Statement for the Record

House Committee on Veterans' Affairs

Subcommittee on Health

Submitted by Independence Blue Cross (IBX)

Introduction

Chairman, Ranking Member, and Members of the Subcommittee—thank you for the opportunity to submit this statement for the record. Independence Blue Cross (IBX) appreciates the Subcommittee's leadership and focus on improving care coordination, quality, and outcomes for our nation's veterans. IBX supports all three pieces of legislation before the Subcommittee that seek to enhance care coordination for veterans navigating multiple health systems. While these proposals represent important progress toward improving data sharing and alignment across federal health programs, IBX believes Congress could go a step further by requiring VA Medical Centers (VAMCs) to participate in regional Health Information Exchanges (HIEs), ensuring a more consistent bidirectional exchange of clinical information across care settings.

Independence Blue Cross is a leading health insurer with an 87-year history of serving customers in our service area, with access to care across the country, and a deep, longstanding presence in Southeast Pennsylvania. IBX has participated in the Medicare Advantage (MA) program since its inception and today serves over 123,000 MA members in our market. IBX's MA plans consistently perform above the national average on CMS Star Ratings, reflecting our sustained commitment to high-quality, coordinated, and person-centered care.

As a regional, community-based plan, IBX partners closely with local providers, academic medical centers, and community organizations. Our success in Medicare Advantage depends fundamentally on timely, accurate, and complete clinical information that allows us to coordinate care, manage chronic conditions, and ensure medication safety for our members.

The Challenge Facing Veterans Enrolled in Both VA Care and Medicare Advantage

Several years ago, IBX identified a significant and growing population within our MA membership: veterans who are dually enrolled in both the Veterans Health Administration (VHA) and a MA plan, and who appropriately seek care in both systems.

Our analysis revealed a critical and persistent problem: **care delivered at VA Medical Centers is largely invisible to MA plans.** When a veteran receives services,

prescriptions, or diagnostic testing through the VA, that information is generally not shared with the MA plan responsible for coordinating the veteran's broader health care needs.

As a result, IBX—and similarly situated MA plans—often lack awareness of:

- Active diagnoses and treatment plans established at VA facilities
- Medications dispensed by VA pharmacies
- Laboratory results, imaging, or procedures performed within the VA system

This absence of bidirectional data sharing creates meaningful clinical and operational risks. Our research found that MA-enrolled veterans receiving care across unconnected systems are at higher risk of adverse clinical, medical, and pharmacological interactions, including duplicative therapies, contraindicated medications, and gaps in follow-up care.

Impact on Quality Measurement and Medicare Advantage Accountability

The lack of visibility into VA-provided care also has direct implications for CMS Star Ratings, which CMS uses to measure care quality and performance in the MA program.

For example:

- Medication adherence measures may appear deficient when a member fills prescriptions at a VA pharmacy rather than through the MA plan's pharmacy benefit.
- Preventive services or chronic care management delivered at the VA may not be reflected in MA quality reporting.

In these circumstances, MA plans may be penalized by CMS for apparent gaps in care that are not attributable to poor performance, but instead to missing data. This misalignment undermines the integrity of the Star Ratings program and discourages effective coordination across federal health systems.

Importantly, the consequences are not limited to plans. Veterans themselves bear the greatest risk—through fragmented care, increased likelihood of adverse events, and unnecessary duplication of services.

Why Congressional Action Is Needed Now

IBX strongly supports the bipartisan efforts before the Subcommittee that seek to improve coordination between the Department of Veterans Affairs, CMS, and MA plans. Recent legislative proposals appropriately recognize that veterans increasingly navigate multiple federal health care programs and that data sharing is essential to program integrity, quality, and patient safety.

While existing bills move in the right direction by authorizing interagency data sharing agreements, IBX believes Congress must go further to ensure bidirectional clinical data exchange between systems.

Absent a clear statutory requirement, connectivity remains inconsistent, fragmented, and dependent on local arrangements. Veterans should not experience different levels of care coordination based solely on geography or the technical capabilities of individual facilities.

A Practical and Scalable Remedy: Connecting VA Medical Centers to Health Information Exchanges

To address these challenges, IBX urges Congress to require that all VA Medical Centers and associated outpatient clinics connect to regional Health Information Exchanges (HIEs) and actively participate in bidirectional data exchange.

This approach builds on infrastructure that already exists across much of the health care system and aligns with CMS's established interoperability framework, including the use of Fast Healthcare Interoperability Resources (FHIR) APIs.

Specifically, IBX supports legislative language that would:

- Require VA Medical Centers to connect to applicable regional HIEs within a defined timeframe
- Mandate the sharing and receipt of core clinical data, including diagnoses, medications, allergies, procedures, and laboratory results
- Ensure that VA systems are interoperable with CMS standards and capable of secure, two-way data exchange
- Provide reporting and oversight to measure progress and impact on veteran outcomes

Such a requirement would not alter veterans' eligibility, benefits, or choice of where to receive care. Instead, it would ensure that all providers and plans involved in a veteran's care have the information necessary to deliver safe, coordinated, and high-quality services.

Conclusion

Veterans who rely on both the VA health care system and MA should not be forced to navigate fragmented systems that do not communicate with one another. The current lack of bidirectional data sharing places veterans at risk, undermines quality measurement, and creates avoidable inefficiencies across federal health programs.

IBX respectfully urges the Subcommittee to advance legislation that requires VA Medical Centers to participate fully in health information exchange and to adopt CMS-aligned interoperability standards. Doing so will improve care coordination,

strengthen accountability, and—most importantly—better serve the veterans who have earned a seamless and high-quality health care experience.

IBX appreciates the opportunity to share our perspective and stands ready to serve as a resource to the Subcommittee as it considers these important reforms.