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Report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

October 1994

VETERANS' HEALTH CARE

Use of VA Services by Medicare-Eligible Veterans

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GAO

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Health, Education, and
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The Honorable Lane Evans
Chairman, Subcommittee on Oversight
and Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

Most of America's veterans now have public or private insurance programs that provide alternatives to health care available through the Department of Veterans Affairs (VA). When veterans have multiple health care options, changes in one option can have unforeseen repercussions on the others. Many changes were proposed for both programs during this year's health care reform debate, including expanding entitlement to free VA health care services and adding a Medicare outpatient prescription drug benefit.

Medicare-eligible veterans form a substantial portion of VA's user group, accounting for almost one-half of the more than 2.2 million veterans using VA health care services in 1990.[1] To get a better idea of how various health care reforms might affect the demand for VA health care services from this user group, you asked us to analyze factors that might affect veterans' choices to obtain care under Medicare or through VA. As agreed with your office, we focused our review on the following:

- Determining the extent to which veterans use VA to obtain services not extensively covered under Medicare, such as prescription drugs, nursing home care, and routine dental care.
- Comparing the income and private health insurance coverage of Medicare-eligible veterans who chose Medicare, VA, or a combination of the two.
- Examining the potential effects of proposed reforms of VA and Medicare benefits on Medicare-eligible veterans' demand for VA health care services on the basis of the above data.

[1]When veterans have both Medicare and VA coverage, they overwhelmingly use Medicare. In 1990, for example, almost 62 percent of Medicare-eligible veterans used Medicare, fewer than 7 percent used VA, and fewer than 8 percent used both. The remaining 24 percent used no services under either program. See Veterans' Health Care: Most Care Provided Through Non-VA Programs (GAO/HEHS-94-104BR, Apr. 25, 1994).

Results in Brief

Medicare-eligible veterans make substantial use of VA services not extensively covered under Medicare. Our analysis suggests that many Medicare-eligible veterans turn to VA specifically to obtain several of these services, particularly prescription drugs, inpatient psychiatric care, and long-term nursing home care. Also, Medicare-eligible veterans who use VA health care facilities generally have lower incomes and less private insurance than those who rely solely on Medicare. This suggests that out-of-pocket costs may have influenced these veterans' decisions to use VA for health care services.

Changes to Medicare or veterans health benefits made as a result of health care reform could significantly affect future demand for VA health care services. Changes in Medicare to add benefits (such as outpatient prescription drugs) or to reduce beneficiary cost sharing could reduce demand for VA health care services. On the other hand, changes in VA benefits, such as the elimination of restrictions on access to outpatient services, improved access to care, and expanded entitlement to free care, could increase demand for VA health care. Finally, the historic reluctance of Medicare beneficiaries to enroll in health maintenance organizations (HMOs) could reduce their willingness to enroll in VA health plans as long as traditional fee-for-service care remains available under Medicare.

Background

In 1990, VA provided health care services to over 2.2 million of the nation's estimated 28.2 million veterans through a system of 158 medical centers, 240 outpatient clinics, 126 nursing homes, and 32 domiciliaries.[2] Of those who used VA health care services in 1990, almost one-half were eligible for Medicare—a federal health insurance program that covers almost all Americans aged 65 and older and certain individuals under 65 who are disabled or suffer from kidney failure.

While VA offers an extensive array of services, it has eligibility and entitlement provisions that limit the extent to which individual veterans may be eligible for and entitled to services. For example, priority for receiving VA hospital and nursing home care is divided into two categories—mandatory and discretionary. VA must provide cost-free hospital care and, if space and resources are available, may provide nursing home care to veterans in the mandatory care category. VA may provide hospital and nursing home care to those in the discretionary category if space and resources are available in VA facilities.

[2]Domiciliaries provide shelter, food, and necessary medical care on an ambulatory self-care basis to veterans who are disabled by age or disease but not in need of skilled nursing care or hospitalization.

Included in the mandatory care category are veterans who have service-connected disabilities,[3] are former prisoners of war, served during the Mexican border period or World War I, or have nonservice-connected disabilities and are unable to defray the cost of care.[4] Veterans eligible for Medicaid, receiving VA pensions, or having financial resources below a prescribed level are considered unable to defray the cost of necessary care.

VA must furnish comprehensive outpatient medical services to veterans who have service-connected disabilities rated at 50 percent or more. VA may provide comprehensive outpatient care to veterans who (1) are former prisoners of war, (2) served during World War I or the Mexican border period, (3) are housebound or in need of aid and attendance, or (4) are participants in VA-approved vocational rehabilitation programs.

VA must furnish all outpatient services needed for the treatment of conditions related to any veteran's service-connected disability regardless of the veteran's disability rating. VA must also provide hospital-related outpatient care to veterans (1) with service-connected disabilities rated at 30 or 40 percent or (2) whose annual incomes do not exceed VA's pension rate for veterans in need of regular aid and attendance.[5,6] VA may, to the extent resources permit, furnish hospital-related outpatient care to all veterans not otherwise entitled to outpatient care. Additional restrictions apply to the availability of dental care.

Once in the VA system, however, veterans are generally offered a broader range of services with fewer limitations and less cost sharing than are available under other public or private health benefits programs such as Medicare. For example, VA offers coverage of outpatient prescription drugs and dental care that are not available under Medicare. VA also has no limit

[3]A service-connected disability is one that results from an injury or disease or other physical or mental impairment incurred or aggravated during military service. VA determines if veterans have service-connected disabilities and, for those with such disabilities, assigns ratings of from 0 to 100 percent based on the severity of the disability. These ratings form the basis both for determining the amount of compensation paid to the veterans and the types of health care services to which they are eligible and entitled.

[4]Veterans exposed to certain toxic substances during the Vietnam War, to ionizing radiation, or to environmental hazards during the Persian Gulf War are also included in the mandatory care category for treatment of conditions that may be related to such exposures.

[5]Hospital-related care refers to those outpatient services needed to (1) prepare for a hospital admission, (2) obviate the need for a hospital admission, or (3) complete treatment begun during a hospital stay.

[6]In 1991, the income limits were either $11,409 or less for veterans with no dependents or $13,620 or less if married or single with one dependent, plus $1,213 for each additional dependent.

on the number of days of care that can be obtained in VA-operated hospitals and nursing homes, while Medicare limits its coverage of general hospital care to 90 days per benefit period (with 60 nonrenewable reserve days available during the beneficiary's lifetime) and its coverage of inpatient psychiatric care to 90 days per benefit period with a lifetime limit of 190 days.[7] Medicare's coverage of nursing home care is limited to post-hospital skilled nursing care. In addition, VA generally requires no cost sharing for inpatient hospital care while Medicare requires beneficiaries to pay substantial deductibles and copayments.[8]

Scope and Methodology

Our review consisted of four main segments. The first segment centered on analyzing Medicare-eligible veterans' use of a variety of inpatient and outpatient services in fiscal year 1990 using nationwide data files maintained by VA and by the Health Care Financing Administration (the federal administrator of Medicare) within the Department of Health and Human Services.[9] The second segment dealt with the one outpatient service—prescription drugs—not covered in the nationwide data for 1990. Because VA does not maintain a centralized database for prescription drugs and because most VA medical centers do not maintain readily accessible files that go back to 1990, we determined the number of prescriptions filled for Medicare-eligible veterans during fiscal year 1993 and VA's costs for acquiring the drugs from 10 of VA's 158 medical centers. The third segment dealt with determining the income, health insurance, and other characteristics of Medicare-eligible veterans. We used VA's 1987 Survey of Veterans because it is the most recent complete source of such

[7]A benefit period begins with admission to a hospital and ends when the beneficiary has been out of the hospital or any other facility providing skilled nursing or rehabilitation services for 60 consecutive days.

[8]In 1993, Medicare beneficiaries were required to pay an inpatient hospital deductible amount of $676 and copayments of $169 per day for inpatient stays of 61-90 days, $338 a day for stays of 91-150 days, and 100 percent of costs for stays beyond 150 days. In addition, they had to pay a copayment of 20 percent of approved charges for doctors' fees and other professional fees. VA requires cost sharing only for higher-income veterans with no service-connected disabilities. It requires such veterans to pay the lesser of the cost of care or $676 plus $10 a day for the first 90 days of care and $338 plus $10 a day for each additional 90 days.

[9]We used 1990 because we had developed a database on the population of Medicare-eligible veterans through an earlier study and we also had Medicare and VA computerized treatment records for that year.

data.[10] Finally, we based our analysis of the potential effects of health reform proposals on Medicare-eligible veterans' use of VA health care services primarily on the Administration's proposed Health Security Act (S. 1757/H.R. 3600), including the Mitchell (S.2357) and Gephardt proposals, and the Dole/Packwood proposal (S. 2374) because they have provisions relating specifically to VA.

Our review relied extensively on computerized data from VA, the Health Care Financing Administration, and other federal agencies that were obtained and verified during prior reviews. However, we verified some of the data fields used in this review. (App. I describes our methodology in greater detail.) Our work was done in accordance with generally accepted government auditing standards between January 1994 and August 1994.

Use of VA Services Not Extensively Covered Under Medicare Is Substantial

Medicare-eligible veterans were making substantial use of VA health care services that were not extensively covered under Medicare. We reviewed six such services: outpatient prescription drugs; dental, audiology, and optometry care; inpatient psychiatric care; and nursing home care. For several of the services, the data indicate that Medicare-eligible veterans may be using VA specifically to obtain these services.

Most Medicare-Eligible Veterans Received Outpatient Prescription Drugs

Medicare-eligible veterans who use VA for all or part of their medical services receive substantial amounts of outpatient prescription drugs. At the 10 medical centers where we analyzed prescription drug usage, about 72 percent of the 87,607 Medicare-eligible veterans using VA health services during fiscal year 1993 received outpatient prescription drugs. On average, they received 30 prescriptions during the year at an average acquisition cost to VA of $374 per recipient.[11] While most of the Medicare-eligible veterans at the 10 centers received prescriptions that cost VA less than $200 for the year, about 8 percent received prescriptions costing VA $1,000

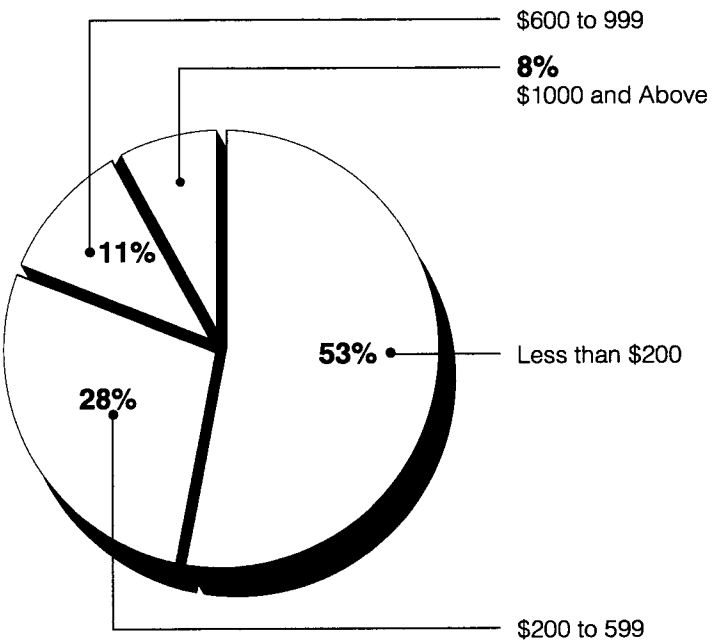
[10]VA, in conjunction with the Bureau of the Census, conducted the survey to evaluate its programs and to assess the status and well-being of veterans across the nation. Based on survey participants' responses to questions concerning Medicare eligibility and use of VA and Medicare health care services, we grouped respondents who were eligible for Medicare into dual users, VA-only users, and Medicare only users. We then analyzed income and insurance coverage of the three groups.

In 1993, VA conducted an updated survey, but the data were not yet available at the time we completed our review.

[11]VA's cost is based on the cost of acquiring the ingredients for the prescriptions and is substantially lower than the market value of the prescriptions because (1) federal law requires pharmaceutical companies to charge VA no more than 76 percent of the nonfederal average manufacturer price of prescription ingredients and (2) besides ingredient costs, retail pharmacies generally add overhead and dispensing fees to the price that they charge consumers.

or more (see fig. 1). For dual users of VA and Medicare services, the maximum amount of prescriptions received by one veteran was 408 prescriptions costing VA $18,199; for VA-only users, the maximum was 420 prescriptions costing VA $17,303.

Figure 1: Medicare-Eligible VA Users Receiving Outpatient Prescriptions, by VA Costs (1993)



Dual users may be coming to VA in part to obtain prescription services they cannot obtain under Medicare. Dual users had fewer VA outpatient visits than VA-only users but obtained about the same number of prescriptions. Dual users averaged less than 10 outpatient visits compared with over 13 for VA-only users; further analysis showed similar variation across all age groups of Medicare-eligible veterans. This suggests that dual users obtained at least a portion of their outpatient care through Medicare or other sources. Similar differences between VA-only and dual users did not, however, exist in use of VA outpatient prescription drugs. Although dual users were somewhat less likely than VA-only users to receive prescription drugs, there was little difference between VA-only users and dual users in the average number of prescriptions received or the average value of

prescriptions received (see table 1). This suggests that VA coverage of outpatient prescription drugs coupled with the lack of similar coverage under Medicare is one of the factors dual users consider in deciding between use of their VA and Medicare benefits.

Table 1: Prescription Drug Use by Medicare-Eligible Veterans Using Outpatient Services at 10 Selected VA Medical Centers, by Age (1993)

	Younger than 65		65-74		75 and older	
Characteristic	Dual users	VA-only users	Dual users	VA-only users	Dual users	VA-only users
Percent receiving prescriptions	72	78	69	77	68	77
Average number of outpatient visits	13	17	9	11	9	12
Average number of prescriptions	34	35	29	29	28	27
Average cost of prescriptions	$473	$434	$366	$349	$324	$305

As table 1 shows, Medicare-eligible veterans under 65 years of age also had more outpatient visits and received more prescription drugs than older age groups. This is consistent with Medicare eligibility criteria. People 65 years of age or older are generally eligible for Medicare regardless of their health status, while people under 65 have to be disabled to qualify for Medicare. It is not surprising, therefore, that we found that Medicare-eligible veterans under the age of 65 are in greater need of health services in general, including prescription drugs.

One in Five Medicare-Eligible Veterans Visited a Dental, Hearing, or Vision Clinic

About 22 percent of the approximately 1 million Medicare-eligible veterans using VA for outpatient services in 1990 used dental, hearing, or vision services, services not generally covered under Medicare. Compared with outpatient prescription drugs, the data for these services do not show as clear a trend with regard to whether dual users are coming to VA specifically to obtain these services or whether they are receiving the services incidental to receipt of other outpatient care. Dual users were slightly less likely than VA-only users to use dental and optometry services but slightly more likely than VA-only users to use audiology services (see table 2). The frequency of visits to these clinics was about the same for VA-only users and dual users—five clinic visits for dental services and two clinic visits each for audiology and optometry services.

Table 2: Percentage of Medicare-Eligible Veterans Using VA Outpatient Services Who Received Dental, Vision, or Hearing Services (1990)

Clinic	Dual users	VA-only users
Dental	8	11
Hearing	8	7
Vision	8	10
At least one of the three clinics	20	24

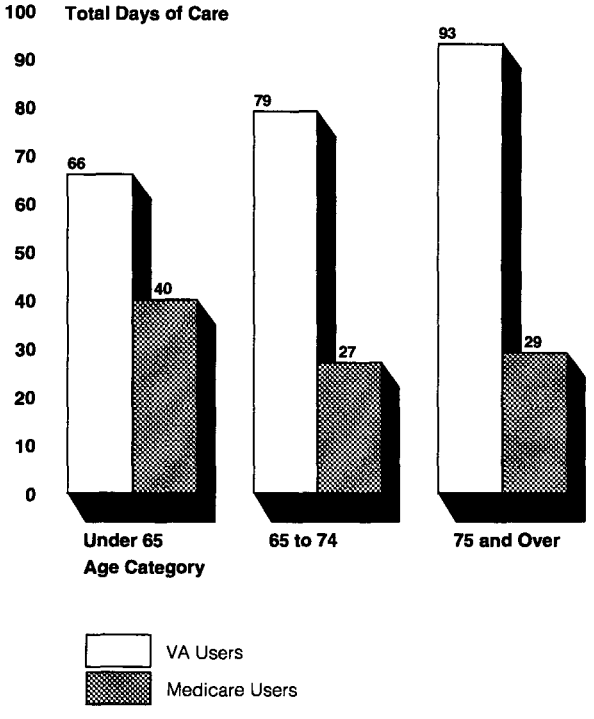
VA Is the Primary Source for Inpatient Psychiatric Care

While Medicare covers some inpatient psychiatric care,[12] VA is the major provider of inpatient psychiatric care for Medicare-eligible veterans. In 1990, over 71 percent of the 41,271 Medicare-eligible veterans using inpatient psychiatric care used only VA for inpatient psychiatric care, our analysis of VA and Medicare treatment records shows. By contrast, about 24 percent used only Medicare inpatient psychiatric care and 5 percent used both VA and Medicare.

Medicare-eligible veterans using VA psychiatric care also tend to have longer lengths of stay than those who obtain this care through Medicare. On average, users of VA facilities had 70 days of inpatient psychiatric stay in 1990, compared with 39 days for those who used non-VA facilities paid for under Medicare. While the stays by VA-only users were longer in all age categories, they became more pronounced among the oldest veterans. As figure 2 shows, stays for veterans younger than 65 years old averaged 66 days for users of VA facilities and 40 days for users of non-VA facilities paid for under Medicare, while stays for veterans 75 years old and older averaged 93 days for VA facilities and 29 days for non-VA facilities. The significant difference in average length of stay between VA users and Medicare users could be due in part to the duration limits imposed under Medicare, particularly for veterans in the older age groups who may have exceeded the lifetime limit of 190 days on inpatient psychiatric care.

[12]Medicare's coverage for inpatient psychiatric care is limited to 190 days in a person's lifetime.

Figure 2: Average Length of Stay for Inpatient Psychiatric Care by Medicare-Eligible Veterans at VA and Non-VA Facilities (1990)



VA Is an Important Source for Long-Term Nursing Home Care

While Medicare is the primary source of short-term skilled nursing home care for Medicare-eligible veterans,[13] VA also plays an important role in meeting the nursing home needs of veterans, particularly for those whose care needs exceed the limits of Medicare coverage. In 1990, 68 percent of the 61,524 Medicare-eligible veterans using nursing home care relied solely on Medicare, 31 percent relied solely on VA, and 1 percent relied on both. However, on average, VA users had 236 days of nursing home care in 1990, compared with 40 days for Medicare users.

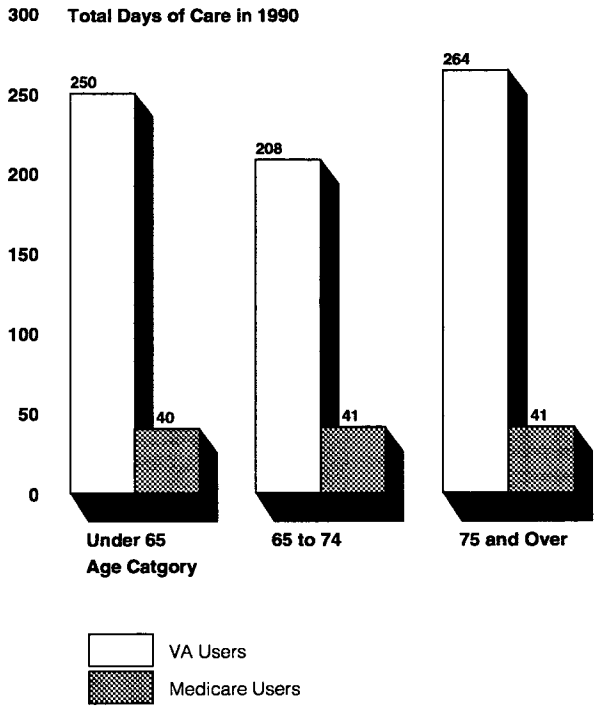
The significant difference in the average length of stay between VA users and Medicare users is likely due to differences in nursing home coverage under the two programs. Medicare covers only short-term skilled nursing home care following a hospitalization, whereas VA covers both short-term and long-term nursing home care and both skilled and intermediate nursing home care. Veterans who need care that exceeds the limits of Medicare coverage, either because of level of care or length of coverage

[13]Medicare's nursing home coverage is limited to skilled nursing care following a hospitalization and allows 20 days of nursing home care during a benefit period without a copayment. In 1993, patients had copayments of $84.50 per day for days 21 through 100 and had to pay all costs after 100 days.

limits, must rely on VA or other programs, such as Medicaid, the primary source of public funding for nursing home care, to meet those needs.[14]

As with inpatient psychiatric care, usage patterns for VA long-term care vary somewhat by age (see fig. 3). The difference between VA users and Medicare users is greatest among veterans 65 years old and younger and 75 years old or older. Again, this is consistent with what one would expect if users tended to rely on VA for long-term care. Nursing home usage generally increases with age; those 75 years of age or older are most likely to be in nursing homes. Persons younger than 65 tend to use nursing homes because of severe, debilitating diseases such as acquired immune deficiency syndrome (AIDS) and multiple sclerosis or permanent disabilities such as spinal cord injuries. Persons older than 75 tend to have longer stays in nursing homes than their counterparts ages 65 to 74 because they have more chronic illnesses and may no longer have the informal network of caregivers to allow them to return to their homes.

Figure 3: Average Nursing Home Length of Stay, by Age and Source of Payment (1990)



[14]Medicaid is a combined federal and state program of medical assistance to certain categories of low-income persons.

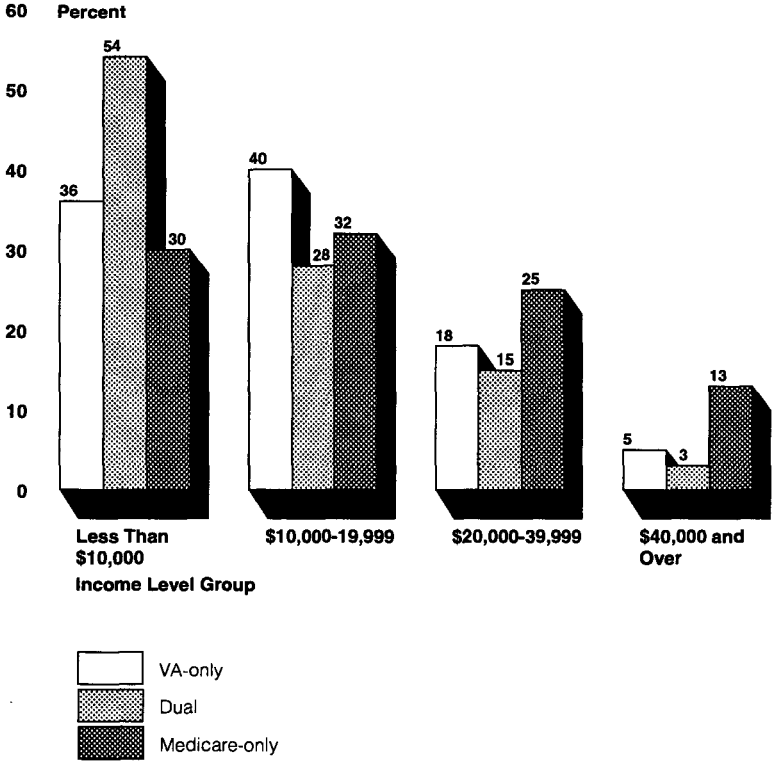
Users of VA Facilities Generally Have Lower Incomes and Less Private Insurance

Medicare-eligible veterans who use VA services tend to have lower incomes and less private insurance coverage than those who rely on Medicare. This suggests that out-of-pocket costs and the lack of private insurance to cover them may have influenced these veterans in their decision to use VA for health care services.

Low-Income Medicare-Eligible Veterans More Likely to Use VA

Our analysis of data from VA's 1987 Survey of Veterans shows that VA users generally had lower incomes than Medicare-only users. About 54 percent of the approximately 308,000 dual users and 36 percent of the approximately 318,000 VA-only users had annual family incomes below $10,000, compared with 30 percent of the approximately 3,675,000 Medicare-only users. At the other end of the scale, 13 percent of Medicare-only users had incomes higher than $40,000, while only 3 percent of dual users and 5 percent of VA-only users were at this level (see fig. 4).

Figure 4: Income Distribution of VA-Only, Dual, and Medicare-Only Users (1987)



Since the time the VA survey was conducted, the situation may have changed. The Medicare Catastrophic Coverage Act of 1988 requires state Medicaid programs to pay the Medicare part A and part B premiums and all deductibles and coinsurance for most Medicare beneficiaries with incomes below 100 percent of the federal poverty level ($9,430 for a family of two in 1992).[15] Under the Omnibus Budget Reconciliation Act of 1990, this requirement was made effective January 1, 1991. The act also required state Medicaid programs to begin paying by 1995 the part B premiums of Medicare beneficiaries with incomes of 120 percent or less of the federal poverty level.

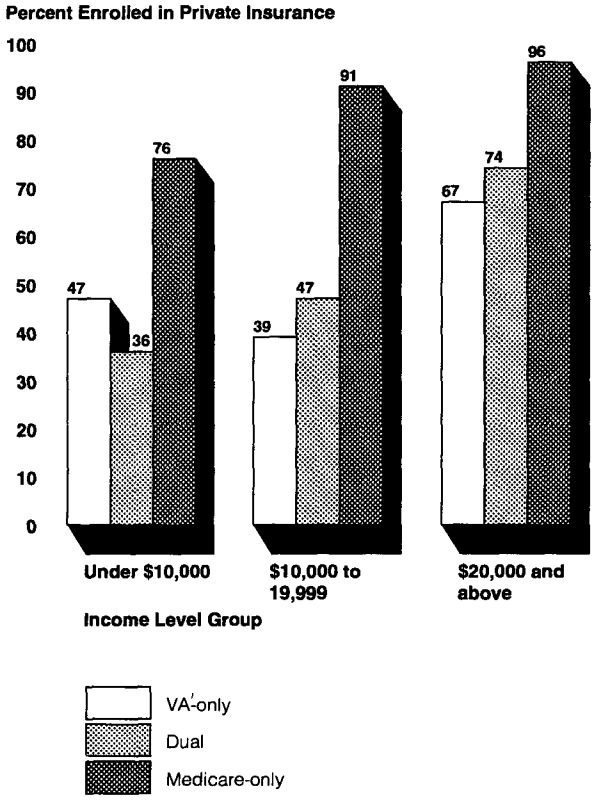
As a result of these changes, veterans with incomes below the federal poverty level can now obtain Medicare-covered services from private-sector providers with no out-of-pocket expense. Their financial advantage in coming to VA for services may thus have largely disappeared. VA recently conducted a new survey of veterans that could enable us to determine whether the availability of free care under Medicare resulted in a decline in VA use by low-income Medicare-eligible veterans, but data from the new survey are not yet available.

VA Users Less Likely to Have Insurance Coverage

Medicare-eligible users of VA services (both VA-only and dual users) were much less likely to have private health insurance to help pay for Medicare copayments, deductibles, and coinsurance than were Medicare-only users. Most Medicare-eligible veterans are retired or no longer able to work because of disability. For the majority of such veterans, Medicare is the primary source of health care coverage. Because of the high copayments and deductibles imposed under Medicare, many beneficiaries purchase supplemental private health insurance policies, typically referred to as Medigap policies. In 1987, less than 50 percent of VA-only and dual users had private health insurance, compared with almost 90 percent of Medicare-only users. The difference in private insurance coverage among the groups was consistent across all income levels (see fig. 5).

[15]Part A, Hospital Insurance, helps to pay for inpatient hospital care, posthospital care in skilled nursing facilities, posthospital home health services, and hospice care. Part B, Supplementary Medical Insurance, supplements part A by helping to pay for doctors' services, outpatient hospital services, and a number of other medical services and supplies.

Figure 5: Private Insurance Enrollment Rates of VA-Only, Dual, and Medicare-Only Users, by Income Category (1987)



Implications of Health Care Reform Proposals on Medicare-Eligible Veterans

Changes to Medicare or VA health care, such as those that were proposed under this year's health care reform debate, could substantially affect the future demand for VA health care services. The specific effect on the demand for VA services would vary greatly and depend on the changes, if any, that are made to either program as a result of health reform.

Proposed Changes to Medicare Would Likely Have Decreased Demand for VA Services

Several health care reform proposals contained provisions that would have expanded Medicare coverage or decreased Medicare out-of-pocket costs. For example, the administration's proposed Health Security Act and the Mitchell (S.2357) and Gephardt proposals would have expanded Medicare to cover outpatient prescription drugs. In general, such changes would tend to decrease the demand for VA services because they would reduce the need and the accompanying financial advantage to seek such

services from VA. High out-of-pocket costs for a Medicare drug benefit (initially a $500 deductible and 20 percent copayment would have been imposed under the Gephardt proposal and a deductible and 20 percent copayment under the Mitchell proposal) would likely lessen the effect on demand for VA outpatient drugs.

One change to Medicare—subsidies for low-income Medicare-eligible families under the Medicare Catastrophic Coverage Act of 1988—implemented after VA's 1987 Survey of Veterans, may also have this effect. As explained earlier, this change requires state Medicaid programs to pay premiums, deductibles, and coinsurance for most Medicare beneficiaries living below the poverty level. In a recent study, however, we found that many Medicare beneficiaries eligible for such subsidies were not enrolled in the program.[16]

Healthcare reform proposals generally did not contain provisions that would have reduced Medicare benefits by restricting services or raising deductibles or copayments. One notable exception to this was home health benefits. The administration's original proposal and the Gephardt and Mitchell proposals would have imposed a 20 percent copayment on Medicare home health services; such services are currently free under part A. Such proposals would likely have increased the demand for VA services. This is because Medicare-eligible veterans might turn to VA to reduce their out-of-pocket costs or to obtain services no longer available under Medicare.

Proposed Changes to VA Coverage Would Have Had Uncertain Effect on Demand for VA Services

Some of the health reform proposals considered in this year's debate would have substantially changed the VA health care delivery system. For example, the proposed Health Security Act and the Mitchell and Gephardt proposals would have (1) transformed VA facilities into a series of managed care plans to compete with private sector plans, (2) changed VA eligibility requirements to allow veterans greater access to the full range of VA services, and (3) provided financial incentives for service-connected and low-income veterans to enroll in VA health plans. These changes would have essentially removed current VA restrictions on the availability of outpatient services covered under the standard benefits package and entitled about 3.3 million Medicare-eligible veterans with service-connected disabilities or low incomes to cost-free care if they enrolled in VA health plans.

[16]Medicare and Medicaid: Many Eligible People Not Enrolled in Qualified Medicare Beneficiary Program (GAO/HEHS-94-52, Jan. 20, 1994).

Under the Gephardt proposal, current restrictions on access to outpatient care services not included in the standard benefit package would also have been eliminated; core group veterans enrolling in VA health plans would have been entitled to receive such services (including prescription drugs and vision- and hearing-related services) cost-free. Coverage of dental care would not have been changed under the Gephardt or Mitchell proposals. Finally, the Gephardt proposal would have created a new entitlement to nursing home care for veterans with service-connected disabilities rated at 50 percent or higher or in nursing homes for treatment related to their service-connected disabilities.

The Gephardt provisions would have created strong financial incentives for service-connected and low-income Medicare-eligible veterans to enroll in VA health plans. While veterans currently make substantial use of services such as hearing and vision care not well covered under Medicare, their access to such services is restricted by VA's complex eligibility and entitlement provisions. Because such provisions would have been largely eliminated under the Gephardt proposal, VA might have seen a significant increase in demand for services not included in the standard benefits package. Similarly, creating an entitlement for cost-free nursing home care might have increased demand for VA-supported nursing home care, particularly if such care were provided through contracts with community nursing homes.

The Mitchell proposal, however, contained a provision that would have created a strong disincentive for Medicare-eligible veterans to enroll in VA health plans. Veterans remaining under Medicare's fee-for-service program or enrolling in Medicare HMOs (other than a VA health plan) would have been ensured of receiving all medically necessary care covered under the Medicare program. Veterans enrolling in VA health plans, however, would have been ensured receipt of medically necessary care only if VA appropriations were sufficient to cover the costs of care. The Secretary of Veterans Affairs would have been given the discretion to reduce the standard benefits covered by VA health plans if sufficient funds were not appropriated. In effect, the financial risks of operating VA health plans would have been shifted from the government to the health plans' enrollees.

The net effect of the types of changes considered in the VA system on the demand for VA services by Medicare-eligible veterans is uncertain. On one hand, such changes might have enticed more Medicare-eligible veterans to use VA services, particularly if VA health plans included services such as

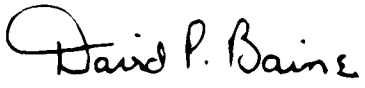
dental, vision, and hearing that are not covered under Medicare. However, the documented reluctance of Medicare beneficiaries to enroll in HMOs might have made it difficult for VA to keep those who are currently dual users of Medicare and VA, particularly if VA plans did not guarantee the availability of Medicare benefits. In 1993, less than 10 percent of all Medicare beneficiaries were enrolled in HMOs. Those who already rely exclusively on VA would have been the most likely to remain.

The Dole/Packwood proposal would also have made changes in the VA health care system, basically allowing VA to function as a provider under state health care reform programs. While the proposal would not have specifically reformed VA eligibility, it appears that it might have allowed VA to provide any health care items and services covered under state health reform programs regardless of whether the veteran would otherwise have been eligible to receive the service from VA. In addition, because the proposal did not specifically limit VA's role under state health reforms to providing services to veterans, it is not clear whether VA facilities in states enacting health reforms would have been able to provide services to nonveterans, including Medicare beneficiaries. Such changes could have increased demand for VA health care services in states implementing health reforms.

In summary, significant changes in either Medicare or VA health care benefits or cost sharing such as those considered in the recent health reform debate could have significant effects on future demand for VA health care services. The reluctance of Medicare beneficiaries to join managed care plans could, however, reduce the effect of reforms that would convert the VA health care system into a series of managed care plans unless the financial incentives, either through reduced cost sharing or added benefits are sufficient to overcome this reluctance.

At the request of your office we did not obtain agency comments on this report. As agreed with your office, we are providing copies of this report to the Ranking Minority Member of your Subcommittee, the Chairmen and Ranking Minority Members of the Senate and House Committees on Veterans' Affairs and the Senate and House Committees on Appropriations, the Secretary of Veterans Affairs, and other interested parties. Copies also 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 report are listed in appendix II.

Sincerely yours,



David P. Baine
Director, Federal Health
Care Delivery Issues

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Abbreviations

HCFA	Health Care Financing Administration
HMO	health maintenance organization
VA	Department of Veterans Affairs

Scope and Methodology

This study consisted of four main parts. The first part centered on inpatient and outpatient services received by Medicare-eligible veterans in fiscal year 1990. It was based on nationwide data files maintained by VA and by the Department of Health and Human Services' Health Care Financing Administration (HCFA). The second part dealt with VA prescription drug usage, based on fiscal year 1993 data from 10 of VA's 158 medical centers. The third part dealt with income and private health insurance coverage, using data from VA's 1987 Survey of Veterans. Finally, we reviewed various health reform proposals to analyze the potential effects of health reform on the demand for VA health care services. A brief discussion of our methodology for each part follows.

Analysis of Inpatient and Outpatient Usage of Medicare-Eligible Veterans

In an earlier study,[17] we used a combination of VA, HCFA, and other federal records to create a database (LIVEVETS) identifying 19,119,295 of the veterans who were alive in 1990. We decided to use this database for this study because we already had Medicare and VA medical data on hand for that year. Although the LIVEVETS file does not include every veteran (we estimate that there were about 28.2 million veterans in 1990), it includes all those veterans who are the focus of this study—the ones who used VA medical services.

We focused our attention on the 4,411,558 Medicare-eligible veterans identified in the LIVEVETS file. Based on their VA and Medicare usage, we divided them into four population groups:

- VA-only users (490,404 veterans),
- Medicare-only users (2,495,502),
- Dual users of VA and Medicare services (564,345), and
- Nonusers of VA and Medicare services (861,307).

This classification provided a means to analyze and compare health care usage rates by different groups of veterans.

After identifying the Medicare-eligible veterans, we added selected health care information contained in VA's automated Patient Treatment File and Outpatient Clinic System to each record. VA's Patient Treatment File contains detailed records of admission, discharge, treatment procedures, and medical specialty units used by patients during each episode of VA inpatient care. VA's Outpatient Clinic System contains records of VA

[17]Veterans' Health Care: Most Care Provided Through Non-VA Programs (GAO/HEHS-94-104BR, Apr. 25, 1994)

outpatient visits, including clinic stops made by patients during each visit.[18] These clinic stop codes identify the various clinics visited by patients, but not the specific services provided by the clinics. They do not indicate, for example, whether a visit to the optometry clinic was to treat ocular and vision defects or for a routine eye examination or obtaining eye glasses.

Using codes contained in HCFA's Medicare Automated Data Retrieval System, we also compared selected health care services paid by Medicare for dual users and Medicare-only users. This system contains detailed inpatient treatment data—admission date, total inpatient days, procedures and diagnosis, and a transaction code that identifies types of inpatient facilities used. The transaction code is particularly useful in identifying Medicare-eligible veterans who used Medicare for inpatient psychiatric care and nursing home care. These data allowed us to assess whether there were differences in usage patterns between dual users and Medicare-only users with regard to inpatient psychiatric care and nursing home care.

Analysis of VA Prescription Drug Usage

VA has no centralized database on prescription drugs. According to VA officials, each of its 158 medical centers maintains its own pharmacy database, which is generally kept on-line for only 9 to 18 months. After that time, the data are archived onto tapes, which are extremely difficult to retrieve. Because 1990 data had already been archived, it was impractical for us to obtain prescription data for the same 1990 study populations that we used in analyzing VA inpatient and outpatient services. As a result, we (1) obtained 1993 prescription drug data from a sample of medical centers and (2) identified a new Medicare-eligible veteran population for our analysis of VA prescription usage.

Obtaining Prescription Data From Medical Centers

We first worked with officials at VA headquarters' Office of Pharmacy Services to identify medical centers where 1993 pharmacy data were still on-line. From a list of centers identified, we judgmentally selected 10 centers to provide geographic and size representation as follows:

Albany, New York,
Bay Pines, Florida,
Columbia, South Carolina,
Hampton, Virginia,

[18]The term clinic stop is used to identify a patient encounter with one or more providers assigned to a particular clinic during the course of a patient's visit to a facility. For example, laboratory, X ray, and general medicine are shown as separate clinic stops in VA's Outpatient Clinic System.

Madison, Wisconsin,
Muskogee, Oklahoma,
Newington, Connecticut,
Phoenix, Arizona,
St. Cloud, Minnesota, and
St. Louis, Missouri.

Officials at VA's Birmingham Information System Center extracted 1993 prescription data from the 10 centers we selected and provided us data tapes that contain social security number, number of prescriptions, and VA acquisition costs of the prescriptions for each veteran who received prescriptions from the 10 centers during fiscal year 1993.

Determining Medicare-Eligible Veteran Population

We used VA's 1993 inpatient and outpatient data files to produce a file containing social security numbers of all veterans who used the 10 selected medical centers for inpatient or outpatient services during fiscal year 1993. At our request, HCFA matched this listing against its Medicare Standard Analytical Files to determine each veteran's Medicare eligibility and usage status. We matched the data that we received from VA and HCFA to (1) identify VA users who were Medicare-eligible and divide them into VA-only and dual users and (2) compare the number and costs of prescription drugs received by VA-only users and dual users.

Analysis of Income and Private Insurance Coverage

The 1993 and 1990 VA and Medicare data files that we analyzed did not contain income and private health insurance data on Medicare-eligible veterans. For this reason, we used data from VA's 1987 Survey of Veterans to analyze income and private insurance coverage.[19] Based on survey participants' responses to questions concerning Medicare eligibility and use of VA and Medicare health care services, we grouped respondents who were eligible for Medicare into VA-only users, Medicare-only users, dual users, and nonusers. We then analyzed income and insurance coverage data reported by each of these groups of respondents.

Analysis of Health Reform Proposals

We reviewed health reform proposals focusing on changes to Medicare or VA programs to analyze their potential effects on the demand for VA health care services. We based our analysis primarily on the administration's proposed Health Security Act (S. 1757/H.R. 3600) as introduced, the

[19]VA, in conjunction with the Bureau of the Census, conducted the 1987 Survey of Veterans to evaluate its programs and to assess the status and well-being of veterans across the nation. In 1993, VA conducted an updated survey, but the data were not yet available at the time we completed our review.

Mitchell (S. 2357) and Gephardt (H.R. 3600) proposals, and the Dole/Packwood proposal (S. 2374) because they were the only proposals we identified that specifically addressed the VA health care system.

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