

Changes in Cost-Sharing Have Little Impact on VHA Reliance

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Bottom Line Up Front

Most Veterans enrolled in health care coverage through the Veterans Health Administration (VHA) are also enrolled in additional coverage through public programs or private payers, such as Medicare or employer-sponsored insurance. This policy brief describes: 1) the division of services across programs for Veterans 65 years and older, and 2) the findings of an evaluation that suggest that increasing patient cost-sharing (e.g., outpatient visit and prescription drug copayments) does not alter the division of services by a large amount. The implication is that policymakers should not expect a large shift in demand from altering patient cost-sharing.

Introduction

The Veterans Health Administration (VHA) provides health care coverage and services to over nine million Veteran enrollees across its 171 medical centers, 1,112 outpatient sites, and extensive Community Care Network (CCN).^{1,2} While VHA offers an array of services at little to no cost, most VHA enrollees have secondary coverage from either public insurance programs (e.g., Traditional Medicare [TM], Medicaid) or private payers (e.g., Medicare Advantage [MA] or employer-based plans). Nearly all 65+ year old Veterans are passively enrolled in Medicare and approximately 36% of Veterans enrolled in Medicare and VHA elect to enroll in MA.³

Although Veteran enrollment in MA is lower than the general population, it has grown significantly in recent years, with regulatory changes increasing the value and flexibility of MA coverage. Changes in MA enrollment may affect the division of coverage among public programs and therefore alter the necessary budget to cover services. How changes in MA enrollment impacts reliance on VHA services has historically been unclear.⁴

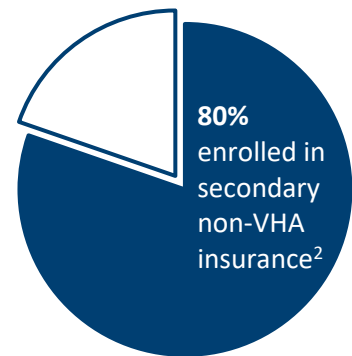
Evaluation

Approach

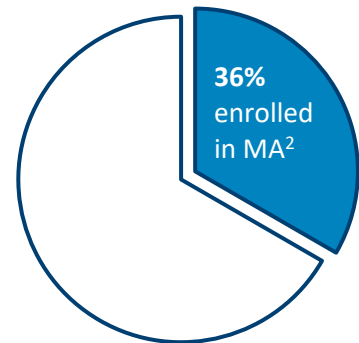
An evaluation by the Partnered Evidence-based Policy Resource Center (PEPREc) explores whether recent changes in MA plan benefit design in terms of patient cost sharing (relative to that of VHA plans) led to changes in reliance^{5,6}, including 1) higher enrollment in MA among Veterans who were already enrolled in VHA, and 2) a shift in coverage of services and Veterans' choices between VHA and non-VHA services.³

The study uses novel data provided by Milliman on the actuarial valuation of MA plans and VHA benefits, which are based on the cost-sharing structure of the plans (e.g., copayments, coinsurance, out-of-pocket maximums, deductibles, and premiums). The valuations are based on services covered by both programs. The study controls for other factors that might affect Veterans' choice of coverage, including income, education, and access to providers.

VHA Enrollees



Dual Enrollees of VHA and Medicare



Reliance



Reliance is measured as the proportion of total health care services across all sources of payment that is paid for by VHA.

PEPREc simulates several policy scenarios that illustrate the impact of changes in copayments for office visits and prescription drugs. Analyses are performed by Veteran priority group, which consider military service history, disability rating, income level, Medicaid eligibility and other benefits received. Priority groups 1, 5, 7 and 8 are evaluated in the study.³

Main Findings

The study indicates that plan benefit design, increases in physician visit copays and the combined effect of increasing outpatient and prescription drug copays, yields a **minimal** (but statistically significant) impact on VHA reliance.

Benefit Design

As VHA net plan value (relative to MA plan valuation from Milliman MACVAT data) decreases, Veterans are more likely to enroll in MA plans and shift services to be covered by MA instead of VHA. However, the effects are small. VHA reliance would decrease from 46.88% to 46.83% (**-0.05 percentage point difference**).³

Outpatient and Prescription Drug Copays

When increasing VHA copays for outpatient visits (\$10 increase for primary care physicians and \$20 increase for specialty care physicians) and increasing copays for prescription drugs (\$15 increase in copays for generic prescriptions and \$30 increase in copays for brand name prescriptions), utilization shifts very little from VHA to MA. The overall changes in reliance for this combined policy scenario results in a \$346.8 million decrease in spending for priority groups 1,5,7, and 8, which is **only 0.9%** of VA's total spending for these groups. The benefit values below are from actuarial calculations by Milliman.

<1%
of VA's total spending for priority groups 1,5,7, and 8 will be reduced from changes to reliance in this policy scenario.

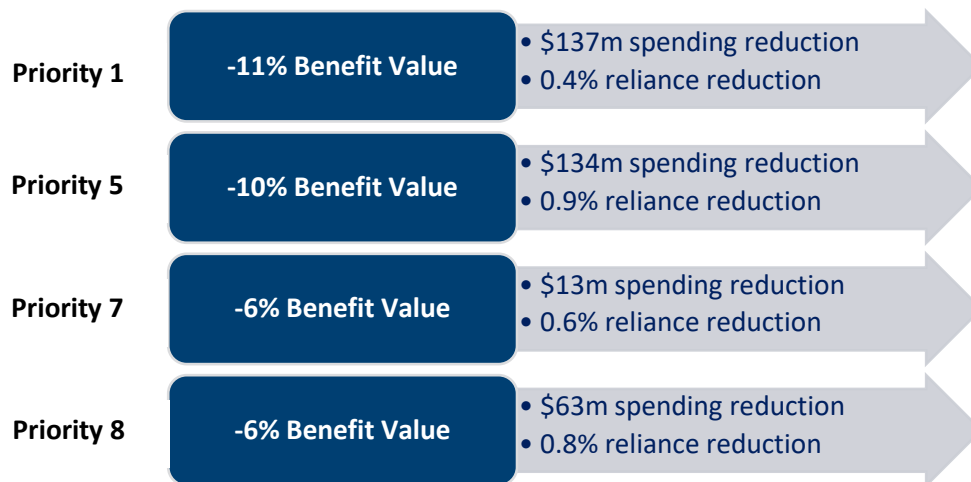


Figure 1: Combined Effect of Increased Outpatient and Prescription Drug Copays by Priority Group, numbers rounded

Conclusion

Changes in plan benefit design **marginally** affect VHA reliance. Despite results being minor, the evaluation helps inform where enrollees' care may be shifting. Because VHA is funded through congressional appropriation and has a fixed budget, while MA is funded through the same open-ended mandatory spending as TM, the federal government has an opportunity to optimize the coverage it offers.^{5,7} Policymakers will have to determine whose financial obligation it is to pay for care when determining budgets for the MA and VHA managed care systems, as well as whether VHA should pay more than alternative coverage for similar services.

Evidence from this study suggests that changes in cost sharing design might not have a large impact on the division between Medicare and VHA. More research is needed to evaluate other components of plan design, not covered in this study, to yield an optimal mix of in-house, community care, and non-VHA care.

References

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ABOUT PEPR_eC POLICY BRIEFS

This evidence-based policy brief is written by Partnered Evidence-based Policy Resource Center (PEPR_eC) staff to inform policymakers and Veterans Health Administration (VHA) managers about the evidence regarding important developments in the broader health system and economy. PEPR_eC is a Quality Enhancement Research Initiative-funded resource center that collaborates with operational partners to design and execute randomized evaluations of VHA initiatives, develops and refines performance metrics, and writes evidence-based policy briefs.

