016. https://www.gao.gov/assets/gao-16-137.pdf

[37] "2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds Communication from the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds Transmitting the 2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust funds." 2025. https://www.cms.gov/oact/tr/2025

[38] "…Such organization or sponsor shall, to the extent such item or service is covered under such Medicare Advantage plan or prescription drug plan, reimburse the Secretary for such item or service regardless of any additional documentation, utilization management, or other administrative requirement the plan may impose on the item or service." Doggett, Lloyd. "Text - H.R.4077 - 119th Congress (2025-2026): GUARD Veterans' Health Care Act." Congress.gov, 2025. https://www.congress.gov/bill/119th-congress/house-bill/4077/text

[39] www.pbm.va.gov. "VA National Formulary - Pharmacy Benefits Management Services," n.d. https://www.pbm.va.gov/nationalformulary.asp

[40] "Veterans Affairs (VA) National Formulary Frequently Asked Questions 1) Q: Where Can I Find Detailed Information about the VA National Formulary Management Process?" Accessed November 14, 2025. https://www.pbm.va.gov/PBM/nationalformulary/VANationalFormularyFrequentlyAskedQuestions.pdf

[41] E.g. Viagra prescriptions were historically limited to 4 tablets per month thus significantly impacting veteran well-being, See: Spencer, Samantha H, Katie J Suda, Bridget M Smith, Zhiping Huo, Lauren Bailey, and Kevin T Stroupe. "Erectile Dysfunction Medication Use in Veterans Eligible for Medicare Part D." Journal of Managed Care & Specialty Pharmacy 22, no. 7 (June 27, 2016): 818–24. https://doi.org/10.18553/jmcp.2016.22.7.818

[42] Both topical JAK inhibitors for eczema are non-formulary, See: Va.gov. "VA Formulary Advisor," 2025. https://www.va.gov/formularyadvisor/drugs/4040838-RUXOLITINIB-CREAM-TOP and Va.gov. "VA Formulary Advisor," 2025. https://www.va.gov/formularyadvisor/drugs/4044150-DELGOCITINIB-CREAM-TOP

[43] Miller, Brian J. "'Hearing on Medicare Advantage: Past Lessons, Present Insights, Future Opportunities.,'" July 22, 2025. https://waysandmeans.house.gov/wp-content/uploads/2025/07/Miller-Testimony.pdf

[44] Miller, Brian J. "'Reducing Waste, Fraud and Abuse through Innovation: How AI & Data Can Improve Government Efficiency.,'" April 9, 2025. https://www.jec.senate.gov/public/_cache/files/61ff3480-92d4-4798-abbb-35fa2360a278/dr.-brian-j.-miller-testimony.pdf

costs for beneficiaries dually enrolled in VA and/or the DoD health programs,[45] a process last updated in 2022.[46] Instead of statutory change as proposed in H.R. 4077 allowing the VA to bill Medicare for service-connected and non-service-connected care, policymakers should improve data-sharing. Improved and permanent data sharing (beyond any time-limited agreement) would improve VA – Medicare benefits coordination in both the FFS Medicare and MA programs. In FFS Medicare, CMS could implement pre-payment claims editing to ensure that duplicative payment is not made and utilize complete and accurate data as to Veterans' health care utilization across both VA and Medicare to construct the FFS benchmarks underlying MA. In MA, plan would be provided with diagnostic coding occurring in the VA, thus discouraging diagnosis coding "harvesting" behavior that has become a target of significant regulatory and Congressional scrutiny. Subsequent to improved data sharing, Congressional oversight can ensure that CMS updates the VA/DoD adjuster as appropriate and thus completely address any overpayments using existing operational infrastructure.

Instead of the proposed H.R. 4077 GUARD Veterans' Health Care Act, policymakers should focus on data-sharing and benefits coordination. On the care delivery side of the VA, doctors and hospitals participating in Community Care have begun to experience early results from initial data sharing improvements. Regardless, more work must be undertaken to support the prior VA-Department of Defense data partnership through the Joint Health Information Exchange initiated in 2020. The Veteran Interoperability Pledge is in the first phase of 3 steps – (1) accurately identify vets, (2) connect vets, (3) coordinate care;[47] a journey with many long-term, real-world operational challenges highlighted at recent hearing[48] and in OIG reports.[49]

In contrast, the VA has not undertaken the same degree of effort to improve data sharing for its health financing activities such as benefits coordination. MA plans lack access to VA diagnosis coding and utilization, and the VA and MA plans lack a durable, meaningful data interface, creating operational challenges to appropriate payment, with the GAO noting the need for this data coordination as far back as 2016 (a recommendation that the VA has not yet fully executed on resulting in a persistent data feed issue).

Policy should neither favor the VA nor the Medicare program; rather, it should be built around the veteran to ensure that they can access the full potential of their earned benefits. Thus, VA-Medicare benefits coordination must be addressed for the VA and the entire Medicare program, inclusive of both FFS Medicare and MA. To address either without addressing the other would prevent one group of veterans from fully accessing their earned benefits from the Veterans Health Administration and the Medicare program. Furthermore, benefits coordination across Medicare necessitates that the VA and CMS undertake the work to figure out which health costs are the responsibility of the VA due to service-connected disability v. Medicare-funded health benefits. Finally, policymakers will need to undertake subsequent work to address coordination of benefits for the VA and other programs such as Medicaid, just as they have for the Medicare program's interface with Medicaid and other health benefit programs.

2. Lessons from TRICARE and Employer-Sponsored Insurance

Two other insurance markets that interface with the Medicare program – TRICARE military health benefits and Employer-Sponsored Insurance (ESI) – provide examples of how policymakers can improve Veterans-Medicare benefits coordination.

[45] See page 39, "NOTE TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part c and Part D Payment Policies," January 10, 2025. https://www.cms.gov/files/document/2026-advance-notice.pdf

[46] See B6 starting on page 27, "NOTE TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2022 for Medicare Advantage (MA) Capitation Rates and Part c and Part D Payment Policies - Part II," October 30, 2020. https://www.cms.gov/files/document/2022-advance-notice-part-ii.pdf

[47] Nebeker, Jonathan. "Closing the Data Gap: Improving Interoperability Between VA and Community Providers." March 24, 2025. https://www.congress.gov/119/meeting/house/118027/witnesses/HHRG-119-VR11-Wstate-NebekerMDJ-20250324.pdf

[48] Congress.gov. "Closing the Data Gap: Improving Interoperability Between VA and Community Providers," March 24, 2025. https://www.congress.gov/event/119th-congress/house-event/118027

[49] "Facilities Faced Challenges Retrieving Medical Records from Community Providers and Importing Them into Veterans' Electronic Health Records," August 7, 2025. https://www.vaoig.gov/sites/default/files/reports/2025-08/vaoig-24-02154-154_final.pdf

TRICARE is a successful health benefits program benefit jointly administered by the government and private contractors with a long history of continued legislative improvements,[50] including the creation of a wraparound plan to allow military retirees to utilize their TRICARE benefits in conjunction with Medicare.

In general, retirees need a holistic health benefits package. Traditional Medicare provides Part A (hospital/skilled nursing facility care) and Part B (physician care) benefits. Beneficiaries must purchase separately supplemental coverage to obtain an maximum out of pocket (MOOP) cap on annual expenses in addition to standalone Part D prescription drug coverage. Part A coverage has no premium, while the Part B premium is income-adjusted. In order to acquire supplemental coverage and prescription drug coverage, retirees can:

1. Purchase a Medigap plan and a standalone Part D prescription drug plan
2. Purchase an MA plan (typically includes functionally both Medigap/Medicare supplemental and Part D coverage as above)

Medicare beneficiaries who are TRICARE-eligible have a third option: to utilize TRICARE for Life as a supplemental plan in place of Medigap (see Figure 1) and utilize TRICARE pharmacy benefits as creditable prescription drug coverage (TRICARE has a Department of War P&T Committee).[51] The 2001 National Defense Authorization Act (NDAA)[52,53] created TRICARE for Life (TFL).[54] Executed through both rulemaking[55,56] and programmatic infrastructure, TFL now covers 2.15 million beneficiaries.[57] TFL serves as a Medigap plan[58,59] and secondary payer for beneficiaries with Medicare A/B benefits who are TRICARE eligible.[60] Features include automatic payment crossover – Medicare pays, then forwards the claim to TRICARE for processing. Since 1995, VA facilities are in-network providers for TRICARE.[61] Unfortunately, TRICARE has no MA option and does not interface with MA and requires the beneficiary to manually file a claim. This is likely a product of timing: TFL was created in 2001 while the 2003 MMA created the modern MA program.

[50] "Evaluation of the TRICARE Program: Fiscal Year 2024 Report," n.d. https://www.health.mil/Reference-Center/Reports/2024/09/23/Annual-Evaluation-of-the-TRICARE-Program-FY24
[51] Military Health System. "DOD Pharmacy & Therapeutics Committee," November 5, 2025. https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Pharmacy-Operations/DOD-PT-Committee
[52] Subtitles B, C "NATIONAL DEFENSE AUTHORIZATION, FISCAL YEAR 2001," October 30, 2000. https://www.congress.gov/106/plaws/publ398/PLAW-106publ398.pdf
[53] DVIDS. "TRICARE for Life Celebrates First Anniversary," July 4, 2025. https://www.dvidshub.net/news/528593/tricare-life-celebrates-first-anniversary
[54] Philpott, Tom. "Tricare for Life | Air & Space Forces Magazine." Air & Space Forces Magazine, December 1, 2001. https://www.airandspaceforces.com/article/1200tricare/
[55] Federal Register. "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)/TRICARE; Partial Implementation of Pharmacy Benefits Program; Implementation of National Defense Authorization Act Medical Benefits for Fiscal Year 2001," February 9, 2001. https://www.federalregister.gov/documents/2001/02/09/01-3240/civilian-health-and-medical-program-of-the-uniformed-services-champustricare-partial-implementation
[56] Department of Defense. "TRICARE; Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Eligibility and Payment Procedures for CHAMPUS Beneficiaries Age 65 and Over." Federal Register 66, no. 150, August 3, 2001: 40601–40636. https://www.govinfo.gov/content/pkg/FR-2001-08-03/pdf/01-19184.pdf
[57] See page 15 of "Evaluation of the TRICARE Program: Fiscal Year 2024 Report," n.d. https://www.health.mil/Reference-Center/Reports/2024/09/23/Annual-Evaluation-of-the-TRICARE-Program-FY24
[58] tricare.mil. "TRICARE for Life Cost Matrix | TRICARE," n.d. https://tricare.mil/Publications/Costs/tricare_for_life_costs
[59] Tricare.mil. "TRICARE for Life Handbook | TRICARE," 2025. https://tricare.mil/Publications/Handbooks/tricare_for_life
[60] tricare.mil. "TRICARE for Life | TRICARE," n.d. https://tricare.mil/tfl
[61] www.va.gov. "VA & TRICARE Information - VA/DoD Health Affairs," n.d. https://www.va.gov/VADODHEALTH/TRICARE.asp

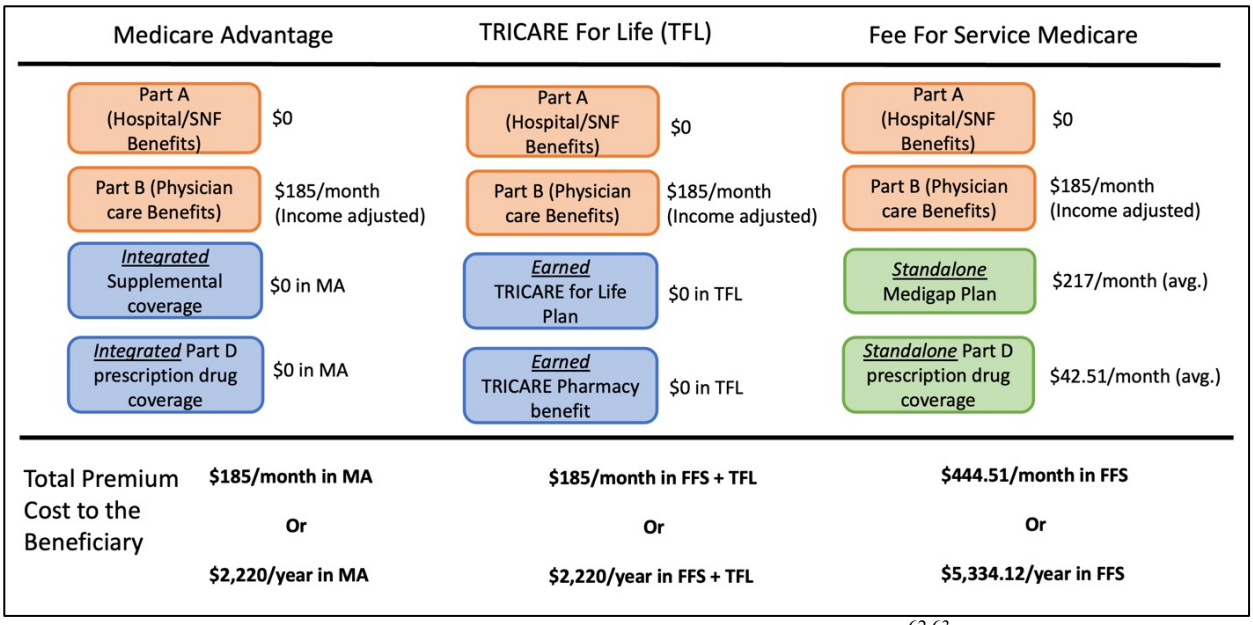

Figure 1: TRICARE Interface with the Medicare benefit[62,63]

The ESI market – while a market subject to much fiscal consternation for the cost of current retiree benefits – has promoted policy innovation in retiree health benefits. For years, employer retiree health benefit plans suffered under the strain of rising costs.[64] In 1988 an estimated 66% of employers offered health benefits[65] a number that decreased by the year 2000 to 37% of large employers offering retired health benefits[66] – now this number stands at 21% of large employers. As has been the case for decades, public employers are more likely than for-profit employers to offer retiree health benefits (63 v. 10%), while large firms with unions were more likely to offer than not (36 v. 16%).[67] In this setting, employers mirrored broader changes in health insurance markets, shifting from indemnity to fee for service to managed care model to create a population-based budgetary framework to manage costs.

Many employers have shifted to managed care as a model for retiree health benefits, as it sets a clear population-based budget for expenditures for the employer.[68] Today's managed care models also decreases health retiree benefit administrative burdens and associated administrative costs for employers, as the employer contracts with a plan administrator and designs benefits in tandem – the employer no longer has to manage benefits directly. From a fiscal responsibility standpoint, MA allows employers to "buy above" the standard Medicare A/B benefits funded by taxpayers and the federal government in a managed care form. Through an Employer Group Waiver Plan (EGWP) or a group MA plan, employers can purchase a unified benefits package that bundles the FFS features of Medigap and Part D with additional supplemental coverage such as vision, dental, and hearing delivered as a customized managed care plan for the retiree group. In exchange, beneficiaries accept a provider network and certain utilization management requirements that are not part of traditional FFS Medicare.

[62] KFF. "Weighted Average Monthly Premium for Medicare Part D Stand-Alone Prescription Drug Plans | KFF State Health Facts," August 9, 2025. https://www.kff.org/medicare/state-indicator/average-premium-for-pdps/?currentTimeframe=0
[63] Druckman, Jennifer, and Ledia Tabor. "Preliminary Work on Medigap," March 6, 2025. https://www.medpac.gov/wp-content/uploads/2024/08/Medigap-MedPAC-03.25sec.pdf
[64] Schmidt, Robert, and Eric Walters. "2025 Milliman Retiree Health Cost Index." Milliman.com, September 2, 2025. https://www.milliman.com/en/insight/retiree-health-cost-index-2025
[65] Neuman, Tricia, and Anthony Damico. "Retiree Health Benefits: Going, Going, Nearly Gone? | KFF." KFF, April 12, 2024. https://www.kff.org/medicare/retiree-health-benefits-going-going-nearly-gone/
[66] Levitt, Larry, Erin Holve, and Jain Wang. "Employer Health Benefits." KFF, 2000. https://www.kff.org/wp-content/uploads/2013/04/7002.pdf
[67] KFF. "2023 Employer Health Benefits Survey | KFF," October 18, 2023. https://www.kff.org/health-costs/2023-employer-health-benefits-survey/#9862c2c9-b1df-4fbe-9329-e222d483d571
[68] "The Value of Medicare Advantage Employer Group Waiver Plans in the Public Sector: An Introduction." National Institute for Public Employee Health Care Policy, May 9, 2024. https://healthcarepolicy-institute.org/Documents/The%20Value%20of%20Medicare%20Advantage%20Employer%20Group%20Waiver%20Plans%20in%20the%20Public%20Sector_Final.pdf

For the retiree, the EGWP is often richer in terms of benefits and looser in network controls compared to conventional MA plans albeit EGWPs are more restrictive than the any-willing-provider network of FFS Medicare. In this sense, managed care lets the employer transform an uncapped retiree health benefits into a more defined contribution with richer benefits and decreased administrative management headaches. A real world example is the North Carolina State Health Plan[69,70] on whose Board of Trustees I serve, which has ~86% of Medicare retirees in its EGWP product and 14% in its Medigap product.

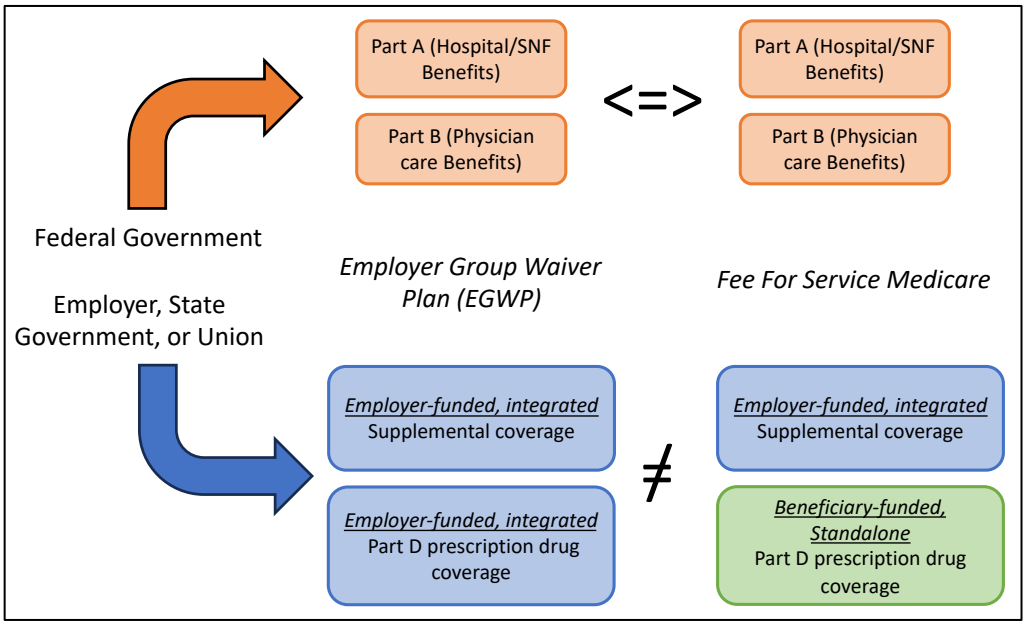

Figure 2: Employer Interface with the Medicare benefit

In contrast to EGWP options, Medigap retiree coverage serves as wraparound plan for Medicare A/B benefits, and lacks networks and utilization review thus exposing employers to higher financial liability without budgetary controls or population-based payment (i.e. capitation). Unsurprisingly, in a setting of real world tradeoffs with a lightly managed retiree health benefits package offer far greater value for the retiree and a more well-defined financial contribution from employers, group MA enrollment has grown from 1.8 million in 2010 to 5.7 million in 2024, including a wide range of unions, state/local governments in addition to large private employers.[71] Half of large employers offering retiree health benefits only offer an EGWP while the other half offer both an EGWP option and what is functionally a Medigap plan.[72]

EGWP payment facilitates a clear delineation between Medicare-funded benefits and employer-funded retiree benefits. With the most recent CMS enabling rule dating back to 2017 and most recently updated for 2026 to modernize the determination of plan bids, the EGWP market offers fiscal and benefit design stability for retirees, employers, and taxpayers. EGWPs are paid based upon the "bid to benchmark ratio" for their MA county quartile of conventional FFS Medicare spending as utilized to determine the conventional MA plan benchmark quartile (ranging from 95-115% of FFS spending). For FY2026 this bid to benchmark ratio averaged 77-78%[73] with separate preferred

[69] North Carolina State Health Plan. "State Health Plan Board of Trustees Meeting," August 15, 2025. https://www.shpnc.gov/documents/board-trustees/board-trustees-presentation-8152025/download?attachment

[70] Briner, Brad, Brian J. Miller, Thomas Friedman, and Emma Turner. "Solving the Challenges of Employee Health Benefits: The North Carolina State Health Plan Story." Forefront Group, October 23, 2025. https://doi.org/10.1377/forefront.20251021.733866

[71] Freed, Meredith, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman. "Medicare Advantage in 2024: Enrollment Update and Key Trends | KFF." KFF, August 8, 2024. https://www.kff.org/medicare/medicare-advantage-in-2024-enrollment-update-and-key-trends/

[72] Freed, Meredith, Tricia Neuman, Matthew Rae, and Jeannie Fuglesten Biniek. "Medicare Advantage Has Become More Popular among the Shrinking Share of Employers That Offer Retiree Health Benefits | KFF." KFF, November 18, 2024. https://www.kff.org/medicare/medicare-advantage-has-become-more-popular-among-the-shrinking-share-of-employers-that-offer-retiree-health-benefits/

[73] See page 50 of Seshamani, Meena, and Jennifer Wuggazer Lazio. "NOTE TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part c and Part D Payment Policies," January 10, 2025. https://www.cms.gov/files/document/2026-advance-notice.pdf

provider organization (PPO) and health maintenance organization (HMO) calculations, a number lower than that of conventional MA plans whose bids average 83% of the benchmark. This suggests that the EGWP marketplace is the best of all worlds: a good deal for the employer, retiree and the federal government. EGWP bid to benchmark ratios are increased for star ratings from contracts, resulting in higher payments for quality.[74] STARS is computed at the contract, not plan product level, so the STAR rating likely includes EGWP and conventional MA benes, an opportunity for policy improvement.

EGWPs are popular in states with large numbers of public sector and union retirees. Notably, Michigan has the highest penetration as a share of Medicare enrollees in 2023 with 22%, due to the United Auto Workers and State of Michigan.[75] Union presence is associated with EGWPs, benchmarks are not the driving factor for plan entry.

3. Opportunities to Improve Benefits Coordination

Policymakers have near and long term policy reform opportunities to promote VA – Medicare benefits coordination.

In the near term, CMS and VA need to both execute and expand on recent data sharing agreements and update the VA/DoD adjuster in order to combat fraud, waste, and abuse for veterans enrolled in Medicare (both FFS Medicare and MA) who also have VA benefits. In late 2024, CMS established a computer matching agreement (CMA)[76] expiring December 22, 2025 to allow for CMS and the VA to identify claims where duplicate payments are made. This is a first step in the need for expanded and long-term VA – CMS data sharing, which would help promote better technical and operational integration. For FFS Medicare, this would permit the CMS Center for Program Integrity and eventually the Unified Program Integrity Contractors (UPICs) to regularly identify and address duplicative payment as part of routine pre-payment claims editing. For MA, this would allow CMS to identify services utilized and derive better adjusted FFS benchmarks for MA plans through updating of the VA/DoD adjuster.

Improved and permanent data sharing would allow CMS to have VHA enrollment, utilization, diagnosis data, and other necessary information to improve the accuracy of MA benchmarks and update the VA-DoD adjuster. It is also important for either the VA directly or CMS to indirectly share this information with health plans, so as to avoid duplicative payment and service. Further coordination will be needed between the VA, CMS, and health plans in order to ensure that each item and service provided is funded by the right program – VA or Medicare.

In the long-term, policymakers have an opportunity to drive benefits coordination between the VA and Medicare, allowing veterans to fully access their earned benefits. As a first principle, veterans should be able to fully utilize both earned benefits. Benefits coordination brings up Medicare as secondary payer issues. If Medicare were a primary payer and VA were a secondary payer for all dually eligible veterans for all care, this would decrease financial stress on VA, while simultaneously increasing fiscal stress on Medicare spending. Alternatively, if the VA remained a primary payer for service-connected medical care, with Medicare as a secondary payer as appropriate (or primary payer for non-service connected medical care), the VA would be required to adjudicate in conjunction with CMS which services were financed by VA or Medicare for each veteran, an operationally challenging process.

Creating a Veterans Health Benefits Marketplace is a third and more viable long-term approach that could use elements of the aforementioned two models. A VA Health Benefits Marketplace could allow an annual election of either a veterans-specific Medigap or managed care wrap plan for veterans' combined VA-Medicare benefits during an annual enrollment period for veterans aligned with Medicare annual enrollment. Veterans could choose a VA for Life option[77] modeled after TRICARE for Life which would preserve the veterans' ability to access any VHA facility and the broad,

[74] See page 136 of "Medicare." Accessed November 14, 2025. https://www.medpac.gov/wp-content/uploads/2025/07/July2025_MedPAC_DataBook_Sec9_SEC.pdf
[75] See page 8, Skopec, Laura, and Stephen Zuckerman. "Medicare Advantage Employer Group Waiver Plans a Primer," 2024. https://www.urban.org/sites/default/files/2024-01/Medicare%20Advantage%20Employer%20Group%20Waiver%20Plans.pdf
[76] "Computer Matching Agreement Between The Department of Health and Human Services Centers for Medicare and Medicaid Services and the Department of Veterans Affairs Veterans Health Administration For Identification And Recovery of Duplicate Payments for Medical Claims Centers for Medicare & Medicaid Services No. 2024-64 Department of Health and Human Services No. 2403." Accessed November 14, 2025. https://department.va.gov/privacy/wp-content/uploads/sites/5/2024/05/CMS-VHA-New-Establishment-CMA-2403_Final_03042024_508.pdf
[77] Miller, Brian J., Jennifer Slota, Theresa A. Cullen, Boris D. Lushniak, and Gail R. Wilensky. "To Transform Veterans Health Care for the next Generation, We Should Learn from TRICARE." Forefront Group, July 26, 2021. https://doi.org/10.1377/forefront.20210721.600774

any-willing-provider network present in FFS Medicare. This would be in addition to promoting that veterans retain and utilize the VA pharmacy benefit.

Alternatively, the veteran could elect a Veterans' Health Advantage Program[78] modeled after the EGWP marketplace allowing the VA, like employers, to "buy above" the Medicare A/B benefit and deliver veteran-specific health benefits on top of Medicare in a managed care form, inclusive of all VA facilities and some privately-delivered care through a select subset of Medicare providers. Akin to the ACA's creation of the CMS Medicare-Medicaid Coordination office, policymakers could task CMS with creating a Medicare-VA coordination office, redeploying staff from other CMS offices, such as the CMS Innovation Center. The VA would need to designate an existing VHA Office (e.g. Community Care) to serve as the point of contracting and regulatory authority.

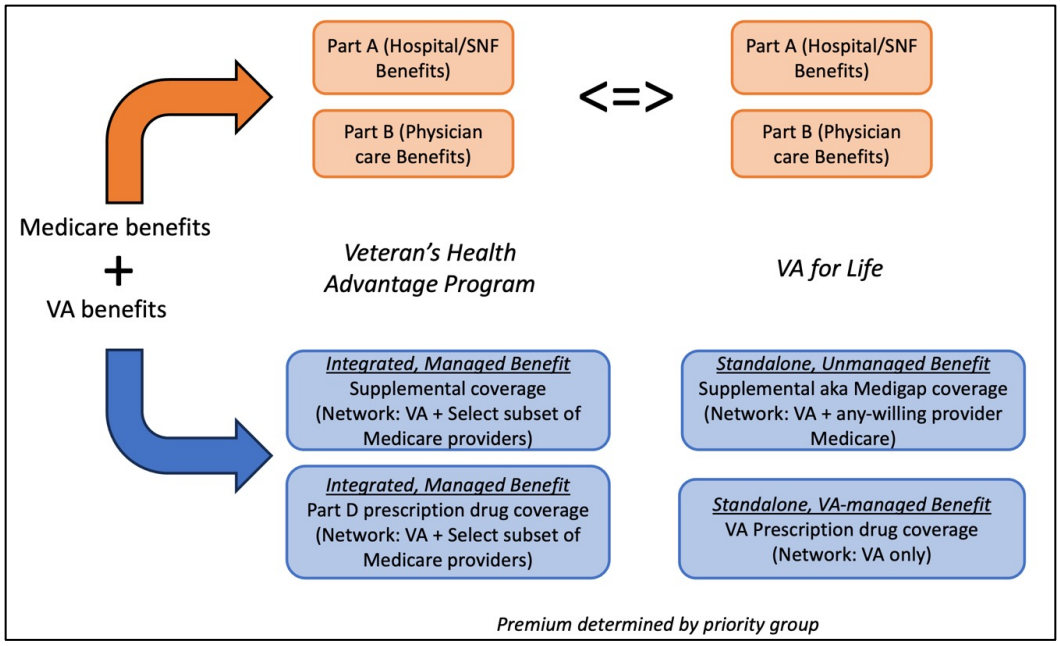

Figure 3: Potential VA Interface with the Medicare benefit

Both the VA for Life and Veterans Health Advantage Program options would:

- Provide the veteran, for the first time, with full access to both their earned veterans' and Medicare benefits simultaneously
- Facilitate benefits coordination across publicly-funded health benefits programs, reducing fraud, waste and abuse in both the VA and the Medicare program (inclusive of FFS Medicare and MA)
- Solidify the primacy of the VA delivery system as the veterans' health care home and maintain the specialized services that VHA is best at providing (and often the private sector does not provide)
- Create a clearer organizing financing chassis for VA Community Care, improving administration and oversight of the program to combat fraud, waste, and abuse

In order to promote continuous policy improvement and oversight, policymakers could statutorily authorize the program on a 5-year cycle to allow for policy improvements and innovation, akin to user fee cycle for prescription drugs and medical devices that permits continued regulatory innovation. Financing could come from annual appropriations to support coverage for VA-Medicare dual eligibles in the VA for Life and Veterans Health Advantage Programs, just as unions and large employers use annual financing to fund the retiree health Medigap and EGWP options.

[78] Miller, Brian J., Jennifer Slota, Theresa A. Cullen, Rhonda Randall, and Arthur M. Southam. "Choice and Competition: The Veterans' Health Advantage Program." Forefront Group, April 29, 2019. https://doi.org/10.1377/forefront.20190424.383802

4. Conclusion

VA-Medicare benefits coordination has been a challenge for decades, with the GAO, HHS OIG, and academic researchers documenting problems in benefits coordination between the VA and both the FFS Medicare and MA programs. Policymakers can look to the Medicare–TRICARE and Medicare–Employer retiree health benefits interfaces for lessons in how to improve VA–Medicare benefits coordination.

H.R. 4077 GUARD Veterans' Health Care Act is not the way to solve this problem, as it does not address the root causes in the challenges of VA—Medicare benefits coordination, subverts medical policy and utilization review in both the VA and Medicare programs, and does not enable veterans to fully access their earned VA and Medicare benefits together in a way that they choose, eliminating veteran agency.

Instead, policymakers should work to improve benefits coordination through a few key steps:

Near term

1. Implement a permanent data sharing agreement between the VA and CMS and promote the creation of long-term technical and operational data integration for enrollment, utilization, diagnosis data, and other necessary information.
2. Subsequent to the above, review and modify the VA-DoD adjuster for MA plans as appropriate, while simultaneously ensuring that UPICs implement durable pre-payment claims editing in FFS Medicare to avoid duplicative payment.

Long term:

1. Create coordination offices at the VA and CMS using the model of the CMS Medicare-Medicaid Office at CMS and ideally tasking the VA Community Care Office on the VA side.
2. Create a Veterans Health Benefits Marketplace with an annual enrollment period aligned with Medicare enrollment.
3. Applying lessons from TRICARE and Large Employer/Union Retiree health benefits, authorize on a 5-year cycle a VA for Life and Veterans' Health Advantage Program to ensure that veterans can fully access their earned VA and Medicare benefits simultaneously.

Thank you, and I look forward to your questions.