TOPIC: COST SHIFTING TO THE VETERANS AFFAIRS (VA)

Background

People can have health insurance coverage from multiple payers, including Medicare, Medicaid, employers, the U.S. Department of Veterans Affairs (VA), and TRICARE.[1,2] For example, in 2022, more than 1.3 million veterans were enrolled in private Medicare Advantage (MA) health plans but also qualified for VA benefits.[3] The coordination of benefits is a process that determines which insurance is responsible for paying for specific services and in what order. For example, if someone has coverage through both a large employer group health plan and Medicare, the employer-sponsored plan is the primary payer and pays first for any covered services while Medicare is the secondary payer and covers any remaining eligible costs.[4] The Centers for Medicare & Medicaid Services (CMS) has the infrastructure to coordinate benefits and ensure that Medicare does not pay when another insurer is the primary payer. However, there is no coordination of benefits between Medicare and the VA.[5]

Key Points

- MA enrollees who also have health benefits through the VA can receive care that is paid for by either system; the VA spent an estimated $22.7 billion in 2023 on care for veterans who were enrolled in MA plans.
- This scenario creates waste when Medicare pays a capitated rate for MA plans to provide all services for their enrollees but the VA also pays for health care services. MA organizations may abuse overlap by steering enrollees to maximize VA utilization, thereby shifting costs to the VA.
- Mitigation strategies include improving data sharing, allowing VA to seek reimbursement from MA plans for services it delivered to MA enrollees, revising capitation rates paid to MA plans for veterans, creating a Special Needs Plan (SNP) for beneficiaries eligible for Medicare and VA benefits, and regulating the use of rebate dollars.

Potential for Fraud, Waste, and Abuse (FWA)

To reduce costs, MA plans may identify ways to shift costs to other parties, including providers, beneficiaries, and other payers. For veterans enrolled in Traditional Medicare (TM), the VA typically will pay only for covered services delivered by VA providers, while Medicare will pay for covered services rendered by non-VA providers. However, when veterans are enrolled in MA health plans, the government pays a fixed per-person, per-month, or capitated, amount for

veterans even if they receive all or most of their services through the VA. In this case, the federal government is making duplicate payments for health coverage for these beneficiaries. A 2023 U.S. Department of Health and Human Services Office of Inspector General (OIG) report found that between 2017 and 2021, TM and the VA paid approximately $128 million in duplicate payments.[6] The scope of the problem is potentially much greater for MA, with another study estimating that in 2020 alone, Medicare paid MA plans $1.3 billion for VA enrollees who received no care from their MA plan; this number would be much higher if it included waste due to payments to MA plans for enrolled veterans who receive a mix of services from both MA and the VA.[7] In addition, the VA spent an estimated $22.7 billion in 2023 on care for veterans who were enrolled in MA plans, a 77% increase since 2019 over a period when the number of veterans with VA coverage who were also enrolled in an MA plan increased by 28%.[8] CMS adjusts county-level capitated rates based on the relative TM costs for beneficiaries who are eligible for benefits through the VA, the Department of War (DoW) (formerly the Department of Defense), and the Uniformed Services Family Health Plan, but it does not account for actual service utilization among MA enrollees using VA or DoW benefits and it increases payments to plans in counties with large numbers of veterans and lower traditional Medicare spending on veterans.[9,10] MA plans may also selectively market to and enroll beneficiaries who qualify for and utilize VA services because their utilization of MA benefits will be relatively low (see also the Favorable Selection section), and may steer beneficiaries to maximize their use of VA services, thereby shifting costs to the VA.

While precedence rules are clearer for most other payers, there is still some risk that MA plans may shift costs to other payers. For example, state Medicaid agencies will pay the monthly premium for beneficiaries who are dually eligible for Medicaid and Medicare and enrolled in an MA plan.[11] For some categories of Medicaid coverage, states will also cover MA copayments.[12] Because enrollees in these plans do not pay premiums or cost sharing, they derive no direct benefit from a reduction in premiums or copayments. When organizations offering MA plans bid below the applicable county benchmark, they receive a portion of the difference between the bid and the benchmark through a rebate that they can use to reduce beneficiary premiums and cost sharing or to offer supplemental benefits like dental and vision coverage. MA plans have an incentive to use rebates on supplemental benefits that will appeal to beneficiaries and to retain higher beneficiary premiums and cost sharing, thereby shifting costs to the Medicaid programs paying the premium and possible copayments for beneficiaries enrolled in both programs. Similarly, TRICARE For Life (TFL) provides Medicare-wraparound coverage for veterans by paying deductibles and coinsurance for services covered by Medicare and TRICARE for beneficiaries who are enrolled in both.[13] This reduces or eliminates out-of-pocket costs for the enrollee. Therefore, MA plans may have an incentive to increase out-of-pocket costs because they do not directly affect enrollees and instead use rebates to provide supplemental

benefits that are attractive to beneficiaries. This cost shifting increases total health care costs for the government and could be considered waste or abuse.

There are also some instances where MA plans may shift costs to enrollees or to providers. For example, "ghost networks,"[14] which refers to inaccurate representation of certain providers' availability or status as an in-network provider, especially providers of frequently utilized or expensive services (e.g., behavioral health), may force enrollees to seek more expensive out-of-network care than the MA plan would otherwise have covered, thereby shifting costs to enrollees. (See Network Adequacy and Misrepresentation of Provider Networks section). There are also instances where MA organizations may shift costs to providers by requiring providers to cover a portion of the costs for the plan's advertised supplemental benefits through a Division of Financial Responsibility clause in provider contracts.[15]

Mitigation Approaches

Improve Data Sharing. OIG concluded that duplicate payments between the VA and TM were caused by a lack of CMS oversight.[16] One policy option that OIG recommended was for CMS to integrate VA data and establish a process to identify and address FWA.[17] Although this strategy was targeted toward duplicate payments with TM, it could also help CMS to understand and address FWA associated with MA. CMS commented that it is working with the VA to establish a comprehensive, ongoing data sharing agreement.[18] CMS also stated that once the data sharing agreement is implemented, it will work toward an interagency process to integrate VA enrollment, claims, and payment data into CMS data.[19] These data could be used for both TM and MA. As of July 2025, a data matching agreement was established between the VA and CMS.[20] Improved data sharing could identify some instances of providers or suppliers submitting duplicative claims to MA plans and the VA and would be critical in implementing other payment reform options.

Allow the VA to seek reimbursement from MA plans for services it delivered to MA enrollees. MA plans could be designated as the primary payer and the VA as the secondary payer (or vice versa).[21,22,23,24] A similar system currently exists for Medicare and Medicaid where Medicare is the primary payer and Medicaid is the secondary payer.[25] For example, if MA were the primary payer, the VA could seek reimbursement from MA plans when it delivers or pays for services that are also covered by MA plans.[26,27,28,29]

This policy option would reduce confusion about which payer a provider should bill and which program pays for services and it could reduce duplicative payments between payers. A weakness of this approach is that, although it would reduce waste from duplicative government spending, it would achieve this by shifting costs away from VA (discretionary spending), with minimal impact on MA (mandatory) spending if MA plans were to become the primary payer.

Total Medicare spending on VA-eligible veterans enrolled in MA would remain higher than it would be if they were covered by TM. Another limitation is that this approach could create uncertainty about which entity is responsible for managing and coordinating a veteran's care, as both the VA and MA plans each operates their own distinct provider networks and may cover similar services.[30] This concern could be mitigated through clear guidance about the use of prior authorization, VA facilities, and provider networks, such as requiring MA plans to treat all VA facilities as in-network providers and not charge any patient cost sharing for use of those services.

To implement VA reimbursement from MA plans, data sharing and coordination processes would be critical to ensure that CMS can identify services delivered or paid for by the VA for MA enrollees and notify the VA to seek payment from the appropriate MA plan. In addition, as outlined in the proposed GUARD Veterans' Health Care Act, Congress would need to make changes to the current statutes that limit the VA's ability to collect reimbursements.[31,32]

Revise the capitation rates paid to MA plans for veterans. Although CMS adjusts county-level rates, it does not account for actual service utilization among MA enrollees who are also eligible for benefits through the VA or DoW.[33,34] The benchmark adjustments do not account for the fact that enrollees may receive a majority of their care through the VA and they exacerbate the problem by creating higher benchmarks where spending on veterans is likely to be lower. For example, a study using 2021 data found that beneficiaries enrolled in both high-veteran MA plans and VA were more likely to have surgical care paid for by the VA than by the MA plan.[35] Payments to MA plans for veterans who receive all or most of their services from the VA represent significant waste.[36] An option to address this risk is for CMS to revise the capitation rates paid to MA plans for veterans who receive all (or some) of their care through the VA, either prospectively or retrospectively.[37,38,39,40] By revising the capitation rates to reflect actual use of services, payments to MA plans would be more accurate and reduce possible wasteful or duplicative payments to MA plans and VA.[41] Current, detailed data on MA beneficiary use of VA services and on MA plan spending on VA-eligible enrollee care would be necessary to determine the feasibility and implications of this option.

One weakness of revising capitation rates is that it may disincentivize MA plans from enrolling veterans, because they will become less profitable.[42,43] Capitation rates could be set to ensure that VA-covered beneficiaries are no less profitable for MA plans than other beneficiaries on average. Significant variation in MA utilization among VA-covered beneficiaries could also make it difficult to set rates appropriately and incentivize favorable selection among VA-covered beneficiaries. Such changes also could further incentivize MA plans to encourage veterans to maximize use of VA-funded services to try to manage spending within the capitation rate. In

addition, changes in capitated rates would need to be designed carefully to address additional complexities such as veterans' TRICARE eligibility.[44]

Create a Special Needs Plan (SNP) for beneficiaries who are eligible for Medicare and VA. If the law were changed to allow the VA to collect reimbursement for care delivered to MA enrollees, Congress could also authorize CMS to design a SNP option for MA enrollees with VA coverage. A SNP is an MA coordinated plan that is designed to provide care for certain enrollees, such as those with chronic conditions.[45] For example, dual eligible SNPs (D-SNPs) are a type of MA plan designed for people who qualify for both Medicare and Medicaid.[46] Fully integrated D-SNPs are required to coordinate and integrate services and payments across both programs. A similar fully integrated plan could reduce care fragmentation and promote more efficient government spending by avoiding duplicative utilization across the two systems and minimizing cost shifting. There are currently no requirements for MA plans to coordinate benefits with the VA, even when they claim to do so. Weaknesses may be similar to D-SNPs where MA plans may offer look-alikes or "mirror" plans, which primarily enroll dually eligible individuals but are not D-SNPs.[47] Look-alike plans are not subject to the same regulatory requirements, such as care coordination, which may create a risk for fraud and abuse if plans mislead beneficiaries about the coverage offered under these plans. They may present risks of waste if lack of coordination contributes to duplication of services or payments (see D-SNP Look-alikes section). CMS and the VA would need to collaborate to address implementation challenges, including coordinating appeals processes, designing appropriate coordination for veterans with different levels of VA benefits, and managing VA and MA provider networks without unduly limiting beneficiary choice.

Regulate the use of rebate dollars. Another policy option would be for CMS or Congress to regulate how MA organizations spend rebates. MA plans receive rebates from CMS when they bid below the benchmark for providing Medicare-covered services to their enrollees. When other payers, like Medicaid or the VA, cover beneficiaries' premiums and cost sharing, MA organizations still receive rebate dollars from CMS. CMS or Congress could consider whether rebates should be used first to reduce beneficiary premiums and cost sharing for Part A and Part B services before offering supplemental benefits in plans designed for beneficiaries who are also eligible for VA, Medicaid, or TFL. If rebates were required to reduce the beneficiary payments that the other payer would usually cover, this could reduce cost shifting to other payers and reduce waste by reducing total government health care spending, although it would not reduce MA spending. MA plans would face complexities in implementing this approach as copayments may differ for beneficiaries within a given plan depending on their level of eligibility for Medicaid or VA benefits. It also would not address the risk of cost shifting to other payers—such as Medicaid, VA, or TFL—for beneficiaries who are eligible for Medicare and another health insurance program but are not enrolled in a plan designed for dually eligible

beneficiaries. A variant of this option would be to give secondary payers the ability to recoup premium and cost-sharing costs from MA plans if they offer supplemental benefits. For example, when a Medicaid payer receives a copayment bill from a provider for a covered service delivered to an MA enrollee, the Medicaid payer could demand payment from the MA plan if the plan offers supplemental benefits. This would be consistent with the intent that Medicare, as the primary payer, is responsible for all Part A and B services, and could incentivize MA plans to focus on reducing costs for those services. However, it could also reduce supplemental benefit offerings, which can be attractive to beneficiaries and a valuable tool for MA plans to enroll and retain beneficiaries. To implement this option for VA-covered beneficiaries, Congress would also need to determine that Medicare is the primary payer over the VA as discussed above.

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