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POLICY BRIEF

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Veteran Enrollment in Medicare Advantage: Impact on Veterans Health Administration Reliance

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Bottom Line Up Front

There is growing concern over potentially duplicative payments to Medicare Advantage (MA) plans for Veterans dually enrolled in MA and the Veterans Health Administration (VHA). Evaluators at the Partnered Evidence-based Policy Resource Center (PEPReC), in partnership with Harvard University collaborators, found that the federal government has paid some MA plans up to $1.3 billion in one year for enrollees who did not use Medicare services at all. They also found that MA plans often enroll healthier Veterans (compared to Traditional Medicare [TM]) and actively target Veterans in their marketing. Findings suggest policymakers should consider ways for VHA to recoup costs from MA plans and improve data sharing with the Centers of Medicare and Medicaid Services (CMS) to reduce waste and enhance care coordination.

Introduction

The Veterans Health Administration (VHA) provides affordable health care to over nine million enrolled Veterans. However, most of these enrollees also have other forms of insurance. For example, nearly all Veterans aged 65 and older are dually-enrolled in Medicare, and over 1 in 3 Veterans are enrolled in Medicare Advantage (MA)—the private, managed care alternative to Traditional Medicare (TM).[1] This dual enrollment raises important policy and budgetary concerns, as receiving care from both VHA and MA can lead to potentially duplicative federal spending under the current MA payment structure.

As such, evaluators at the Partnered Evidence-based Policy Resource Center (PEPReC), in partnership with Harvard University collaborators, have examined the growing MA enrollment among Veterans and whether this affects their reliance on VHA services.[2] This brief explores recent findings on Veteran health care utilization, access, and system efficiency, outlining key considerations for improving coordination and reducing potential duplication in federally funded care.

Background

MA enrollment has surged in recent years, covering over 52% of Medicare beneficiaries in 2024, up from 46% in 2022.[3] This trend is mirrored among Veterans, with increasing dual enrollment between MA and the VHA. Between 2011 and 2020, dual system use among MA–VHA enrollees grew by 63%, accounting for an estimated $78 billion in VHA spending.[1]

This overlap raises fiscal and policy concerns. While MA plans receive full capitation payments from Medicare for each enrollee, the VHA does not receive payments for Medicare-covered services rendered, creating a potential for duplicative federal spending. Specifically, a landmark study estimated that over $13 billion in duplicative payments were made between 2004 and 2009[4], and recent data further highlights that 1 in 5 Veteran dual enrollees do not utilize any Medicare-financed services in a given year.[1]

The work suggests that some MA plans are *disproportionately* enrolling Veterans, and that some plans are marketing to and tailoring benefits for the Veteran population through Veteran Medicare Advantage plans (VMAPs).[5] Despite longstanding concerns about the integrity of payments to MA plans for these dual enrollees, this topic is largely understudied. To address this gap in the literature, PEPReC and Harvard investigators undertook a series of evaluations to examine trends and patterns of dual-MA and VHA-enrollment and utilization across systems.

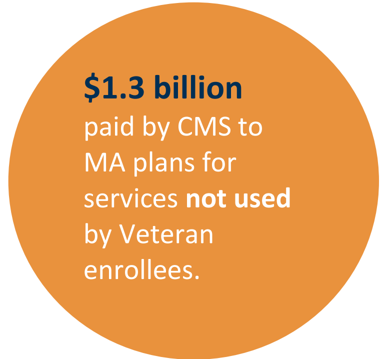
Evaluation: Dual-Enrollee Utilization of VHA[1]

Approach

In this evaluation, investigators examined Veterans' use of both VHA and MA services to identify plans with high Veteran enrollment. They also analyzed whether these Veterans differ from those in other MA plans and how their use of Medicare and VA services compares. Lastly, they estimated how much the federal government is paying to MA plans for Veterans who don't use any Medicare services—raising concerns about possible duplicative spending and overpayments to plans.

Results

From 2016 to 2022, high-veteran Medicare Advantage (MA) plans—just 6% of all MA plans—enrolled over 285,000 Veterans, or 20% of VA users in MA. In 2020, 21% of Veterans in these plans used no Medicare-financed services, compared to 10% in other MA plans and under 4% in the general MA population. Still, CMS paid $1.3 billion to MA plans for these non-users, with 19% going to high-veteran plans. Veterans in these plans were more likely to rely on VA care, especially after the 2018 VA MISSION Act expanded access to VA-paid community care.



Conclusion

This national evaluation documented the rise in Veterans' enrollment in Medicare Advantage (MA) plans, particularly in high-veteran MA plans. The findings reveal a growing challenge for the federal government: paying full MA capitation rates while also covering the Veterans' care through the VA. The rapid growth of high-veteran MA plans—especially following the VA MISSION Act—highlights the urgent need for policy solutions to reduce potentially duplicative spending and improve coordination between CMS and the VHA.

Evaluation: MA Marketing to Veterans[4]

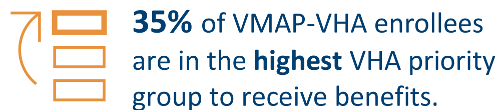
Approach

PEPReC evaluators sought to identify the growth of VMAPs and characterize their benefit designs and Veteran enrollees. They further investigated what plans may be offering to attract VHA enrollees, as well as if plans may be more successful in attracting certain types of enrollees.

Using standardized mean differences, evaluators compared the plan benefit design, supplemental benefit offerings, and Veteran enrollee characteristics of all VMAP and other MA plan enrollees in 2022. VMAPs were identified based on military-associated words in their plan name (e.g., "honor" and "valor") and further validated through a web-based search. Data included a novel directory of VMAPs using CMS MA Landscape Files, CMS Master Beneficiary Summary File, VHA Planning Systems Support Group, and publicly available CMS Plan Benefit Package Data.

Results

Nearly 60% of enrollees in VMAPs were Veterans dually covered in the VHA system, and more than one-third were in priority group 1, which means they faced no cost sharing when receiving care in the VHA.[6] Veterans enrolled in VMAPs were also slightly younger and more likely to be Black.



Evaluators further observed that 92% of VMAPs were administered by for-profit insurers, including Aetna, Humana, and United HealthCare. These VMAPs were also **more likely** than other MA plans to offer cash back benefits (up to $450 in savings annually), and additional supplemental benefits like dental.

Benefits	VMAPs	Other MA Plans
$0-Plan Premiums	99%	60%
Part B Premium Reductions	75%	9%
PPO (vs HMO)	60%	38%
NO Part D Drug Coverage	99%	4%

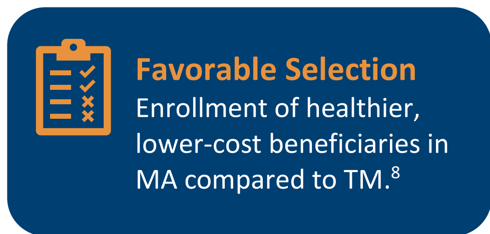
Conclusion

Findings suggest MA plans may be designing benefits to attract Veterans who rely on VHA care, making them highly profitable enrollees for the plans. Unlike typical strategies targeting healthier individuals, like offering gym memberships, VMAPs almost entirely exclude Part D prescription benefits, appealing to Veterans who get prescriptions through the VHA. Since the VHA do not bill MA plans, this could lead to increased federal spending while plans financially benefit from VHA-reliant enrollees.

Evaluation: Favorable Selection in MA vs. TM[7]

Approach

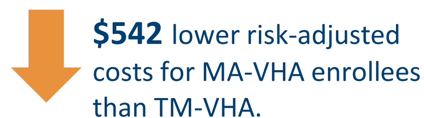
Broadening focus from VMAP plans, PEPReC evaluated whether dual MA-VHA enrollees in general are healthier and less costly than those in TM, and if any favorable selection exists after adjusting for diagnoses, demographics and pharmacy use. They investigated how much can be accounted for by the Centers for Medicare & Medicaid Services Hierarchical Condition Category (CMS-HCC) risk score methodology used to adjust MA plan payments.



This evaluation used nationally representative VHA survey and administrative data between 2016-2019, including the VHA Survey of Enrollee Data, VHA Nosos Risk Scores, and HERC Average Cost Files. Evaluators analyzed differences in dual TM and MA enrollees' risk scores over time. Generalized linear models quantified cost differences between TM and MA enrollees, adjusting for factors excluded from the CMS-HCC risk adjustment model such as Veteran-specific characteristics, mental health diagnoses, and pharmacy use.

Results

Compared to TM-VHA enrollees, MA-VHA enrollees were slightly older, more likely to have Medicaid coverage (14% vs 5%), and more likely to be in the lowest priority group facing VHA copays (22% vs 18%). MA-VHA enrollees also had significantly lower risk-adjusted costs than TM-VHA enrollees.



Conclusion

Evaluators found that MA plans enroll VHA enrollees who are **healthier** and **less costly** than TM enrollees. The findings underscore plans' ability to attract lower cost enrollees due to characteristics not

accounted for in Medicare's HCC risk adjustment model.

Policy and Practice Implications

Veterans have the right to choose between traditional Medicare and Medicare Advantage (MA) plans, including Veteran-targeted MA plans (VMAPs). However, many Veterans enrolled in VMAPs continue to rely primarily on Veterans Health Administration (VHA) services, leading to duplicative federal spending. In 2020, CMS paid over $1.3 billion to MA plans for Veterans who did not use any Medicare-financed services, while the VHA simultaneously provided their care.

To address this inefficiency, policymakers should consider adjusting MA payments to reflect actual Medicare service use, allow the VHA to recoup funds for care it provides, and improve data sharing between CMS and the VHA. Additionally, stronger oversight of VMAPs is needed to ensure they deliver promised benefits without shifting care costs to the VA.

These findings highlight the need for fair and accurate payment systems that account for Veterans' unique patterns of care. VHA policymakers need current evidence about economic factors influencing demand for VHA services. Ongoing evaluation is essential to develop effective strategies to reduce duplicative spending and improve care coordination.

Key Recommendations

- **Adjust** MA payments to reflect actual VHA service use.
- **Allow** VHA to recoup funds for care it provides from MA plans.
- **Improve** data sharing between CMS and VHA.

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ABOUT PEPReC POLICY BRIEFS

This evidence-based policy brief is written by Partnered Evidence-based Policy Resource Center (PEPReC) staff to inform policymakers and Veterans Health Administration (VHA) managers about the evidence regarding important developments in the broader health system and economy. PEPReC 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. *The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.*