The Changing Face of Veterans and Implications for Policy: Insurance Coverage for US Veterans from 2010-2021

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Acknowledgements

- This material is based upon work supported by the Department of Veterans Affairs, Veterans Health Administration, Office of Research and Development grants RCS 17-154 and IIR 19-421.

- No conflicts of interest

- Any views expressed today are mine alone and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

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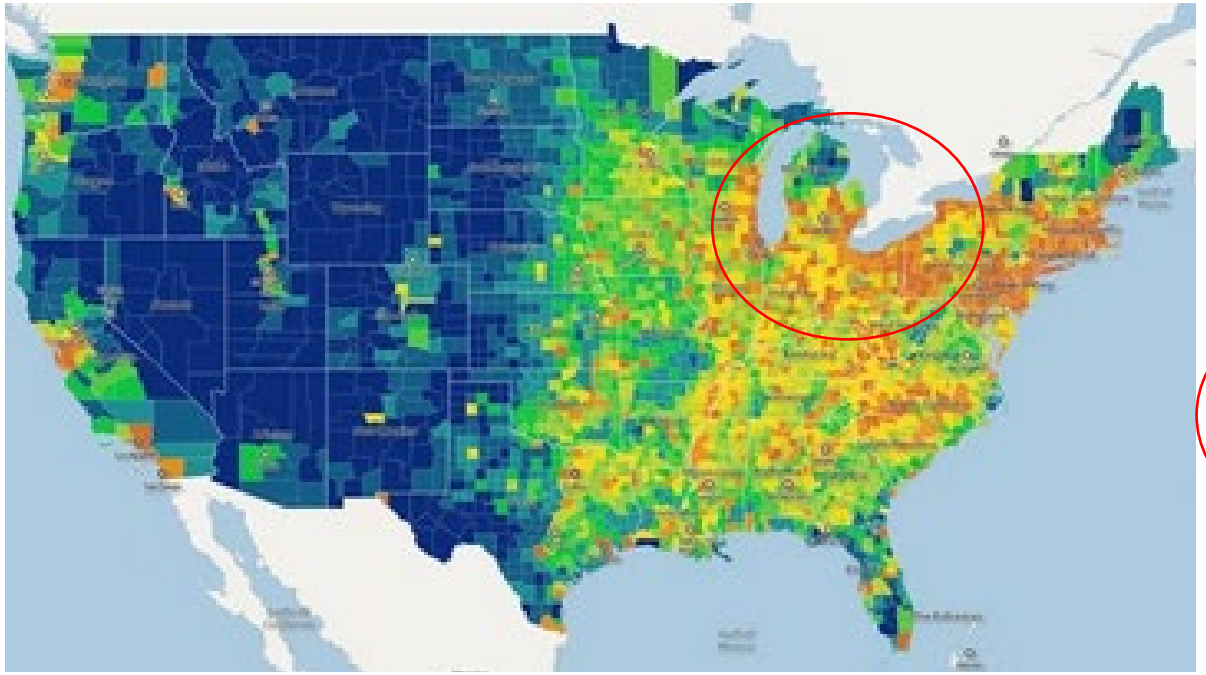
VA Access

- VA has always grappled with providing Veterans access to care.
- In the 1940s, the VA decided to build VA hospitals
- This created facilities where Veterans had priority and services were specialized for Veterans, but there are tradeoffs
  - Fixed assets
  - Current hospitals do not always match demand
  - Newest VA hospital was Las Vegas 2012, excluding New Orleans which was rebuilt after Katrina

Population Changes



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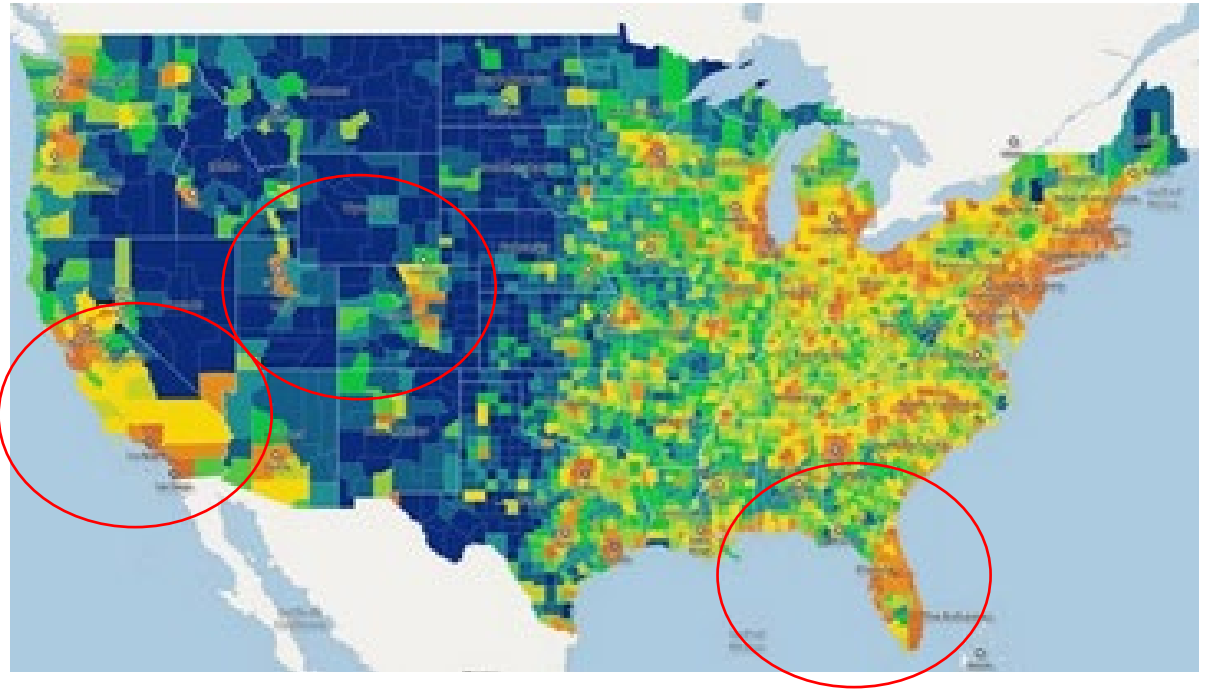

2010

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Tradeoffs

- Ongoing tensions about VA investments in:
  - Specialty or primary care
  - VA provided or VA purchased care
  - Investing in in-person care or virtual care
  - Building new facilities (what kind, location, etc) or mobile units

- This tradeoff came to a head in 2014.

Epidemic of VA Mismanagement

On April 23, CNN aired an interview with retired VA physician Dr. Sam Foote, who made allegations about scheduling practices, delayed care and patient deaths in the Phoenix VA system. More whistleblowers came forward across the country and it soon became apparent that VA's problems went far beyond Phoenix.

1 Phoenix, Ariz.

APRIL 2014

Multiple whistle blowers in the Phoenix VA Health Care System step forward with allegations of two separate waiting lists, the public electronic list, and an offline secret list maintained to enable falsifying the electronic results to keep patient wait times within VA's acceptable guidelines.

As many as 40 veterans or more may have died while waiting to receive care.

MAY 2, 2014

In the aftermath of allegations, two VA employees are motivated to move to secure documents alleging that there was a systematic effort underway at the hospital to shred documents to eliminate evidence of the waiting list cover-up.

PHOENIX VA - BY THE NUMBERS

1,400 Phoenix VA patients included on the Electronic Wait List, but no primary care appointment scheduled.

1,700 Phoenix VA patients never entered into the Electronic Wait List (EWL).

1,100 newly enrolled patients in the Phoenix New Enrollee Appointment Request (NEAR) tracking report who requested a primary care appointment. As of April 28, 2014, these patients were not included on the EWL and did not have appointments.

400 newly enrolled veterans who called the Phoenix Helpline and requested a primary care appointment. As of April 28, 2014, these patients were not included on the EWL and did not have appointments.

200 Phoenix VA patients who, as of April 2014, were not included on the EWL and did not have appointments after being given a "Schedule an Appointment Consult" from emergency department physicians, inpatient services, or mental health providers.

$9,345 Bonus received in 2013 by Phoenix VA Director Sharon Helman for a "highly successful rating," which included "significant improvements in removing some of the access concerns, the long waits, moving to the electronic wait list." according to *The Wall Street Journal*. Helman is currently on administrative leave.

4 Cheyenne, Wy.

MAY 9, 2014

A VA employee is put on leave when an email surfaces on CBS News detailing specific instructions for "gaming the system" to "get off the bad boys list."

The employee is placed on suspension in May, when the story breaks, but another whistle blower in the Cheyenne office notes VA's Office of the Special Counsel was informed of the situation in December 2013, five months before VA response to the accusations.

2 Fort Collins, Colo.

MAY 2014

As mentioned in the Texas allegations, employees in Fort Collins, Colo., were directed to manipulate the books to conceal evidence of lengthy wait times for appointments.

9 Albuquerque, N.M.

MAY 18, 2014

According to a doctor at the center, veterans with serious heart conditions, gangrene and even brain tumors waited months for care at the Raymond G. Murphy VA Medical Center.

3 Austin and San Antonio, Texas

MAY 8, 2014

A former staff member for VA is quoted in the Austin *American Statesman* accusing supervisors of forcing concealment of long wait times by manipulating the scheduling system.

The alleged falsification is said to have occurred in locations in Austin and the Central Texas Veterans Health Care System in San Antonio.

6 St. Louis

May 12, 2014

In an interview with AP, former St. Louis VA chief of psychiatry alleges that he was demoted for trying to improve productivity, prompting an investigation.

7 Chicago

May 13, 2014

A VA social worker details on CBS News how scheduling wait times are manipulated in order to protect pay bonuses.

8 Burlington, Vt.

May 14, 2014

Veteran suffering from PTSD dies in incident with son after long struggle to receive care from VA, frustrated by being shuttled between multiple counselors with maddening wait times.

Pittsburgh

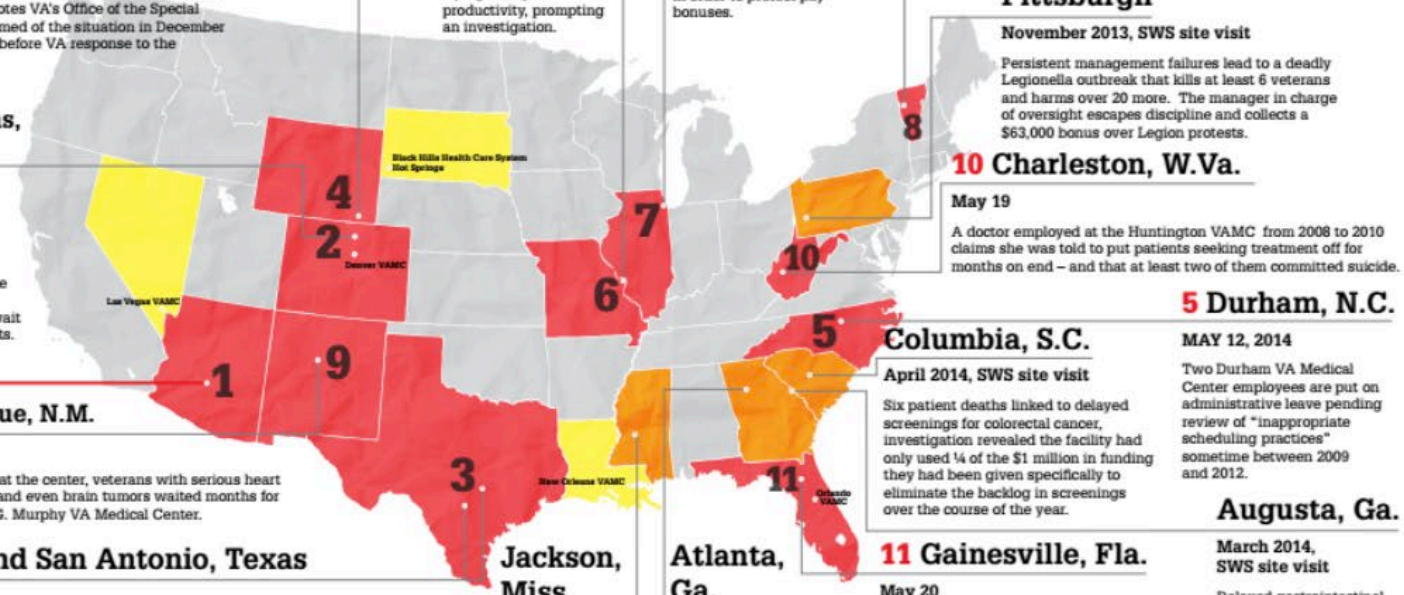
November 2013, SWS site visit

Persistent management failures lead to a deadly Legionella outbreak that kills at least 6 veterans and harms over 20 more. The manager in charge of oversight escapes discipline and collects a $63,000 bonus over Legion protests.

10 Charleston, W.Va.

May 19

A doctor employed at the Huntington VAMC from 2008 to 2010 claims she was told to put patients seeking treatment off for months on end – and that at least two of them committed suicide.



5 Durham, N.C.

MAY 12, 2014

Two Durham VA Medical Center employees are put on administrative leave pending review of "inappropriate scheduling practices" sometime between 2009 and 2012.

Columbia, S.C.

April 2014, SWS site visit

Six patient deaths linked to delayed screenings for colorectal cancer, investigation revealed the facility had only used ¼ of the $1 million in funding they had been given specifically to eliminate the backlog in screenings over the course of the year.

Augusta, Ga.

March 2014, SWS site visit

Delayed gastrointestinal consults result in at least seven veterans adversely affected by the delays in care.

Jackson, Miss.

January 2014, SWS site visit

Multiple whistleblower complaints range from misdiagnosis of fatal illnesses to improper sterilization of instruments and failures in hospital management practices. After nearly 70% turnover in management, slow progress is now being made.

Atlanta, Ga.

January 2014, SWS site visit

Despite four preventable patient deaths, three of which were linked to widespread mismanagement, medical center director received $65,000 in bonuses over four years over the protest of The American Legion and local veterans.

11 Gainesville, Fla.

May 20

An audit team sent to the Malcom Randall VAMC discovered a list of patients needing follow-up appointments that was kept on paper instead of in VA's electronic system.

Construction and resource allocation concerns

In addition to preventable patient deaths, The American Legion has voiced concern over other mismanagment issues. In Orlando, Fla., New Orleans, Denver and Las Vegas, massive mismanagement of construction contracts result in four major projects that were $1.5 billion over budget and were delayed an average of 35 months. Once completed, the Las Vegas hospital lacked an ambulance bay for their Emergency Room, requiring an additional $16-25 million in funding to repair the grievous oversight.

In Hot Springs, S.D., The American Legion supports local veterans' protests against the shutdown of a VA medical facility which would require patients in rural areas to travel to a distant facility for care.

The VA Claims Backlog

VA reports a backlog of 271,740 disabilty benefit claims that exceed 125 days for adjudication. The types of claims that VA includes in this backlog statistic are initial claims for service connected disability, pension or claims for surviving dependents. The claims not included in that statistic are:

- Award adjustments such as dependency claims – 305,788
- Program Reviews – 53,416
- Other compensation reviews – 129,628
- Pension adjustments – 17,291
- Pension program reviews – 24,944
- Other pension reviews – 2,314
- Appeals – 275,181

When VA's acknowledged numbers are combined with the unreported claims awaiting adjudication, the true backlog number comes to 1,080,301. While they may have made improvements to a portion of the backlog, VA only reports on about 25% of the actual backlog.

#NotJustPhoenix

THE AMERICAN LEGION

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Response

- VA Secretary Shinseki resigned
- Congress/Obama allocated $15 billion for FY2015-17 to improve access
  - $5 billion used to expand VA clinics and reduce wait times
  - $10 billion designated to expand VA's ability to purchase care in the community.
- Congress/Trump passed the MISSION act to continue and expand the Community Care program.

Access

- Since 2014, policymakers in DC have been laser-focused on whether Veterans have sufficient access to health care.

- In total, they have passed four major bills to expand access to health care
  - Choice Act of 2014
  - MISSION Act of 2018
  - Compact Act of 2020
  - PACT Act 2022

Eligibility for VA-Purchased Care

- Veterans Choice Program (Oct. 2015 - June 2019)
  - Wait times >30 days
  - Live > 40 miles from the facility
- MISSION Act (June 2019-present)
  - 30-minute drive time for primary care or mental health care
  - 60-minute drive time for specialty care
- Compact Act
  - Acute psychiatric distress
  - VA is responsible for all veterans (not just those honorably discharged)
- PACT Act
  - Toxic exposures

Some in Congress Want Further Expansions

- Tester (Montana) Introduced Comprehensive Bill to Improve Veterans' Access to Timely Community Care.

  https://www.Veterans.senate.gov/2023/9/tester-introduces-comprehensive-bill-to-improve-Veterans-access-to-timely-community-care

- "Red Team" Commission issues serious warning.

  "The increasing number of Veterans referred to community providers … threaten to materially erode the VA's direct care system."

  https://prospect.org/health/2024-04-11-privatization-warning-veterans-affairs/

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Current State of Evidence

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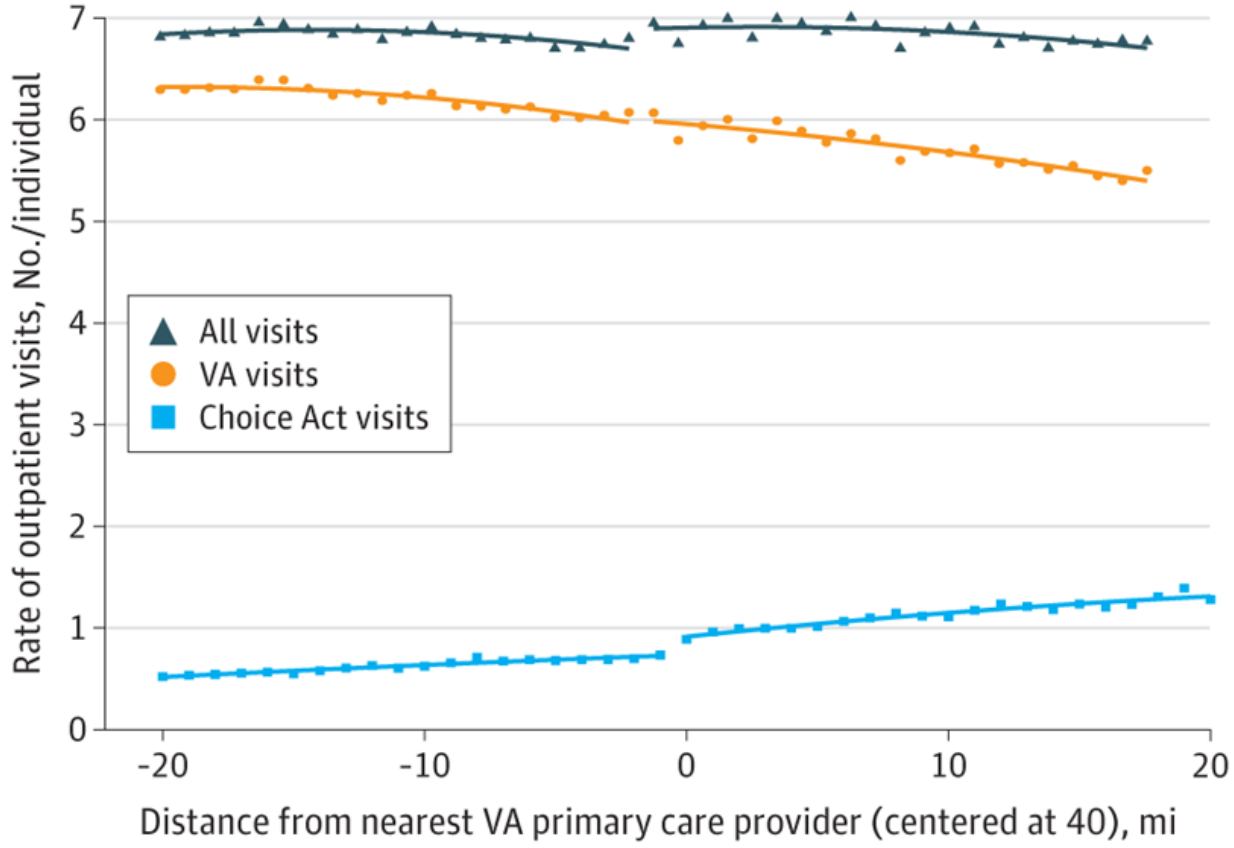
Outpatient Utilization Increased as a Result of the Choice Act

Regression Discontinuity



Rose L, Aouad M, Graham L, Schoemaker L, Wagner T. Association of expanded health care networks with utilization among Veterans Affairs enrollees. JAMA Network Open. 2021 Oct 1;4(10):e2131141-.

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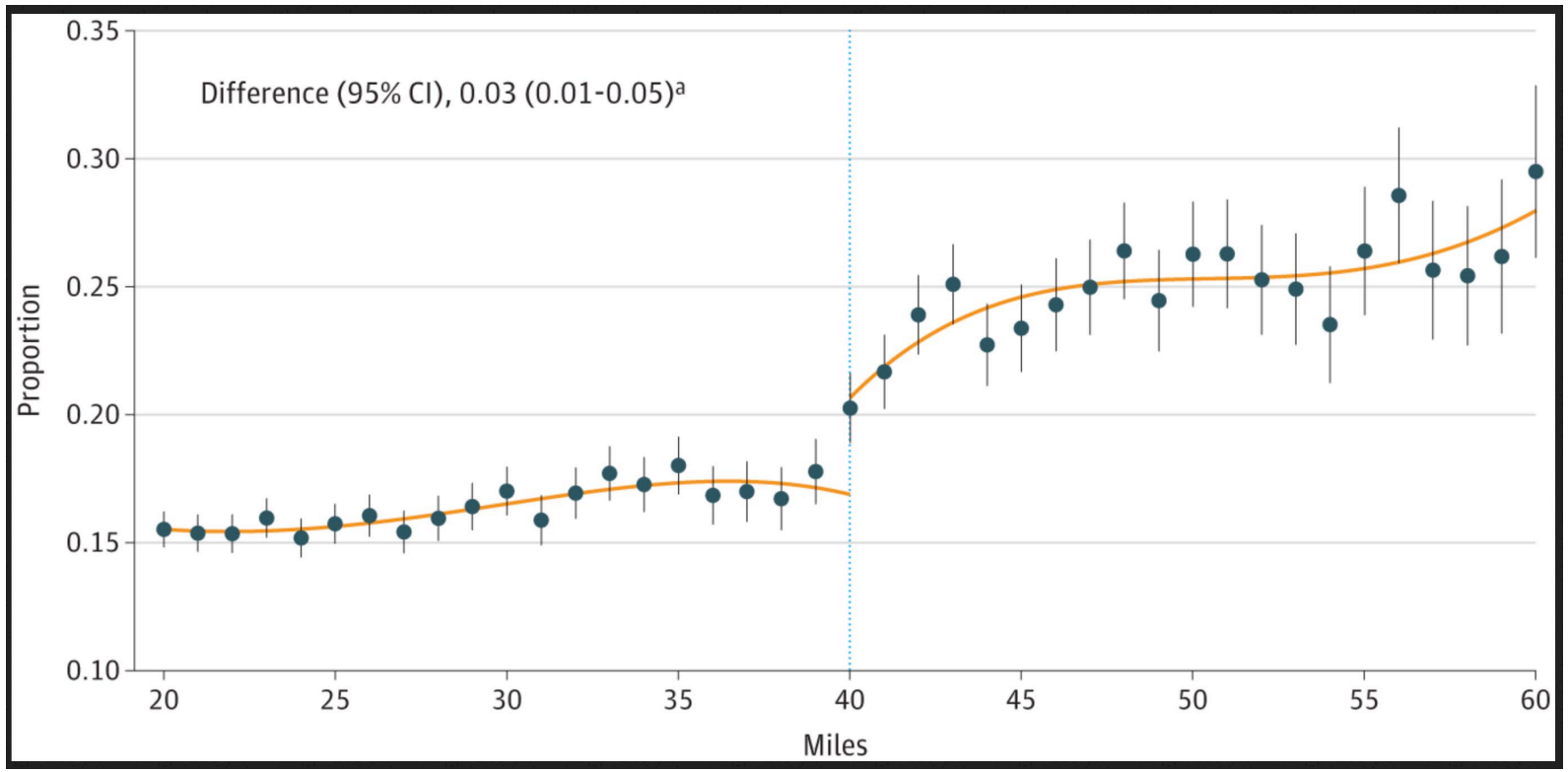
Similar Increases in Surgical Care:
Regression Discontinuity



Graham LA, Schoemaker L, Rose L, Morris AM, Aouad M, Wagner TH. Expansion of the Veterans Health Administration network and surgical outcomes. JAMA surgery. 2022 Dec 1;157(12):1115-23.

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Similar Results with Different Methods

Difference in Hospitalization Rates by System and Payer

	Mean difference in outcome rates, % (95% CI)[a]		
	Hospitalizations		
Characteristic	VA	VA-paid community	Medicaid
Post-VCA period	−4.3 (−5.3 to −3.2)	5.0 (2.6 to 7.3)	NA
Medicaid expansion	−2.5 (−3.4 to −1.5)	NA	19.3 (15.9 to 22.7)

Abbreviations: NA, not applicable; VA, Veterans Affairs; VCA, Veterans' Choice Act.

Yoon J, et al. Health care access expansions and use of Veterans Affairs and other hospitals by Veterans. In JAMA Health Forum 2022 Jun 3 https://jamanetwork.com/journals/jama-health-forum/fullarticle/2793286

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Spending Increased Markedly

- In 2010, VA spent approximately $10 billion on VA purchased care.
- In 2023, VA spent over $26 on VA purchased care.
- Congressional Budget Office report noted that the President's 2024 budget included $551 billion for military compensation
  - VA $321 billion
  - Department of Defense $230 billion.
  - "Since 2000, the total budget for military compensation has been rising steadily, even though the number of military personnel and Veterans has been declining. Spending by VA has accounted for most of that increase…"

Congressional Budget Office. Atlas of Military Compensation. 2024 https://www.cbo.gov/publication/59475

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Outcomes Did Not Improve:
Regression Discontinuity

- Despite increases in utilization no improvements in outcomes.

	Enrollee group					
Outcome	All	High CCI	Priority group 1-4	<65 y, Priority group 8	PTSD	Medicare enrolled
Patient-years, No.	8 029 135	146 696	4 307 710	1 518 362	899 741	4 897 373
Mortality						
Mortality rate per 10 000 enrollees at mile 39	346.0	575.5	315.7	56.2	223.5	498.5
Change in mortality rate per 10 000 enrollees at mile 40, No. (95% CI)	3.4 (-10.7 to 17.5)	7.4 (-21.6 to 36.4)	6.8 (-15.1 to 28.6)	-2.5 (-12.5 to 7.4)	8.8 (-15.2 to 32.7)	-0.7 (-17.4 to 16.1)
Change in mortality rate per 10 000 enrollees at mile 40, % (95% CI)	1.0 (-3.1 to 5.1)	1.3 (-3.8 to 6.3)	2.1 (-4.8 to 9.1)	-4.5 (-22.2 to 13.2)	3.9 (-6.8 to 14.6)	-0.1 (-3.5 to 3.2)

- Additional Outcomes: postoperative mortality, readmissions, or emergency department visits.

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Mortality Effect Replicated

Mean difference in outcome rates, % (95% CI)	
Characteristic	**Mortality**
Post-VCA period	0.02 (−0.02 to 0.06)
Medicaid expansion	0.002 (−0.03 to 0.04)

Yoon J, et al. Health care access expansions and use of Veterans Affairs and other hospitals by Veterans. In JAMA Health Forum 2022 Jun 3 https://jamanetwork.com/journals/jama-health-forum/fullarticle/2793286

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Why No Improved Outcomes?

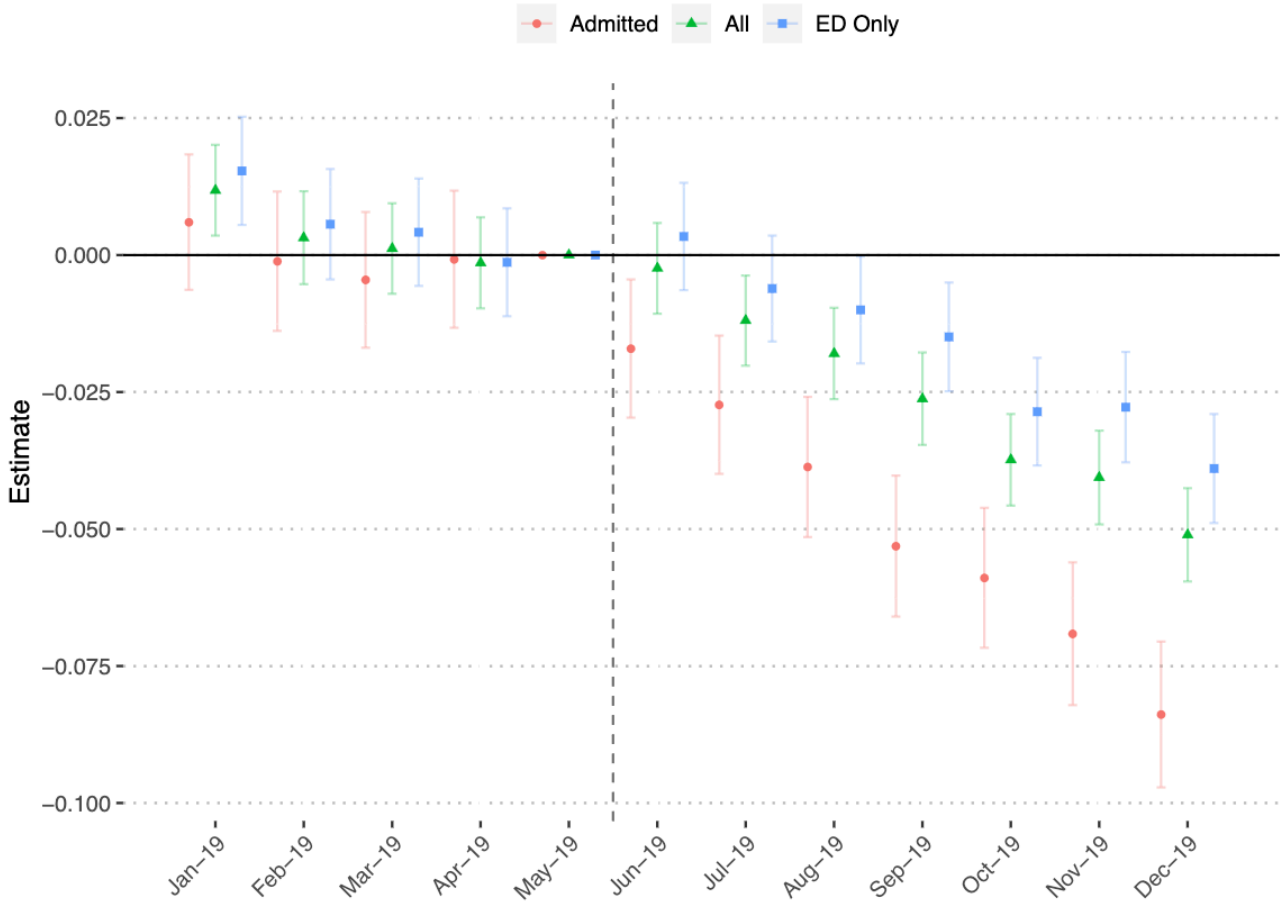
- Maybe we are measuring the wrong outcomes.
- Maybe there are heterogeneous treatment effects, although we've tested for this.
- Maybe there were no improvements. This could happen if Veterans were shifting their payer.

What is Payer Shifting

- A Veteran gets care in the community as they did before, but instead of using their other insurance, they use VA.

- Payer shifting rests on some key assumptions
  - Veterans are dual covered (VA plus another form of insurance)
  - Supply of physicians who are willing to take VA payment
  - Shifting is not harmful to Veterans
  - The pace of shifting depends on the marginal benefits
    - Convenience
    - Out of pocket costs

Payer Shifting



Difference in probability of having Medicare as the payer of an emergency department (ED) visit for VA enrollees compared to all other individuals

Event study figure showing the difference in probability that Medicare pays for an ED visit between VA enrollees and all others by month.

Rose L, Tran D, Wu S, Dalton A, Kirsh S, Vashi A. Payer shifting after expansions in access to private care among veterans. Health Services Research. 2023 Apr 19.

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Payer Shifting Is Intriguing But Preliminary

- Analysis uses all payer claims data from NY state (SPARCS data)
  - SPARCS data included inpatient and ED visits
  - Ideally would be confirmed by other all payer claims data
- Making projections is challenging because the population of Veterans changes over time.
- We sought understand how insurance coverage has changed over the past 15 years.

How is Insurance Coverage among Veterans Changing?

- We analyze four national surveys to understand how insurance coverage and enrollment in VA has changed between 2010 and 2021.
  - National Health Interview Survey (NHIS) 377,856 adults, 9% Veterans
  - The American Community Survey (ACS) 27,000,161 adults, 8% Veterans
  - The Behavioral Risk Factor Surveillance System (BRFSS) 4,612,289 adults, 12% Veterans
  - VA Survey of Enrollees (SOE) 535,394 adults
- Surveys used different questions and some even changed questions during this time. We worked to harmonize as best as possible.
- Triangulation is a key benefit of multiple surveys.

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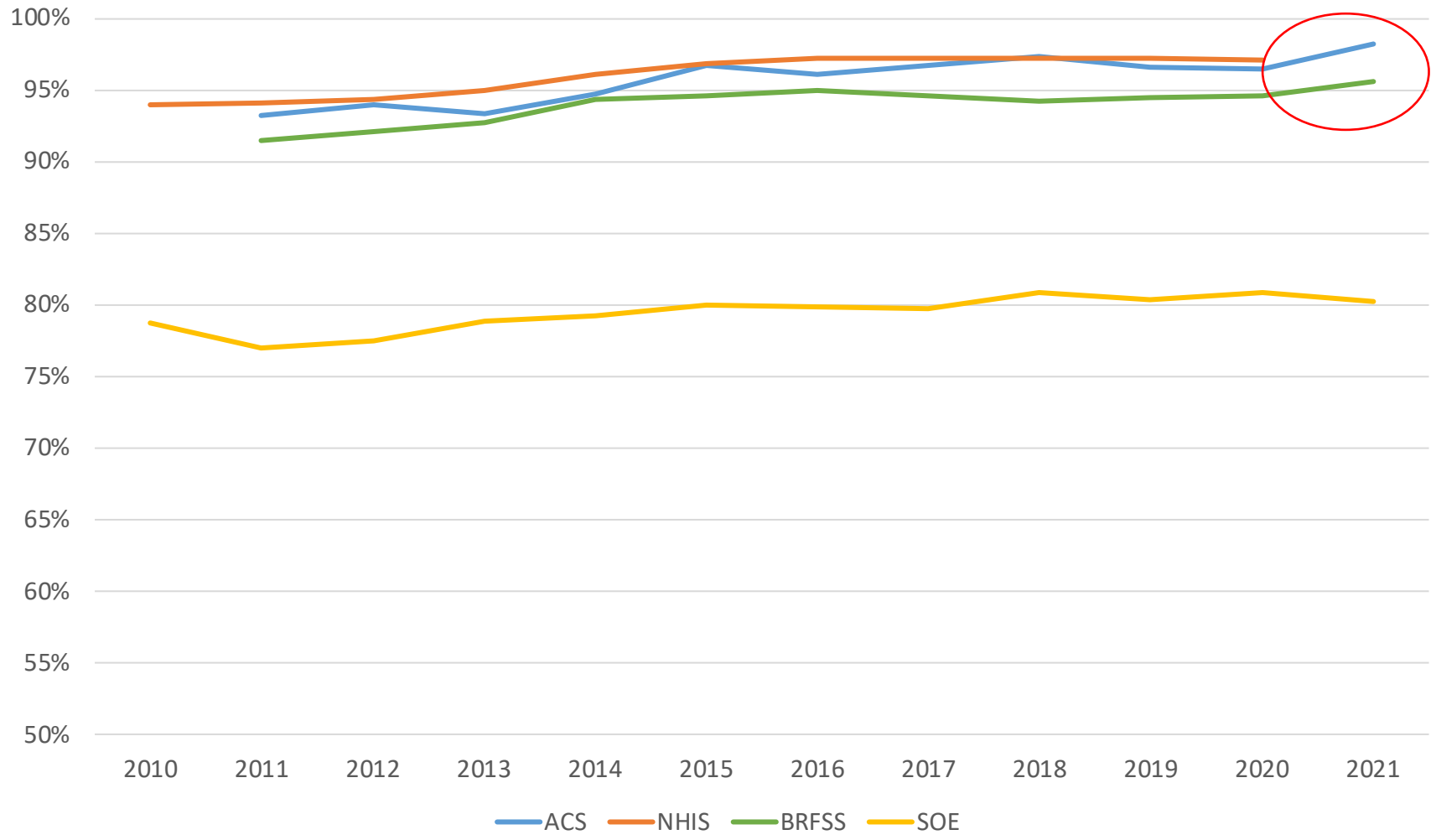
Analysis

- We weighted the descriptive analyses using the weights provided.
- We did not run any regression models. We wanted to provide unconditional population statistics.
- We are presenting the top 5 findings.

1) Veterans are well insured

Any Insurance Coverage



In 2021, 96% of Veterans had health insurance

Other coverage excluding VA

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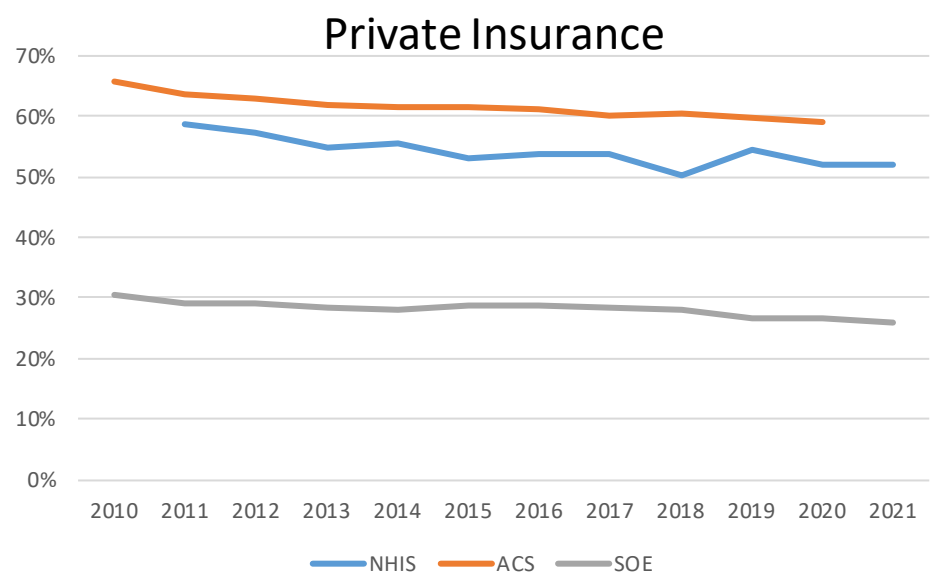
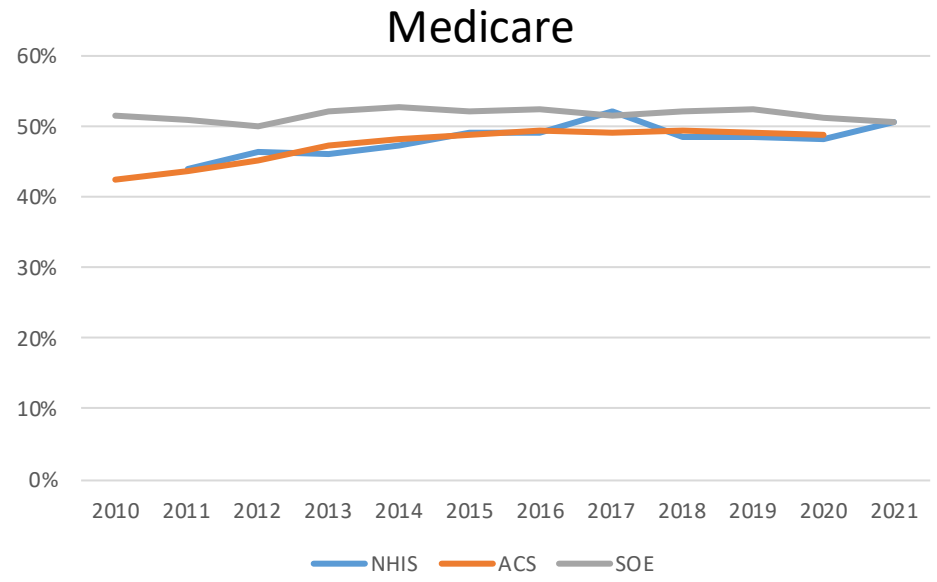
Changes by Insurance Type over Time





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2) Most Veterans Do Not Report Enrolling In VA

3) 80% of VA-enrollees have another source of insurance

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Insurance Coverage by VA Enrollment Status (2019-2021)

	Overall			Not enrolled in VA			Enrolled in VA		
	NHIS	ACS	SOE	NHIS	ACS	SOE	NHIS	ACS	SOE
VA	32.0	34.8	85.8						
Private	52.8	59.4	26.4	58.8%	61.9	36.7	38.9	54.7	24.7
Medicare	49.1	48.9	51.4	48.5%	44.3	47.4	48.1	57.6	52.0
Tricare	22.1	23.8	22.5	18.3%	21.9	26.2	34.4	27.4	22.0
Medicaid	4.0	9.3	7.2	4.4%	8.0	8.3	3.1	11.7	7.0

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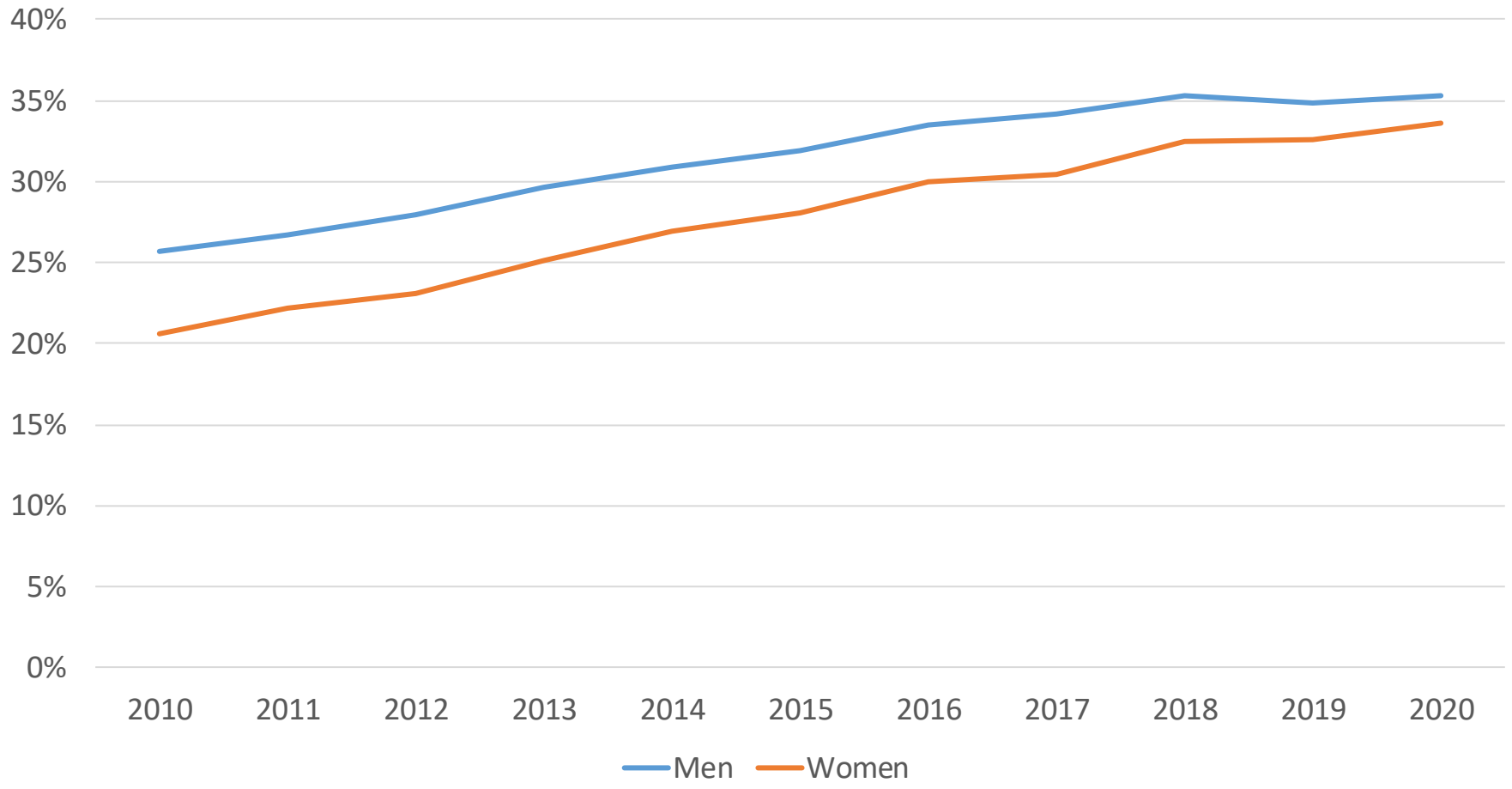
VA Enrollment Has Increased Among Women Veterans



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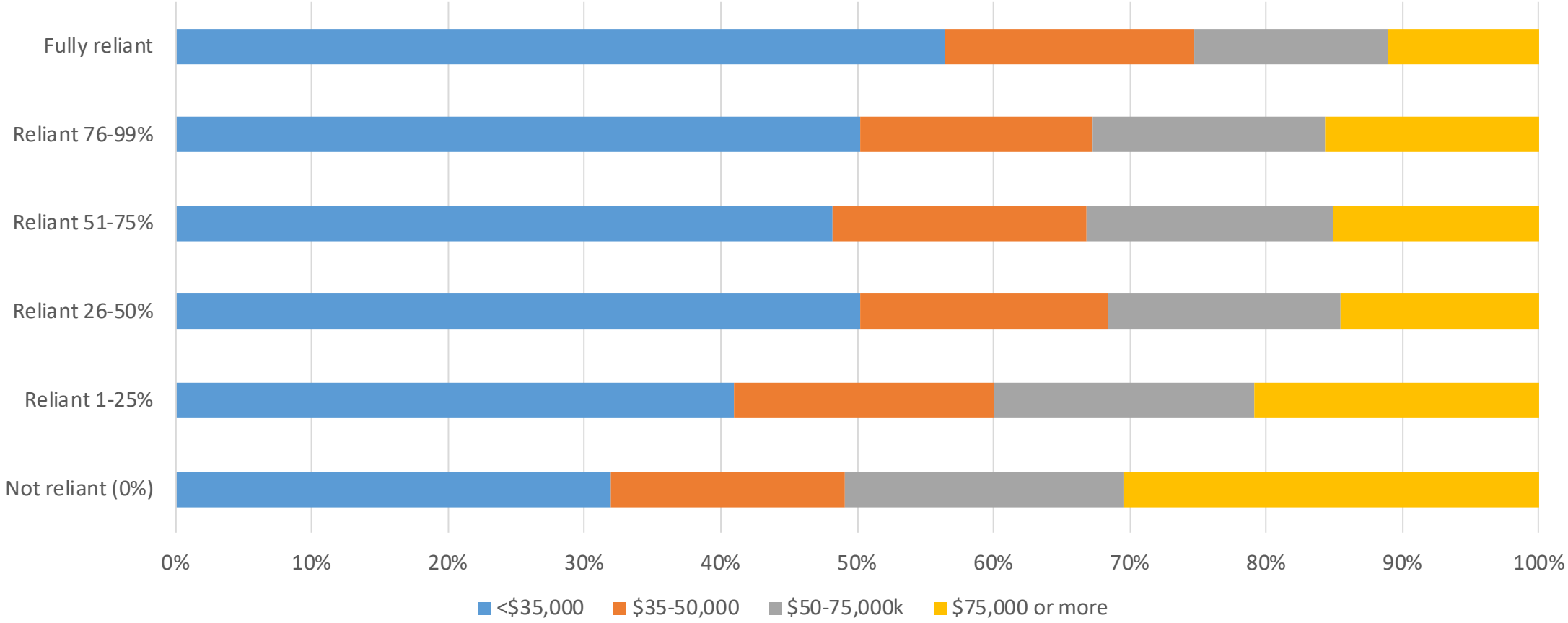
4) Veterans who enroll in VA are sicker and have fewer means

Reliance on VA by Household Income



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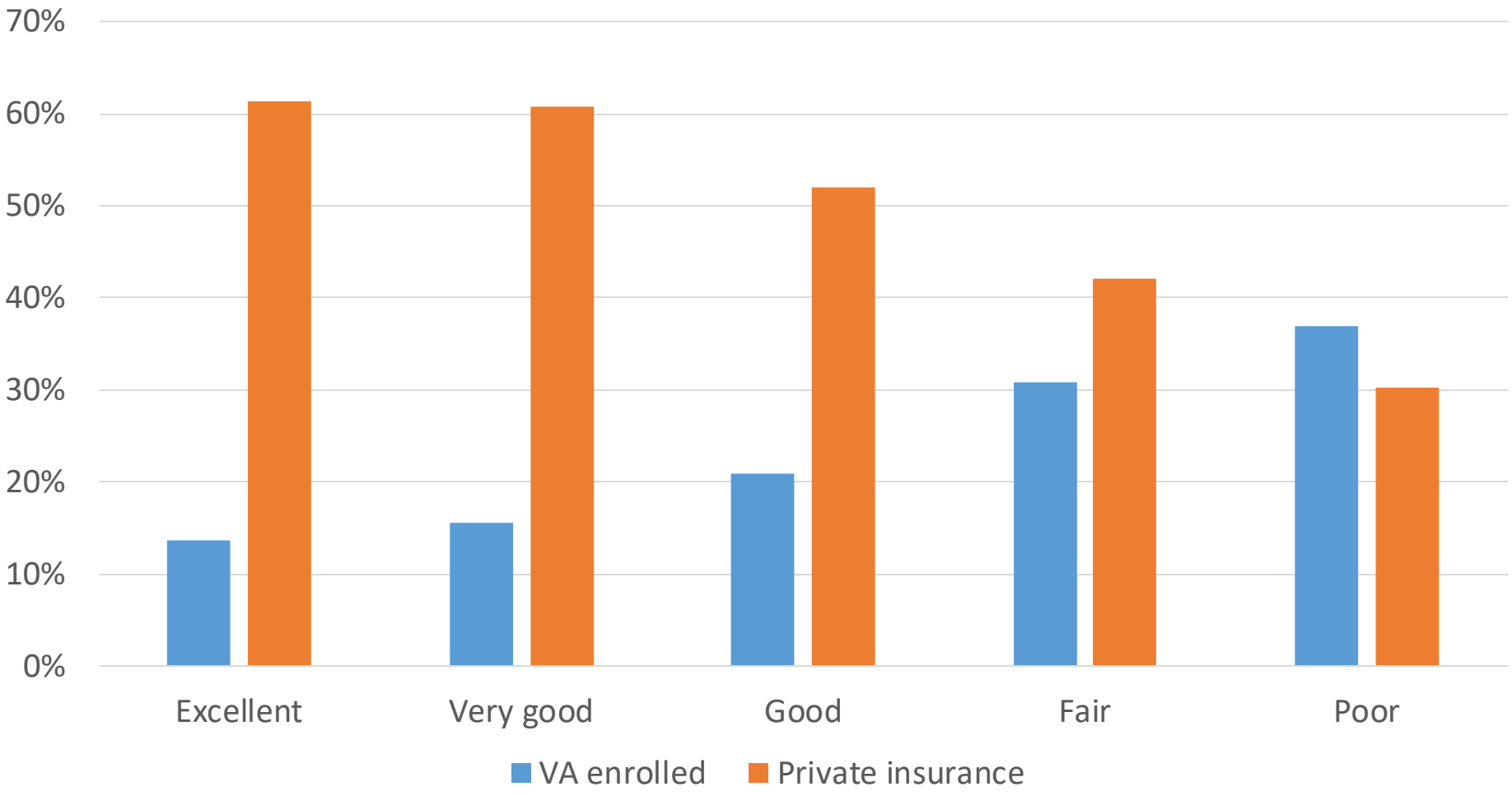
Reliance by Health Status



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5) Insurance coverage is uniformly good. There are no marked disparities.

Differences by Race and Ethnicity

- Any insurance coverage is uniformly high among all race/ethnic groups.

	ACS		NHIS	
	Non-Hispanic ethnicity	Hispanic ethnicity	Non-Hispanic ethnicity	Hispanic ethnicity
	Any Insurance			
white	96%	94%	96%	94%
Black	94%	93%	94%	93%
Asian	96%	95%	95%	99%
Other	93%	93%	91%	92%

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Variation in Secondary Insurance Coverage Exists

- We see variation, but this is likely driven by other factors, such as age or employment
  - white non-Hispanic Veterans had the highest rates of private insurance (64%).
  - In comparison to white non-Hispanic Veterans, Black non-Hispanic Veterans had higher rates of VA coverage (35% vs 30%), and the higher rates of Medicaid enrollment (13% vs 8%).
  - There was variability in levels between ACS and NHIS surveys, but the relative differences between racial and ethnic groups were quite low.

	ACS		NHIS	
	Non-Hispanic ethnicity	Hispanic ethnicity	Non-Hispanic ethnicity	Hispanic ethnicity
	Private insurance			
white	64%	56%	56%	49%
Black	54%	49%	48%	51%
Asian	61%	56%	53%	68%
Other	52%	52%	43%	47%

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Summary

- For many Americans, no or limited insurance coverage limits access.
- However, for most Veterans, access problems are not due to a lack of insurance coverage.
  - Approximately 95% of Veterans have some form of health insurance.

- Among enrollees, being dually covered is common.
  - 80% of enrollee are covered by another health insurance plan
  - Dual VA and Medicare coverage partly reflects the aging Veteran population
  - An estimated 49.3% of Veterans are over age 65, and another 18.4% will be Medicare eligible in the next decade

Payer Shifting is a Valid Concern

- Payer shifting can happen because most Veteran enrollees are well insured.
  - Community providers are willing to accept VA payment.
  - VA coverage is relatively generous (i.e., low copayments).
  - Community care is convenient.

- Any legislation that does not consider differential pricing (i.e., out-of-pocket costs) could just shift payers, rather than address unmet needs.

- We desperately need more evidence on the context surrounding payer shifting (who, what, when, and why).

Is Payer Shifting Bad?

- It can be beneficial for Veterans.
- It is probably not optimal from a policy perspective.
- Unlike Medicare, VA faces a fixed annual budget set by Congress.
- Payer shifting will make the budget less predictable and may lead VA facility leaders to cut valuable programs.
  - This scenario has played out in the past.
  - For example, despite evidence that substance use treatment was cost-effective, VA facilities cut these programs, in part because the "returns" go to criminal justice.
  - This is happening today.

Ettner SL, et al. Benefit-cost in the California treatment outcome project: does substance abuse treatment "pay for itself"? Health Serv Res 2006;41(1):192–213.
Humphreys K, et al. If substance use disorder treatment more than offsets its costs, why don't more medical centers want to provide it? J Subst Abuse Treat 2011;41(3):243–51.

Payer Shifting

- VA also lacks the same tools to improve value that Medicare uses.
  - VA does not currently engage in selective contracting. Community care contracts encourage “any willing provider”
  - VA also holds all the financial risk in the current community care contracts
  - VA needs to explore and adopt “managed care” tools

Looking into the Future

- MISSION Act provided VA with authority to set up a Center for Care and Payment Innovation (CCPI)
  - https://www.innovation.va.gov/careandpayment/

- We need to measure more than just access. Faster access does not mean better care or better outcomes.

- Moreover, VA currently pays a lot of attention to wait times, but wait times are not evidence based.

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VA is Part of the Safety Net

- In many regards, the safety net is working as it should
  - Consistently over time there is a negative correlation between VA enrollment and health status and household income
- However, a closer inspection shows a net with some holes.
  - Some Veterans without health insurance may not be eligible for VA benefits.
  - The Compact Act partly addressed this gap by making VA responsible for any Veteran who arrives under acute psychiatric distress at any hospital.
- But if Congress truly desires the VA to be a safety net for all Veterans, then VA should be authorized to support all Veterans, not just those who enroll in VA.

Thanks

Any questions?

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