

GAO

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

October 1997

VA MEDICAL CARE

Increasing Recoveries From Private Health Insurers Will Prove Difficult



**Health, Education, and
Human Services Division**

B-271726

October 17, 1997

The Honorable Terry Everett
Chairman, Subcommittee on Oversight
and Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

Since 1986, the Department of Veterans Affairs (VA) has been authorized to recover a portion of the costs VA incurs to provide health care services to veterans with no service-connected disabilities from veterans' private health insurers. This includes individual and group insurance plans, Medicare supplemental insurance plans,¹ and self-insured plans under the Employee Retirement Income Security Act of 1974 (ERISA). VA's recovery authority was expanded in 1990 to include recoveries for care provided to veterans with service-connected disabilities, as long as that care was for treatment of conditions unrelated to the veterans' service-connected disabilities.

In fiscal year 1996, VA sought recovery of about \$1.6 billion of its costs but only recovered 31 percent of the billed amount, or \$495 million, a 5-percent decline from fiscal year 1995 recoveries. In its fiscal year 1998 budget submission, however, VA estimated that it will be able to increase its recoveries from private health insurance, reaching \$826 million in fiscal year 2002. This is important because VA sought and was recently given authority to retain the funds it recovers and to use them to supplement future appropriations.

This report responds to your request that we

- identify those factors that limit VA's ability to recover more of its billed charges,
- evaluate VA's ability to achieve its revenue targets by (1) identifying factors that could decrease future recoveries and (2) assessing the potential for VA initiatives to increase medical care cost recoveries, and

¹Medicare beneficiaries may be covered under individually purchased Medicare supplemental policies ("Medigap" insurance) or under employer-sponsored health insurance. According to a 1994 survey of large employers by Foster Higgins, a health care consulting firm, 40 percent of employers offer retirees "carve-out coverage," a type of coverage that pays the difference between a plan's allowed charge for the service and the amount that Medicare pays for the same service.

- evaluate the way VA applies insurance payments to veterans' copayment liability for veterans in the discretionary care category.

Scope and Methodology

To identify whether factors limit VA's ability to recover more of its billed charges, we studied the recovery programs at VA's Martinsburg, West Virginia, and Washington, D.C., medical centers. We selected the two medical centers in consultation with officials working in VA's Medical Care Cost Recovery (MCCR) program. The Martinsburg medical center was selected because it was (1) viewed by VA officials as operating an efficient recovery program and (2) 1 of 10 medical centers participating in MCCR's reengineering pilot project.² The recovery program at the Washington DC's medical center was chosen for contrast. Although Martinsburg's medical center is much smaller than Washington's, it was recovering roughly the same amount from private health insurance.

At the two medical centers, we examined a random sample of the bills VA had submitted to insurers during May 1994.³ We focused our statistical analyses on bills for which VA had completed recovery actions (closed bills). For each bill, we examined the insurers' explanation of benefits, VA's patient insurance information, and VA's financial tracking reports to determine (1) why insurers denied or partially paid VA bills and (2) what actions VA had taken to determine whether additional funds could be recovered. We discussed bills denied or partially paid for administrative or other nonclinical reasons with VA staff at the medical centers to find out which factors had affected recoveries. To the extent possible, we reviewed, with the assistance of a registered nurse, the discharge summaries for those inpatient claims denied for clinical reasons to determine whether insurers' denials were appropriate. We used appropriateness-of-care criteria developed by InterQual, a utilization

²In 1994, VA selected 10 facilities to participate in an effort to improve and automate the information necessary to bill health insurers effectively. Components of the project included outpatient preregistration to improve the collection of data on insurance coverage and automated capture of data on outpatient services provided.

³We chose bills submitted to insurers in May 1994 to be reasonably sure that bills this old would be resolved by the time we did our work. We sampled about 56 percent of inpatient and 36 percent of outpatient closed bills submitted by the Washington, D.C., medical center. For the Martinsburg medical center, we sampled about 39 percent of inpatient and 11 percent of outpatient closed bills.

review firm, in our assessments.⁴ We confirmed the prevalence of these findings with MCCR staff at other facilities and in VA's headquarters.

To evaluate VA's ability to achieve its revenue targets, we reviewed (1) VA's fiscal year 1998 budget submission, the MCCR program's 1996 business plan, and other documents detailing VA's health care restructuring plans, such as VA's Prescription for Change, new budget allocation system, and its use of performance measures; (2) interviewed MCCR and health care staff from VA facilities and VA's headquarters; and (3) interviewed staff and reviewed documents from VA's General Counsel and Regional Counsels.

To assess the application of discretionary veterans' copayments to their third-party liability, we reviewed VA's General Counsel decisions and discussed the implementation of these decisions with VA's General Counsel as well as MCCR staff from central office and VA facilities.

We did our work between May 1995 and July 1997 in accordance with generally accepted government auditing standards.

Results in Brief

Attaining VA's goal to increase recoveries from private health insurance from \$495 million in fiscal year 1996 to \$826 million in fiscal year 2002 will be difficult. First, for our sample, most of the charges VA was unable to recover for bills submitted to private health insurers were appropriately denied or reduced by the insurers. Insurers can deny or reduce payments when (1) VA care is medically inappropriate, (2) VA bills Medicare supplemental insurance for the full cost of VA services when such insurance generally pays only Medicare deductibles and copayments, (3) VA bills health maintenance organizations (HMO) and other managed care plans that restrict payment for nonemergency care to participating providers, and (4) policy provisions require policyholders to pay a portion of covered charges.

Second, recoveries from private health insurance dropped for the first time in fiscal year 1996 and have continued to drop during fiscal year 1997. Several factors help explain the decreases and suggest that further decreases are likely. These include (1) the declining and aging of the veteran population, meaning that VA must serve a greater proportion of

⁴InterQual, a utilization review firm, has developed level-of-care criteria to evaluate the appropriateness of acute and critical medical care, based on an assessment of the patient's clinical status. The criteria encompass objective clinical findings to establish the severity of illness upon admission, associated medical or other professional interventions to establish the intensity of service to use during concurrent reviews, and clinical indicators to use as discharge screens.

veterans to maintain its current workload and that more VA users will have secondary, rather than primary, health insurance coverage in the future; (2) veterans' increased enrollment in HMOs and other managed care plans—and decreased enrollment in fee-for-service plans—which reduces the number of veterans covered by insurance from which VA can reasonably expect to recover; (3) changes in how insurers process VA claims that could result in refunds to insurers that VA estimates exceed \$600 million and could reduce future recoveries by over 20 percent; and (4) shifts in care from inpatient to outpatient settings that, while both needed and appropriate, could reduce private insurance recoveries and increase recovery costs.⁵

VA has a number of initiatives to address some of these problems and to help it attain its recovery goals. These include legislation to (1) allow VA to retain recoveries from private health insurance and veteran copayments as an incentive to improve the identification and pursuit of recoveries and (2) extend lapsing authority to recover the costs of services provided to veterans for conditions unrelated to their service-connected disabilities. In addition, VA plans administrative actions to, among other things, improve the identification of veterans' insurance coverage, improve the process for submitting claims to Medicare supplemental insurers, and develop new billing rates and itemized bills. Finally, VA plans to increase the number of veterans using the VA system by 20 percent, and expects many of the new users to be higher-income, Medicare-eligible veterans, likely to also have private insurance.

VA's initiatives would address some, but not all, of the factors affecting future recoveries. However, considerable uncertainty remains about VA's ability to achieve its revenue goal. VA was unable to provide an analytical basis for its recovery projections. Projected increases in VA's future recoveries were not supported by or not attributed to improvements related to its planned initiatives. Finally, VA's General Counsel interprets the relationship between recoveries from private health insurance and veterans' copayments as requiring that a portion of insurance recoveries be used to reduce veterans' copayment obligations. This will make it more difficult for VA to attain its overall recovery goals under the MCCR program and significantly increase administrative costs, particularly for pharmacy bills.

⁵In a draft of this report, we noted that a portion of VA's recovery authority was scheduled to lapse on September 30, 1998, potentially precluding future recoveries for treatments of nonservice-related conditions provided to veterans with service-connected disabilities. The Balanced Budget Act of 1997 extended the recovery authority until September 30, 2002.

We have identified a number of actions the Congress and VA could take to improve operation of the MCCR program, increase recoveries, and prevent recovery efforts from adversely affecting veterans.

Background

VA collects money from third-party insurers and directly from some veterans to offset the cost of providing health care services for veterans' nonservice-connected conditions. Until recently, these moneys, other than amounts needed to operate the recovery program, have been returned to the U.S. Treasury. In fiscal year 1996, the MCCR program retained almost \$119 million to offset the costs of operating the recovery program and deposited \$455 million in the Treasury. With passage of the Balanced Budget Act of 1997 (P.L. 105-33), VA will retain amounts collected after June 30, 1997, to supplement its annual appropriations and finance the cost of serving additional veterans.

While the law prevents insurers from arbitrarily denying payment to VA for services that would be covered in private sector facilities, VA, like other health care providers, must generally comply with the terms and conditions set out in veterans' health insurance policies. Insurance policies typically contain a number of provisions that limit the amount of billed charges that the insurer is responsible for paying. In addition to requiring that care be medically necessary and provided in an appropriate setting, policies may

- require the policyholder to pay a specified amount (such as \$500), referred to as a deductible or out-of-pocket payment, for covered health care services before the insurance begins paying;
- require policyholders to pay a certain percentage of covered charges, known as a copayment or coinsurance;
- specify what services are covered and any limits on the days of coverage or frequency of services;
- require, as a condition for payment, that providers or policyholders obtain prior approval from the insurer before admission to a hospital;
- preclude or reduce payment (other than for emergency care) to providers that are not members of HMOs, preferred provider organizations (PPO), or point-of-service (POS) plans;⁶ and

⁶A preferred provider organization (PPO) is a managed care plan that provides enrollees with a financial incentive to receive care from a network of providers that are normally reimbursed at a discounted fee-for-service rate. A point-of-service (POS) plan is a hybrid that combines features of both managed care and indemnity insurance. Under POS plans, an enrollee decides whether to use a network or nonnetwork provider at the time care is needed and usually is charged a sizable copayment for selecting a nonnetwork provider. For additional information, see *Health Insurance: Management Strategies Used by Large Employers to Control Costs* (GAO/HEHS-97-71, May 6, 1997).

- “wrap around” other insurance coverage and pay only that portion of approved charges not paid by the primary insurance, such as Medicare.

Unlike most providers, however, VA does not bill health plans for the individual tests and procedures it provides to its policyholders. Instead, VA prepares bills based on its average costs for providing a day of hospital care and an outpatient visit. In fiscal year 1997, VA billed insurers \$1,046 per day for inpatient care provided in medical bed sections, \$1,923 per day for care provided in surgical bed sections, \$194 for each outpatient visit, and \$20 for each prescription refill. In other words, the amount VA bills insurers for a 5-day surgical stay is the same regardless of the type of surgery performed. Similarly, it bills the same amount for an outpatient visit regardless of the types or number of services provided during that visit.

In fiscal year 1995, VA recovered \$522.8 million from third parties, including private health insurers, workers’ compensation programs, and no-fault insurance. Recoveries declined to \$495.2 million in fiscal year 1996 and to \$213.4 million during the first two quarters of fiscal year 1997.

VA’s 1998 budget proposal requested medical care funding of \$17.6 billion, consisting of an appropriation of almost \$17 billion and a legislative proposal to retain insurance payments, veterans’ copayments, and other third-party reimbursements estimated to total about \$600 million in fiscal year 1998. VA proposed to freeze its appropriation at about \$17 billion over the next 5 years and rely instead on increased efficiency and increases in third-party reimbursements to offset the effects of inflation. VA estimated that the third-party recovery authority would enable it to generate \$1.7 billion in additional revenues in 2002, including \$826 million from private health insurance. The Balanced Budget Act of 1997 authorized VA to retain recoveries and collections after June 30, 1997. The act provides that if the amounts recovered in fiscal years 1998, 1999, or 2000 fall short of projections by at least \$25 million, VA will receive an additional appropriation.⁷

Most Charges Denied by Insurers Are Not Recoverable

Most VA bills in our sample prepared by the Martinsburg and Washington, D.C., medical centers that were denied or reduced by private health insurers were appropriately closed by MCCR staff with little additional

⁷VA also sought, but was not granted, authority to recover a portion of its costs from the Medicare program for providing care to additional higher-income veterans with Medicare coverage.

recovery possible. Additional amounts were generally not recoverable because

- insurers deemed VA's inpatient care to be medically inappropriate;
- VA billed Medicare supplemental insurance for the full cost of VA services, even though such insurance generally pays only the Medicare inpatient deductible and about 20 percent of the costs of outpatient care;
- VA billed HMOs and other managed care plans for nonemergency care when the VA facility was not a participating provider; and
- insurers reduced payments to VA on the basis of the insurance plans' cost-sharing requirements.

In addition, VA's pursuit of additional recoveries is hindered because (1) VA has limited knowledge of veterans' insurance policies and terms of coverage and (2) many insurers continue to use exclusionary clauses denying payment for care given in VA facilities, although such clauses have no legal effect.

Much of VA Inpatient Care Denied as Medically Inappropriate

Nearly 30 percent of the unpaid charges for inpatient care at the Martinsburg and Washington, D.C., medical centers resulted from insurers' determinations that the care was medically inappropriate.⁸ Medically inappropriate care includes care deemed to be medically unnecessary, excessive lengths of stay, and care that should have been provided on an outpatient basis. For example, insurers denied or reduced claims at the Martinsburg medical center for cataract surgeries that were unnecessarily performed on an inpatient basis. Similarly, insurers denied or reduced claims when the medical center allowed veterans who traveled considerable distances for care to be admitted early, to be discharged later, or to receive inpatient treatment instead of outpatient services.

When such claims were reduced or denied, the Martinsburg medical center often negotiated payment for ancillary and professional services associated with inpatient care that should have been provided on an outpatient basis. In addition, the medical center was sometimes able to obtain payment for clinic visits and ancillary services provided to veterans in the medical center's nursing home and domiciliary beds. Such

⁸At the 95-percent confidence level, we estimate that 27.1 percent (plus or minus 13.2 percent) of the charges at the Martinsburg medical center were unpaid because insurers considered the inpatient care to be medically inappropriate; 29.7 percent (plus or minus 14.6 percent) of the charges at the Washington, D.C., medical center were unpaid because insurers deemed the inpatient care to be medically inappropriate.

payments, however, accounted for significantly less than half of billed charges.

Unlike Martinsburg, the Washington, D.C., medical center generally did not vigorously pursue claims denied as medically inappropriate and seldom pursued payment of ancillary or professional services. Since the period covered by our claims review, however, the Washington medical center has brought in a new manager for the recovery program and has reorganized its functions to strengthen the billing, collection, and appeals processes. Billing and collections staff are no longer in separate units but are paired together in teams to expedite recovery actions. An August 1996 review of the Washington, D.C., program by MCCR staff from headquarters and other VA facilities, however, identified the need for further improvements. For example, the reviewers suggested that the facility (1) develop a mechanism to consistently track patients' inpatient and outpatient treatments, (2) identify a physician adviser and establish a multidisciplinary utilization review committee to assist with appeals, and (3) develop procedures to identify and bill for professional fees where appropriate.

Medicare Supplemental Insurers Limit Payment as Secondary Insurance

VA bills Medicare supplemental insurers for the full cost of VA services, even though such policies provide coverage that is secondary to Medicare. And because it does not have the authority to bill Medicare, VA does not receive a determination of benefits—either a “remittance advice” or an “explanation of benefits.” Medicare supplemental insurers typically use such determinations to calculate their liability.

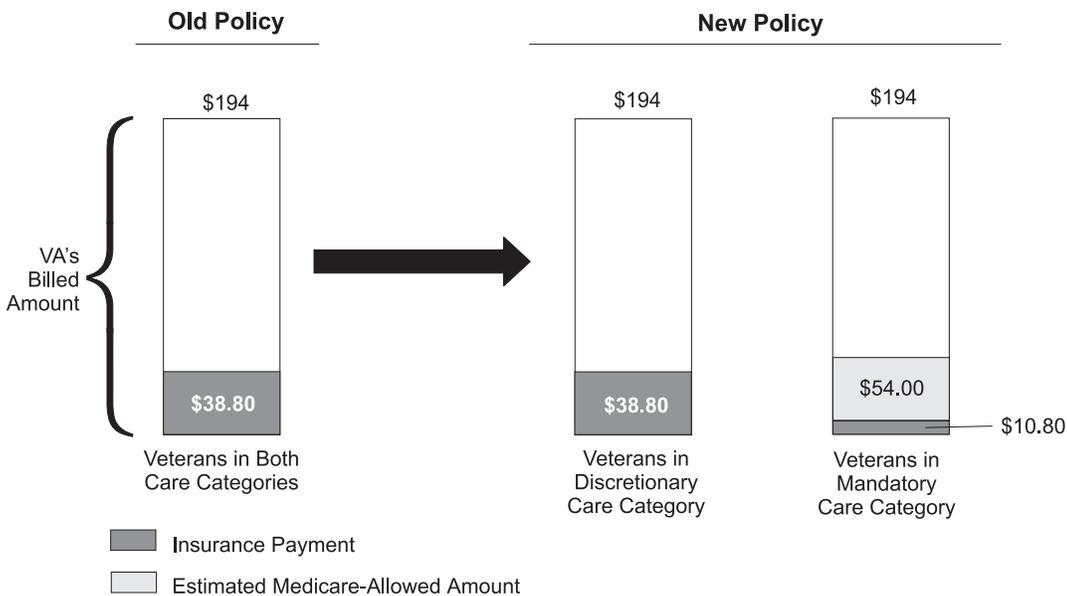
In the absence of a Medicare determination of benefits, supplemental insurers use different methods to determine their liability as secondary payers. For inpatient care, these insurers typically pay the Medicare inpatient deductible (\$760 in 1997) or the inpatient deductible plus 20 percent of the professional services component of the VA per diem rate. As a result, VA recovers only a small percentage of its billed charges. For example, VA can expect to recover only \$760 to \$835 for a 3-day VA hospital stay for which it billed \$3,138. Similarly, for an outpatient visit, Medicare supplemental insurers typically pay no more than 20 percent of the billed charges.

The largest Medigap insurer, the American Association of Retired People (AARP), however, no longer pays VA 20 percent of billed charges for most of its veteran policyholders. In September 1995, AARP began paying VA

20 percent of what it estimates Medicare would have paid for the service in a physician’s office for veterans in the mandatory care category (primarily those with service-connected disabilities or low incomes). AARP continues to pay 20 percent of VA’s billed charges for veterans in the discretionary care category (those with no service-connected disabilities and incomes above the “means-test” level, which is about \$21,000 for a single veteran) who are subject to copayments to cover their out-of-pocket costs.

The effect of this change on VA recoveries is unclear. For veterans in the mandatory care category who are not subject to VA’s copayments, recoveries are likely to decrease for outpatient bills involving routine office visits. For example, because Medicare pays about \$54 for a routine office visit, AARP would pay VA less than \$11 for such care under the new policy rather than almost \$39 (20 percent of VA’s \$194 outpatient rate) it would have paid under the old policy. On the other hand, to the extent that VA provides these veterans high-cost services or procedures, such as cataract surgery, as outpatient services, AARP’s payments to VA should increase under the new policy. (See fig. 1.)

Figure 1: Change in AARP Payment Policy for Medicare Supplemental Insurance, Given a \$194 Outpatient Charge



VA's right to collect from Medigap insurers was upheld in earlier court decisions.⁹ However, some insurers still contend that they are not liable for the amounts sought by VA until they receive an adjudicated claim indicating what portion of VA's bill is covered by Medicare. The insurers claim that calculating the amount owed to VA is unduly burdensome because VA does not give them a Medicare remittance advice or explanation of benefits explaining Medicare-approved charges.¹⁰ When the matter is resolved, VA expects to recover on the backlog of claims submitted to insurers involved in the case. Like other Medicare supplemental policies, however, these plans would pay secondary rather than primary benefits, and therefore most of VA's billed charges would not be collectable.

Because the Martinsburg medical center was billing Medicare supplemental insurance more often than the Washington medical center, a larger percentage of unpaid charges resulted from denials and reduced payments by such insurers. About a third of Martinsburg's unpaid charges for inpatient care are attributable to billing Medicare supplemental insurers.¹¹ By contrast, only about 13 percent of the Washington, D.C., medical center's unpaid inpatient charges are attributable to billing Medicare supplemental insurance.¹² Similarly, about 40 percent of the unpaid outpatient charges for the Martinsburg medical center resulted from billing Medicare supplemental insurance for the full cost of outpatient care.¹³ Because the Washington, D.C., medical center did not bill Medicare supplemental insurance as extensively, only 11 percent of its unpaid charges resulted from billing the full cost of outpatient care.¹⁴

⁹See, for example, *United States v. Blue Cross Blue Shield of Maryland, Inc.*, 989 F.2d 718 (4th Cir. 1993), cert. denied, 510 U.S. 914, and *United States v. Blue Cross/Blue Shield of Alabama*, 999 F.2d 1542 (11th Cir. 1993), cert. denied, 510 U.S. 1112, 1994.

¹⁰*United Servs. Auto. Ass'n v. Jesse Brown*, No. SA-94-CA-0379 (D. Tex. filed May 12, 1994). Other plaintiffs include USAA Life Insurance, the Health Insurance Association of America, Hartford Life Insurance Company, the Retired Officers' Association, and several individuals.

¹¹At the 95-percent confidence level, 32.4 percent (plus or minus 19.6 percent) of the Martinsburg medical center's inpatient unpaid charges were attributed to Medicare supplemental insurers.

¹²At the 95-percent confidence level, 12.7 percent (plus or minus 10 percent) of the Washington D.C., medical center's inpatient unpaid charges were attributed to Medicare supplemental insurers.

¹³At the 95-percent confidence level, 41 percent (plus or minus 5.4 percent) of the Martinsburg medical center's outpatient unpaid charges were attributed to Medicare supplemental insurers.

¹⁴At the 95-percent confidence level, 11.3 percent (plus or minus 5.4 percent) of the Washington, D.C., medical center's outpatient unpaid charges were attributed to Medicare supplemental insurance.

HMOs Deny or Reduce Payments Because VA Facilities Are Not Participating Providers

HMOs and certain other managed care plans generally will not pay a nonparticipating provider for services rendered to their policyholders, except for emergency care. Neither the Washington, D.C., nor the Martinsburg medical center has been able to negotiate provider agreements with any HMOs (see pp. 27-31.). About 19 percent of the claims denied by insurers for inpatient care provided by the Washington, D.C., medical center, representing over 20 percent of the center's unpaid inpatient charges, were billed to HMOs and other managed care plans that limit payments for nonemergency care to participating providers.¹⁵ About 19 percent of the bills insurers denied for outpatient care provided by the Washington, D.C., medical center, representing about 35 percent of unpaid charges, were billed to HMOs and other managed care plans that limit payments for nonemergency care to participating providers.¹⁶ Because VA could not provide support that the care was for a medical emergency, the medical center had no basis for pursuing collection.

Denials by HMOs and certain other managed care plans did not account for as much of the unpaid care at the Martinsburg medical center because that facility generally did not bill managed care plans unless it was fairly certain that the plan would pay for VA care. In addition, HMOs appear to have a significantly lower market penetration in the Martinsburg area than they do in the Washington, D.C., area. About 4 percent of Martinsburg's inpatient bills (representing about 3 percent of the unpaid charges) were billed to managed care plans.¹⁷ About 3 percent of outpatient bills (representing about 6 percent of unpaid charges) were billed to managed care plans.¹⁸

¹⁵At the 95-percent confidence level, 18.8 percent (plus or minus 6 percent) of the Washington, D.C., medical center's inpatient bills were reduced and 22.3 percent (plus or minus 11.4 percent) of the inpatient charges were unpaid because HMOs were billed for care that was neither emergency nor preauthorized.

¹⁶At the 95-percent confidence level, 18.7 percent (plus or minus 2.8 percent) of the Washington, D.C., medical center's outpatient bills were reduced and 34.6 percent (plus or minus 6.6 percent) of the outpatient charges were unpaid because HMOs were billed for care that was neither emergency nor preauthorized.

¹⁷At the 95-percent confidence level, 3.7 percent (plus or minus 2.6 percent) of the Martinsburg medical center's inpatient bills were reduced and 2.8 percent (plus or minus 2.6 percent) of the inpatient charges were unpaid because HMOs were billed for care that was neither emergency nor preauthorized.

¹⁸At the 95-percent confidence level, 3 percent (plus or minus 1.8 percent) of the Martinsburg medical center's outpatient bills were reduced and 5.6 percent (plus or minus 3.4 percent) of the outpatient charges were unpaid because HMOs were billed for care that was neither emergency nor preauthorized.

Insurers Reduce Payments on the Basis of Cost-Sharing Provisions

For both the Washington, D.C., and Martinsburg medical centers, insurers often reduced their payments to VA on the basis of the policies' cost-sharing provisions. Insurance policies typically require policyholders to pay a certain amount for health care services out of pocket before coverage begins. Such deductibles can either be a yearly amount or apply to a specific episode of care such as a hospital stay. In addition, policies frequently require policyholders to pay a certain percentage of charges (a copayment or coinsurance). These provisions limit the insurers' liability to that portion of covered charges that is not the responsibility of the policyholder.

Insurers reduced payments to the Washington, D.C., medical center on the basis of cost sharing provisions for over half of the inpatient bills and over 70 percent of the outpatient bills we examined.¹⁹ Similarly, insurers reduced payments for about 31 percent of the inpatient bills and about 56 percent of the outpatient bills we examined at the Martinsburg medical center for the same reason.²⁰

Reductions because of cost-sharing provisions had a greater impact on recoveries from outpatient bills, accounting for about a third of the unpaid outpatient charges at Martinsburg medical center and about 43 percent of unpaid charges at Washington.²¹ By contrast, reductions on the basis of cost-sharing requirements accounted for less than 10 percent of unpaid inpatient charges at each facility.²²

Since our study period, the percentage of outpatient charges that are unpaid because of cost-sharing requirements has probably increased because of the trend in fee-for-service health plans toward higher copayments. For example, the Blue Cross and Blue Shield standard option plan under the Federal Employees Health Benefits Program (FEHBP)

¹⁹At the 95-percent confidence level, 51.6 percent (plus or minus 7 percent) of the Washington, D.C., medical center's inpatient bills were reduced because of veterans' cost-sharing requirements; 71.1 percent (plus or minus 4 percent) of outpatient bills were reduced.

²⁰At the 95-percent confidence level, 31 percent (plus or minus 10 percent) of the Martinsburg medical center's inpatient bills were reduced because of veterans' cost-sharing requirements; 56 percent (plus or minus 4.4 percent) of outpatient bills were reduced.

²¹At the 95-percent confidence level, we estimate that 34.4 percent (plus or minus 5.4 percent) of the unpaid outpatient charges at the Martinsburg medical center and 42.9 percent (plus or minus 7 percent) of the unpaid outpatient charges at the Washington, D.C., medical center were attributable to veterans' cost-sharing requirements.

²²At the 95-percent confidence level, we estimate that 9.5 percent (plus or minus 6.4 percent) of the unpaid inpatient charges at the Martinsburg medical center and 5.7 percent (plus or minus 3.2 percent) of the unpaid inpatient charges at the Washington, D.C., medical center were attributable to veterans' cost-sharing requirements.

increased the copayment on a \$194 outpatient bill from approximately \$49 to \$100 between 1994 and 1996.²³

Limited Knowledge of Plan Provisions Hinders Recovery

VA's efforts to pursue recoveries from private health insurers are hindered by VA's limited access to the terms and conditions of veterans' insurance policies. Neither the insurer nor the veteran is required to supply a copy of the health benefit plan to VA. As a result, VA generally relies on telephone calls to insurers to obtain information on the specific provisions of veterans' policies.

MCCR field staff indicated that insurers frequently refuse to give them copies of veterans' policies, benefit summaries, or booklets when requested, citing privacy concerns. Although VA's General Counsel indicates that insurers can be compelled to provide contracts and policy information during litigation, such extreme actions have seldom been used. However, VA's General Counsel has been able to obtain more than 300 policies from health insurers that are seeking refunds for what they claim are overpayments.

MCCR staff at the Martinsburg and Washington, D.C., medical centers generally billed insurers to identify what services were covered, what policy restrictions existed, and where the veteran stood in relation to annual deductibles or lifetime limits on benefits. Depending on the information contained in the insurers' remittance advice, MCCR staff made follow-up telephone calls to see why payments were denied or reduced. For example, after repeated telephone conversations with an employer-sponsored health benefit plan, MCCR staff at the Martinsburg medical center discovered that outpatient bills that had been denied for apparent coverage limitations were in fact payable if billed on a different form. On the basis of that information, the facility was able to obtain additional recoveries by resubmitting previously denied outpatient claims for other veterans.

VA's other potential source of policy information—the veteran policyholder—has little incentive to give VA detailed information about insurance coverage. If a private sector provider has trouble obtaining payment from an insurer, the policyholder is generally liable for any unpaid charges and thus has a financial incentive to see that insurance pays the maximum benefit in accordance with the plan provisions.

²³In 1994, Blue Cross standard option coverage paid member facilities 75 percent of the outpatient facility charge. In 1996, this coverage paid member facilities 100 percent of the outpatient facility charge after deducting a copayment of \$100 payable by the covered person.

Because most veteran policyholders obtaining services from VA facilities do not have any financial liability for their care, they have little incentive to intercede on VA's behalf in obtaining detailed policy information.

On the other hand, veterans in the discretionary care category have some financial incentive to help VA obtain information about their insurance coverage because a portion of insurers' payments is used to reduce their copayments. For example, the Washington, D.C., medical center was able to obtain payment from one employer-sponsored managed care plan after a veteran in the discretionary care category gave VA information on policy provisions indicating that his insurance would pay nonparticipating providers.

Exclusionary Clauses Hinder Recoveries and Increase Costs

Before VA's recovery authority was established, most health insurance plans and contracts contained exclusionary clauses indicating that the plans would not pay for care (1) provided in VA hospitals or (2) provided at no cost to the policyholder. Such exclusionary clauses were eliminated as a legal basis for denying payment of VA claims as part of the Comprehensive Omnibus Budget Reconciliation Act of 1986 (P.L. 99-272). Ten years later, however, exclusionary clauses that prohibit payment to federal facilities appear to be fairly common. Although such clauses no longer have any legal effect on VA recoveries, they can delay recoveries and increase the cost of recovery actions. Follow-up actions by VA staff, including VA's regional and general counsels, may be necessary to challenge the clauses and enable VA to recover from the health plans.

The regulation of insurance is primarily a state function. Insurance policies, but not ERISA plans, must generally be reviewed and approved by a state insurance commissioner before they can be offered for sale in the state.²⁴ For example, the Maryland Insurance Commission reviews all policies approved for sale in Maryland. An official from the Maryland Insurance Commission confirmed that the Commission continues to approve policies containing clauses excluding payment for services provided in VA facilities. Commission staff told us that such clauses are common in health insurance policies sold in the state, and they expressed a willingness to work with VA officials to help eliminate the clauses. VA MCCR officials indicated that they rely on federal enforcement to require insurers to pay and have not attempted to work with state insurance commissions to remove exclusionary clauses.

²⁴ERISA plans fall under the purview of the Department of Labor.

Officials from one of the largest health plans in Maryland—Blue Cross—confirmed that their plans still contain exclusionary clauses. They told us that the language in the exclusionary clauses will be revised in future policies to make it clear that the insurer will pay for care VA provides for nonservice-related conditions.

Many Factors Could Lead to Decrease in Future Recoveries

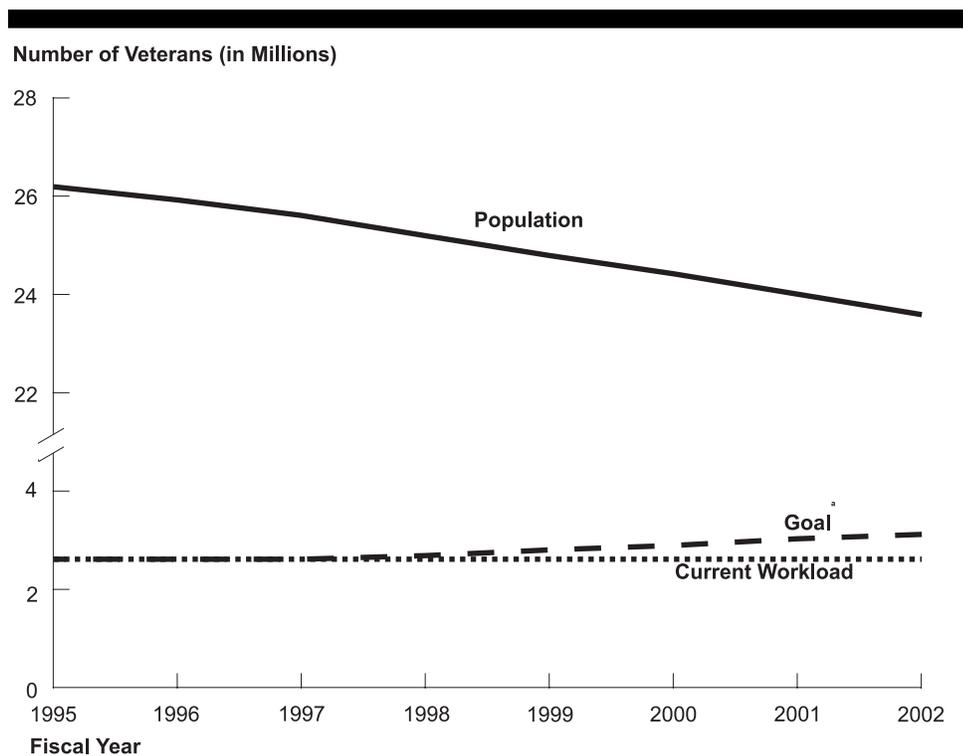
Many factors help explain the decline in VA recoveries from private health insurance since fiscal year 1995 and make it likely that, without significant changes in the recovery program and/or an increase in the number of VA users with fee-for-service insurance coverage, declines will continue over the next 5 years. These factors include

- the declining and aging of the veteran population,
- increased enrollment in HMOs and other managed care plans,
- changes in how insurers process VA claims,
- shifts in care from inpatient to outpatient settings, and
- difficulty identifying care provided to veterans with service-connected disabilities for treatment of nonservice-connected conditions.

Declining and Aging of the Veteran Population

The veteran population is projected to decline from 26.2 million to 23.6 million between 1995 and 2002. This means that VA would have to increase the percentage of veterans using VA services just to maintain current workload. In 1995, VA facilities provided services to about 2.6 million veterans, or roughly 1 out of 10 veterans. With fewer veterans, VA will need to attract roughly 1 of every 9 veterans in 2002 to maintain its current workload. To attain its goal of increasing by 20 percent the number of veterans using VA services by 2002, VA will have to attract more than one out of every eight veterans in 2002. (See fig. 2.)

Figure 2: Declining Veteran Population May Affect VA's Ability to Increase Number of Veterans Served



Calculation of workload projection assumes a constant proportion of nonveteran users.

Just as the declining numbers of veterans will make it more difficult to maintain recoveries, so too will the aging of the veteran population. As an increasing proportion of veterans become eligible for Medicare, potential recoveries decrease. Between 1995 and 2002, the percentage of veterans aged 65 and older is expected to increase from 34 to 39. This is important because at age 65, most veterans' private health insurance becomes secondary to Medicare. Currently, about 60 percent of veterans who have health insurance and who are treated by VA are over 65 years of age. Typically, Medicare supplemental plans cover only the \$760 deductible for the first 60 days of inpatient care and 20 percent of the outpatient charge. An increase in the percentage of insured veterans covered only by Medicare supplemental policies is thus likely to decrease future recoveries.

Continued Increase in Managed Care Plan Enrollment Could Reduce Future Recoveries

Continued increases in enrollment in HMOs, PPOs, and POS plans are likely to reduce future VA recoveries from private health insurance. VA has had limited success in negotiating to become a participating provider under HMOs (see pp. 27-31) and therefore is generally unable to recover any of its costs of providing routine care to HMO members. Between 1982 and 1994, enrollment in HMOs increased from 9 million to over 50 million. Similarly, because VA is not a preferred provider under any PPOs, its potential recoveries are reduced. Although it may be able to recover from PPOs by becoming a participating rather than preferred provider, it receives lower reimbursement. Finally, POS plans allow their policyholders to obtain care from any willing provider but typically require their members to pay a larger portion of the cost of services they obtain from providers outside of the plan, such as VA facilities. In other words, POS plans pay less of the billed charges when care is provided by an out-of-plan provider, expecting the member to pay the remainder.

Nearly three-fourths of workers with employer-provided health insurance are now covered under a managed care plan, most by an HMO or PPO. In 1993, 49 percent of American workers with health insurance were covered by a conventional fee-for-service plan, but by 1995 that percentage had dropped to 27. By contrast, during the same time period, the percentage of workers covered under HMOs or PPOs increased from 42 percent to 53 percent; workers covered under POS plans increased from 9 to 20 percent.²⁵

Even recoveries from Medicare supplemental policies may decrease because of the increased enrollment of Medicare beneficiaries in risk-contract HMOs. Between 1987 and 1996, enrollment in Medicare risk-contract HMOs increased from 2.6 percent to 10 percent of total Medicare beneficiaries, and by 2002 enrollment is projected to be 22.9 percent of total beneficiaries.²⁶

Even now, physicians from VA medical centers in California, Florida, New Mexico, and other states have noted an increase in the number of elderly veteran patients who seek care at VA facilities while enrolled in HMOs. Two studies at individual VA facilities found that HMO enrollment ranged from 10 percent among veterans of all ages to about 25 percent among elderly

²⁵Gail A. Jensen and others, "The New Dominance of Managed Care: Insurance Trends in the 1990s," *Health Affairs*, Vol. 16, No. 1 (Jan./Feb. 1997).

²⁶Jo Ann Lamphere and others, "The Surge in Medicare Managed Care: An Update," *Health Affairs*, Vol. 16, No. 3 (May/June 1997).

veterans.^{27,28} Data from the West Los Angeles medical center suggest that its elderly veteran users are opting to enroll in Medicare HMOs rather than purchase Medigap insurance.²⁹ For all VA facilities, approximately 1.5 percent of VA's inpatient discharges and almost 2.5 percent of VA's outpatient visits in fiscal year 1995 were provided to veterans enrolled in Medicare risk contracts.

The growth in Medicare HMO enrollment is likely to affect VA recoveries for two primary reasons. First, VA is generally unable to recover any of its costs for providing care to veterans enrolled in Medicare HMOs. Second, increased enrollment in HMOs is accompanied by corresponding decreases in the number of beneficiaries covered under Medicare supplemental insurance, from which VA can attempt to recover.

FEHBP enrollment is also shifting away from fee-for-service insurance toward managed care arrangements. In 1990, 26 percent of federal employees and annuitants chose to enroll in HMOs. By 1997, 29 percent of the FEHBP enrollees selected HMOs. In 1990, four fee-for-service plans offered significant preferred provider options within the structures of their plans.³⁰ Under the plans, enrollees retain the freedom to choose providers but have lower out-of-pocket payments if they use preferred providers. By 1997, all fee-for-service plans within FEHBP identified themselves as "managed fee-for-service plans." Most plans offered enrollees services through PPOS, and several offered significant POS products. The number of enrollees who use only the preferred providers in these hybrid plans is not measured.

As veterans continue to shift from conventional fee-for-service health plans to HMOs, PPOS, and POS plans, VA recoveries will likely continue to decline unless VA facilities become preferred or participating providers. VA efforts to this end have, however, generally been unsuccessful, as discussed in the next section.

²⁷E. Yano and others, Survey of Health and Medical Care for Veterans in Ambulatory Care (Sepulveda, Calif.: VA Medical Center, Evaluation and Decision Support Service, 1994).

²⁸R. Morgan, B. Virnig, and C. Devito, Medicare HMO Membership and Use of VAMC Medical Care (Poster presentation at the 14th annual meeting, VA Health Services Research and Development Service, Washington, D.C., Feb. 28-Mar. 1, 1996).

²⁹L. Passman and others, "Elderly Veterans Receiving Care at a Veterans Affairs Medical Center While Enrolled in Medicare-Financed HMOs: Is the Taxpayer Paying Twice?" Journal of General Internal Medicine, 12 (4) (Apr. 1997), pp. 247-9.

³⁰Francis Walton, "The Political Economy of the Federal Employees Health Benefits Program," Health Policy Reform, Competition and Controls (Washington, D.C.: American Enterprise Institute Press, 1993).

Changes in How Insurers Process VA Claims Could Lead to Refunds and Reduced Recoveries

Changes in how insurers process VA claims could result in refunds of over \$600 million in overpayments and reduce VA's future recoveries by over 20 percent. Specifically, some insurers

- claim they overpaid VA under Medicare carve-out policies and are seeking refunds,
- are increasingly reluctant to pay any portion of billed charges when the care was provided in a hospital unnecessarily, and
- increasingly use pharmacy benefit managers (PBM) to administer prescription benefits.

Possible Overpayments Under Carve-Out Policies

A number of insurers maintain that they have overpaid VA claims under Medicare carve-out policies. Such policies differ from Medigap policies in that they offer the same health care benefits to both active employees and retirees but contain provisions making their coverage secondary to Medicare as the retirees become eligible for Medicare. Some insurers offering such carve-out policies have paid VA for services provided to their Medicare-eligible policyholders as the primary, rather than secondary, insurer. As a result, they are seeking refunds of millions of dollars in prior payments and are reducing current payments.

VA's position is that it is entitled to recover from a health plan to the same extent that the insurer would have been liable for the care if it was provided in the private sector. If VA determines, following a review of an insurer's policy provisions, that the insurer overpaid VA under the terms of its policy by paying primary when the insurer would have had a secondary liability in the private sector, VA will refund timely and well-grounded claims.³¹

On the basis of a review of fiscal year 1995 data on potential overpayments, MCCR staff estimate that about 40 percent of the paid claims for veterans aged 65 and older were paid at an amount greater than the Medicare deductible and coinsurance. The MCCR staff estimated that overpayments to all VA medical centers in fiscal year 1995 were \$110 million (+/- \$35 million). Over the 6-year period of liability, refunds could amount to as much as \$600 million.

³¹The Department of the Army, which also bills insurers for care provided in its facilities, has a different interpretation of how its facilities should be reimbursed under carve-out policies: It believes the policies should pay its facilities as the primary insurer because its facilities, like VA facilities, are not Medicare providers. See *Third Party Collection Program*, Report No. 96-113 (Washington, D.C.: Department of Defense, Office of the Inspector General, May 7, 1996).

Other issues related to carve-out policies could also affect future VA recoveries. VA's General Counsel determined that refunds for overpayments made during the current year must be charged against that year's recoveries but that refunds of overpayments from prior years should come out of the Treasury. This approach does, however, involve certain risks:

- Insurers could offset overpayments from prior years against payments for current-year bills. One plan in Indiana has begun offsetting overpayments, although other plans appear willing to wait for refunds to be paid out of the Treasury.
- Allowing VA to authorize refunds from the Treasury gives the agency little incentive to protect the government's interests in determining the appropriateness of refund requests.
- Aggressively reviewing refund requests could adversely affect current-year recoveries because staff would be diverted from billing for current services to verifying refund requests.

Like some private sector carve-out policies, FEHBP plans have been paying VA as primary insurance for Medicare-eligible federal retirees. Officials in the Office of Personnel Management (OPM) have indicated that federal retirees' health coverage will become secondary to Medicare when care is provided to veterans covered by Medicare in VA facilities, as of the 1998 benefit year. OPM officials have indicated that existing policy will be modified to implement this change prospectively and that FEHBP plans will not seek refunds from VA. Since VA included FEHBP payments for Medicare-eligible veterans in its estimate of amounts to be refunded, that estimate is overstated. VA could not indicate the extent that payment amounts from FEHBP plans were included in its refund estimate. This benefit change will cause VA's future recoveries from FEHBP plans to decline.

Insurers Are Becoming More Reluctant to Provide Partial Payment

VA's ability to obtain partial payment for care unnecessarily provided in an inpatient hospital is declining. As discussed earlier, the Martinsburg medical center and, to an increasing extent, the Washington, D.C., medical center, have been successful in obtaining partial payment from insurers for inpatient care that should have been provided in an outpatient clinic. At both medical centers, however, several major insurers have changed their policies and will no longer make such partial payments.

Changes in Processing of Prescription Benefits

VA's ability to recover for prescription refills may be declining as plans' benefit designs change and use of pharmacy benefit managers (PBM) increases. PBMs are companies that administer the prescription drug coverage of health insurance plans on behalf of plan sponsors, such as FEHBP plans, insurance companies, self-insured employers, and HMOS. Many PBMs offer a range of services to plan sponsors, such as processing prescription claims, operating mail order pharmacies, and developing networks of retail pharmacies to serve plan enrollees.³² The PBMs' mail order and retail services provide enrollees prescription drugs at discounted prices. To take advantage of these discounts, the plans offer enrollees financial incentives to fill their prescriptions only through the PBMs' mail order programs or participating network retail pharmacies.

In 1989, PBMs managed prescription drug benefits for about 60 million people. Four years later, they were managing prescription drugs for about 100 million people, almost 40 percent of the U.S. population. By the end of 1995, about 58 percent of FEHBP enrollees were covered by a PBM.

Because no VA medical centers or mail service pharmacies are participating providers under PBMs, VA is generally unable to obtain payment for prescription refills when veterans' insurance plans contract with PBMs. In such cases, VA facilities may submit their bills to the health insurers for processing as outpatient claims. Changes in insurers' copayment requirements for outpatient services, however, could further reduce VA recoveries. For example, the FEHBP Blue Cross and Blue Shield high-option plan will not pay the first \$50 of outpatient charges submitted by nonpreferred providers such as VA facilities. As a result, VA, which bills \$20 for a prescription refill regardless of type or amount of the drug provided, can no longer recover any of its costs of providing prescription refills from the Blue Cross plan unless it combines three or more refills into a single bill.

Even though VA is not a participating provider, one PBM has been authorized by 30 of its 2,000 plan sponsors to process and pay VA's bills for prescription refills. However, we also identified instances in which PBMs paid the insured veteran directly rather than the VA medical center, since VA is not a participating provider in the network. In such cases, VA has difficulty in getting veterans to forward the payments.

³²For more information on services offered by PBMs, see *Pharmacy Benefit Managers: FEHBP Plans Satisfied With Savings and Services, but Retail Pharmacies Have Concerns* (GAO/HEHS-97-47, Feb. 21, 1997) and *Pharmacy Benefit Managers: Early Results on Ventures With Drug Manufacturers* (GAO/HEHS-96-45, Nov. 9, 1995).

Shifts From Inpatient to Ambulatory Care Reduce Recoveries and Increase Recovery Costs

As VA shifts more of its care from inpatient to outpatient settings, insurance recoveries decrease and the cost of recovery increases.

VA has set goals to significantly reduce the amount of care provided in inpatient settings. For example, it has set goals to reduce the hospital bed-days of care provided per 1,000 unique users by 20 percent from the 1996 level, enroll 80 percent of users in primary care, and shift a large portion of surgeries to ambulatory care settings. VA has also implemented a new system for allocating resources to its networks—the Veterans Equitable Resource Allocation system—that is intended to eliminate the financial incentives previous allocation methods gave facilities to unnecessarily admit patients to hospitals and to encourage facilities to provide care in the most cost-effective setting. To the extent facilities respond to such performance measures and financial incentives, reimbursable inpatient care will decline and reimbursable outpatient care will increase.

Under its current rate schedules, VA must generate approximately 20 outpatient bills to produce recoveries equivalent to one inpatient bill. In addition, because MCCR staff have had to review medical records to generate outpatient bills, it frequently costs more to generate an outpatient bill for about \$200 than it does to generate an inpatient bill for thousands of dollars.

Billable Care Rendered to Veterans With Service-Connected Conditions Is Difficult to Identify

Almost 40 percent of the funds VA recovers from private health insurance is for services provided to veterans with service-connected conditions. VA loses opportunities for additional recoveries, however, because of the nature of decisions as to what services are billable. Identifying and billing the cost of care provided to veterans with service-connected disabilities for treatment of their nonservice-related conditions is administratively cumbersome and often subjective.

Because data on veterans' service-connected disabilities are not always precise, it is often difficult for MCCR staff to determine whether the care provided was related to the service-connected disability. For instance, knee surgery provided to a veteran with a service-connected disability was found to be billable when the MCCR staff discovered that his service-connected condition was associated with injuries to his other leg.

In addition, the ability of MCCR staff to differentiate between treatments for service- and nonservice-connected conditions depends on the quality of

the documentation in the medical record and the cooperation of the physician and other clinical personnel involved in providing the care. For example, billable medical services provided to a veteran who has a service-connected condition relating to hypertension can be difficult to identify. Depending upon the documentation, MCCR staff may view an EKG provided to this veteran as billable and view a routine physical (which requires that the veteran's blood pressure be checked) as unbillable.

Recent legislation minimized insurers' ability to exclude coverage for preexisting conditions. The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA) prevents private health insurers from excluding payment for policyholders' preexisting conditions for more than 12 months for conditions diagnosed or treated within 6 months before becoming insured.³³ Although service-connected disabilities are preexisting conditions, the VA recovery program will not benefit from this change, because VA's recovery authority does not allow it to bill health insurers for treatment related to a service-connected disability.

Changing the statutory language in title 38 of the U.S. Code to authorize VA to recover its costs from private health insurance for treating service-connected conditions, consistent with the provisions of HIPAA, could, however, be viewed as shifting to the private sector the government's obligation to provide care for veterans disabled during or as a result of their military service. On the other hand, authorizing such recoveries could generate significant additional revenues to be retained by VA for improving health care services for veterans. In addition, it could offset the incentives created by the Balanced Budget Act for VA facilities to target their services toward privately insured veterans with no service-connected disabilities.

VA Initiatives Seek to Reverse Decline and Increase Recoveries

VA officials identified a number of legislative and management initiatives intended to address the previously mentioned factors and help it achieve its recovery goals. VA sought and was given legislative authority to (1) allow it to retain copayment and third-party recoveries and (2) extend the lapsing recovery provisions. Planned administrative actions include

- improving the process for identifying veterans' insurance coverage;

³³Nonpayment for preexisting conditions may extend to 18 months in the case of a late enrollee in a group plan.

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- improving the process for submitting claims to Medicare supplemental insurers;
 - developing new rate schedules that allow itemized billing;
 - strengthening follow-up on claims denied or partially paid;
 - negotiating provider agreements with HMOs and other managed care plans;
 - strengthening efforts to ensure the medical appropriateness of VA care; and
 - automating the capture of data on patient diagnoses, procedures, and providers.

In addition, VA's goal of increasing the number of veterans using the VA health care system by 20 percent should bring additional insured veterans into the system. It is not clear, however, whether these actions will allow VA to counteract the factors contributing to declining recoveries, let alone allow it to significantly increase future recoveries.

Seek New Legislative Authority

Historically, facility directors have had little incentive to aggressively identify and pursue insurance recoveries because the funds, less the costs of operating the recovery program, were returned to the Treasury. Under the legislative proposal contained in its fiscal year 1998 budget submission, VA sought authority to keep all funds recovered from private health insurance. VA expects such authority to give VA facilities stronger incentives to identify veterans' insurance coverage and aggressively pursue recoveries. They will also have stronger incentives to market their services toward such revenue-generating veterans rather than nonrevenue-generating veterans such as veterans without private health insurance. The Balanced Budget Act of 1997 authorized VA to retain recoveries from private health insurance and collections for veterans' copayments after June 30, 1997.

The second problem VA sought to address through legislation was the lapsing of its authority to recover its costs for providing health care services to veterans with service-connected disabilities for conditions unrelated to their service-connected disabilities. The Balanced Budget Act of 1997 subsequently extended the authority until September 30, 2002.

With this legislation, VA expects to significantly increase recoveries for services provided to veterans with service-connected disabilities. By the year 2002, VA estimates that recoveries from private health insurance for services provided to veterans with service-connected conditions will increase to \$253 million. Allowing VA to retain all insurance recoveries creates a strong incentive for VA facilities to classify more of the care

provided to veterans with service-connected disabilities as unrelated to treatment of those disabilities.

Improve Methods for Identifying Insurance Coverage

VA has identified three approaches for improving identification of veterans with private health insurance and estimates that these initiatives could lead to increased recoveries totaling nearly \$200 million per year. However, VA appears to have overestimated the additional recoveries that are likely to be generated by the initiatives. Moreover, a fourth option for improving the identification of insurance coverage would be to include such information in the enrollment database being created as part of the implementation of eligibility expansions.

The first approach is to obtain, through a Medicare contractor, information on Medicare-eligible veterans who have private health insurance coverage that is primary. MCCR is particularly interested in identifying Medicare-eligible veterans whose private health insurance is primary. MCCR estimated that 5.9 percent of the over-65 population treated by VA could be expected to have primary health insurance other than Medicare. The MCCR program further estimated that if its assumption is correct, potential recoveries from such veterans may total about \$97 million.

VA appears to overestimate the potential for additional recoveries under this initiative. There are two basic groups of Medicare beneficiaries for whom private health insurance is primary. The first group is beneficiaries who are over 65 and still working or have a spouse who is still working. Those Medicare beneficiaries still working are likely to be healthier and thus likely to use fewer health care services, including services from VA. The second large group of Medicare beneficiaries likely to have other primary health insurance consists of individuals who retired from state and local governments before April 1, 1986, or from the federal government before January 1983.

In addition, VA does not know how many such veterans have already been identified. As discussed earlier, 60 percent of the veterans VA currently identifies as having private health insurance are over age 65. Accordingly, even if the estimate of the percentage of Medicare-eligible veterans with private health insurance that is primary is correct, the estimate of potential recoveries is overstated because it does not back out current recoveries.

On the other hand, VA may understate the potential for additional recoveries resulting from matching VA and Medicare records because such a match could also be used to identify Medicare beneficiaries under 65 years of age who have private health insurance that is primary. VA's 1992 National Survey of Veterans estimates that 23 percent of VA users under the age of 65 are covered by Medicare, and about a third of these veterans have private health insurance. MCCR, however, does not currently plan to use these data to identify private health insurance coverage for such veterans under the age of 65.

The second approach MCCR tested for improving identification of insurance coverage was the use of a contractor to identify insurance coverage. In August 1995, VA provided Health Management Systems, Inc., the names and identifiers of 38,748 patients for whom VA facilities had no insurance information. The contractor, however, was able to identify only 649 matches with its insurance records. VA further determined that only 236, or 0.6 percent, of the records reviewed had billable insurance coverage. However, even with the limited identification of insurance coverage, the contract proved to be cost effective.

The final approach was the institution of a preregistration process under which patients scheduled for outpatient visits within the next 10 days were contacted to remind them of their appointment and to request updated personal information, including employment and insurance data. On the basis of results of the pilot test, VA estimated that nationwide implementation of a preregistration process could result in an additional \$100 million in recoveries annually from newly identified insured patients.

It is not clear, however, whether the billable cases identified through the preregistration process would not otherwise have been identified. In other words, was preregistration a substitute for data-gathering efforts that would have taken place at the time of the visit? In addition, the preregistration process would also identify some insurance coverage that also would be identified under the first two methods, so the additional collections from the three approaches overlap and should not be fully added together.

Implementation of VA's health care enrollment process gives VA another option for capturing and updating veterans' health insurance data. Public Law 104-262 expanded veterans' eligibility for VA health care services and required VA to establish a system of enrollment. After September 30, 1998, veterans, other than those with service-connected disabilities rated at

50 percent or higher or seeking treatment for a service-connected disability, will not be able to obtain care from the VA health care system unless they have enrolled. Capturing insurance information during the enrollment process and including such data in the enrollment database could facilitate billing efforts. Information obtained at the time of enrollment and subsequent reenrollment could include the policy number and, upon request, a copy of the policy. By including other information, such as income and detailed information on adjudicated service-connected disabilities, MCCR staff could more readily identify billable insurance and prepare and process bills.

The effectiveness of such a process would, however, continue to be dependent on (1) the willingness of veterans to give VA complete and accurate information on their insurance coverage, employers, and incomes and (2) the thoroughness of VA efforts to obtain and verify the information provided. VA data show that much of the information VA currently gathers is inaccurate—veterans fail to reveal their insurance coverage or underestimate their incomes in applying for VA health care. For example, the VA initiatives described indicate that VA is not currently obtaining complete and accurate information on insurance coverage. Similarly, only about 3 percent of veterans with no service-connected disabilities are identified through VA's admission process as having incomes that place them in the discretionary care category. About 15 percent of veterans identified during the admission process as having incomes that place them in the mandatory care category, however, are subsequently identified through matches with income tax data as having incomes that might place them in the discretionary care category.

Currently, VA's only recourse when it determines that veterans knowingly provided false information in order to avoid copayments is to retroactively seek recovery of those copayments. A VA official told us that VA medical centers frequently waive such copayments. VA does not, however, maintain data on the extent to which such copayments are actually billed retroactively and recovered.

Negotiate Provider Agreements

The MCCR program is attempting to negotiate with HMOs and other managed care plans to enable VA facilities to become participating providers. HMOs, however, have little incentive to accept VA as a participating provider because, to the extent their enrollees obtain care from nonparticipating providers, HMOs' costs are reduced and profits increased. The MCCR

Business Plan proposes that VA consider a legislative proposal that would require HMOs to recognize VA as a preferred provider.

VA currently has a contract with only one HMO—Dakota Care—in South Dakota. VA does not, however, view this contract as a model easily transferrable to other HMOs because the VA medical center is in a small state with limited health care options. VA has been negotiating with at least two other HMOs—U.S Healthcare in Philadelphia and HMO Illinois, a subsidiary of Blue Cross of Illinois—but, to date, discussions have not resulted in provider agreements.

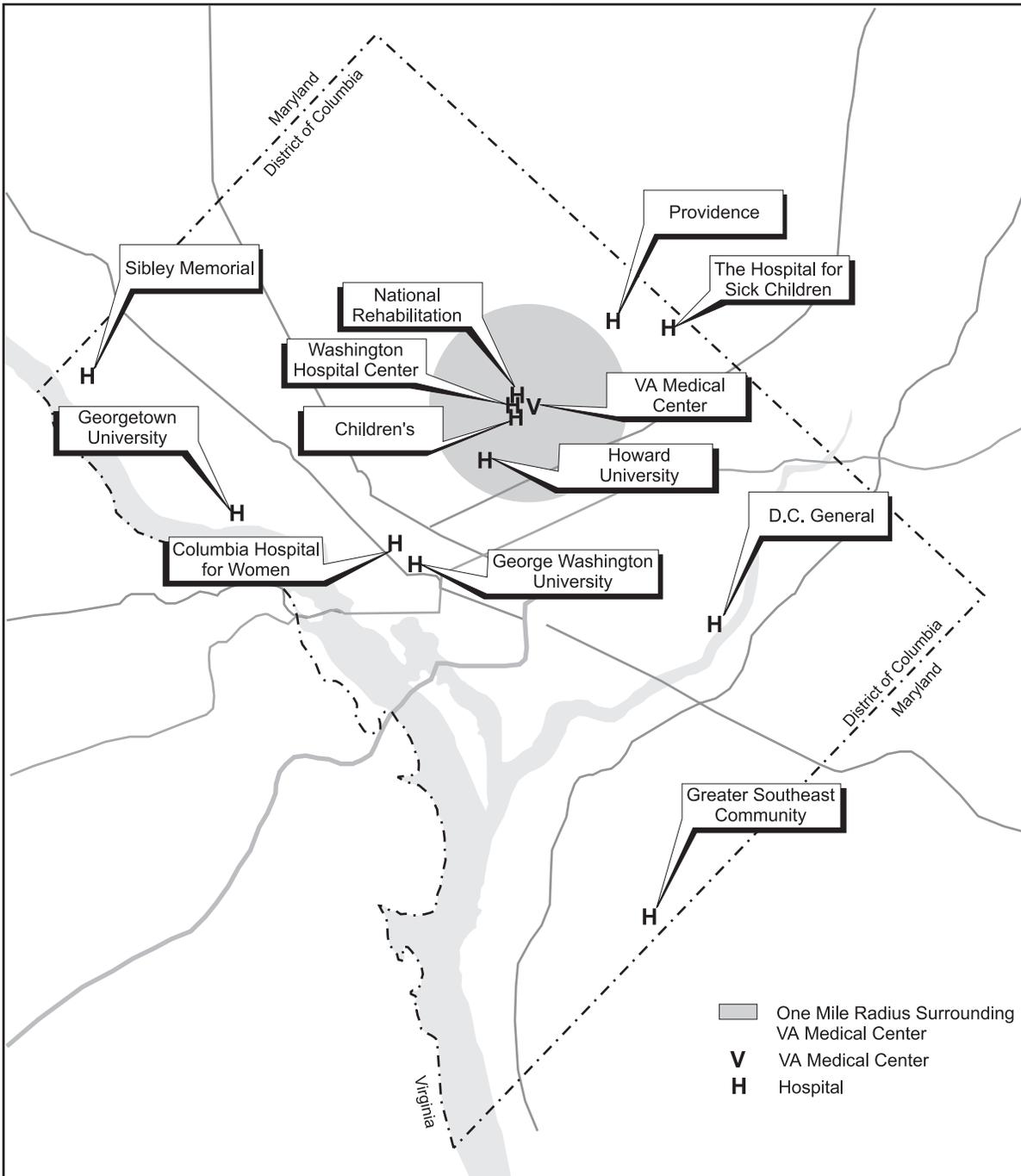
VA is having more success in negotiating provider agreements with POS plans. Unlike HMOs and PPOS that may be able to avoid all payments to VA (other than for emergency care) by excluding VA from their list of participating providers, POS plans have less to gain by refusing to accept VA as a participating provider. This is because a POS plan has an obligation to pay any willing provider for nonemergency care, including those without a provider agreement.

Since February 1995, VA's Office of General Counsel has reviewed and approved 32 provider agreements between VA facilities and managed care plans submitted by regional counsels and medical centers. Twelve of those agreements were signed; 5 agreements were closed with no further action, and 15 agreements remain open. Neither VA's General Counsel nor the Veterans Health Administration maintained readily accessible information on the number and status of contracts submitted for headquarters review prior to February 1995. As a result, we could not determine how many provider agreements are in effect or whether they are for preferred or participating provider status.

However, even in instances in which managed care plans are willing to accept VA as a participating provider, they may be unwilling to accept VA as a preferred provider. This distinction is particularly important to VA because being a participating provider essentially lowers VA recoveries. For example, the Washington, D.C., VA medical center has an agreement with Blue Cross of the National Capital Area as a participating, rather than preferred, provider. This means that veteran policyholders who use the Washington, D.C., medical center rather than a preferred provider are subject to higher copayments. These higher copayments essentially mean that the insurer pays less of the billed charges; thus VA recoveries are lower than they would be if VA was a preferred provider.

Although the Washington, D.C., medical center is trying to become a preferred provider, Blue Cross of the National Capital Area has little incentive to allow VA to join its preferred provider network. For one thing, the VA medical center is surrounded by preferred providers in the Blue Cross network; as the following map indicates, 4 of the 12 hospitals that are preferred providers in Washington, D.C., are within a mile of the VA hospital. Moreover, because the Washington, D.C., medical center's billing process differs from those of other hospitals, VA bills are perceived as more difficult and costly for the insurer to process.

Figure 3: Location of Participating Providers in Blue Cross Network Relative to Washington, D.C., VA Medical Center



A number of other factors also affect VA's ability to negotiate preferred provider status. First, to become a preferred provider under some plans, VA would be required to accept discounted payments. Historically, VA has not been allowed to negotiate discounted payments.³⁴ Second, VA may be unwilling or unable to comply with the utilization management policies and standards insurers often impose as requirements for preferred provider status.

The 1996 business plan for the MCCR program identified plans to address VA's inability to recover from HMOs by seeking legislation requiring HMOs to include VA as a preferred provider. VA has taken no official position on the proposal contained in the MCCR business plan and has not estimated potential revenues from this initiative, but revenues could be substantial given the rapid increase in HMO enrollments. Such legislation, however, would essentially require HMOs to treat VA providers differently than they would other providers, raising questions of equity and fairness.

A number of alternative approaches could be taken to ensure that government funds are not used to subsidize health plans unless the plan includes VA as a participating provider. For example, legislation could be enacted authorizing VA to (1) deny enrollment in the VA health care system to any veteran enrolled in a managed care plan unless that plan includes VA as a provider and (2) refuse to provide drugs to any veteran covered by PBMs unless the sponsoring health plan reimburses VA, or the plan's PBM includes VA as a participating provider in the PBM's pharmacy network.

Similarly, in instances in which health plans send their payments to veterans rather than to VA and the veterans refuse to return the payments, VA could be authorized to deny veterans enrollment in the VA health care system or to recover the funds through an offset against other government benefits. Because they are directed at veterans rather than at health plans, such solutions would likely be viewed as reducing veterans' benefits.

Provide Medically Appropriate Care

VA actions aimed at providing care in the most cost-effective setting consistent with good patient care should increase the percentage of billed charges recovered, but would not necessarily increase overall recoveries. At the two facilities included in our review, however, preliminary results from the utilization reviews showed that most of the hospital admissions continue to be medically unnecessary. Nevertheless, further actions could

³⁴Under the Balanced Budget Act, VA can recover the reasonable charge for care or services starting October 1, 1997.

be taken to strengthen utilization reviews or give physicians incentives to provide services in the most cost-effective setting.

The Under Secretary for Health directed VA facilities to implement an inpatient utilization review program no later than September 30, 1996, to assess, monitor, and evaluate the appropriateness of hospital care provided. As part of that program, all scheduled acute admissions are to be assessed prospectively for the appropriateness of the level of care provided. Following admission, nurse-reviewers are to monitor the appropriateness of care through continuing stay reviews, that is, though periodic reviews of a patient's care during the hospital stay.

VA's action addresses a long-standing problem with overutilization of acute-care beds and inpatient services identified by the VA Inspector General, VA researchers, and us. For example, a January 1996 study by VA researchers reported that about 40 percent of the admissions to acute medical and surgical services were assessed as nonacute; more than 30 percent of the days of care in the acute medical and surgical services of the VA hospitals reviewed were nonacute.³⁵ VA's action responded to our recommendation last year that it establish an independent, external preadmission certification program.³⁶

Systemwide data on the effectiveness of the new utilization review program are not yet available. Data from the Martinsburg and Washington, D.C., VA medical centers, however, indicate that about 45 percent of the acute inpatient admissions and about 60 percent of the acute days of care reviewed in both facilities since the implementation of the utilization review program did not meet InterQual standards for acuity or intensity of care.

In addition to implementing the utilization review program, the Martinsburg medical center established (1) a subacute pilot program that allows patients no longer needing acute care to be transferred to a special unit offering care that is less intensive, (2) a 23-hour observation unit to

³⁵C. Smith and others, "Overutilization of Acute-Care Beds in Veterans Affairs Hospitals," *Medical Care*, 34 (1) (Jan., 1996), pp. 85-96. In the study, reviewers from 24 randomly selected VA hospitals applied the InterQual criteria to assess the appropriateness of 2,432 fiscal year 1992 admissions and days of care in acute medical, surgical, and psychiatry services. The study found similar rates of nonacute admissions and days of care in all 24 hospitals. The nonacute admissions and days were attributed to several factors, including lack of an ambulatory care alternative, conservative physician practices, delays in discharge planning, and social factors such as homelessness and long travel distances to the hospitals.

³⁶VA Health Care: Opportunities for Service Delivery Efficiencies Within Existing Resources (GAO/HEHS-96-121, July 25, 1996).

allow patients to be monitored without being admitted to the hospital, (3) a “hoptel” to provide temporary lodging for patients with transportation problems, and (4) a Preadmission Surgical Screening program through which preoperative tests are performed on an outpatient basis so that patients can be admitted the morning of surgery. In addition, daily reports on all nonacute admissions are given to the bed service chiefs, and a weekly utilization review activity report is provided to bed service chiefs and the chief of staff.

These initiatives enabled Martinsburg medical center to decrease nonacute admissions to medical wards from 72 to 59 percent and nonacute admissions for surgical wards from 78 to 70 percent. The data from continuing stay reviews showed that nonacute days of care provided in medical wards decreased from 92 to 79 percent, and nonacute days of care provided in surgical wards decreased from 82 to 69 percent. Although these are important improvements, with well over half of admissions and days of care continuing to be nonacute, further actions appear warranted. For example, under the current utilization review program, neither the medical center nor the admitting physician suffer any financial consequences from ignoring the findings of the reviewer and admitting patients who could be cared for on an outpatient basis.

Managed care plans also control the use of hospital care through physician incentives. These include profiling of physicians, preferred provider arrangements, and specific financial incentives. Through profiling, physicians are given specific data that compare their practice and admission patterns with those of other physicians. Profiling largely relies on peer pressure to achieve changes in practice patterns.

VA’s MCCR program developed one form of profiling—a report indicating how many days of care were denied by health insurers for each attending physician. The report also shows the reasons for the insurer denials. It is not clear, however, how many facilities have implemented the report or whether the information is shared with the attending physicians. For example, the Martinsburg medical center produces the report and distributes it to the chief of Clinical Support, while the Washington, D.C., medical center does not produce the report.

A second method managed care plans use to create physician incentives is through preferred provider arrangements. PPOs use physician profiling to identify cost-effective providers. Those whose practice patterns vary

significantly from the norm are not accepted or not retained as preferred providers.

Finally, many HMOs use specific financial incentives to encourage physicians to reduce hospital use. These incentives can range from financial arrangements, in which physicians are placed at risk for a portion of hospital costs, to bonuses if hospital use is kept below a certain level. Such financial incentives, however, carry with them an increased risk that physicians will overreact to the financial incentives and fail to admit patients in need of hospital care. VA has limited legislative authority to establish incentive pay provisions for physicians.

Actions to reduce claim denials because of inappropriate medical care are largely beyond the control of the MCCR program. The MCCR program can continue to (1) observe insurers' certification procedures and (2) negotiate for partial payments to the extent feasible, but it cannot resolve the core issue.

Obtain Medicare Remittance Advice

VA also expects to increase recoveries by improving its process for submitting claims to Medicare supplemental insurers. As discussed earlier, VA has considerable and increasing difficulty in collecting from Medicare supplemental insurance, in part, because of VA's inability to submit claims to insurers similar to the claims of Medicare providers that have accompanying remittance advice and explanation of benefits payment vouchers. The MCCR program is exploring the feasibility and costs associated with having a Medicare contractor prepare such documentation for veterans covered by Medicare who use VA facilities. VA has not estimated the potential increased recoveries from the initiative, but notes that the initiative is important to prevent further decreases in recoveries from Medicare supplemental policies.

Develop Itemized Bills

VA also expects to increase recoveries by developing new rate schedules that allow itemized billing. In the past, Veterans Health Administration has been limited to use of per diem and per-visit rates because of the lack of detailed cost and workload data from its accounting and information systems. As VA completes implementation of the Decision Support System and other improvements to its information and accounting systems, it proposes to implement new rate schedules to optimize third-party recoveries.

As VA shifts from inpatient to outpatient care, the importance of developing a more detailed outpatient charge structure increases. Although many high-cost services, such as cataract surgery, are increasingly performed on an outpatient basis, under its current rate structure, VA can bill only \$194 for an outpatient visit, regardless of the type and amount of services provided during the visit.

To resolve this problem, the MCCR program is developing a procedure-specific rate schedule for outpatient physician services. These rates will be billed along with a facility charge. VA plans to implement the new rate structure in October 1997. Implementation of the new rates should help compensate for the decline in recoveries likely to accompany the shifting of care from inpatient to outpatient settings.

The 1996 MCCR business plan also estimated that VA should see between a 15- and 25-percent increase in collections if it uses a diagnosis-related group (DRG) rate schedule for inpatient billing. Although the DRG rates are still being developed, VA no longer intends to implement DRG billings in fiscal year 1997. Rather, its efforts have turned to developing a rate schedule for inpatient physician services. Other proposed changes in billing rates are targeted for succeeding years, leading to implementation of locally developed itemized rates in fiscal year 2000.

Strengthen Follow-Up

VA believes it can increase recoveries from currently billable insurance by strengthening follow-up on claims denied or partially paid. The business plan notes that some medical centers do not have utilization review coordinators adequately trained in third-party recoveries to facilitate requests for reconsideration of claims. The plan notes that some utilization review coordinators have successfully negotiated payments from insurers; it estimates that approximately 10 percent of denied claims could be overturned and recovery achieved through strong utilization review coordinators.

Our work at the Martinsburg and Washington, D.C., medical centers confirmed that there is some potential to achieve additional recoveries through follow-up action. It is unclear, however, whether such actions would result in 10 percent of denied claims being overturned and recovery achieved through follow-up actions. As discussed earlier, for most denied claims, there is little, if any, recovery potential.

The utilization review coordinator at Martinsburg was able to negotiate partial payments for many claims denied because of medical necessity, but such recoveries accounted for only a small portion of billed charges. While the Washington, D.C., medical center did not actively pursue partial payment during the time of our review, its ability to achieve the same success in obtaining partial payment from insurers depends on a number of factors, including the willingness of insurers to make partial payments. As discussed earlier, insurers are increasingly denying all payment for services unnecessarily provided in hospitals.

Automate Capture of Encounter Data

VA also expects its efforts to automate the capture of data on patient diagnoses, procedures, and providers to increase collections and reduce recovery costs. Prior to April 1995, VA did not require its facilities to include such data for outpatient visits in any of its computer databases. As a result, the MCCR program had to manually review outpatient medical records in order to prepare insurance billings.

In April 1995, the Under Secretary for Health changed Veterans Health Administration policy to require the capture of diagnosis, procedure, and provider data for all ambulatory care encounters and services. When fully implemented, the MCCR program estimates that the automated capture of encounter data will enable it to (1) utilize the automatic billing features of its integrated billing system and (2) eliminate staff positions comparable to 572 full-time-equivalent employees currently used to manually review and code data from patient medical records.

Among the benefits from the data capture initiative identified by a VA contractor were improved identification of billable visits and increased reimbursement because of improved capture and reporting of procedures. These benefits would result from shifting the staff positions saved by eliminating manual review to improving identification of insurance coverage and follow-up on denied claims. The contractor estimated that using the positions to strengthen identification and follow-up would enable VA to generate about \$100 million a year in additional outpatient recoveries. In its fiscal year 1998 budget submission, VA indicates that the automated capture of encounter data will also result in additional recoveries of \$23 million in fiscal year 1997, increasing to \$116 million in fiscal year 2002.

Attract New Users

Another of VA's goals is to increase the number of VA users by 20 percent over the next 5 years. One way to meet its recovery projections would be to focus its marketing efforts on attracting veterans with fee-for-service private health insurance.

VA officials told us that they do not know how many veterans in their 2.9 million patient base have insurance or how many insured veterans receive billable care. This lack of information on key elements affecting its projections creates considerable uncertainty about the number of new insured users it would need to attract or identify in order to generate its target revenues.

Use of Insurance Payments to Pay Veterans' Copayments Reduces Overall Recoveries

VA's General Counsel has determined that a portion of any payments received from a veteran's private health insurance should be applied toward any copayments owed by the veteran, including both means test, per diem, and pharmacy copayments. While VA's interpretation is understandable as it applies to Medicare supplemental insurance policies, it is more questionable to apply recoveries from primary insurance toward veterans' copayments. In addition, as interpreted by VA's General Counsel, the application of insurance recoveries to offset veteran copayments creates a significant administrative burden for MCCR staff and reduces overall third-party recoveries.

Under Public Law 99-272, certain veterans, in order to become eligible for VA medical care, must agree to pay the lesser of the cost of that care or the so-called "means test" copayment. The copayment for inpatient hospital and nursing home care is based on the Medicare deductible, while the copayment for outpatient care is equal to 20 percent of the average cost of an outpatient visit. The means test copayments apply to veterans with no service-connected disabilities who have incomes above the means test threshold—\$21,611 for a veteran with no dependents in 1997.

Public Law 101-508, effective November 5, 1990, added additional cost-sharing requirements. First, it added per diem payments—\$5 a day for nursing home care and \$10 a day for hospital care—to the means test copayment. In addition, it created a new cost-sharing requirement for prescription drugs. All veterans—other than those receiving treatment for a service-connected condition, those with service-connected disabilities rated at 50 percent or higher, and those with incomes below the maximum VA pension level—are required to pay \$2 for each 30-day supply of an outpatient prescription.

The VA law is silent about the relationship between insurance recoveries and veteran copayments, and VA's General Counsel provided guidance in 1990 on how the two recovery programs should interact. Specifically, the General Counsel opinion, as expanded through a 1996 reevaluation, provides that

- recoveries from Medicare supplemental insurance policies should be used first to satisfy veterans' means test payments, per diem payments, and prescription copayments; and
- for non-Medicare supplemental insurance, recoveries are to be divided in equal proportions between VA and the veteran; in other words, if the insurer pays 80 percent of allowable charges, then insurance proceeds will be used to pay 80 percent of the veteran's copayment after the veteran has satisfied any deductible imposed by the insurer.

VA's interpretation of recovery provisions as they apply to supplemental insurance follows from an assessment that Medicare supplemental insurance is specifically intended to pay policyholders' deductibles and copayments and is purchased or provided expressly for that purpose. However, using funds insurers provide to VA to pay for veterans' financial obligation when these insurance policies have established deductibles and copayments to discourage unnecessary use of health services is harder to defend. One of the primary arguments insurers made against the enactment of the law authorizing VA recovery from private health insurance was the lack of VA cost-sharing provisions to discourage inappropriate use of health care services.

VA argues that it should be treated by insurance companies the same way any private sector hospital is treated. But private sector hospitals do not give a portion of the payment they receive from a patient's health insurance to the patient. Although VA may not collect more than the cost of its services, insurers typically pay VA less than VA's billed charges because the insurers reduce the payment in accordance with their cost-sharing provisions. Only in instances in which the combined insurance recoveries and copayments would exceed the cost of VA services would VA be compelled to apply insurance recoveries toward veterans' copayments.

The administrative burden of applying insurance recoveries toward veteran copayments, particularly for \$2 prescription copayments, may be an issue as well. In 1994, VA estimated that it cost it \$.38 for each \$1 it collected under the pharmacy copayment program. With the added burden of offsetting insurance recoveries against prescription copayments, the

administrative costs are likely to exceed recoveries for veterans with health insurance. This is because VA would typically be able to bill only \$.40 of a \$2 copayment after the offset.

Conclusions

Although VA currently recovers less than a third of the amounts it bills to private health insurers, opportunities to recover more of its billed charges appear to be limited. The amounts that insurers deduct from their payments to VA generally reflect application of insurance policy provisions restricting payments for medically inappropriate care and setting policyholder cost-sharing requirements. In addition, some Medicare supplemental insurers contend that they have overpaid VA claims for years. They are reducing payments and seeking refunds for past overpayments.

VA has set goals for its medical care cost recovery program that would require it to almost double recoveries from private health insurance over the next 5 years when VA's estimates of past overpayments are considered. Because there is little potential to increase recoveries through current billings, the success of VA's efforts depends largely on its ability to attract new users with private health insurance or improve its efforts to identify current users' insurance coverage.

VA's ability to achieve its goals is uncertain considering the many factors likely to decrease future recoveries. Although VA has a number of initiatives planned and under way to address some of these factors and increase recoveries, it is not addressing other problems. For example, VA has not

- contacted state insurance commissions to obtain their help in removing exclusionary clauses in insurance policies that appear to preclude payment to VA;
- developed procedures to ensure that the time-consuming tasks associated with identifying, confirming, and returning overpayments are not performed at the expense of current billing activities;
- established mechanisms to provide its physicians with incentives to make appropriate use of VA hospitals; or
- developed adequate mechanisms for gathering complete and accurate information on veterans' health insurance policies.

Now that the Congress has authorized VA to retain health insurance recoveries, VA needs to develop procedures to ensure that such authority does not detract from services available to low-income veterans and

veterans with service-connected conditions who have no health insurance. Allowing VA to retain insurance recoveries creates strong financial incentives for VA facilities to place a higher priority on serving insured rather than uninsured veterans.

Matters for Consideration by the Congress

The statutes governing VA recoveries from private health insurance and veteran copayments do not clearly specify the relationship between the two provisions. In the absence of definitive guidance in the law, VA's General Counsel has determined that insurance recoveries should be used to offset veterans' copayment responsibilities. The effect of its interpretation is a reduction in overall cost recoveries, increased administrative expense, and reduced incentive for veterans to manage their use of health care services.

The Congress may wish to consider clarifying the cost recovery provisions of title 38 of the U.S. Code to direct VA to collect means test copayments, per diem charges, and pharmacy copayments from patients regardless of any amounts recovered from private health insurance except in instances where the insurer pays the full cost of VA care.

The identification of billable care provided to veterans with service-connected conditions is administratively cumbersome. Moreover, HIPAA prevents private health insurance from excluding payment for preexisting conditions for more than 12 months after the enrollment. The Congress may wish to take advantage of the provisions of HIPAA to authorize VA to recover the costs of service-connected treatments from private health insurance after the specified exclusionary period.

A change in the statutory language in title 38 of the U.S. Code to authorize VA to recover from private health insurance its costs for providing treatment for service-connected conditions, consistent with the provisions of HIPAA, could, however, be viewed as shifting to the private sector the government's obligation to care for veterans disabled during or as a result of their military service. On the other hand, now that VA retains recoveries from third-party insurers, this change could generate significant additional revenues for improving health care services for veterans. Moreover, it could offset the incentives created by the Balanced Budget Act for VA facilities to target their services toward privately insured veterans with no service-connected conditions.

Finally, VA's ability to increase recoveries is often hindered by incomplete and inaccurate information on veterans' employers, incomes, and insurance coverage. Veterans, however, have little direct or indirect incentive to cooperate with VA recovery efforts. The Congress may wish to consider giving VA the authority to disenroll veterans from the VA health care system who knowingly provide VA incomplete or inaccurate data about their incomes, employers, or insurance coverage.

Recommendations

We recommend that the Secretary of Veterans Affairs do the following:

- Establish procedures to work with state insurance commissions to ensure that exclusionary clauses inconsistent with VA's recovery authority are removed from private health insurance policies.
- Work with the Director, OPM, to identify options for including VA facilities as preferred or participating providers under FEHBP plans, including HMOS and preferred provider plans.
- Design physician incentives to encourage appropriate use of hospital care. Such incentives should not, however, be so strong that they would result in denial of needed hospital care.
- In designing the enrollment process for the veterans' health care program, develop procedures for gathering and updating detailed information on veterans' employment, insurance, and service-connected disabilities.
- Assign adequate resources to MCCR activities to protect the government's interest in resolving insurers' requests for refunds of claimed overpayments.
- Develop procedures to ensure that authority to retain health insurance recoveries would not detract from services to veterans who lack private health insurance.

Agency Comments and Our Evaluation

We obtained comments on a draft of this report from the Acting Director of Medical Care Cost Recovery (MCCR) and other VA officials. The officials generally concurred with all but one of our recommendations. However, according to a Senior Management Analyst, Management Review and Administration, VA does not agree with our recommendation that it design physician incentives to encourage appropriate use of hospital care. She said that VA believes adequate incentives have already been established through the new Veterans Equitable Resource Allocation system and performance measures.

Although the new allocation procedure and performance measures will give veterans integrated service networks and VA facilities greater incentives to provide appropriate care, we do not think that these initiatives will provide sufficient inducement for individual physicians to modify their practice patterns significantly. Existing efforts to reduce inappropriate inpatient care, such as VA's recently implemented utilization review program, constitute a solid first step to addressing VA's traditional reliance on institutional care. However, as indicated by the extent of the nonacute care that continues to be provided at the Martinsburg and Washington, D.C., facilities since the program's inception, this effort may not be sufficient to address physicians' lack of accountability for their treatment decisions. In our view, VA needs to develop incentives such as physician profiling or financial risk-sharing to encourage appropriate use of hospital care.

The Acting Director emphasized that limited opportunities exist for VA to collect more of its billed charges and that the key to increased recoveries is improved identification of insurance coverage. He said that VA is pursuing a match with Medicare records that should help to identify private health insurance coverage of Medicare-eligible veterans.

In a draft of the report, we recommended that the Secretary of Veterans Affairs work with the Director, OPM, to (1) determine the extent to which FEHBP plans overpaid VA for care provided to veterans who were covered by Medicare and the extent that overpayments should be refunded and (2) develop mutually beneficial changes in how FEHBP plans will reimburse VA for services provided to veterans covered by Medicare. In commenting on the report, VA officials indicated that they had relied on the Department of Justice to handle negotiations with OPM to discuss mutually beneficial changes. After follow-up discussions with OPM, we revised the report to indicate that FEHBP plans will pay VA facilities as secondary to Medicare for those veterans who are covered by Medicare, that this benefit change will occur prospectively, and that past payments will not be refunded. We have also deleted the associated recommendations.

VA also provided several technical comments, which have been incorporated in the report as appropriate.

We are sending copies of this report to appropriate congressional committees; the Secretary of Veterans Affairs; the Director, Office of

Management and Budget; and other interested parties. We will also make copies available to others upon request.

This report was prepared under the direction of Stephen P. Backhus, Director, Veterans' Affairs and Military Health Issues. Please call Mr. Backhus at (202) 512-7116 if you or your staff have any questions. Other contributors to this report included Jim Linz, Sibyl Tilson, Mary Ann Curran, Lesia Mandzia, and Greg Whitney.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Richard L. Hembra".

Richard L. Hembra
Assistant Comptroller General

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