BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Legislation To Authorize VA Recoveries From Private Health Insurance Would Result In Substantial Savings

Most health insurance policies will not pay for non-emergency care provided to the companies' policyholders by Veterans Administration medical facilities. Such policies have exclusionary clauses which state that the insurance companies will not pay for care for which the policyholder has no obligation to pay. GAO analyzed concerns raised by the insurance industry and others about a legislative proposal to prevent health insurance companies from refusing payment for treatment of non-service-connected disabilities in VA medical facilities.

GAO concludes that no overriding legal or administrative problems are preventing the enactment and implementation of a VA cost recovery program. GAO estimates, based on a questionnaire survey, that VA could have recovered at least $98 million to $284 million from private health insurance in fiscal year 1982 with minimal impact on health insurance premiums.

GAO recommends that the Congress enact recovery legislation to enable VA to recover the costs of care provided to privately insured veterans for non-service-connected medical conditions.

GAO/HRD-85-24
FEBRUARY 26, 1985

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

B-204640

To the President of the Senate and the
Speaker of the House of Representatives

This report shows the need for legislation to authorize Veterans Administration facilities to recover the cost of medical care provided to veterans for non-service-connected disabilities from private health insurance. We have previously reported on the need for legislation to prevent insurance companies from refusing payment for care provided in Department of Defense and Public Health Service medical facilities. The President's fiscal year 1986 budget proposal states that legislation will be proposed to require reimbursement from private health insurance along the lines we are recommending.

Copies of this report are being sent to the Administrator of Veterans Affairs; the Director, Office of Management and Budget; the Secretary of Health and Human Services; the Secretary of Defense; the Director, Office of Personnel Management; the Blue Cross and Blue Shield Association; and the Health Insurance Association of America.

Charles A. Bowsher

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

LEGISLATION TO AUTHORIZE VA RECOVERIES FROM PRIVATE HEALTH INSURANCE WOULD RESULT IN SUBSTANTIAL SAVINGS

D I G E S T

The Veterans Administration (VA) operates the largest health care delivery system in the United States. During fiscal year 1983, VA operated 172 hospitals, 226 outpatient clinics, 99 nursing homes, and 16 domiciliaries. VA's fiscal year 1983 medical care budget was about $8 billion.

Veterans eligible for VA medical care are classified into two broad categories: those with disabilities resulting from their military service and those without such disabilities. Veterans with non-service-connected disabilities are eligible for care at VA hospitals only if they are (1) at least 65 years old or (2) unable to pay for their care at a private hospital. In fiscal year 1983, about 90 percent of the approximately 1 million episodes of care provided by VA hospitals were for non-service-connected disabilities.

This report focuses on the potential recovery through insurance of a portion of VA's costs incurred for the treatment of veterans' non-service-connected medical conditions.

PRIVATE HEALTH INSURANCE WILL NOT PAY FOR VA CARE

When veterans with private health insurance obtain treatment for non-service-connected disabilities at private sector hospitals, their insurance pays all or part of the cost of care. However, most health insurance policies have exclusionary clauses which state that they will not pay for care provided in VA hospitals or care for which the policyholder has no legal obligation to pay. Veterans generally have no obligation to pay for care provided in VA facilities.

Tear Sheet

GAO/HRD-85-24
FEBRUARY 26, 1985

In a 1970 report, GAO stated that it would be necessary to enact legislation in order for VA to recover the costs of medical care provided to privately insured veterans from their health insurance unless insurance companies voluntarily reimbursed VA. Since then, VA has, on several occasions, submitted such legislative proposals to the Congress. During 1979 Senate hearings on proposed recovery legislation, concerns were raised about

--the reliability of VA's estimate of the potential recoveries,

--the increased administrative costs VA and insurance companies would incur,

--the effect VA recoveries of costs for treatment of non-service-connected medical conditions would have on health insurance premiums, and

--the legality of recovery legislation.

The Senate Committee on Veterans' Affairs said that it believed these concerns should be resolved before seriously considering the enactment of recovery legislation. As of January 1985, recovery legislation had not been enacted. (See pp. 1 to 7.)

THE CONGRESS AUTHORIZES VA TO ESTABLISH ABILITY-TO-PAY CRITERIA

The Congress, however, enacted the Veterans Administration Health Care Amendments of 1980 (Public Law 96-330) as an alternative to recovery legislation. The amendments authorize VA to establish specific ability-to-pay criteria and to verify veterans' ability to defray the expenses of non-service-connected medical care before providing such care except under specified circumstances. As of January 1985, VA had not published proposed regulations to implement the ability-to-pay provisions of Public Law 96-330. (See p. 2.)

Whether veterans are covered by private health insurance would be one element in assessing their ability to pay. Implementation of the ability-to-pay provisions of Public Law 96-330 would likely reduce the number of veterans with insurance using the VA system. Public

Law 96-330 should, in GAO's opinion, be viewed as a supplement, rather than an alternative, to recovery legislation.

Without recovery legislation, VA would continue to be prevented from recovering costs of care provided to those insured veterans who (1) have service-connected disabilities but receive treatment for non-service-connected conditions, (2) are receiving a VA pension or are eligible for Medicaid, or (3) are 65 years of age or older. These three groups of veterans are currently eligible for care in VA facilities because they are presumed under Public Law 96-330 to be unable to pay for their care. Also, insured veterans who are determined to be unable to defray the costs of deductibles or coinsurance at private sector facilities would still be eligible for care in VA facilities. However, VA would be unable to recover from their private health insurance.

WHY THE REVIEW WAS MADE

GAO made this review to obtain and analyze sufficient information regarding the above concerns to allow further consideration to be given to the enactment of recovery legislation. As part of its study, GAO sent a questionnaire to a random sample of veterans who were discharged from VA hospitals during fiscal year 1982 after being treated for non-service-connected disabilities.

The questionnaire asked veterans whether they were covered under a health insurance policy provided through their present or former employer, spouse's employer, union, or retirement plan. GAO excluded from its analysis veterans whose insurance policies would not cover the services they received at VA hospitals because their coverage either had been exhausted before they went to VA or did not cover the type of services VA provided.

RESULTS OF GAO'S QUESTIONNAIRE SURVEY

GAO estimates that about 18 percent of the veterans in its questionnaire universe of about 345,000 episodes of non-service-connected care had private health insurance. The care provided such veterans cost VA between $188 million and $284 million. (See pp. 13 to 17.)

GAO's projections are conservative. Many veterans excluded from the GAO universe probably had private health insurance. For example, about 240,000 episodes of care were excluded because of veterans who could not or did not respond to the questionnaire. GAO's review of admissions documents for a sample of such veterans showed that about 6 percent had advised VA that they had private health insurance.

Also excluded from GAO's projections were about 130,000 episodes of psychiatric care. Psychiatric care was excluded because of the limitations in psychiatric coverage under insurance policies. A 1982 survey by the Health Insurance Association of America showed that 90 percent of employees with group major medical coverage had some psychiatric coverage. About 65 percent of them had policies that paid full hospital charges for psychiatric care. (See pp. 19 to 22.)

ESTIMATING POTENTIAL RECOVERIES

Private health insurance policies generally cover from 80 to 100 percent of the cost of hospital care. (See pp. 17 to 18.) If insurance companies had reimbursed VA based on actual lengths of stay in VA hospitals, GAO estimates that VA would have recovered from $150 million to $284 million of the $188 million to $284 million in costs incurred in providing care to the veterans.

Because patients generally stay longer in VA hospitals than in community hospitals, GAO also estimated potential recoveries based on the lengths of stay of comparable patients in community hospitals. If insurance companies limited reimbursement to VA based on community lengths of stay, VA could have recovered at least $98 million to $160 million of the $188 million to $284 million in costs incurred. (See pp. 15 to 19.)

GAO's estimates are based only on inpatient hospital care. In fiscal year 1982, VA also provided about 6.4 million outpatient visits for non-service-connected conditions at a cost of about $400 million. VA recoveries could have been increased to the extent that costs incurred for such veterans were covered by private health insurance. (See p. 21.)

In projecting VA recoveries, GAO used the billing rates in effect at the time the care was provided. However, in February 1984, GAO reported that VA's rates were about 26 percent too low to recover actual VA costs. Accordingly, recovery estimates are conservative. (See p. 22.)

ADMINISTRATIVE COSTS

VA's increased administrative costs to recover from private health insurance should be less than 1.8 percent of recoveries based on VA's historic costs for processing similar claims. GAO estimates that VA would have incurred increased administrative costs of about $1.7 million to recover the $98 to $284 million from private health insurance projected in this report. This represents from about 0.6 percent to about 1.8 percent of the projected recoveries. Because VA already identifies veterans' private health insurance coverage during the admissions process, the increased VA administrative costs would result primarily from preparing and collecting the bills. (See pp. 23 to 30.)

GAO attempted to obtain data on insurers' administrative costs from the Health Insurance Association of America and the Blue Cross and Blue Shield Association. However, the Health Insurance Association said that it does not compile such data, and the Blue Cross and Blue Shield Association, which does, declined to provide administrative cost data to GAO.

Insurance companies should incur increased administrative costs of less than 6 percent of VA recoveries based on the highest level of administrative costs incurred by federally administered health insurance programs. Accordingly, GAO estimates that insurance companies would have incurred administrative costs of, at most, about $6 million to $17 million to process the $98 million to $284 million in claim payments projected in this report. (See pp. 30 to 33.)

EFFECT ON HEALTH INSURANCE PREMIUMS

In 1982 insurance companies paid almost $88 billion in claims, and they collected almost $99 billion in insurance premiums. Insurance companies would likely pass on increased benefit

payments and administrative costs resulting from VA recoveries to their policyholders. Accordingly, the $98 million to $284 million in VA recoveries projected in this report should increase health insurance premiums between $0.93 and $2.69 per year for each of the approximately 112 million policyholders with comprehensive hospitalization insurance coverage if the companies pass on the benefit payments and administrative costs to all of their policyholders.

Officials from the Health Insurance Association of America and the Blue Cross and Blue Shield Association pointed out that the effect on individual policyholders would vary. They said, and GAO agrees, that the effect could be the greatest in areas where there are large concentrations of veterans and VA hospitals. (See pp. 33 to 35.)

It is important to note that implementing the ability-to-pay provisions of Public Law 96-330 would also likely result in increases in health insurance premiums if veterans with private health insurance are referred to private sector facilities. However, implementing those provisions would also increase veterans' out-of-pocket costs since those who are able to pay would be expected to pay any deductibles and coinsurance at private sector facilities.

THE CONGRESS CAN REGULATE INSURANCE AND PROHIBIT EXCLUSIONARY CLAUSES

The Health Insurance Association of America and the Blue Cross and Blue Shield Association have expressed concern about the legality of legislation to prohibit exclusionary clauses. GAO believes, based on a review of case law, that the insurance industry's rights would be adequately protected and recovery legislation such as that proposed in 1979 would be legal. (See ch. 4.)

RECOMMENDATION TO THE CONGRESS

GAO believes, based on its analysis, that the government should not be precluded from recovering the cost of non-service-connected medical care provided to insured beneficiaries if recovery would have been available to private sector hospitals. GAO therefore recommends that the Congress enact legislation to enable VA to

recover the costs of care provided for non-service-connected disabilities of privately insured veterans.

AGENCY COMMENTS AND GAO'S EVALUATION

VA, the Office of Management and Budget, and the Department of Justice were given the opportunity to provide comments on a draft of this report. The Department of Justice said that it found no constitutional difficulties with GAO's recommendation that the Congress enact legislation to enable VA to recover the costs of care provided to privately insured veterans for non-service-connected conditions. (See p. 55.)

VA agreed with GAO's recommendation but stated that GAO underestimated the potential administrative costs that VA would incur in preparing and processing billings. GAO continues to believe that its estimate of potential VA administrative costs is reasonable. (See pp. 56 to 59.)

The Office of Management and Budget had not provided comments when the 30-day statutory comment period expired, nor when this report was finalized. However, the President's proposed budget for fiscal year 1986 states that legislation will be proposed to require reimbursement along the lines recommended by GAO. (See p. 55.)

Contents

ILLUSTRATIONS

ABBREVIATIONS

CARS	Centralized Accounts Receivable System
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Veterans Administration
DM&S	Department of Medicine and Surgery
DRG	diagnosis related groups
DVB	Department of Veterans Benefits
FEHBP	Federal Employees Health Benefits Program
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HMO	health maintenance organization
MAS	Medical Administration Service
OMB	Office of Management and Budget
PTF	patient treatment file
VA	Veterans Administration

CHAPTER 1

INTRODUCTION

The Veterans Administration (VA) operates the largest health care delivery system in the United States. In fiscal year 1983, VA provided care in 172 hospitals, 226 outpatient clinics, 99 nursing homes, and 16 domiciliaries.[1] During the year, about 1.3 million patients were hospitalized in VA facilities, and about 16.6 million visits were made for outpatient care. VA's fiscal year 1983 medical care budget was about $8 billion.

WHO CAN GET CARE AT A VA HOSPITAL?

The eligibility criteria for veterans seeking VA medical benefits are set forth in sections 610 and 612, title 38, United States Code. To be eligible for VA medical benefits, an individual must have served on active duty in the Armed Forces and have been discharged under other than dishonorable conditions. Eligible veterans are classified into two broad categories: those with disabilities resulting from their military service and those without such disabilities. Veterans with service-connected disabilities are afforded highest priority when seeking medical care at VA facilities and are eligible to receive inpatient and outpatient care for treatment of their service-connected disabilities.

Veterans can obtain inpatient care (to the extent that VA facilities have the capacity to provide the services needed) for non-service-connected disabilities if they are at least 65 years old or are unable to defray the costs of necessary hospital, nursing home, or domiciliary care. They are also eligible for outpatient care to (1) prepare them for hospital care, (2) complete treatment incidental to hospitalization, or (3) obviate the need for hospitalization.

In addition to veterans legally entitled to VA benefits, VA is authorized by 38 U.S.C. 611(b) to provide medical care as a humanitarian service to individuals who are in need of emergency care.

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[1]Domiciliaries provide shelter, food, and necessary medical care on an ambulatory, self-care basis to veterans who are disabled by age or disease, but not in need of hospitalization or skilled nursing care services.

HOW DOES VA DETERMINE WHETHER VETERANS ARE ABLE TO PAY FOR THEIR CARE?

Before enactment of the Veterans Administration Health Care Amendments of 1980 (Public Law 96-330), the Administrator of Veterans Affairs was required to accept the statements under oath of applicants that they were unable to defray the expenses of necessary hospital care as sufficient evidence of inability to defray the expenses even if the veterans had private health insurance that could have paid for all or a portion of their care. Under the 1980 amendments, veterans who are receiving a VA pension, are 65 years of age or older, have a service-connected disability, or are eligible for Medicaid are presumed to be unable to defray their medical expenses. The amendments' effect was to authorize VA to establish specific ability-to-pay criteria and to verify veterans' ability to defray medical expenses before providing medical care except under the above circumstances (or in an emergency). The amendments do not, however, require VA to establish ability-to-pay criteria.

According to the Administrator of Veterans Affairs, VA has an obligation to make case-by-case determinations of veterans' ability to pay even though Public Law 96-330 does not expressly direct VA to establish and impose ability-to-pay criteria. The Administrator said that the law gives VA broad latitude as to the criteria used to establish an applicant's ability to pay and the means by which those criteria are implemented. However, as of January 1985, VA had not published proposed regulations to implement the law.

VA continues to accept veterans' oaths as sufficient evidence of inability to defray medical expenses.[2] VA admission forms state that a veteran's certification of inability to pay for medical expenses should be based on the following factors:

--The applicant's monthly income from all sources.

--The cash value of the applicant's ready assets, other than home of residence (cash, savings deposits, stocks, bonds, property, etc.).

--The applicant's entitlement to medical care under an insurance policy of any kind, including insurance liability of third parties in accident cases.

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[2]According to a VA official, veterans are no longer required to sign the oath if they are receiving a VA pension, are over 65 years of age, have income below the pension rate, or are Medicaid recipients.

CAN VA CHARGE FOR THE CARE PROVIDED?

VA is authorized to charge only for care provided to patients (1) injured on the job or because of another person's negligent or wrongful actions, (2) in an emergency for care otherwise not authorized, or (3) later found to be ineligible for care. Specifically:

--The Federal Medical Care Recovery Act (42 U.S.C. 2651) authorizes recovery of the "reasonable value" of care provided to eligible patients needing medical treatment for injuries resulting from negligent or other wrongful actions of a third party (tort-feasor).

--The Veterans' Health Care, Training, and Small Business Loan Act of 1981 (38 U.S.C. 629) extended VA's recovery authority to include veterans' injuries or illnesses stemming from (1) employment and covered by a workers' compensation law or plan, (2) a motor vehicle accident for which the veterans had no-fault coverage, and (3) a violent crime occurring in a jurisdiction that reimburses for such victims' medical care.

--The Veterans Benefits Act of 1957 (38 U.S.C. 611) authorizes recovery of the costs of emergency care provided to persons otherwise ineligible for VA care.

In addition, VA attempts to recover the cost of medical care provided to persons presumed to be eligible at the time of admission, but later found to be ineligible.

HOW MUCH DOES VA CHARGE?

VA prepares bills on the basis of two national average per diem rates (one for medical and surgical patients and one for psychiatric patients) which are intended to cover all related costs of care, including room and board, physicians' costs, ancillary services, and all indirect and support costs. VA does not maintain cost data by patient or by treatment provided or procedure performed.

Under Executive Order 11060, the Office of Management and Budget (OMB) is responsible for setting the rates used by VA in billing liable third parties. OMB has generally accepted the national per diem rates developed by VA for use at all VA facilities. VA medical/surgical billing rates for fiscal years 1982 through 1984 were:

Fiscal year	Room and board	Physicians' services	Ancillary services	Total
May 1981 - Jan. 1982	$159	$62	$24	$245
Jan. 1982 - Dec. 1982	184	72	29	285
Dec. 1982 - Nov. 1983	203	80	32	315
Nov. 1983 - Sept. 1984	206	81	32	319

CAN VA RECOVER FROM PRIVATE HEALTH INSURANCE?

In a 1955 decision,[3] a U.S. district court ruled that an insurance carrier was not liable for payment to VA for treatment furnished to a veteran policyholder since the insurance policy insured against expenses actually incurred by the insured veteran, and the veteran incurred no medical or hospital expenses while being treated in a VA hospital. Since then, most health insurance policies have had exclusionary clauses which state that they will not pay the federal government for medical care when it was provided in a government facility, a federal agency provided such care at no charge, or the policyholder had no legal obligation to pay for the care.

MASSACHUSETTS VETERANS' HOMES RECOVER FROM PRIVATE HEALTH INSURANCE

State veterans' homes are state-operated hospitals, nursing homes, and domiciliaries providing care primarily to veterans incapable of earning a living. VA helps the states defray the costs of operating and constructing state home facilities through a program of per diem payments and construction grants. The Commonwealth of Massachusetts operates two state homes, and veterans are not charged for their care at these homes.

In 1960 Massachusetts enacted legislation that invalidated any provisions in an insurance contract which excluded liability on the part of an insurance company for care provided in its two state veterans' homes. In 1975 the act was amended to prevent insurance companies from denying payment to homes because veterans have no legal obligation to pay for their care (Mass. Ann. Laws, ch. 175, sec 22 (1984)). During fiscal years 1979 through 1983, the two Massachusetts homes recovered $5.7 million from private health insurance.

Appendix V contains further details on the Massachusetts homes' experience in collecting from private health insurance

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[3]United States v. St. Paul Mercury Indemnity Co. (133 F. Supp. 726 (D. Neb. 1955)).

companies (including recoveries, administrative costs, and effects on health insurance premiums).

HAS VA SOUGHT LEGISLATION TO BAR EXCLUSIONARY CLAUSES?

In a February 1970 report,[4] we stated that it would be necessary to enact legislation to attempt to obtain reimbursement for the cost of VA care provided to veterans who have health insurance (unless private health insurance companies would voluntarily agree to pay for care VA furnished to veterans). In 1977[5] and 1981[6] reports, we recommended that similar legislation be enacted to enable the government to recover the costs of medical care furnished to privately insured beneficiaries in the Department of Defense and the Public Health Service facilities.

VA has, on several occasions, submitted legislative proposals to the Congress to enable VA to seek reimbursement from private health insurance companies. For example, in 1979, S. 759 (see app. VI) was introduced at VA's request:

> "To amend title 38 of the United States Code to provide for the right of the United States to recover the costs of hospital, nursing home, or outpatient medical care furnished by the Veterans' Administration to veterans for non-service-connected disabilities to the extent that they have health insurance or similar contracts or rights with respect to such care . . ."

Although provisions of S. 759 to provide for VA recoveries under workers' compensation or automobile accident reparation statutes were incorporated in the Veterans' Health Care, Training, and Small Business Loan Act of 1981 (Public Law 97-72), the provisions relating to recoveries from private health insurance were excluded because of concerns raised during Senate hearings on the bill.

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[4]Possible Ways for the Veterans Administration to Seek Reimbursement From Insurance Companies for Hospital Care Furnished to Privately Insured Veterans, B-114859, February 13, 1970.

[5]New Strategy Can Improve Process for Recovering Certain Medical Care Costs, HRD-77-132, September 13, 1977.

[6]Cost-Cutting Measures Possible If Public Health Service Hospital System Is Continued, HRD-81-62, June 10, 1981.

WHAT CONCERNS WERE RAISED ABOUT RECOVERIES FROM PRIVATE HEALTH INSURANCE?

In its report discussing S. 759 (S. Rep. No. 96-747), the Senate Committee on Veterans' Affairs detailed the specific concerns raised by the insurance industry and others during hearings which it believed need to be resolved before seriously considering legislation to prohibit exclusionary clauses. The concerns were:

--The reliability of VA's estimate of the potential recoveries from private health insurance (see ch. 2).

--The administrative costs VA would incur (see ch. 3).

--The increased administrative costs insurance carriers would incur (see ch. 3).

--The shifting of the economic burden of paying for non-service-connected care from federal taxpayers to those who pay insurance premiums (see ch. 3).

--The constitutionality of such legislation (see ch. 4).

--The ability of VA to develop an acceptable billing system (see ch. 5).

--The willingness of VA to submit to utilization reviews of the type that insurance carriers require of private facilities (see ch. 5).

Although recovery legislation was again introduced in 1981, the Congress has not seriously considered enacting such legislation since 1979. In recent discussions, staff from the Senate Committee on Veterans Affairs expressed an interest in obtaining an analysis of the concerns.

GRACE COMMISSION RECOMMENDS VA SUPPORT RECOVERY LEGISLATION

The President's Private Sector Survey on Cost Control, also known as the Grace Commission, was established by executive order in June 1982 to identify opportunities to increase efficiency and reduce costs of government programs. The Commission issued 47 reports containing 2,478 recommendations on 784 issues. A final summary report was presented to the President on January 16, 1984.

One of the Grace Commission's recommendations for reducing the cost of VA medical care programs was that VA and the Department of Justice actively pursue legislation to eliminate exclusionary clauses. The report did not, however, address the concerns raised by the insurance industry and others about the enactment of recovery legislation. As noted above, the Senate Committee on Veterans' Affairs indicated that the concerns need to be resolved before serious consideration is given to enacting legislation to prohibit exclusionary clauses.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our overall objective was to obtain and analyze sufficient information regarding the above concerns to allow further consideration to be given to the enactment of recovery legislation. Accordingly, our specific review objectives were to

- --estimate the extent of potential VA recoveries from private health insurance and the effects such recoveries would have on VA and insurance companies' administrative costs and policyholders' premiums,
- --determine whether changes in billing methods had occurred since 1979 that would enhance VA's ability to prepare billings acceptable to the insurance industry,
- --evaluate concerns about the legality of recovery legislation, and
- --determine how private insurance companies perform utilization reviews and VA's willingness to submit to such reviews.

To accomplish our objectives, we

- --sent a questionnaire to a random sample of veterans who had been treated for non-service-connected disabilities and discharged from VA hospitals during fiscal year 1982 to determine the extent of their private health insurance coverage;
- --validated a sample of veterans' questionnaire responses relating to employer-related insurance by sending questionnaires to their employers;
- --interviewed officials from VA, private health insurers, the Department of Health and Human Services, and various trade associations; and
- --reviewed pertinent laws, regulations, procedures, and records.

Additional details on the objectives, scope, and methodology of our review are contained in appendixes I, II, III, and IV. Appendix I contains details on our work steps and limitations, appendix II contains details on our questionnaire design and sampling methodology, and appendixes III and IV, respectively, contain copies of the veterans' and employers' questionnaires.

Our review was conducted in accordance with generally accepted government auditing standards.

CHAPTER 2

VA COULD HAVE RECOVERED AT LEAST $98 MILLION TO $284 MILLION FROM PRIVATE HEALTH INSURANCE IN FISCAL YEAR 1982

Our questionnaire survey showed that about 18 percent of the veterans in our universe of about 345,000 fiscal year 1982 non-service-connected episodes of care had private health insurance that would have paid all or a part of the cost of their care in private hospitals. We estimate that VA could have recovered at least $98 million to $284 million through privately insured veterans in our universe if insurance carriers had not precluded government reimbursement. We believe that this is a conservative estimate of potential VA recoveries.

About 89 percent of the privately insured veterans responding to our questionnaire did not object to VA use of their insurance to help defray the government's cost of providing non-service-connected care if there were no cost to them for their episode of care. Although the recoveries projected in this report would not result in any out-of-pocket costs to the veteran, they would likely result in increases in health insurance premiums (see p. 33). In our opinion, such increases would be too small to affect veterans' desires to have health protection for their families.

OUR SURVEY DESIGNED TO ADDRESS CONCERNS ABOUT VA ESTIMATE

VA, in submitting S. 759 in 1979, estimated that, if enacted, the legislation would have enabled it to recover about $170 million from private health insurance in fiscal year 1980 and about $227 million in fiscal year 1981. However, in its report on S. 759, the Senate Committee on Veterans' Affairs, citing Congressional Budget Office and Congressional Research Service reviews of the VA study, stated that VA's estimate of potential recoveries was not soundly based because VA

- --relied, without verification, on data from VA admission forms to determine the type and extent of veterans' insurance coverage;
- --included reimbursement for psychiatric treatment without assurance that private health insurance policies would cover such care;
- --did not determine whether the insurance policies would cover the type of treatment VA provided;

--did not determine whether the veterans' insurance coverage had been exhausted before the veterans sought VA treatment;

--assumed that insurance carriers would reimburse VA for the entire length of stay; and

--assumed, without documentation, that insurance carriers would reimburse VA for certain percentages of VA's costs of providing care.

The Committee report said that:

> ". . . it is essential to undertake a further investigation of the total cost impact of health insurance reimbursement legislation. For such investigation, an adequate data base must be developed in order to determine not only the number of veterans with health plan coverage who are utilizing VA health-care facilities but also whether that coverage would prove to be a source of recoveries."

Accordingly, we designed a survey to estimate potential VA recoveries from private health insurance. To address the concerns voiced about the VA study, we

--designed a questionnaire to determine the type and source of veterans' health insurance coverage at the time they were treated by VA instead of relying solely on data on admissions documents,

--validated random samples of veterans' responses about employer-provided health insurance in two states by sending questionnaires to their employers,

--excluded patients treated for psychiatric conditions from our questionnaire sample and projections,

--developed a "typical" health insurance policy for use in estimating potential recoveries,

--adjusted the lengths of stay of insured veterans in our questionnaire sample to the average lengths of stay of comparable patients in community hospitals, and

--asked insured veterans in our questionnaire sample whether they knew of any reason why their insurance coverage would not have covered the care provided.

RESULTS OF OUR QUESTIONNAIRE SURVEY

We conducted a random questionnaire survey of veterans discharged from VA hospitals in fiscal year 1982 after treatment of non-service-connected disabilities to determine (1) the extent of their health insurance coverage at the time of their VA treatment and (2) whether veterans having private health insurance would object to VA recovering from their insurance if there were no cost to the veterans for their episodes of care.

VA's computerized patient treatment file (PTF) compiles data on patients discharged from VA facilities. According to PTF, about 1 million episodes of care were provided to patients discharged from VA hospitals in fiscal year 1982, about 900,000 of which were for treatment of non-service-connected conditions.[1] In establishing our initial universe of 685,410 episodes, we excluded the episodes provided to veterans who (1) were treated for psychiatric conditions (because of the limited coverage of psychiatric care under some private health insurance policies), (2) died in the hospital, or (3) were admitted and discharged on the same day. We selected a random sample of 2,693 episodes of care from our initial universe. Of the 1,803 questionnaires delivered,[2] 1,497 were answered, an 83-percent response rate. Based on questionnaire responses and VA compensation records, we identified and excluded from further analysis 141 veterans whose treatment was incorrectly indicated in VA medical records as being for non-service-connected conditions, leaving 1,356 usable questionnaires. After making all necessary adjustments, our effective universe was reduced to 345,105 episodes of care. Appendix II provides a detailed description of those adjustments and our sampling methodology.

The questionnaire inquired about veterans' health insurance coverage at the time they received VA care by asking the veterans whether they were, at that time,

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[1]In fiscal year 1983 the proportion of VA episodes of care for non-service-connected conditions remained at about 90 percent.

[2]The remaining 890 veterans were removed from our sample (1) because the veterans could not be located, died between the time they were discharged from the VA hospital and the time our questionnaire was mailed, or were treated in a non-VA hospital, or (2) for other miscellaneous reasons, such as incomplete records or errors during data transmission.

--employed;

--covered under a health insurance policy provided through their employer, former employer, union, or spouse's employer; and

--covered by Medicare,[3] Medicaid,[4] the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)[5] or the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA),[6] an insurance supplement to Medicare, health insurance provided as part of a retirement plan, or insurance that paid them cash while they were hospitalized.

The veterans who indicated that they had some form of health insurance were asked whether they (1) knew of any reasons why their insurance would not cover the non-service-connected care they received at VA hospitals and (2) would have any objections if VA could collect some payment from their health insurance company to help defray the cost of non-service-connected care, if there were no cost to them for their episodes of care.

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[3]Medicare, the largest federal health financing program, provides health insurance to most people 65 years of age or older and many disabled people.

[4]Medicaid is a federal/state medical assistance program that assists low-income people.

[5]CHAMPUS provides financial assistance for medical care provided by civilian sources to dependents of active duty members, retirees and their dependents, and dependents of deceased members of the uniformed services--the Army, the Navy, the Air Force, the Marine Corps, the Coast Guard, the commissioned corps of the Public Health Service, and the commissioned corps of the National Oceanic and Atmospheric Administration.

[6]CHAMPVA provides financial assistance for medical care provided by civilian sources to certain VA beneficiaries.

Number and source of veterans' insurance coverage

Based on the 1,356 usable questionnaires, we estimate that about 18 percent (or 63,371 out of 345,105) of the episodes of care in our sample universe were provided to veterans who had one or more forms of private health insurance coverage at the time of their VA treatment through their employers, former employers, spouses' employers, unions, or retirement plans.[7] We excluded from our projections those episodes of care for which veterans indicated that their insurance would not cover the services provided because their coverage had been exhausted before they went to VA or did not cover the type of services VA provided. (See p. 15 for a more detailed discussion of the reasons cited by veterans.) Many veterans reported having more than one form of private health insurance coverage or other forms of insurance coverage, such as Medicare or Medicaid. The table below provides additional details on the types and sources of insurance coverage.

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[7]About 25 percent of the veterans who indicated in their questionnaire responses that they had private health insurance coverage through their employers, former employees, spouses' employers, unions, or retirement plans indicated that they also had Medicare coverage. We did not exclude such cases from our projections, however, because Medicare does not pay for care in VA facilities, making private health insurance the primary coverage. We did, however, exclude from our projections those episodes where the veterans' private health insurance was limited to a Medicare supplement.

Veterans' Health Insurance Coverage

Source of coverage	Number of answers in questionnaire sample	Percent[a]
Private health insurance through:		
(1) employers	110	8
(2) former employer	72	5
(3) unions	25	2
(4) spouses	42	3
(5) retirement plans	63	5
Total	249[b]	18
Government-financed health insurance:		
(1) Medicare	458	34
(2) Medicaid	62	5
(3) CHAMPUS or CHAMPVA	33	3
Other insurance coverage:		
(1) Medicare supplements	51	4
(2) Insurance plans that pay cash when policyholder is hospitalized	26	2
(3) Other health plan (such as cancer and black lung policies, and HMOs[c])	59	4

[a]Based on 1,356 usable questionnaires.

[b]Many veterans identified more than one source of coverage. The total is the number of veterans having one or more sources of coverage.

[c]Health maintenance organizations (HMOs) are prepaid health care plans that provide comprehensive medical services through doctors and technicians in medical centers or through direct payments to doctors or hospitals that the plans have agreements with.

Veterans generally do not object to VA recoveries

Of the 249 questionnaire respondents who indicated that they had private health insurance coverage through their employers, former employers, spouses' employers, unions, or retirement plans at the time of their VA hospitalization, 208 answered our question about whether they would object to VA recovering from their health insurance if there were no cost to them. Based on the responses, we estimate that about 89 percent of the privately insured veterans in our sample universe would not object to VA recovering a portion of the cost of their non-service-connected care from their insurance company, if there were no cost to them for their episode of care.

Veterans identify few instances where private health insurance would not cover VA services

Of the 1,356 usable questionnaire responses, only 8 indicated that the veteran had private health insurance through their employers, former employers, unions, spouses' employers, or retirement plans at the time of their VA hospitalization, but that their insurance would not have covered the services VA provided. As noted on page 13, these veterans were excluded from our projections. Of the eight veterans, seven said that their insurance would not have covered their VA care because they

- --were treated for a preexisting condition not covered by their health insurance (three veterans),
- --had exhausted their private health insurance coverage before being admitted to the VA hospital (three veterans), or
- --received cosmetic surgery not covered by private health insurance.

The other veteran did not provide an explanation.

RECOVERIES COULD HAVE RANGED FROM $98 MILLION TO $284 MILLION

To estimate the range of potential VA recoveries from private health insurance, we

- --determined the upper limit on costs subject to reimbursement by multiplying the VA days of care provided to veterans with private health insurance by VA's fiscal year 1982 per diem costs for medical/surgical care,

--determined the lower limit on costs subject to reimbursement by adjusting the VA lengths of stay based on the average days of care provided comparable patients in community hospitals and multiplying them by VA's fiscal year 1982 per diem costs,

--identified the "typical" inpatient hospital care provisions of private health insurance plans, and

--applied those provisions to the upper and lower limits on costs subject to reimbursement to estimate potential recoveries.

Establishing the costs subject to reimbursement

Because patients generally stay longer in VA hospitals than in community hospitals, insurance companies might object to reimbursing VA for patients' entire lengths of stay. In a separate review, we are evaluating VA lengths of stay to determine whether (1) the longer lengths of stay are medically necessary and (2) VA utilization reviews are effective in reducing lengths of stay. However, to project potential savings for this review, we established estimates of costs subject to reimbursement based both on the actual VA lengths of stay and the average lengths of stay of comparable patients in community hospitals.

The 249 episodes of care provided to privately insured veterans in our questionnaire sample covered 3,437 days of medical/surgical care. Based on VA per diem rates in effect at the time the patient was admitted, we calculated, at a 95-percent confidence level, the upper limit of costs subject to reimbursement for the 249 episodes to be $929,225, or an average of about $3,732 (plus or minus $637) per episode. Applying this average cost per episode to the projected number of episodes in our universe provided to privately insured veterans, we estimate that the upper limit of costs subject to reimbursement was about $236 million (plus or minus $48 million).

To obtain a comparison with private sector hospitals, we determined, for each of the 249 episodes of care provided to privately insured veterans in our questionnaire sample, the average lengths of stay of comparable patients in community hospitals. To do this, we used data from VA's patient treatment file and the Professional Activities Survey, prepared by the Commission on

Professional and Hospital Activities.[8] The Survey data show, by age group, the average length of stay by diagnosis, both with and without secondary diagnoses, and with and without surgery.

The average number of community days of care for the 249 episodes of care was 8.1 days. Based on VA per diem rates in effect at the time the patients were admitted, we calculated the lower limit of costs subject to reimbursement for the 249 episodes to be $555,983, or an average of $2,233 (plus or minus $155) per episode covered by insurance. Projecting the average cost per episode in the overall sample to the number of episodes in the universe, we estimate that the lower limit of costs subject to reimbursement was $141 million (plus or minus $19 million).

Establishing the "typical" insurance coverage

Although there is significant variation in the benefits provided under private health insurance policies, they generally pay from 80 to 100 percent of covered expenses. An analysis of 47 employer-sponsored health insurance policies by our actuaries showed that most of them fully covered expenses for non-psychiatric, non-Medicare admissions.

According to officials from the Health Insurance Association of America, insurance policies differ in their provisions, such as the extent of coverage, the percentage of co-insurance paid by the policyholder, and the deductibles that policyholders are required to pay. However, the Association officials said that certain provisions have become somewhat standard. They said that most insurance policies now contain a 20-percent co-insurance provision, but waive further co-insurance once the policyholder's out-of-pocket expenses exceed $2,000.

The Association examined the extent of health insurance coverage among 21.8 million employees covered under group policies at the end of 1980 and found that, among employees with hospital expense coverage, 99 percent had coverage at a level of 80 percent or more of the average semiprivate room and board rate in the employee's local area. The study also showed that 99 percent of the employees were covered under policies that provided

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[8]The Commission on Professional and Hospital Activities is a nonprofit/nongovernment/noncommercial education, publishing, and systems development organization. It is sponsored by the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the Southwestern Michigan Hospital Council.

surgical benefits at a level of 80 percent or more of the usual, customary, and reasonable charge.[9]

However, policies often provide coverage above the 80-percent level. For example, the Health Insurance Association of America's survey of new group health insurance policies issued during the first 3 months of 1982 showed that 89 percent of the employees with basic hospital plans[10] had coverage which provided full payment for a semiprivate room. Further, over 60 percent of the employees with major medical expense coverage[11] had out-of-pocket limits of $1,000 or less after which their insurance paid in full for covered services.

Similarly, our review of the 1981 in-hospital benefits of 47 health insurance plans (including 12 federal employees health plans and 35 nonfederal plans[12]) showed that plans generally provided for payment in full for a semiprivate room for from 120 to 365 days. Many also provided payment in full for physicians' and surgeons' in-hospital services. Others provided for payment of surgeons and physicians services based on a fee schedule or provided for payment in full up to some maximum. Most nonfederal plans and high option federal plans had no deductible or coinsurance for in-hospital services.

Estimating potential recoveries

As shown above, VA recoveries from private health insurance for in-hospital care should be between 80 and 100 percent of the costs of services subject to reimbursement. Accordingly, we estimate that VA recoveries would range from $98 million to $160 million under the assumption that insurance companies would reimburse VA based on average community lengths of stay. Under the assumption that insurance companies would reimburse VA based on the actual VA length of stay, we estimate recoveries to be

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[9]A usual, customary, and reasonable charge is for health care which is consistent with the going rate or charge in a certain geographical area for identical or similar services.

[10]Basic group hospital expense plans provide benefits separately for hospital room and board and other hospital services (such as laboratory fees, drugs, and X-rays).

[11]Group major medical insurance coverage helps pay for virtually any type of medical care, in or out of the hospital, provided a licensed physician prescribes it.

[12]The 35 nonfederal plans were submitted by veterans' employers in response to our validation questionnaires.

from $150 million to $284 million. The graph on the following page illustrates the potential recoveries based on the various assumptions.

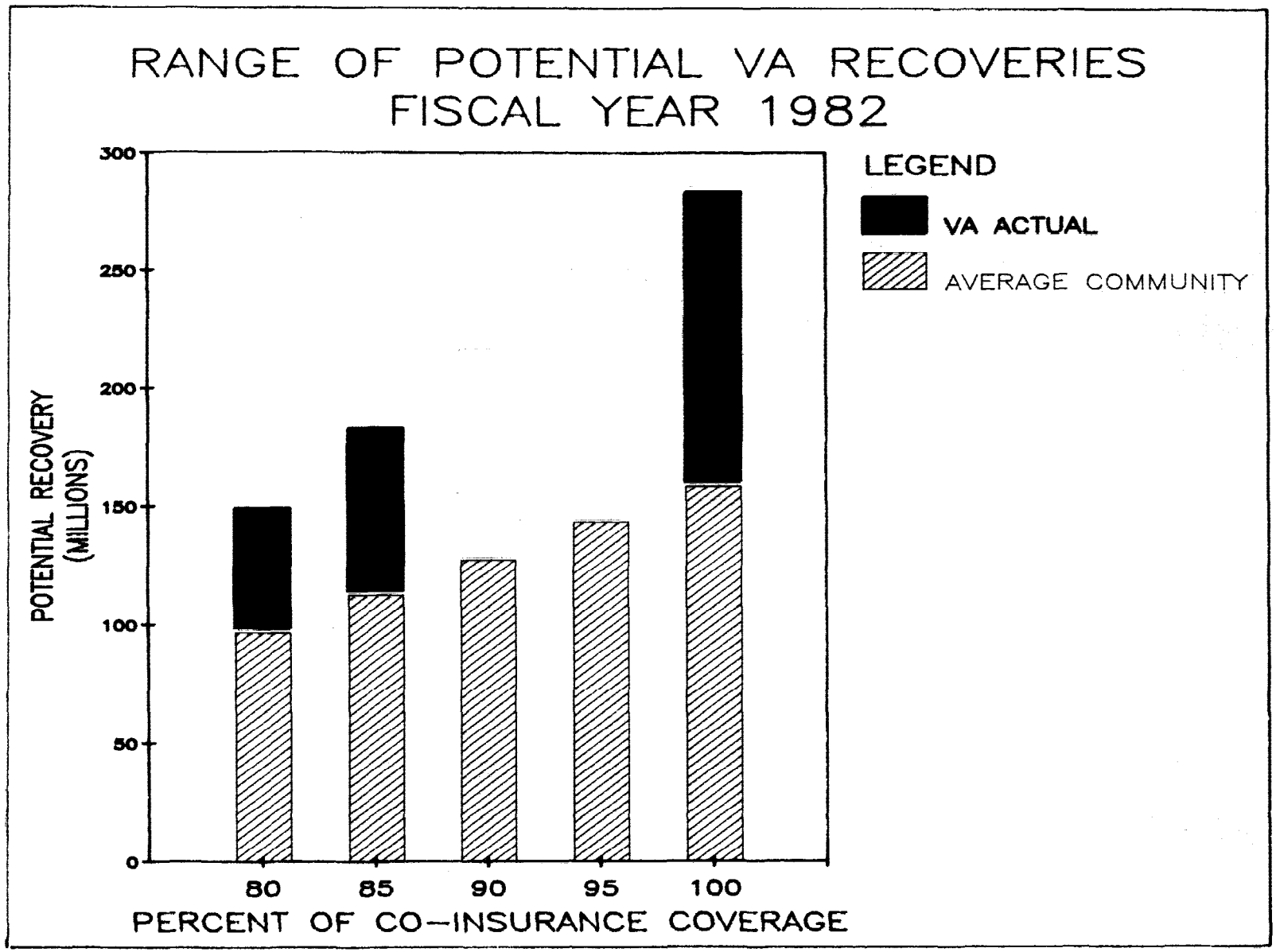
ACTUAL RECOVERIES COULD BE HIGHER THAN PROJECTIONS

Actual VA recoveries from private health insurance could be much higher than our projections because

- --many of the approximately 240,000 non-service-connected episodes of care excluded from our sample universe because veterans could not or did not respond to our questionnaire were probably provided to insured veterans,
- --potential recoveries from outpatient services and inpatient psychiatric care were excluded from our projections,
- --veterans in our validation samples appeared to understate their employment-related health insurance coverage in their questionnaire responses, and
- --VA per diem rates used for projecting recoveries were too low to reflect actual costs and could have resulted in potential recoveries being understated by as much as 26 percent.

Veterans excluded from sample universe may have insurance

In establishing the sample universe used for our projections, we excluded about 240,000 non-service-connected episodes of care provided to veterans who were deceased, could not be located, or did not respond to our questionnaire. Our review of the admissions forms of 784 such veterans included in our initial questionnaire sample showed that 48 (about 6 percent) had advised VA that they had private health insurance.


RANGE OF POTENTIAL VA RECOVERIES
FISCAL YEAR 1982
LEGEND
VA ACTUAL
AVERAGE COMMUNITY
POTENTIAL RECOVERY (MILLIONS)
300
250
200
150
100
50
0
80
85
90
95
100
PERCENT OF CO-INSURANCE COVERAGE

Outpatient services excluded from projections

In fiscal year 1982 VA provided about 6.4 million outpatient visits for non-service-connected conditions at a cost of approximately $400 million. Because there were no readily available data bases from which to select a sample of outpatient care episodes, we did not include outpatient care in our questionnaire universe or projections. In a March 1984 study on the Department of Defense health care system, the Congressional Budget Office assumed, mainly because of applicable insurance policy deductibles, that private health insurance would pay 40 percent of expenses for outpatients. Accordingly, VA recoveries could be increased to the extent that non-service-connected outpatients have private health insurance.

Psychiatric care excluded from projections

Because of the limitations in private health insurance coverage of psychiatric services, we excluded over 130,000 inpatient psychiatric episodes of care from the initial universe. We did not attempt to determine how many of the psychiatric patients had private health insurance, but a 1977 VA survey showed that about 14 percent had such coverage at that time. Although our actuarial analysis showed that health insurance policies generally have some limits on hospitalization for mental illness, VA recoveries could nonetheless be increased to the extent that psychiatric services were covered.

According to the Health Insurance Association of America's survey of new group health insurance policies written in 1982, 90 percent of employees with group major medical coverage had some type of coverage for nervous and mental disorders. Of those with coverage, 65 percent were insured in full for hospital charges.

Veterans appear to understate extent of employer-provided health insurance

In two states, Florida and Pennsylvania, we selected random samples of employed veterans treated in VA hospitals for non-service-connected conditions during 1982 and sent questionnaires to both the veterans and their employers. Questionnaire responses were received from both the employer and veteran in 126 cases. In 70 cases the employer and veteran both indicated that the veteran had health insurance. However, in 18 cases the veteran indicated that he or she did not have health insurance, while the employer indicated that the veteran was covered by health insurance. In another five cases, the veteran indicated that health insurance coverage existed but the employer indicated that it did not. In the remaining 33 cases, the employer and veteran agreed that no employment-related health insurance existed.

Based on the results of our validation samples, it appears that veterans tend to understate rather than overstate the extent of employer-provided health insurance coverage.

VA's per diem rate understates actual VA costs of care

In projecting potential VA recoveries, we used VA medical care recovery rates in effect at the time the care was provided. However, in a February 1984 report,[13] we stated that those rates were not high enough to enable VA to recover the full costs of care provided. Specifically, we said that VA's fiscal year 1982 medical/surgical per diem rate was about 10.8 percent too low to reflect the costs of care provided to acute medical/surgical patients. In addition, we said that by using individual facility rather than national per diem rates, VA could increase recoveries by about another 15.3 percent. VA planned to establish individual facility per diem rates for acute care in fiscal year 1985, but OMB would not approve the use of individual facility rates because they would not be consistent with the Department of Defense medical care recovery rates. If such rates had been in effect in fiscal year 1982, potential VA recoveries could have been increased by as much as 26 percent.

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[13] Opportunities to Increase VA's Medical Care Cost Recoveries, GAO/HRD-84-31, February 13, 1984.

CHAPTER 3

VA RECOVERIES WOULD NOT PLACE AN UNREASONABLE BURDEN ON VA, INSURERS, OR POLICYHOLDERS

In a March 1979 letter to the Administrator of Veterans Affairs, the Chairman of the Senate Committee on Veterans' Affairs expressed concern about the economic impact of legislation to shift the economic burden of paying for non-service-connected care from federal taxpayers to those who pay insurance premiums. Specifically, he expressed concerns about whether VA would recover enough from private health insurance to justify the increase that would occur in VA's and insurance carriers' administrative costs and policyholders' premiums.

Based on our review, we estimate that (1) VA would incur administrative costs of about $27 for every insurance claim processed, (2) insurance carriers' would incur administrative costs of less than 6 percent of benefit payments to VA, and (3) policyholders' premiums would increase about a dollar for every $100 million in VA recoveries.

VA ADMINISTRATIVE COSTS WOULD BE REASONABLE

In attempting to recover from private health insurers, VA would incur administrative costs to (1) identify potential billing cases, (2) prepare billings, and (3) collect from insurance companies. Because veterans rather than VA personnel identify private health insurance coverage, the increased VA administrative costs would result primarily from preparing and collecting the additional bills. We estimate that the increased VA administrative costs that would have been incurred in recovering from private health insurance for the 63,371 projected episodes would have been about $1.7 million. As noted on page 15, projected recoveries would be between $98 million and $284 million.

Additional administrative costs would not be incurred to identify potential billings

According to the VA manual (M-1, part 1, ch. 15), the Medical Administration Service (MAS) at each medical center is primarily responsible for identifying veterans for whom VA can attempt to recover the costs of medical care provided, including

". . . those entitled to payment for the costs of hospital or nursing home care and/or medical services by reason of membership in a union, group plan, or any form of health plan or those who are eligible under any contractual or statutory insurance plan providing for payment or reimbursement for medical care . . ."

MAS personnel currently obtain information on health insurance coverage through VA form 10-10, "Application for Medical Benefits."

A December 1982 VA circular (10-82-245) directed VA medical centers to establish controls to assure that everyone who assists veterans in completing the 10-10 is familiar with the VA medical care recovery program. The circular said that specific attention would be focused on identifying health insurance coverage and directed that every applicant for medical care, including service-connected veterans, be required to provide information on their health insurance. In addition, the circular required that when the veteran has medical care insurance, a "Power of Attorney and Agreement" (VA form 10-2381) will be completed and signed by the veteran unless the medical care to be provided is for a service-connected disability or for a condition aggravating a service-connected disability. This form assigns the veterans' right to recover from their insurance to VA.

The VA circular also requires that veterans scheduled for admission or placed in an outpatient program for treatment of non-service-connected disabilities present a copy of their medical insurance policy or certificate of insurance or, if it is not available, identify information on the insurance carrier (plan number, type of coverage, etc.).

In February 1984, VA directed its medical centers to stop soliciting information on private health insurance coverage from veterans who have a service-connected disability or who are former prisoners of war, even if they are being provided care for a non-service-connected disability (VA Circular 10-84-23). Although VA no longer identifies private health insurance coverage for such veterans, we believe additional VA administrative costs would not be incurred to reinstitute the December 1982 requirement that information on private health insurance coverage be obtained because veterans, not VA personnel, are expected to complete the health insurance questions on the admissions forms.

Emphasis on identifying insurance coverage may increase under Public Law 96-330

As noted on page 2, Public Law 96-330 authorizes VA, under certain circumstances, to verify veterans' ability to defray medical expenses before providing medical care. The ability-to-pay provisions apply to veterans other than those who are receiving a VA pension, are 65 years of age or older, have a service-connected disability, or are eligible for Medicaid. If VA implements Public Law 96-330, identifying private health insurance coverage will be an important part of the ability-to-pay determinations.

Effective implementation of the ability-to-pay provisions of Public Law 96-330 will depend largely on VA's ability to identify the extent of veterans' private health insurance coverage. The report of the House Committee on Veterans' Affairs on the bill (H. Rep. No. 96-958) indicated that one of VA's primary considerations in making ability-to-pay determinations is the extent of the veterans' private health insurance coverage. As of January 1985, VA had not published proposed regulations to implement Public Law 96-330. As stated on page 2, VA is authorized, but not required, to establish and apply ability-to-pay criteria. VA officials expressed concern about the administrative costs that would be involved in determining veterans' ability to pay and expressed doubt about whether the law will be implemented. However, they agreed that identifying private health insurance coverage will be an essential step in making ability-to-pay determinations if it implements the law. They indicated that administrative costs will be higher if they have to do extensive follow-up to verify veterans' responses.

As a result, the costs of identifying health insurance coverage will continue to be incurred for those veterans subject to the provisions of Public Law 96-330 even if VA is not authorized to recover from insurance carriers.

Increased administrative costs would be incurred to prepare billings

VA would incur additional costs to prepare billings to private health insurance carriers. We developed an estimate of the administrative costs based on the assumption that VA would prepare billings using a recently developed uniform billing form. Insurance carriers favor the use of that form. (See pp. 46 to 47.)

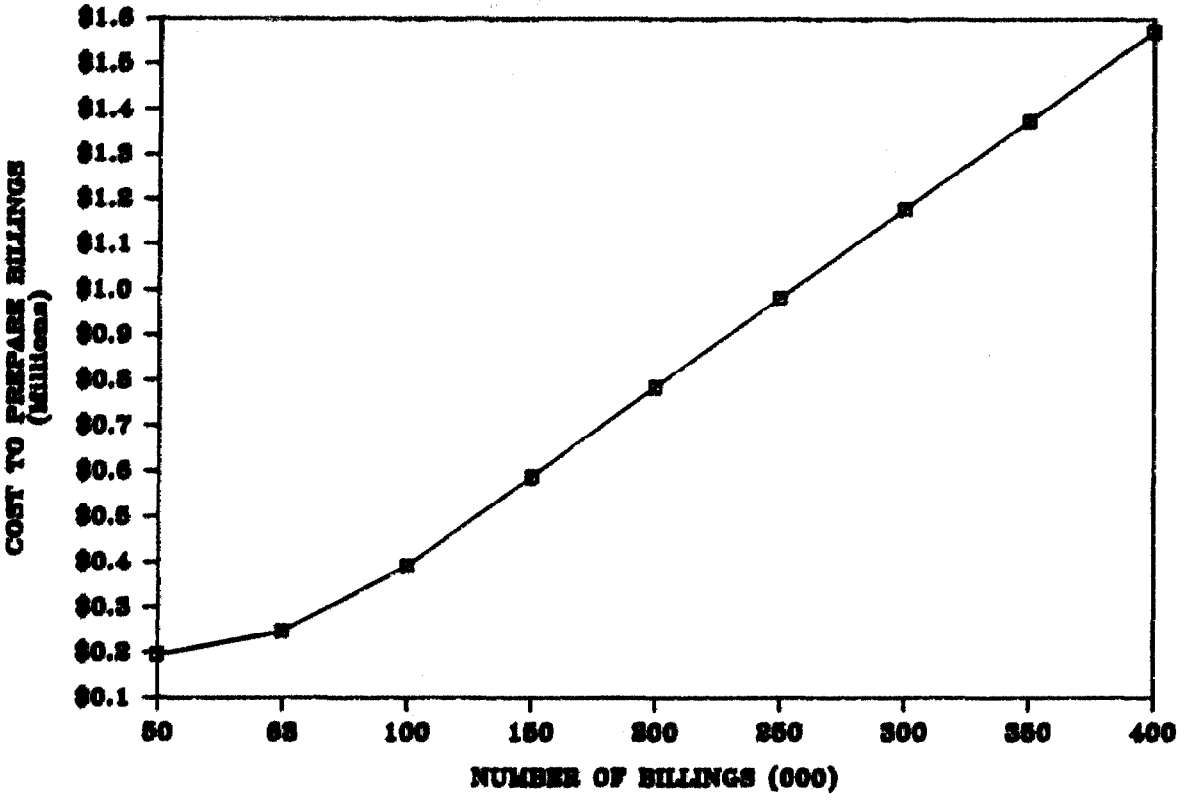
In a request submitted to OMB under the Paperwork Reduction Act and Executive Order 12291, the Health Care Financing Administration (HCFA) estimated that it would take an average of 15 to 20 minutes to complete the uniform billing form. HCFA noted that the estimate, which was based on input from providers, includes the time needed to gather and compile data necessary to complete the form.

VA's policies and procedures division chief, MAS, agreed that 15 to 20 minutes would be a reasonable estimate of the time required by VA staff to prepare billings using the forms. Other VA MAS officials said that billings were ordinarily prepared by a GS-4 or GS-5 clerk.

While additional administrative costs, such as supplies and various overhead costs, would be incurred, a VA MAS official said that personnel costs would account for most of the administrative costs. Accordingly, we did not attempt to estimate the other administrative costs. We believe, however, that our estimate of personnel costs is somewhat overstated because we (1) used 20 minutes per billing as the basis for our estimate of personnel costs and (2) assumed that billings would be prepared by a GS-5, step 6, clerk rather than by a GS-4 clerk. Using pay rates in effect between October 4, 1981, and October 2, 1982, and a 26-percent fringe benefit factor, we estimate that VA would have incurred administrative costs of about $230,000 to prepare billings for the 63,371 projected episodes of care.

The following graph shows the projected costs to prepare billings in 1984 based on the number of billings to be prepared and 1984 federal salaries.

Estimated Fiscal Year 1984 VA Costs
To Prepare Private Health Insurance Billings



Automated debt collection system could be expanded to include medical care recoveries

As noted on page 3, VA currently attempts to recover the costs of care provided to patients (1) injured on the job or because of another person's negligent or wrongful actions, (2) in an emergency, or (3) later found found to be ineligible for care.

Because of the relatively small volume of such recovery actions, VA's Department of Medicine and Surgery (DM&S) operates a manual, decentralized, medical care debt collection system carried out by the Fiscal Service of each of VA's 172 medical centers. By contrast, VA's Department of Veterans Benefits (DVB) operates an automated Centralized Accounts Receivable System

(CARS) to collect debts resulting from overpayments and loan defaults.[1] Both DM&S and DVB officials agreed that CARS could be expanded to include medical care debt collection. Using CARS to collect from private health insurance carriers would have resulted in increased administrative costs of about $1.5 million to collect from private insurers for the projected 63,371 billings in fiscal year 1982.

Under DM&S' current debt collection procedures, billings prepared by MAS are forwarded to the medical center's Fiscal Service for collection. The Fiscal Service manually performs such collection functions as preparing and mailing collection letters, following up on billings when payment has not been received, maintaining the accounts receivable, and referring cases to the district counsel for further action when appropriate. DM&S officials were unable to readily estimate the cost of their collection efforts.

Unlike DM&S' manual debt collection process, once accounts receivable are established in CARS, collection efforts proceed automatically, including

--generating collection letters and follow-up letters,

--monitoring repayment plans,

--collecting debts by offsetting benefits when available, and

--generating requests to the Internal Revenue Service or Postal Service for address information (with concurrent suspension of collection efforts pending receipt of the address).

DVB officials said that the efficiency of the centrally managed debt collection system is further enhanced by the ability of CARS personnel to (1) produce large volumes of typewritten correspondence using standard paragraphs maintained on word processing terminals and (2) handle the mailing of large volumes of correspondence through the use of high-speed inserters and mailing equipment. They also noted that the only responsibility of CARS personnel is debt collection.

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[1]DVB collects debts resulting from (1) veterans' education benefit overpayments, (2) compensation and pension overpayments, (3) VA home mortgage defaults, and (4) direct veterans' loan defaults.

Both DM&S and DVB officials agreed that CARS could be expanded to include medical care debt collection. They said that the debt collection functions currently performed by VA medical centers are similar to those performed under CARS. While acknowledging the feasibility of using CARS, the VA officials cautioned that current DVB debt collection priorities would preclude expanding CARS to include medical care debts for about 4 years. In addition, they said that other procedural problems--such as computer programming requirements, additional staffing needs, and methods for transmitting medical debts to CARS--would have to be resolved. We did not attempt to estimate the initial start-up costs to include medical care debts in CARS or to identify solutions to the procedural problems.

Because administrative cost data for VA's manual medical care debt collection activities are not readily available, VA uses CARS cost data to establish the administrative cost of collection fees[2] for medical care debts. VA's Office of Budget and Finance compiles actual cost data for DVB debt collection operations and develops projections of yearly costs.

In fiscal year 1982 the Office of Budget and Finance estimated that it cost VA about $24 for each of the approximately 477,000 cases closed during the year. A DVB official said that this disposition cost should be used to estimate the cost to collect from private health insurance because it includes all CARS costs incurred from establishment to final disposition of an account.

DVB officials said that while no medical care debt collection data were used in computing CARS costs, the cost components under CARS and medical care debt collection are similar. They said that, for example, both systems send collection letters; make personal and telephone contacts; and make compromises, waivers, and referrals to district counsels.

Officials from VA's Office of General Counsel and MAS said that CARS costs to collect from private health insurance could be significantly higher than the costs to collect DVB debts if insurers follow through on their threat to challenge all VA billings. However, a DVB official said that collection costs for health insurance billings would probably be lower because insurance companies would be more likely to pay upon receipt of the first billing.

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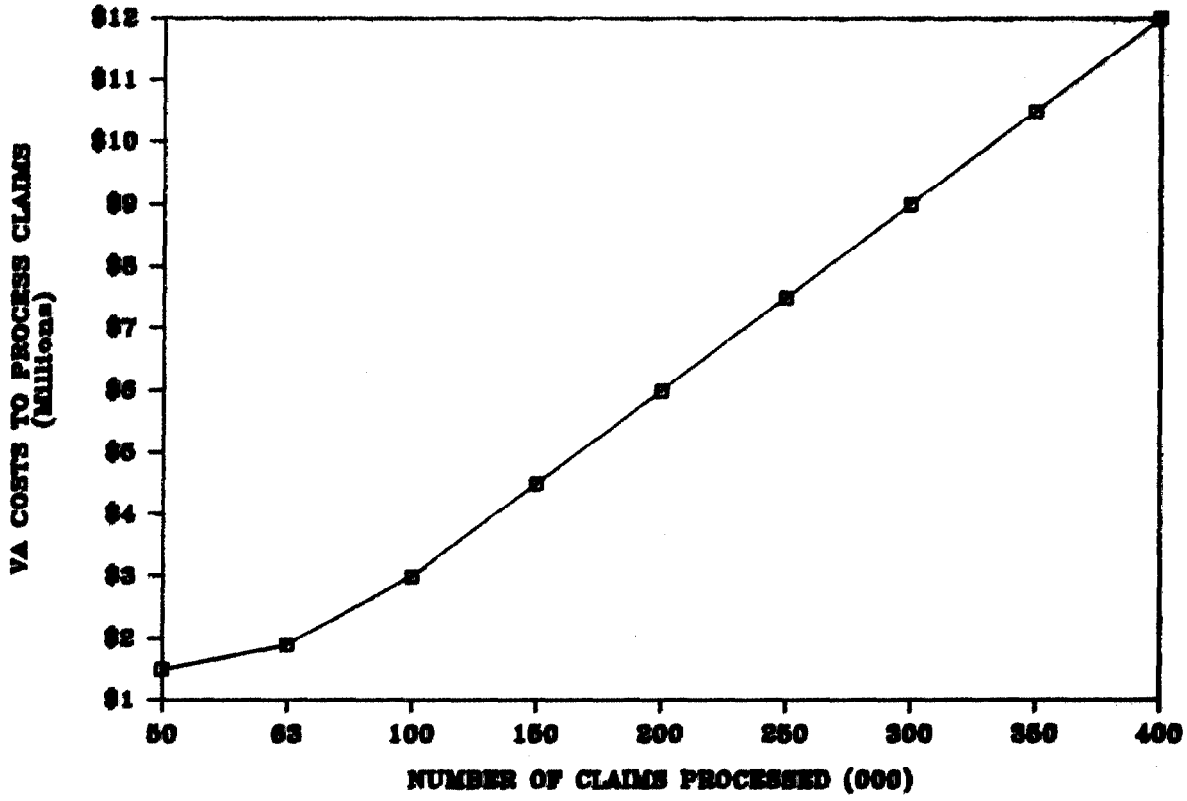
[2]VA is authorized under 38 U.S.C. 3115 to calculate and charge such fees on any amount owed the government from participating in a VA benefit or loan program.

Based on our estimate that VA could have billed insurance carriers for 63,371 episodes of care in fiscal year 1982, we estimate the administrative cost of collections would have been about $1.5 million.

The graph below estimates CARS' cost to collect from private health insurers in fiscal year 1984 based on the number of collection actions.

Estimated Fiscal Year 1984
VA Claims Processing Costs
for Insurance Billings



INSURERS' INCREASED ADMINISTRATIVE COSTS WOULD NOT BE EXCESSIVE

We attempted to obtain data on insurers' administrative costs from the Health Insurance Association of America and the Blue Cross and Blue Shield Association. However, the Health Insurance Association said that it does not compile such data because administrative costs vary by region and company. In addition, these costs are passed on to policyholders. The Blue

Cross and Blue Shield Association maintains such data, but declined to provide them to us.

Therefore, we estimated the increased administrative costs insurance carriers would incur to process VA claims using data from the Federal Employees Health Benefits Program (FEHBP), Medicare, and CHAMPUS.

FEHBP administrative costs

FEHBP, the world's largest employer-sponsored, voluntary health program, provides health insurance to federal employees, annuitants,[3] and their dependents. In 1982, FEHBP provided health insurance to about 3.7 million enrollees and 6.3 million dependents through 119 health plans. About 90 percent of the enrollees were in 1 of the 2 "government-wide plans"[4] (62 percent) or 1 of the 17 "employee organization plans"[5] (28 percent). The other 10 percent of enrollees were in comprehensive medical plans, or HMOs.

In 1982, the administrative costs incurred by the government-wide and employee-organization plans to process claims ranged from 2.9 to 9.4 percent of claim payments and averaged 6 percent. The government-wide plans paid claims of about $2.6 billion and incurred administrative costs of about $157 million (6 percent of benefit payments). The employee organization plans paid benefits of about $1.5 billion and incurred administrative costs of about $87 million (5.8 percent).

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[3]Includes retired and disabled federal workers and survivors of deceased federal workers.

[4]Government-wide plans are available to all eligible employees, annuitants, and dependents, regardless of geographic location. The service benefit plan is administered by Blue Cross and Blue Shield, and the indemnity benefit plan is administered by the Aetna Life Insurance Company.

[5]Employee organization plans are sponsored by an employee organization and are available only to eligible federal employees and their dependents who are, or become, members of the sponsoring organization. Some plans are also open to annuitants and their dependents.

Medicare administrative costs

Medicare, the largest federal health financing program, consists of two parts:

--Hospital Insurance (part A) covers inpatient hospital services and posthospital extended care services (inpatient services in a skilled nursing facility and home health services).

--Supplemental Medical Insurance (part B) covers physician, outpatient services, home health, and various other ambulatory services.

In fiscal year 1982, about 29 million persons had Medicare coverage.

Medicare claims for services provided to beneficiaries are processed and paid by private organizations, generally referred to as fiscal intermediaries. In fiscal year 1982, Medicare fiscal intermediaries paid about $33 billion in Medicare part A claims and incurred administrative costs of about $148 million. The administrative costs to process part A claims were about 0.5 percent of the benefits paid. Similarly, fiscal intermediaries paid about $10.7 billion in Medicare part B claims and incurred administrative costs of about $437 million. The administrative cost to process part B claims was about 4.1 percent of the benefits paid.

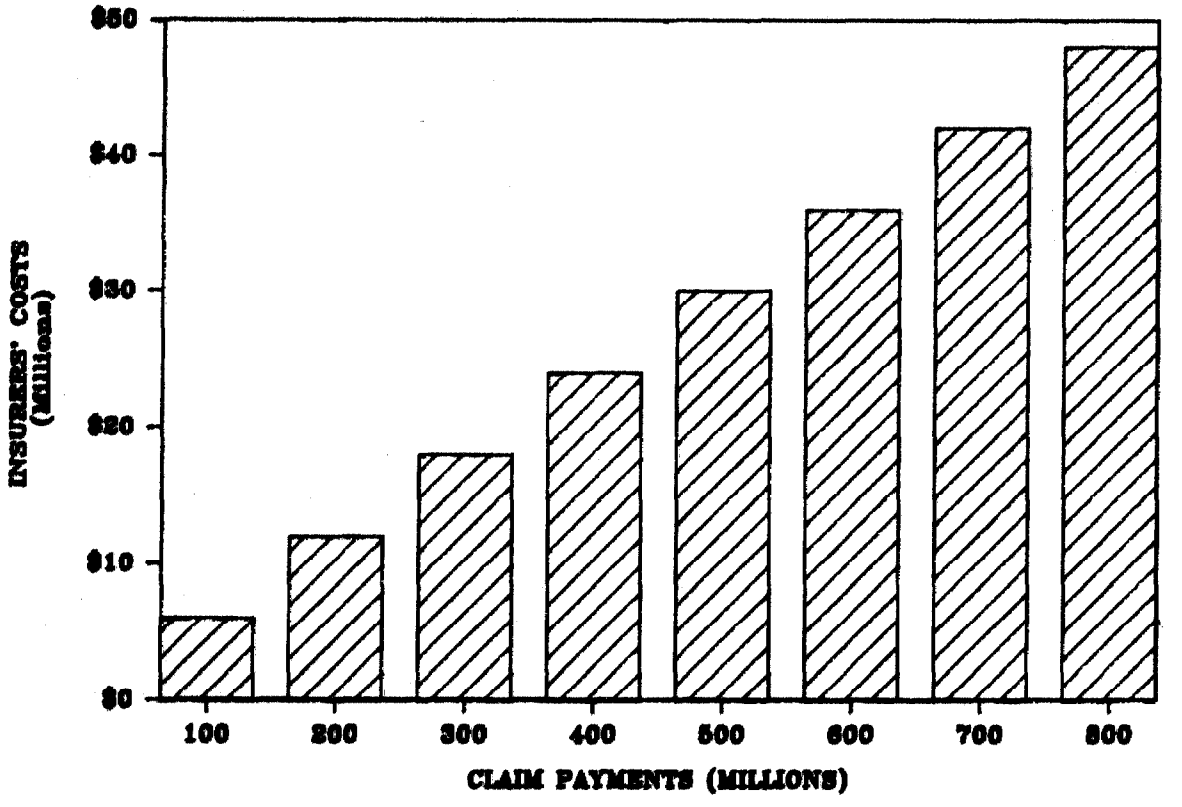
CHAMPUS administrative costs

Like Medicare, CHAMPUS uses fiscal intermediaries to process claims for inpatient and outpatient medical care. In fiscal year 1983, the fiscal intermediaries paid about $1.115 billion in claims and incurred about $59 million in administrative costs. The cost to process CHAMPUS claims was about 5.3 percent of the benefits paid.

Estimated costs to insurers to process VA billings

Based on the highest administrative costs incurred under the above programs, we estimate that the increased administrative costs that would be incurred by insurance carriers to process VA claims would be less than 6 percent of the value of claims paid. The graph on the following page shows the potential increased administrative costs based on the value of claims paid. We estimate that insurance carriers would have incurred increased administrative costs of, at most, about $6 million to $17 million to process the $98 million to $284 million in claim payments projected in chapter 2.

Estimated Insurers' Administrative Costs
to Process VA Claims



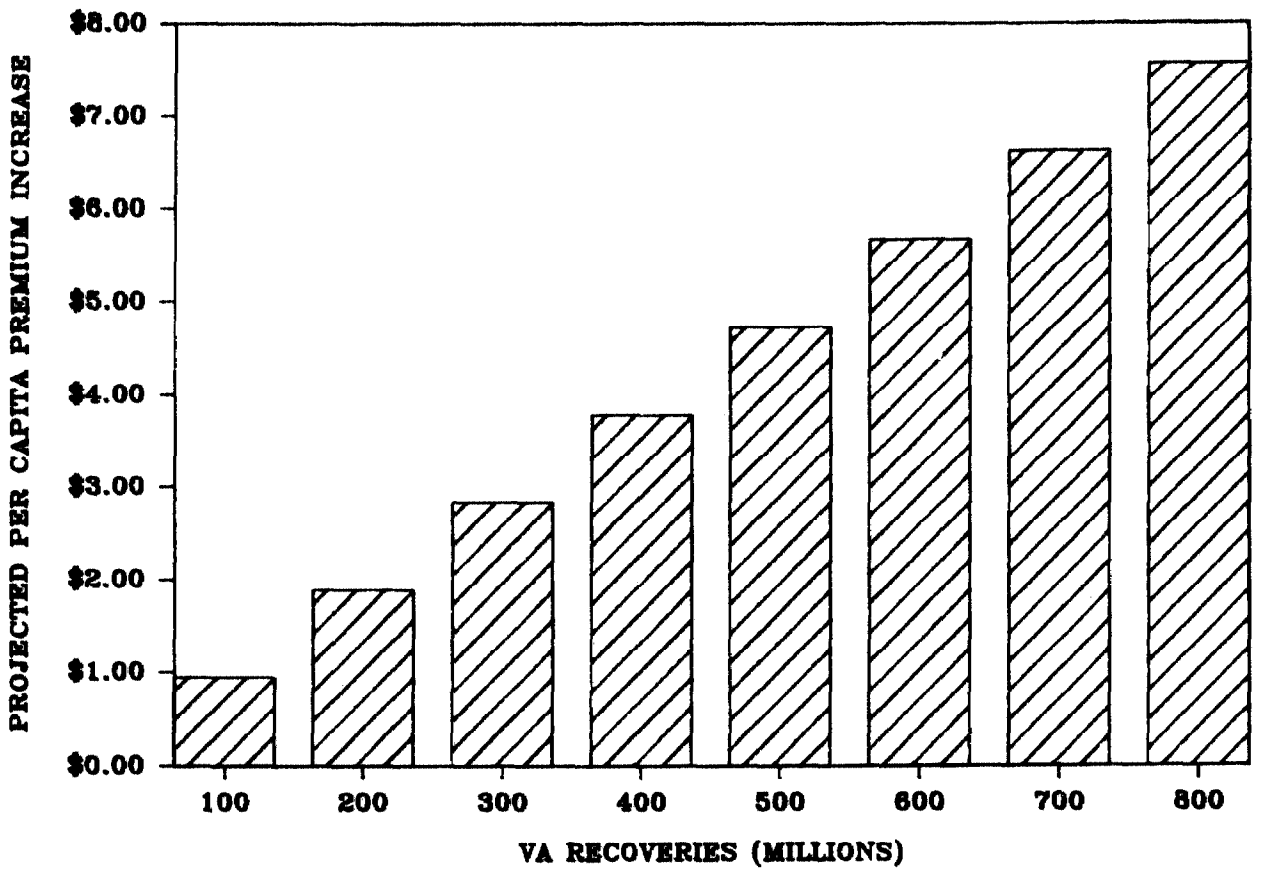
EFFECT ON PREMIUMS WOULD BE MINIMAL

Legislation to allow the government to recover the costs of medical care provided to veterans for non-service-connected disabilities would not significantly increase health insurance premiums.

At present, the burden of paying for VA medical care provided to non-service-connected veterans falls on taxpayers, with each taxpayer's share proportional to his or her share of the nation's total tax burden. If VA is allowed to collect from insurance companies to offset some of the costs, some of the burden will be initially shifted to those companies. Most likely, however, the insurance companies will in turn shift the burden to policyholders in the form of higher premiums.

We estimate that VA recoveries from private health insurance projected in this report would result in an increase in premiums of about a dollar for every $100 million in recoveries. In 1982 health insurance benefit payments were almost $88 billion, and health insurance premiums were almost $99 billion. Assuming that all of the projected $98 million to $284 million increase in benefit payments for care provided in VA hospitals were passed on to policyholders, along with the estimated $6 million to $17 million increase in carriers' administrative costs, the increase in premiums would total from $104 million to $301 million--between $0.93 and $2.69 per year for each of the approximately 112 million individuals with comprehensive hospitalization insurance coverage. The graph below shows the relationship between VA recoveries and increases in health insurance premiums.

Estimated 1984 Per Capita Increase
in Premiums From VA Recoveries



We discussed our estimate of the effect VA recoveries would have on health insurance premiums with officials from the Health Insurance Association of America and the Blue Cross and Blue Shield Association. They agreed that both the benefit payments

and insurers' administrative costs would be passed on to policyholders. They said that the effect on individual policyholders would vary, the effect being the greatest in areas where there are large concentrations of veterans and VA hospitals. We agree that the effects of the small premium increases from payment of non-service-connected VA care may vary according to the concentration of veterans covered by individual policies.

In a March 1984 study Options for Change in Military Medical Care, the Congressional Budget Office discussed proposed legislation to allow the Department of Defense to collect certain medical costs from private health insurers and predicted a similar effect on health insurance premiums. The study noted that:

> "If required to pay for military medical care, insurance companies would probably raise their rates for all policyholders. They would not be able to single out military families for higher premiums because most plans that include military retirees and dependents also include many other civilians. Moreover, the average increase in premiums nation wide would be small, since private insurers would have to pay out less than 0.5 percent a year more in benefits."

CHAPTER 4

THE CONGRESS CAN REGULATE INSURANCE AND PROHIBIT EXCLUSIONARY CLAUSES

During the September 1979 Senate hearings on S. 759, the Health Insurance Association of America and the Blue Cross and Blue Shield Association expressed concern about the legality of legislation to prohibit exclusionary clauses in private health insurance policies. Specifically, they objected to S. 759 because

--state governments rather than the federal government have the right to regulate insurance,

--the government should not be entitled to claim reimbursement for charges for which veterans are not legally obligated to pay, and

--the impairment of contracts that would result from enactment of the legislation would deny the insurance carriers and their policyholders the due process guaranteed by the U.S. Constitution.

Based on our review of case law, we believe the insurance industry's rights would be adequately protected under legislation similar to S. 759. The Department of Justice worked with VA in drafting S. 759 and has, on several occasions, indicated that such legislation would be constitutional. In addition, adequate precedent has been established for federal regulation of insurance contracts. Our analyses of the specific concerns are discussed below.

McCARRAN-FERGUSON ACT DOES NOT PRECLUDE FEDERAL REGULATION OF INSURANCE

In general, the McCarran-Ferguson Act (15 U.S.C. 1011) reserves to the states the right to regulate the business of insurance and provides that no federal law shall be construed to invalidate, impair, or supersede any state law regulating insurance unless the federal statute specifically relates to the business of insurance. In testimony on S. 759, the Health Insurance Association of America maintained that the legislation was contrary to the spirit and intent of the McCarran-Ferguson Act in that S. 759 dictated coverage required in health insurance policies contrary to the intent of the act. Based on an

1868 Supreme Court ruling,[1] insurance transactions were not regarded as transactions of commerce and were not deemed to be within the purview of congressional regulation of interstate commerce. However, in 1944, the Supreme Court overturned the 1868 decision by holding that insurance transactions which cross state boundaries, affecting the people of more than one state, constitute interstate commerce and are not wholly beyond the regulatory power of the Congress under the Commerce Clause in the Constitution (article 1, section 8, paragraph 3). The Supreme Court ruled that insurance transactions were commerce within the meaning of the Commerce Clause and were subject to federal regulation.[2]

By enacting the McCarran-Ferguson Act in 1945, the Congress reaffirmed the states' authority to regulate and tax the business of insurance companies. The act's purpose was to allay doubts thought to have been raised by the 1944 Supreme Court decision as to the power of states to tax and regulate the business of insurance.[3] The report on the original House bill proposing the McCarran-Ferguson Act stated that:

> "It is not the intention of Congress in the enactment of this legislation to clothe the States with any power to regulate or tax the business of insurance beyond that which they had been held to possess prior to the decision of the U.S. Supreme Court . . ."

Thus, the McCarran-Ferguson Act confirmed the states' right to regulate insurance transactions having an intrastate character, while preserving the substance of the 1944 decision that the Congress has the power to regulate insurance transactions of an interstate nature.

Because the use of exclusionary clauses in health insurance contracts relates to health care provided in VA facilities in any state and involves insurance companies doing business across state lines, we believe it affects interstate commerce and is therefore subject to federal regulation.

In a June 11, 1973, letter to OMB's Associate Director for Human and Community Affairs, the Assistant Attorney General, Office of Legal Counsel, citing among others a 1944 Supreme

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[1]Paul v. Virginia, 75 U.S. 168, 183 (1868).

[2]United States v. South-Eastern Underwriters Association, et al., 322 U.S. 533 through 539 (1944).

[3]FTC v. Travelers Health Assn., 362 U.S. 293 (1960).

Court decision, stated that the Department of Justice has no doubt that the Congress has the power to enact legislation to prohibit exclusionary clauses and stated that:

> ". . . It is settled as a general proposition that the business of insurance is in (or 'affects') interstate commerce in such a way as to be subject to Congressional regulation . . ."

The Congress has exercised its power to regulate insurance on several occasions. For example, before 1981, private health insurance policies generally contained clauses that made their coverage secondary to Medicare or otherwise excluded or limited payments to Medicare beneficiaries. The Omnibus Reconciliation Act of 1980 amended the Social Security Act to exclude from Medicare coverage any services for which payment has been made or can reasonably be expected to be made under an automobile liability insurance policy or plan or under no-fault insurance. The Omnibus Budget Reconciliation Act of 1981 makes Medicare benefits secondary to benefits payable under an employer group health insurance plan for services furnished to End Stage Renal Disease (kidney dialysis) patients during a specified period of up to 12 months. HCFA regulations implementing the two acts, in effect, prevent insurance companies from using exclusionary clauses to deny payment under the conditions described.

VA CAN SEEK REIMBURSEMENT OF COSTS THAT VETERANS ARE NOT OBLIGATED TO PAY

In addition to containing provisions specifically excluding payment for services rendered in VA hospitals, many health insurance contracts contain general provisions relieving carriers from liability when services have been furnished without charge or when the policyholder has no legal obligation to pay. As noted on page 4, language providing reimbursement for expenses actually incurred was the subject of litigation in United States v. St. Paul Mercury Indemnity Company. In that case VA brought an action against the insurance company to recover the cost of care provided to veterans. The court held that VA could not recover the cost of care because it did not represent expenses actually incurred by the veterans.

Insurance carriers object to legislation such as that proposed in S. 759 in part because it would authorize the government to claim reimbursement for charges that veterans are not legally obligated to pay. According to the Health Insurance Association of America, health insurance is designed to reimburse the insured for actual expenses.

The Association also said that the insured must have a legal obligation to pay for such services and that such obligation does not arise solely because of the existence of insurance. The Association stated that exclusionary clauses which state that reimbursement will not be made for charges which the insured would not be legally obligated to pay apply to VA hospitals since there is no intent to charge and collect for services if the veteran does not have insurance irrespective of his or her ability to pay from personal funds. In its 1979 testimony on S. 759, the Association concluded that the right of subrogation[4] granted to the government under S. 759 would be meaningless since no benefits are due and payable. Similar views were voiced in the testimony of the Blue Cross and Blue Shield Association.

If the government's claim under legislation such as S. 759 were limited to one of subrogation to the veteran's claim for costs incurred, VA would not be legally entitled to recover because the veteran would incur no cost in obtaining care from VA. However, the government's claim for reimbursement under S. 759 would have stemmed not from subrogation but from a new, independent right of recovery that would have been conferred on the United States by S. 759. The recovery provisions under S. 759 would have been identical to those under the Federal Medical Care Recovery Act. (See p. 3.)

The legislative history of the Federal Medical Care Recovery Act indicates that the references in the act to subrogation are intended merely to prescribe the procedural devices available to the government to effect recovery rather than to alter or diminish the government's right of recovery. As first introduced, the bill (H. Rept. 298) conferred upon the government

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[4]Subrogation is the substitution of one party in place of another with reference to a lawful claim, right, or demand. It passes to the second party all rights, privileges, and remedies, that the first party had against the third party, subject to all equities and defenses that the third party could have exercised against the first.

merely a right of subrogation and assignment.[5] However, the bill, as reported by the House Committee on the Judiciary, was amended to create in the government a distinct right of recovery over and above the rights of subrogation and assignment afforded by the original version. Throughout its report accompanying the bill, the Committee emphasized the independent nature of the new government right.[6]

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[5]H.R. 298, 87th Cong., 1st sess. section (a) 1 (1961):

> "In any case in which the United States is authorized or required by law to furnish hospital, medical, surgical, or dental care and treatment . . . to a person who is injured or suffers a disease . . . under circumstances creating a tort liability upon some third person . . . to pay damages therefor, the United States shall be subrogated to any right or claim that the injured or diseased person . . . has against such third person . . ."

[6]H. Rept. No. 1534, 87th Cong., 2nd sess. 1(1962). The report states

> "The amendments . . . are intended to make it clear that a specific right is recognized on the part of the Government to recover [from] tortiously [sic] liable third persons. It is intended that this right would be exercised without affecting the rights of that individual to recover for losses and damages peculiar to him and in which the Government has no direct interests." (p. 2)
>
> . . . . .
>
> "This amendment makes clear that the United States is granted a distinct right to recover its costs and that this right is to be effectuated through a partial subrogation to any right which the injured or diseased person may have to proceed against the negligent party." (p. 3)
>
> . . . . .
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> "Again, by striking out the words 'subrogation or assignment' and inserting the words referring to the right established in section (1), it is again emphasized that the remedy of the Government to assert its rights to recover the cost and surgical services is provided by this legislation." (p. 4)

By creating an independent federal cause of action, the Congress provided the government greater rights of recovery under certain circumstances than those enjoyed by either the beneficiary or a common law "assignee" or "subrogee." Accordingly, in instances where the beneficiary was provided medical care without charge, the government, but not the beneficiary, has the right to recover from the tort feasor.

Because S. 759 would have created a similar independent federal right of recovery, it would have enabled the government to recover the costs of medical care provided to privately insured veterans even though the veterans had no obligation to pay for their care.

IMPAIRMENT OF CONTRACTS UNDER S. 759 WOULD NOT HAVE DENIED DUE PROCESS

At the 1979 hearings on S. 759, concern was expressed that such legislation would (1) violate the constitutional prohibition against impairment of contracts,[7] (2) deny insurance carriers and their policyholders due process, and (3) abrogate federal obligations to provide veterans' health care.

Prohibition against impairment of contracts directed at states

According to the Health Insurance Association of America, the application of legislation such as S. 759 to contracts subject to renewal would violate the constitutional prohibition

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[7]"A law which impairs the obligation of a contract is one which renders the contract in itself less valuable or less enforceable, whether by changing its terms and stipulations, its legal qualities and conditions, or by regulating the remedy for its enforcement.

"To 'impair the obligation of a contract', within prohibition of Art 1,§ 10, U.S. Const., is to weaken it, lessen its value, or make it worse in any respect or in any degree, and any law which changes the intention and legal effect of the parties, giving to one a greater and to the other a less interest or benefit, or which imposes conditions not included in the contract or dispenses with the performance of those included, impairs the obligation of the contract.

"A statute 'impairs the obligation of a contract' when by its terms it nullifies or materially changes existing contract obligations." Blacks' Law Dictionary, 5th Ed. (1979).

against the impairment of contracts. The bill would have applied to all contracts renewed after the bill's effective date. According to the Association, health insurance policies sometimes remain in force for many years. The Association pointed out that under guaranteed renewable and noncancelable policies (most policies in effect today), the policy may be renewed from term to term solely at the option of the insured, and the insurance company has no control over the renewal.

The Association said that the net effect would be to apply the requirements of the bill to many contracts entered into before the enactment of the new provisions. This, according to the Association, would be a serious impairment of the existing contracts.

In support of its argument, the Association cited a New York court of appeals decision that a state law mandating maternity coverage in health insurance policies containing guaranteed renewable clauses was an unconstitutional impairment of the obligation of contracts.[8] The constitutional prohibition against the impairment of contracts applies to state laws and not to federal laws. The case cited by the Association involved a state law.

In an April 1979 letter to the Chairman, Senate Committee on Veterans' Affairs, the Assistant Attorney General, Office of Legislative Affairs, stated that, as a general proposition, the Congress can, in the exercise of its power to legislate, interfere with existing contracts[9] or establish uniform rules of contract which shall become immediately obligatory.[10]

Due process would not be denied

While federal legislation that impairs the rights and obligations under contracts is not subject to the constitutional prohibition against impairment of contracts, it is subject to the prohibitions of the due process clause of the Fifth Amendment to the U.S. Constitution. Due process refers to the protection of an individual against arbitrary action. According to the Health Insurance Association of America and the Blue Cross and Blue Shield Association, legislation such as S. 759 would

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[8]HIAA v. Harnett, 444 N.Y. 2d 302 (1978).

[9]Louisville & Nashville R.R. Co. v. Mottley, 219 U.S. 467 and 480 through 486 (1911).

[10]Philadelphia, Baltimore & Washington R.R. Co. v. Schubert, 224 U.S. 603, 613 and 614 (1912).

have denied due process to both insurance companies and their policyholders.

According to the Health Insurance Association of America, enactment of S. 759 would have raised a constitutional question of due process in its application to contracts subject to renewal. (See p. 41.) However, in her April 1979 letter to the Chairman, Senate Committee on Veterans' Affairs, the Assistant Attorney General said that the Supreme Court has held that the retroactive application of a statute amounts to a denial of due process only if it would inflict "manifest injustice"[11] or if it were "particularly 'harsh and oppressive.'"[12]

The Assistant Attorney General's letter noted that veterans are charged the same premiums as nonveterans despite the clauses excepting care furnished by VA from the coverage of the contracts. The Assistant Attorney General stated that eliminating the clause from existing insurance contracts would therefore be neither "manifestly unjust" nor "particularly harsh and oppressive."[13] In addition, S. 759 would have applied to existing contracts only at the time of their renewal (i.e., when the insurance companies have an opportunity to adjust their overall premiums and coverage).

The Assistant Attorney General concluded that:

> "The retrospective aspects of this bill therefore are neither 'manifestly unjust' nor 'particularly harsh and oppressive'; to the contrary everything has been done to protect the insurance carriers' reasonable interest."

In the 1979 hearings on S. 759, the Blue Cross and Blue Shield Association disagreed with the Justice Department's analysis, stating that the legislation raised fundamental concerns of equity. According to the Blue Cross and Blue Shield Association, such legislation would create inequities among individual

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[11] Bradley v. Richmond School Board, 416 U.S. 696 and 716 (1974).

[12] United States Trust Co. v. New Jersey 431 U.S. 1 and 17 fn. 13 (1977).

[13] The letter notes that even if the exception of care furnished by VA was taken into account in the computation of the premiums charged to all insured veterans and nonveterans alike, the effect on premiums would, in all probability, be so small that it would not constitute a denial of due process even if the Congress chose to disregard it.

veteran-patients because the veterans with no insurance would pay once for their care--through taxes--while veterans with insurance would pay twice--through taxes and insurance premiums. The Association further stated that such legislation would penalize those otherwise prudent enough to buy health insurance for themselves and their families, thereby discouraging veterans from obtaining health benefit protection that is essential if they and their families are to obtain medical care.

As noted on page 15, about 89 percent of the privately insured veterans responding to our questionnaire said that they would not object to VA recoveries if there were no cost to them for their episode of care. Although VA recoveries would result in increases in health insurance premiums, those increases would be spread among all policyholders, not just veterans obtaining care in VA facilities. As noted in chapter 3, the recoveries projected in this report should result in increases in health insurance premiums of only about 0.3 percent. In our view, the increases would be so small as to have little effect on the veterans' desire to obtain health protection for their families.

The Blue Cross and Blue Shield Association also claimed that legislation such as S. 759 would create inequities among insurance carriers because a prepayment or insurance organization that provided a greater scope and depth of benefit protection for its subscribers than another would be asked to pay a greater share of VA hospital costs. However, differences in the scope and depth of benefit coverage are not related to the proposed legislation. To the extent such differences currently exist, they would create the same "inequities" in payments to private facilities.

Legislation such as S. 759 would not abrogate federal obligations

At the 1979 hearings on S. 759, the Blue Cross and Blue Shield Association claimed that the legislation would have reduced federal expenditures for veterans' health care by transferring obligations from the United States (to provide veterans health care for non-service-connected disabilities if they are unable to pay for care) to the insurance companies. According to the Association, legislation such as S. 759 would conflict with the 1934 Supreme Court decision in Lynch v. U.S.[14] that the Congress had no power to reduce federal expenditures by abrogating its own contract obligations. In the Lynch case, the Congress attempted to abrogate federal obligations under insurance contracts to which the government was a party. The Supreme

[14]292 U.S. 571 (1934).

Court held that the government, as a party to a contract, may not abrogate its responsibilities under the contract (unless that action falls within some paramount federal power, like the police power).

The situation under recovery legislation such as S. 759 would, in our opinion, be factually distinct from Lynch. Under current contracts between veterans and insurance companies, the government is not a party to the contracts and has no responsibility under them. Legislation such as S. 759 would create a right on the part of the government to collect for services rendered. In other words, the government would be establishing a debt and not abrogating a responsibility for paying a debt.

The Justice Department, in its April 10, 1979, letter to the Chairman, Senate Committee on Veterans' Affairs, noted that the Lynch case stands for the proposition that the Congress cannot abrogate the obligations of the United States, not that the Congress cannot regulate the contracts of third parties. According to the Justice Department, the language of S. 759 made it clear that it did not lessen the veterans' right to benefits, but that it deals with the government's right of subrogation.

CHAPTER 5

BILLINGS AND UTILIZATION REVIEW WOULD NOT CREATE MAJOR PROBLEMS

In the 1979 hearings on S. 759, concern was expressed about VA's (1) ability to develop a billing system that would be acceptable to insurance companies and (2) willingness to submit to utilization reviews by insurance companies. Developments since 1979 should enhance VA's ability to prepare acceptable billings. In addition, although VA remains opposed to having insurance companies assess the effectiveness of its utilization review program, insurers' generally do not rely on such assessments in conducting utilization reviews.

VA COULD PROVIDE ACCEPTABLE BILLINGS

In its September 1979 testimony on S. 759, the Health Insurance Association of America said that VA's per diem billing system was not acceptable to the insurance industry and that "a system that requires us to pay for average rather than actual services is fraught with serious problems." The Association further stated that insurers generally require itemized bills to verify that the charges are proper and that services were actually rendered. Since the Association's 1979 testimony, several changes in billing methods have occurred which should enhance VA's ability to prepare billings acceptable to insurance carriers. Specifically, a new uniform billing form was developed, VA increased the detail provided in its billings, and per diem billings gained wider acceptance. In addition, a newly developed prospective payment system based on diagnosis related groups (DRGs) could be adapted for use in preparing VA billings.

VA could use uniform billing form

A national uniform billing form, the "UB-82," has been developed for use by major third-party payors, most hospitals, and, at the option of the hospital, hospital-based skilled nursing facilities and home health agencies. The form was developed by the National Uniform Billing Committee, which is composed of leading provider and payor groups, including representatives from the Blue Cross and Blue Shield Association, the Health Insurance Association of America, HCFA, CHAMPUS, the Federation of American Hospitals, the Hospital Financial Management Association, the American Hospital Association, and individual hospitals.

The data elements identified by the committee as necessary in most cases to process a hospital bill for payment are assigned a designated space on the UB-82 form. Other data elements that are needed occasionally by a limited number of payors were also incorporated on the form. Further flexibility was provided through unassigned codes and spaces on the form to meet unique hospital or payor needs on a state or local level.

The UB-82 is intended to provide the flexibility necessary to promote the greatest use of the form. Both Medicare and CHAMPUS have adopted the form for use in hospital billings. Similarly, all major insurance carriers have now adopted it. A Blue Cross and Blue Shield Association official told us that VA billings would be more acceptable to Blue Cross if submitted on a UB-82, since they would fit into Blue Cross' computerized claims processing. The official stated further that VA does not need to develop a new billing system, just adapt its existing system to the UB-82.

VA has increased detail on billings

At the time of the hearings on S. 759, VA billings were based on an all-inclusive per diem rate (see p. 3) with itemized charges for room and board, physicians' services, and ancillary services being provided only on request.

However, since December 1982, the VA Manual (M-1, part I, chapter 15) has required that all billings for medical care itemize the three component parts of the all-inclusive per diem rate. In addition to the per diem charges, VA billings identify the patient's diagnosis, list the surgical or special diagnostic procedures performed, and describe the services provided.

According to VA's Director of MAS, insurance carriers have seldom objected to VA per diem billings under existing cost recovery programs. Although insurance companies originally challenged the government's per diem billings after the 1962 enactment of the Federal Medical Care Recovery Act, federal district courts ruled in 1966 and 1967[1] that OMB-established rates could not be challenged on the grounds of unreasonableness by a liable third party.

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[1]United States v. Jones, 264 F. Supp. 11 and 14 (E.D. Va. 1967); Phillips v. Trame, 252 F. Supp. 948 and 951, (F.D. Ill. 1966).

Per diem billings gaining wider acceptance

Although health insurance carriers still prefer to receive itemized billings, per diem billings are gaining wider acceptance as a way to contain hospital costs.

According to the Washington counsel of the Health Insurance Association of America, the Association's members remain opposed to per diem reimbursement because such charges do not necessarily reflect the costs of care provided. However, according to the Manager, Performance Strategy and Tactics, Blue Cross and Blue Shield Association, Blue Cross will not necessarily reject a per diem billing. He said that some hospitals and insurance carriers (mainly in the upper midwest and northeast sections of the country) have entered into contracts that provide for per diem billings. According to the Association official, the contracts generally provide for per diem payments during the year with a review of hospital records and actual costs yearly. He said that adjustments to the following year's per diem rate are made based on the review.

California's Medicaid program recently established a new hospital reimbursement system under which hospitals negotiate contracts with the state to provide care at a fixed per diem rate. State officials predict that the contracting program will significantly reduce Medicaid costs.

Blue Cross and Blue Shield of California are negotiating similar per diem reimbursement contracts with hospitals. A Blue Shield of California official told us that the per diem contracts will contain health care costs, but will heighten the need for effective utilization review programs to insure that patients' lengths of stay are appropriate.

The two Massachusetts state veterans' homes bill most private insurance carriers on a per diem basis. According to home officials, the per diem billings have created no significant problems. Officials from Blue Cross of Massachusetts, Inc., which pays about 78 percent of bills from the two homes, agreed but said Blue Cross would prefer itemized bills since they would be more compatible with Blue Cross' computerized claims processing (see app. V).

Prospective payment accepted as alternative to itemized bills

Since the 1979 hearings on S. 759, prospective payment systems are gaining wide acceptance among hospitals and insurance

companies as an alternative to itemized billings. VA is developing a prospective payment system to reimburse non-VA hospitals for care provided to eligible veterans. We believe VA could use the same system to prepare billings for VA care.

In 1983, the Congress enacted legislation (Public Law 98-21) directing the Department of Health and Human Services to establish a prospective payment system for Medicare hospital reimbursement based on DRGs. Hospitals in a few states, including New Jersey, already prepare bills based on DRGs.

Under a prospective payment system, providers are told in advance what they will be paid and the payment level is not retrospectively adjusted to reflect actual costs.[2] The DRGs used in Medicare's prospective payment system were developed by Yale University, which grouped diagnoses by physiological system and severity of illness. The groupings of diagnoses were designed to include cases that are closely related with regard to the extent of resources expected to be devoted to treating the patients.

Public Law 98-21 required the Secretary of Health and Human Services to develop a national and nine regional DRG rates, each with an urban and a rural rate adjusted for local wages. The regional DRG rates will be phased out in 4 years while the national DRG rates are phased in. Capital and educational expenses would be paid on a cost basis. The Medicare prospective payment system is being phased in over a 3-year period.

VA is developing a system for reimbursing non-VA hospitals based on the payment mechanisms and rates of the Medicare system. VA plans to have its facilities submit to VA's Austin Data Processing Center the raw data (such as age, sex, and diagnosis) needed to determine the payment amount based on the DRG. The data processing center will process the information, make a DRG assignment, compute "other" costs, identify the provider by region and by urban/rural designation, compute "pass through" allowances, develop a total amount, and instruct the payment system to issue a check.

VA plans to use DRG payment schedules published by Medicare with adjustments in the schedules for regional costs based on Medicare's nine regions and urban/rural designations. VA also plans to allow an additional 10 percent to all providers over the

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[2]An exception is made for atypical cases known as "outliers." These are cases that have either an extremely long length of stay or an extraordinarily high cost compared to most discharges classified in the same DRG. A per diem payment will be made for each day of care beyond the outliers' threshold.

DRG costs for pass-through costs, rather than making hospital-specific pass-through adjustments as Medicare is doing by paying capital and educational expenses on a cost basis.

As an alternative to per diem billings, VA could use the same prospective payment system developed to pay private sector hospitals to seek reimbursement from private health insurance carriers. The same adjustments and pass-through allowances used in reimbursing private sector hospitals could be used in determining individual DRG rates for VA's 172 medical centers.

We discussed the feasibility of using a prospective payment system to bill insurance carriers with VA's MAS officials. One MAS official said that VA could use the same prospective payment system developed to pay private sector hospitals to bill insurance carriers. In our opinion, such billings could be expedited by revising VA's computerized patient treatment file to include DRGs.

However, another MAS official said that he did not believe it would be appropriate to bill using a system based on Medicare DRGs. He indicated that VA is required to prepare billings based on actual costs and that DRGs are not based on actual costs. He further stated that the American Hospital Association opposes DRGs because they do not provide hospital reimbursement for all of the costs they incur.

As stated on page 3, VA is required under the Federal Medical Care Recovery Act to bill based on the "reasonable value" of the medical care provided. OMB officials stated that DRG billings would reflect the "reasonable value" of care provided in VA facilities and would therefore be acceptable under the Federal Medical Care Recovery Act.

An official from the American Hospital Association said that the Association supports the concept of DRGs. He said that with DRGs a hospital knows in advance how much it will receive for a particular case and any costs below that amount represent a profit to the hospital. According to the Association official, there are no additional costs associated with preparing DRG billings.

According to the Washington, D.C., counsel of the Health Insurance Association of America, the Association also supports the concept of DRGs as a billing method. He said that DRGs represent prospective costs and serve as a means of cost control. The UB-82 billing form accommodates DRG-based billings.

In commenting on a draft of this report, VA said that it does not agree with the suggestion to use the system being de-

veloped for payment of non-VA hospital care based on Medicare's prospective payment system. VA said that the Medicare rates are based on costs in the private sector and not on costs incurred by VA in operating its facilities. According to VA it is mandated by law to recover its "costs." In addition, VA said that under Medicare's prospective payment system, physicians, non-physician anesthetists, and others are paid separately. VA said that VA billings are all inclusive and that it would have no way of generating separate physician costs on a case-by-case basis associating costs with any particular diagnosis.

As stated on page 3, VA is mandated by law to recover the "reasonable value" of services it provides, not the actual "costs" as VA states. Further, one of the insurance industry's objections to VA's current per diem reimbursement system is that it does not reflect the cost of care provided to an individual policyholder. A DRG-based system would more closely reflect such costs. VA currently computes per diem costs for physicians' services and could, in our opinion, factor such costs into a DRG-based billing system.

INSURERS' UTILIZATION REVIEW SHOULD NOT INTERFERE WITH MANAGEMENT OF VA PROGRAMS

VA remains opposed to having insurance companies review the effectiveness of VA utilization review programs. However, most insurers' utilization review efforts are limited to a postclaim review of the appropriateness and necessity of the care provided to individual policyholders and should not interfere with the management of VA's utilization review programs.

Utilization review mechanisms generally involve audit-type examinations of health care facility records to determine (1) the extent to which patients are properly admitted and the care and treatment provided is reasonably necessary in light of accepted medical practice, (2) the conformance by the facility to length-of-stay criteria developed for particular types of episodes of care, and (3) the extent to which available resources are effectively managed and utilized.

During 1977 and 1978 Senate hearings dealing with the National Academy of Sciences' Study of Health Care for American Veterans, VA's Chief Medical Director expressed reluctance to submit to private insurance companies' utilization reviews. By letter dated July 23, 1984, VA's General Counsel advised us that now and in the past a utilization review program has been in effect at VA medical centers. He pointed out that the utilization review program at each medical center is reviewed as part of each accreditation survey conducted by the Joint Commission for the Accreditation of Hospitals. According to the General Counsel, VA would not agree to give insurers any oversight review of

its utilization review program or any role in the management or direction of the program.

Most utilization reviews conducted by insurance companies do not, however, involve review or management of the hospital's utilization review program. According to an official from the Health Insurance Association of America, health insurance companies perform three basic types of utilization review:

--Preadmission review, in which the policyholder's admission must be approved in advance by a peer review organization, a proprietary review group, or the insurance company itself.

--Postadmission review, under which a concurrent review is conducted after admission to evaluate the treatment, length of stay, etc.

--Postclaim review, under which the policyholder's hospital bill is reviewed and, if something is unusual, the insurance company will request the medical records.

A senior Blue Shield of California official told us that under traditional health insurance plans, utilization review is usually postclaim, involving only the review of claims and selected medical records. Similarly, preadmission utilization review by insurance companies is directed toward reviewing the medical necessity for admitting individual policyholders rather than reviewing the effectiveness of a hospital's utilization review program.

Under postadmission utilization review, insurance companies, in effect, review the effectiveness of a hospital's utilization review program. Postadmission review is conducted in the hospital and involves the review of medical records to determine the diagnosis and expected length of stay. The review may be conducted by a peer review organization, a proprietary organization, or the insurance company. The organization may delegate responsibility for conducting the postadmission review to the hospital as a "delegated review." If the organization does not believe that the hospital can do a good job, there is no delegation to the hospital, and it is considered a nondelegated review. Accordingly, if VA is unwilling to perform postadmission utilization reviews for insurance companies, or the insurance companies are not satisfied with the quality of the reviews VA conducts, insurance companies could perform postadmission reviews on a nondelegated basis.

We discussed VA's reluctance to allow insurance companies to review the effectiveness of VA utilization review programs with

officials from the Health Insurance Association of America and the Blue Cross and Blue Shield Association. Officials from both associations said that they should have the same rights to perform utilization reviews of VA facilities as they do to review private sector facilities, particularly in light of the longer VA lengths of stay (see p. 16). We agree.

CHAPTER 6

CONCLUSIONS, RECOMMENDATION TO THE CONGRESS, AND AGENCY COMMENTS

CONCLUSIONS

In 1970, we reported that it would be necessary to enact legislation in order for VA to recover the cost of medical care provided to privately insured veterans. Although VA, on several occasions, submitted legislative proposals to the Congress to enable it to obtain reimbursement from private health insurance, concerns have been raised during hearings on those proposals, and the proposals have not been enacted.

After evaluating the concerns raised about recovery legislation, we believe that the government should not be precluded from recovering the cost of medical care provided to insured beneficiaries if recovery would have been available to private sector hospitals. The insurance industry's rights would, in our opinion, be adequately protected under legislation such as S. 759.

Enactment of recovery legislation could enable the government to recover the hundreds of millions of dollars lost each year because of exclusionary clauses in private health insurance contracts. VA administrative costs to prepare and process billings should be about $27 for every claim processed, or less than 2 percent of recoveries projected in this report.

Although recovery legislation would shift the burden of paying for some non-service-connected care from taxpayers to insurance policyholders, it would not significantly increase health insurance premiums (about a dollar for every $100 million in recoveries). Premiums for health insurance policies reflect the expected health care costs of policyholders. Since premium payments may be used to pay for covered services at private sector hospitals, there is no apparent equity reason that they should not also be used to pay for covered costs incurred by policyholders at VA hospitals.

Public Law 96-330 should, in our opinion, be viewed as a supplement, not an alternative, to recovery legislation for several reasons. First, the ability-to-pay provisions may not be implemented because of VA's concerns about the administrative costs to make such determinations. Second, if implemented, the legislation would not apply to many veterans treated for non-service-connected conditions in VA facilities, even if the veterans had private health insurance. Specifically, it would not

apply to veterans who (1) have service-connected disabilities but receive treatment for non-service-connected conditions, (2) are receiving a VA pension or are Medicaid eligible, or (3) are 65 years of age or older. Without recovery legislation, VA would continue to be prevented from recovering from such veterans' health insurance, although their insurance would pay for their care in a private sector hospital. Finally, veterans subject to the provisions of Public Law 96-330 who have private health insurance but are determined to be unable to defray the costs of deductibles or coinsurance for care at private sector facilities would still be eligible for care in VA facilities. However, VA would be unable to recover from their private health insurance.

It is important to note too that recovery legislation and the ability-to-pay provisions of Public Law 96-330 would have similar effects on insurers' administrative costs and veterans' health insurance premiums if veterans with private health insurance are referred to private sector facilities. However, implementing the ability-to-pay provisions would also increase veterans' out-of-pocket costs since they would be expected to pay any deductibles and coinsurance at private sector facilities.

RECOMMENDATION TO THE CONGRESS

The Congress should enact legislation similar to S. 759 to enable VA to recover the costs of non-service-connected care provided to privately insured veterans.

AGENCY COMMENTS AND OUR EVALUATION

We asked VA, OMB, and the Department of Justice to provide comments on a draft of this report.

OMB

OMB had not provided comments when the 30-day statutory comment period expired, nor when this report was finalized. However, the President's fiscal year 1986 budget proposal states that legislation will be proposed to require reimbursement along the lines we recommended.

Department of Justice

The Department of Justice said that it found no constitutional difficulties with our recommendation that the Congress enact legislation to enable VA to recover the costs of care provided to privately insured veterans for non-service-connected medical conditions. The Department noted that, as our report indicates (see pages 37 and 42), it has previously stated its

opinion that the Congress constitutionally may legislate to prohibit exclusionary clauses in private health insurance policies and that eliminating such clauses concerning the coverage of costs of treatment for veterans would neither violate due process nor abrogate existing federal obligations.

VA comments

In a February 12, 1985, letter, the Administrator of Veterans Affairs stated that while VA is aware of the objections raised when recovery legislation was previously proposed, it is cautiously optimistic that such legislation would enhance VA recoveries. While VA supported our recommendation, it expressed reservations about our estimate of the administrative costs to implement a billing program.

VA believes that estimates of administrative costs it developed in May 1984 (see pp. 101 to 108) are more accurate than those we developed.

VA estimated annual administrative costs of about $50 million to prepare and process private health insurance billings in fiscal year 1986 based on a projected 3.8 million billings per year, or about $13 per billing. By contrast, as stated on page 23, we estimated that VA would have incurred administrative costs of about $1.7 million in fiscal year 1982 to prepare and process the 63,371 billings projected as a result of our questionnaire survey, or about $27 per billing. Thus, VA projects a lower unit cost but a higher volume of billings.

We recognize that the actual number of billings, and thus VA administrative costs, will likely be higher than we noted because we could project only to the universe from which we sampled (see pp. 19 to 22). But we do not believe that VA's estimate of 3.8 million billings per year (and its estimate of $50 million a year in VA administrative costs) is sound. Further, while an increase in the number of billings will increase VA administrative costs, it would also result in a corresponding increase in VA recoveries. Our projections, as well as VA's, show that a cost recovery program would be cost effective. Accordingly, concern over VA administrative costs should not be a deterrent to enactment of recovery legislation.

Our analysis of VA's specific concerns about our estimate of VA administrative costs follows.

Percent of veterans with insurance

VA stated that we underestimated its number of potential billings because of our estimate that 18 percent of non-service-connected veterans had private health insurance. It suggested

that its estimate of 38.2 percent based on VA's 1979 National Survey of Veterans was more realistic. However, in developing its estimate, VA

--double-counted veterans with multiple insurance coverage (the 1979 National Survey of Veterans specifically mentioned that multiple coverage existed.);

--included veterans who are members of health maintenance organizations although such organizations could be expected to pay only for emergency care at VA facilities;

--did not differentiate between veterans with comprehensive hospitalization insurance and those with limited coverage such as Medicare supplements, plans that pay cash when the policyholder is hospitalized, and cancer and black lung policies; and

--assumed that veterans who said they had insurance at the time the survey was conducted (spring 1979) also had insurance at the time they received care at a VA hospital (1978) and that the insurance would cover the services VA provided.

VA used the 38.2-percent estimate in projecting the number of billings (3.8 million) it would prepare and the administrative costs it would incur.

As shown on pages 13 and 14, our projections excluded double-counting of veterans with multiple coverage and veterans who were HMO members, did not have comprehensive hospitalization coverage, did not have insurance at the time they received care from VA, or were provided services not covered by their insurance. Accordingly, we believe our estimate of the percentage of veterans with private health insurance coverage provides a sounder basis for estimating potential recoveries and administrative costs.

Outpatient care excluded

VA said that we underestimated the total workload that would be involved in implementing a billing program by considering only episodes of inpatient care when the 1979 National Survey of Veterans showed that 53 percent of all policies also covered outpatient care.

VA is correct in stating that the preparation and processing of billings for outpatient care would increase total administrative costs. We recognized on pages 19 through 22 that the projected number of billings was conservative and did not include many potential billings both for inpatient and outpatient

care. However, the graphs on pages 27 and 30 estimate the administrative costs that VA would have incurred to prepare and process billings in fiscal year 1984 based on different numbers of billings.

Recovery rates

VA said that we assumed unrealistically that VA would recover 100 percent on all claims covered by health insurance when most health insurance policies have deductible and/or coinsurance clauses.

We did not, as VA asserted, assume that VA would recover 100 percent of all cases covered by health insurance. As discussed on pages 15 through 19, we developed a range of recoveries based on (1) typical health insurance of from 80 to 100 percent of inpatient charges and (2) both actual VA lengths of stay and average community lengths of stay. Under the assumption that insurance companies would reimburse VA based on average community lengths of stay and cover 80 percent of allowed charges, VA would recover only about 50 percent of its costs of providing care to privately insured veterans.

It should also be noted that the VA administrative costs do not depend on the recovery rate. The same costs to prepare and process billings will be incurred whether VA recovers 50 percent or 100 percent of billed charges.

Use of CARS costs

VA questioned our use of DVB's disposition cost from closed CARS cases as an appropriate cost per claim processed by DM&S.

As noted on page 29, VA currently uses CARS costs to establish the administrative cost to process medical care debts. While no medical care debt collection data were used in computing CARS cost, the cost components under CARS and medical care debt collection are similar. For example, both systems send collection letters; make personal and telephone contacts; and make compromises, waivers, and referrals to district counsels.

Start-up costs

VA said that we did not estimate the start-up and continuing maintenance costs that would be incurred for the additional personnel, automated data processing equipment, and software needed to establish and maintain a billing program.

While we did not estimate start-up costs to include medical care recoveries under CARS (see p. 29), VA estimated start-up costs of only about $14 million in automated data processing equipment, mailing equipment, and software to establish such a collection program.

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In an enclosure to his letter, the Administrator provided several technical comments on our draft report. These comments have been incorporated, where appropriate, in this report.

OBJECTIVES, SCOPE, AND METHODOLOGY

Following 1979 hearings on legislation that would have authorized VA recoveries from private health insurance, the Senate Committee on Veterans' Affairs identified a series of concerns raised during the hearings that it believed needed to be resolved before additional consideration was given to legislation to prohibit exclusionary clauses in private health insurance policies. Serious consideration has not been given to enactment of recovery legislation since 1979. Our overall objective was to evaluate the concerns identified by the Committee and determine whether further consideration should be given to the enactment of recovery legislation. Our specific review objectives were to

--estimate the extent of potential VA recoveries from private health insurance,

--estimate the administrative costs VA would incur to recover from health insurance,

--estimate the administrative costs insurance companies would incur to process VA billings,

--estimate the effects VA recoveries would have on health insurance premiums,

--determine whether VA could generate billings acceptable to insurance carriers,

--determine whether there are any legal impairments to enactment of recovery legislation, and

--determine whether private health insurers' utilization reviews would create a significant problem for VA.

To accomplish these objectives, we interviewed officials from VA's Office of the General Counsel and Departments of Medicine and Surgery and Veterans Benefits, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association; reviewed VA policies, procedures, and records pertaining to recoveries from private health insurance; and reviewed congressional hearings and reports relating to recovery legislation. In addition, we obtained information on the experiences of the Massachusetts state veterans' homes in recovering from private health insurance since the enactment of recovery legislation in that state. Our specific review steps are discussed below and in appendix II.

ESTABLISHING POTENTIAL VA RECOVERIES

To develop an estimate of potential VA recoveries from private health insurance, we

- --sent questionnaires to a randomly selected sample of veterans discharged from VA hospitals in fiscal year 1982 after treatment of non-service-connected nonpsychiatric illnesses to determine the extent of their health insurance coverage and VA treatment costs potentially subject to reimbursement,
- --developed information on the percentage of a hospital bill typically covered under private health insurance policies, and
- --applied the provisions of the typical insurance coverage to the projected VA costs subject to reimbursement.

Our survey and sampling methodology for estimating VA treatment cost potentially subject to reimbursement are discussed in appendix II.

To determine the percentage of the typical hospital bill typically covered under private health insurance policies, we (1) interviewed officials from the Health Insurance Association of America and the Blue Cross and Blue Shield Association about the typical coverage under their members' plans, (2) reviewed a Health Insurance Association of America survey of new group health insurance policies issued during the first 3 months of 1982 to determine the extent of hospitalization coverage, and (3) conducted, with the assistance of our actuaries, a review of the 1981 in-hospital benefits of 47 health insurance plans. The 47 plans included 12 FEHBP plans and 35 plans submitted by private sector employers in response to our validation questionnaires (see p. 68).

The range of potential VA recoveries from private health insurance was determined by applying the above percentages to the projected VA costs subject to reimbursement based both on actual VA lengths of stay and lengths of stay of comparable patients in private sector hospitals.

ASSESSMENT OF THE EFFECTS VA RECOVERIES WOULD HAVE ON VA ADMINISTRATIVE COSTS

We divided our analysis of the increase in administrative expenses VA would incur to recover from insurance carriers into

the three distinct parts of the recovery process--identification of veterans with insurance coverage, preparation of billings, and collection efforts.

To determine whether increased administrative costs would be incurred to identify veterans with private health insurance coverage, we

--reviewed VA admissions documents to determine whether they obtain data on health insurance;

--observed the admissions process at the Washington, D.C., VA medical center and reviewed the admissions forms for the veterans in our questionnaire sample to determine whether data on health insurance was being obtained;

--reviewed and discussed VA policies and procedures on recoveries with VA officials; and

--discussed draft regulations to implement the ability-to-pay provisions of Public Law 96-330 to determine whether identification of health insurance coverage will be included in ability-to-pay determinations.

To determine the administrative cost to prepare billings, we (1) reviewed an estimate of the range of time required to prepare a billing using a uniform billing form prepared for HCFA's use, (2) discussed the estimate with a VA MAS official to determine whether it would reasonably reflect the time VA clerks would require to prepare billings, and (3) determined the average grade and step of VA employees who would prepare the billings through discussions with VA officials. We then calculated projected administrative costs based on the number of projected billings, the time required to prepare a billing (using the upper end of the HCFA range to be conservative), and the salary of VA personnel who prepared the billings (including a 26-percent fringe benefit factor).

To determine the cost of collecting from private insurance carriers, we (1) reviewed DM&S' and DVB's debt collection policies and procedures to determine whether they included similar processes, (2) discussed with DM&S and DVB officials the feasibility of using DVB's automated CARS to collect medical care debts, (3) reviewed CARS' cost reports to determine the average cost per claim, and (4) applied CARS' costs to the projected number of private health insurance claims.

We did not attempt to estimate the initial start-up costs to include medical care debts in CARS.

ASSESSMENT OF THE EFFECTS VA RECOVERIES WOULD HAVE ON INSURERS' ADMINISTRATIVE COSTS

To determine the effect VA recoveries would have on insurance carriers' administrative costs, we (1) interviewed officials from the Health Insurance Association of America and the Blue Cross and Blue Shield Association, which represent most major private health insurance companies; (2) discussed with Blue Cross of Massachusetts officials the effects Massachusetts state veterans' home recoveries from private health insurance have had on their administrative costs; and (3) reviewed Medicare, CHAMPUS, and FEHBP statistics on benefits paid and administrative costs.

We originally attempted to obtain data on insurers' administrative costs from the Health Insurance Association of America and Blue Cross and Blue Shield Association. However, because the former did not have such data and the latter declined to provide its administrative cost data, we based our estimate on the Medicare, CHAMPUS, and FEHBP data. We believe the Medicare and CHAMPUS payments to fiscal intermediaries are a good approximation of costs that would be incurred by insurance carriers to process private health insurance claims because the fiscal intermediaries are generally insurance carriers.

To be conservative, we assumed that insurance carriers' administrative costs to process VA claims would be the highest of the costs to process the Medicare, CHAMPUS, and FEHBP claims.

ASSESSMENT OF THE EFFECT VA RECOVERIES WOULD HAVE ON INSURANCE PREMIUMS

To determine whether VA recoveries from private health insurance would have a significant effect on health insurance premiums, we reviewed national statistics on health insurance premiums and benefit payments obtained from the Health Insurance Association of America, and we calculated the percentage increase in premiums and benefit payments that would result from VA recoveries. Since most private health insurance premiums are experience rated, a $1 increase in benefit payments should roughly translate into a $1 increase in premium income.

In addition, we reviewed analyses conducted by the Congressional Budget Office and HCFA on the effects on premiums of government recoveries from private insurers under the Department of Defense's and Medicare's health programs. We also discussed

with Blue Cross of Massachusetts officials the effects that legislation to permit Massachusetts state veterans' homes to recover from private health insurance have had on insurance premiums.

In evaluating the equity of shifting the burden of paying for certain non-service-connected care from the taxpayers to the policyholders, we (1) reviewed recently enacted legislation, including the Veterans Administration Health Care Amendments of 1980; the Veterans' Health Care, Training, and Small Business Loan Act of 1981 (Public Law 97-72); the Omnibus Reconciliation Act of 1980; and the Omnibus Budget Reconciliation Act of 1981, which shifts the burden of paying for certain health care from the government to the private sector; (2) reviewed the Department of Justice correspondence discussing the equity of such transfers; and (3) obtained the views of our chief economist on the equity of such transfers.

ASSESSMENT OF VA'S ABILITY TO GENERATE BILLINGS ACCEPTABLE TO INSURANCE CARRIERS

To determine whether VA could generate billings that would be acceptable to insurance carriers, we (1) interviewed officials from the Health Insurance Association of America, the Blue Cross and Blue Shield Association, and the American Hospital Association about the willingness of their member companies to accept per diem billings or billings based on DRGs; (2) interviewed officials from the Massachusetts state veterans' homes at Chelsea and Holyoke and Blue Cross of Massachusetts about problems experienced with the homes' per diem billings; (3) interviewed VA officials to determine the feasibility of VA billing insurance carriers using the uniform billing form (UB-82) and DRG-billing rates, the status of VA efforts to develop DRG rates for payments to non-VA hospitals, and the feasibility of using those rates to bill for care provided in VA hospitals; (4) reviewed background data on the California Medicaid program's efforts to contract with hospitals on a per diem basis; (5) discussed with a Blue Shield of California official the insurer's plans to negotiate per diem contracts with California hospitals; and (6) obtained from and discussed with the American Hospital Association and the Blue Cross and Blue Shield Association background data on the uniform billing form.

ASSESSMENT OF LEGAL ISSUES RELATED TO VA RECOVERIES

To determine whether legislation to bar exclusionary clauses would be legal, we reviewed (1) the concerns raised

during hearings on S. 759, (2) the legislative history of the McCarran-Ferguson Act to determine whether it would preclude legislation to bar exclusionary clauses, (3) Department of Justice correspondence relating to the constitutionality of recovery legislation, (4) HCFA regulations establishing Medicare as a second payer under certain conditions to determine how they addressed the legal issues, and (5) existing laws and regulations establishing the government's right to recover from third-party payors.

ASSESSMENT OF MASSACHUSETTS STATE VETERANS' HOME RECOVERIES FROM PRIVATE HEALTH INSURANCE

To determine the success the Massachusetts state veterans' homes at Chelsea and Holyoke have had in collecting from private insurance carriers, we (1) visited the two homes and interviewed home officials about their recovery efforts, (2) reviewed contracts between the homes and Blue Cross of Massachusetts, (3) interviewed Blue Cross officials to determine whether they were experiencing any problems because of the homes' per diem billings and the effects the homes' billings have had on Blue Cross' administrative costs and premiums, and (4) obtained data on state home collections from private health insurance for fiscal years 1979-83.

ASSESSMENT OF VA'S OBJECTIONS TO INSURERS' UTILIZATION REVIEWS

To evaluate VA's objections to private health insurers' utilization reviews, we (1) obtained VA's current position on such reviews and (2) discussed with Health Insurance Association of America and Blue Shield of California officials the types and relative frequency of utilization reviews performed by insurance companies to determine the extent to which such reviews would interfere with the management of VA's internal utilization review program.

TECHNICAL DESCRIPTION OF GAO'S SURVEY AND SAMPLING METHODOLOGY

In the fall of 1983, we sent a questionnaire to a random sample of veterans who had been discharged from VA hospitals during fiscal year 1982 after treatment of non-service-connected injuries or illnesses to determine whether they had private health insurance coverage at the time of their hospitalization. To validate the veterans' responses in the nationwide sampling program, questionnaires were simultaneously sent to randomly selected veterans and their employers in Florida and Pennsylvania, and the responses were compared for consistency.

This appendix contains a technical description of our survey design, pretesting of the questionnaires, selection of the samples, calculation of the nonresponse rates and sampling errors, and validation of the questionnaire results.

QUESTIONNAIRE DESIGN

Two different questionnaires were developed and tested. One questionnaire was addressed to veterans and another to employers of the veterans contacted as part of the validation effort. While the questionnaires addressed several issues, questions to veterans were primarily designed to elicit information on whether they had private health insurance at the time they were treated in a VA hospital. The questionnaire sent to employers was designed to identify employment-related health insurance.

Veteran questionnaire

Veterans were asked whether they

--had a VA recognized service-connected disability;

--believed their VA treatment was for a service-connected disability;

--were employed before or during their hospitalization;

--had health insurance coverage under a plan provided by their employer, former employer, or a union;

--were covered under their spouses' private health insurance;

--had any other type of health insurance (such as Medicare, Medicaid, or CHAMPUS);

--knew any reasons why their insurance would not cover the non-service-connected care they received; and

--would have any objections to VA collecting from private health insurers to help defray the cost of non-service-connected medical care providing there were no cost to them.

Employer questionnaire

The employer questionnaire was designed to (1) verify that the veteran was employed during or preceding the time period in question, (2) determine whether the veteran was covered by health insurance provided by the employer or a union, (3) obtain the name of the insurance plan that covered the veteran, and (4) determine the extent of coverage provided by the veteran's insurance plan for room and board charges. The employer was also asked to provide a brochure on the plan.

Questionnaire pretesting

Before the veteran questionnaire was used, it was pretested in two phases. In the first phase, it was pretested with 15 veterans who were being admitted to the Washington, D.C., VA medical center. Of the 15 veterans, 14 were mailed questionnaires and 1 was interviewed.

In the second phase, we mailed the questionnaire to a sample of 199 veterans who were discharged from VA medical centers in California on February 22, 1982, to determine how veterans responded to the mailed questionnaire.

The employer questionnaire was pretested on 14 employers in the Washington, D.C., area who employed veterans we contacted for pretesting of the veteran questionnaire. Of the 14 employers, 10 were mailed questionnaires and 4 were interviewed. We followed the same procedures used in pretesting the veteran questionnaire.

Based on the results of the pretests, we revised the questionnaires to ensure that (1) the potential subjects could and would provide the information requested and (2) all questions were fair, relevant, easy to answer, and relatively free of design flaws that could introduce bias or errors into the study results. We also tested to insure that the task of completing

the questionnaire would not place too great a burden on the veteran or employer.

Questionnaire validation

In a limited effort, we validated the reliability of the veterans' questionnaire responses regarding private health insurance coverage against answers from the veterans' employers. Employers provide most of the private health insurance to veterans.

We carried out independent random sampling programs in Florida and Pennsylvania. The two states were selected on a judgmental basis because they had large veteran populations and they were willing to provide the necessary information on veterans' employers. The validation results cannot be formally projected to the national sampling effort, but we have no reason to believe they are not indicative of other states.

We electronically matched records on VA's patient treatment file for VA medical centers in Florida and Pennsylvania with state wage data files covering 12-month periods in 1981 and 1982. The latter records also carried employer identification, which allowed us to contact the employer. Only records satisfying the selection criteria for the nationwide sampling program were included in the universe. As shown below, this selection methodology resulted in a universe of 4,097 episodes in Florida and 3,555 episodes in Pennsylvania.

Establishing the Universe for Validation Samples

	Florida	Pennsylvania
Number of episodes on PTF for state	42,574	35,489
Number of matches against state wage data	10,328	6,397
Number of unique episodes meeting selection criteria	4,097	3,555

Random samples of about 400 episodes were selected from both the Florida and Pennsylvania universes. Our effective sample sizes were reduced to 318 in Florida and 354 in Pennsylvania because VA hospitals were unable to provide addresses for the remaining veterans. Questionnaires were mailed to both the veterans and their employers. Of the veteran questionnaires mailed, 232 were delivered in Florida and 286 were delivered in Pennsylvania. The remaining questionnaires were returned by the Postal Service as undeliverable.

APPENDIX II

Responses were received from 149 veterans (64 percent) in Florida and 220 veterans (77 percent) in Pennsylvania after three mailings. Employers for 54 of the 149 veterans in Florida and 72 of the 220 veterans in Pennsylvania provided usable responses to our questionnaire. This relatively low response rate was judged acceptable only because the results were to be used for validation and not for projections.

The results of the validation effort confirmed that the veterans' answers on the questionnaires were generally accurate and conservative. For example, for the 54 veteran-employer matches in Florida, consistent answers were obtained 81 percent of the time. When the veteran's answers disagreed with the employer's, the veteran generally stated he or she had no insurance, while the employer stated that the veteran had coverage. Similarly, for 72 veteran-employer matches in Pennsylvania, consistent answers were obtained 82 percent of the time, and again when disagreements occurred the veteran tended to understate the insurance coverage. This is demonstrated in the table below.

Comparison of Veteran and Employer Responses to Validation Questionnaires

	Number of matched responses	
	Florida	Pennsylvania
Consistent responses:		
Employer and veteran agree that coverage existed	33	37
Employer and veteran agree that coverage did not exist	11	22
	44 (81 percent)	59 (82 percent)
Inconsistent responses:		
Veteran indicated no coverage, but employer stated coverage existed	8	10
Veteran stated coverage existed, but employer indicated it did not	2	3
	10 (19 percent)	13 (18 percent)
Total matched responses	54	72

SELECTING THE NATIONWIDE SAMPLE

The universe for our nationwide sample was established using the PTF of patients discharged during fiscal year 1982. We defined the universe to be included in our review as VA treatment episodes that met all of the following criteria:

--The patient was discharged during fiscal year 1982.

--The treatment took place in a VA hospital.

--the treatment was for a non-service-connected, non-psychiatric illness.

--The patient had no service-connected disability or a service-connected disability rated at less than 50 percent.

--The patient was not admitted and discharged on the same day.

--The patient was living at the time of discharge.

A total of 685,410 VA hospital treatment episodes met the above criteria. These episodes corresponded to 448,729 veterans as identified by their social security numbers indicating that many veterans were treated for multiple episodes during fiscal year 1982. A summary of selected and nonselected episodes is shown in the table below.

Selection of the Initial Universe From VA's Fiscal Year 1982 Patient Treatment File

Category		Number of episodes
Episodes included in the initial universe		685,410
Episodes not included in universe:[a]		
Service-connected episodes	121,253	
Psychiatric episodes	130,194	
Deceased	42,456	
Released the same day	38,492	332,395
Total fiscal year 82 episodes on PTF		1,017,805

[a]Episodes were only counted once. For example, a service-connected, psychiatric episode was counted in the "service-connected" category--the primary selector.

Sample selection

A simple random sample of 2,693 episodes was selected from the universe defined above to obtain an overall sampling error of plus or minus 5 percent at the 95-percent confidence level. The sample was selected by electronically matching the last three digits of the veterans' social security numbers (random digits) to six randomly selected three-digit numbers between 000 and 999. In instances when a veteran's number was associated with more than one treatment episode during fiscal year 1982, the episode selected for review was chosen on the basis of a second automated random selection process.

Veterans' addresses were obtained from admissions forms provided by VA medical centers. Addresses were not available for 110 veterans. Further adjustments were made in our sample size because (1) veterans could not be located; (2) veterans had died after being discharged from the hospital; (3) veterans did not, after further investigation, meet all selection criteria; or (4) of other miscellaneous reasons. As shown by the table on page 72, these adjustments reduced our effective sample size to 1,803 veterans.

The nationwide questionnaires were administered by mail. Follow-up letters (including questionnaires) were sent to veterans who failed to respond to the initial mailing. A second follow-up letter (including questionnaire) was sent to those who

still had not responded. Some veterans were contacted by telephone to obtain clarification of individual questionnaire responses.

Adjustments were made to (1) allow for the 17-percent nonresponse rate and (2) remove about 9 percent of the respondents from the sample because they had service-connected disabilities rated at 50 percent or higher. The deletions were based on veterans' questionnaire responses and verifying data in VA's automated compensation and pension file.

Computation of the Effective Sample Size

Category	Number of cases		Percent
Episodes in the initial random sample		2,693	100.00
Less episodes/veterans:			
Not treated in VA hospital		98	3.64
For whom the address is unknown:			
No address available - VA hospital	110		
Returned as undeliverable by Postal Service	277	387	14.37
For whom we were notified that they were deceased:			
By hospital	47		
By Postal Service	201	248	9.21
Miscellaneous discrepancies:			
Date on PTF and admission document disagree	122		
Transmission error	2		
Error in raw data	7		
Other	26	157	5.83
Subtotal of sample deletions		890	33.05
Effective sample size/effective number of questionnaires mailed		1,803	66.95

Disposition of Questionnaires Mailed

Category	Number of cases	Percent
Questionnaires answered	1,497	83
Questionnaires not answered	306	17
Total	1,803	100

Calculation of Final Adjusted Sample Size

Category	Number of cases	Percent
Questionnaires answered	1,497	100
Less adjustment for veterans with 50 percent or higher disabilities per questionnaires answered	141	9
Final adjusted sample size	1,356	91

PROJECTING QUESTIONNAIRE RESULTS AND CALCULATING SAMPLING ERRORS

To develop an estimate of VA medical care cost potentially subject to reimbursement by private health insurance, we (1) calculated the effective universe size, (2) projected the average length of stay and per episode cost of care provided to privately insured veterans, and (3) projected the number and cost of episodes in the universe provided to veterans having health insurance.

Projections were developed based on the assumption that, in accordance with statistical theory, the sample averages and percentages represent unbiased estimators of the corresponding population averages and percentages. Corresponding sampling errors were computed in accordance with standard statistical theories.

Calculating the effective universe size

The following table shows the effective universe size used in the statistical projections.

Calculation of Effective Universe

Category	Percent	Number of episodes
Initial number of episodes in universe	100.00	685,410
Adjustments for veterans who		
--were not treated in a VA hospital or had 50 percent or higher service connected disabilities	(8.88)	(60,864)
--died after discharge	(9.21)	(63,126)
--could not be located	(14.37)	(98,493)
--did not respond to questionnaire (11.36 percent of initial universe, 16.97 percent of questionnaires mailed)	(11.36)	(77,863)
--were deleted for miscellaneous other reasons	(5.83)	(39,959)
Subtotal	(49.65)	(340,305)
Effective universe size for projections	50.35	345,105

The effective universe used tends to be conservative for statistical projection purposes because it underestimates potential VA cost recoveries. Nearly 35 percent of the initial universe, or about 240,000 episodes, could not be reviewed because the veterans associated with these episodes either could not be located, had died, or were otherwise unresponsive.

APPENDIX II

Projecting average length of stay and per episode cost of care

The average length of stay per actual VA treatment episode was computed by averaging individual stays over 249 episodes in the nationwide sample covered by private health insurance. The average per episode cost of care was computed by multiplying individual lengths of stay for 249 sample episodes by VA's per diem rate applicable at the time of admission ($245 per day from 10/1/81 through 1/3/82, $285 per day from 1/4/82 through 9/30/82), summing the results, and dividing by 249 cases.

To determine the average length of stay of comparable patients in community hospitals, we used data from VA's patient treatment file and the Professional Activities Survey, which was prepared by the Commission on Professional and Hospital Activities. For each of the 249 episodes of care provided to privately insured veterans, we determined the average community length of stay of comparable patients matched by age, primary diagnosis, the presence of a secondary diagnosis, and the presence of surgery. The average length of stay and per-episode cost were calculated as above. The calculation of the per-episode cost of care based on community lengths of stay is not intended to reflect medical treatment costs in community hospitals, but to present a conservative estimate of potential VA recoveries.

The projections and sampling errors are shown in the table below.

Average Length of Stay and Costs Subject to Reimbursement for Episodes Provided to Privately Insured Veterans

	Projection value	Sampling errors (+/-) Units	Sampling errors (+/-) Percent
Average VA length of stay	13.80 days	2.50 days	18.10
Average length of stay in community hospitals for comparable patients	8.10 days	0.57 days	7.03
Average cost of stay based on average VA length of stay	$3,731.83	$635.58	17.03
Average cost of stay based on average community length of stay	$2,232.86	$154.96	6.94

Projecting the number of insured veterans and the costs potentially subject to reimbursement

To estimate the number of episodes nationwide provided to privately insured veterans, we multiplied the percentage of veterans covered by insurance in the nationwide sample (18.3628 percent) by the number of episodes in the effective universe (345,105). The upper limit of the treatment costs potentially subject to reimbursement was estimated by multiplying the average cost per episode covered by insurance for the total nationwide sample ($3,731.83) by the number of episodes in the projected universe covered by insurance (63,371). The lower limit was obtained by multiplying the same number of episodes by the average cost per episode based on average community lengths of stay ($2,232.86).

The above and other statistical projections are listed in the table below together with the associated sampling errors. The sampling errors are stated in two ways, first in terms of the units projected, such as dollars or episodes, and second in terms of percentages of the projected total.

Projections of VA Episodes Provided to Insured Veterans and Treatment Costs Potentially Subject to Reimbursement

(Based on the effective universe of 345,105 episodes of care)

	Projection value	Sampling errors	
		Units	Percent
		(+/-)	
Percent of episodes provided to veterans with private health insurance	18.36	2.06	11.22
Number of episodes provided to veterans with private health insurance	63,371	7,471	11.80
FY 82 VA treatment costs subject to reimbursement based on actual VA lengths of stay	$236 million	$48 million	20.30
FY 82 VA treatment costs subject to reimbursement based on average community lengths of stay	$141 million	$19 million	13.69
Percentage of episodes provided to veterans on Medicare	33.78	2.51	7.43
Number of episodes provided to veterans on Medicare	116,438	9,733	8.36
Percentage of episodes provided to veterans on Medicaid	4.57	1.11	24.28
Number of episodes provided to veterans on Medicaid	15,762	3,871	24.56
Percentage of episodes provided to employed veterans	17.92	2.04	11.38
Number of episodes provided to employed veterans	61,778	7,396	11.97

APPENDIX III

U.S. GENERAL ACCOUNTING OFFICE

SURVEY OF VETERANS' HEALTH INSURANCE COVERAGE

Veterans Administration (VA) records show that you received nonservice-connected medical care at the above mentioned facility during the period shown. Please answer all of the questions in this questionnaire even if you believe that your treatment was related to a service-connected condition.

1. Has the VA determined that you have a service-connected disability? *(Check one.)* (6-8)

   1. ☐ Yes—percent of disability determined by VA was _____%

   2. ☐ No

2. Do you feel that the treatment you received during the period mentioned on the label above was service-connected? *(Check one.)* (9)

   1. ☐ Yes—service-connected

   2. ☐ No—not service-connected

3. Were you employed immediately prior to or during the period shown on the label? *(Check one.)* (10)

   1. ☐ Yes—Employer's name and address

   _____ (Name)

   _____ (Address)

   _____ (City, State and ZIP)

   2. ☐ No—not employed

4. During the period you were hospitalized did you have health insurance coverage under a plan provided by your employer at that time or coverage carried over from a former employer? *(Check one.)* (11)

   1. ☐ Yes—employer at time of hospitalization

   2. ☐ Yes—former employer

   For either give the following.

   Name of plan: _____

   _____

   Plan or group number (if known):

   _____

   3. ☐ No—No coverage through employer

5. During the period you were hospitalized, did you have health insurance coverage under a plan provided by a union? *(Check one.)* (12)

   1. ☐ Yes—Name of union: _____

   _____

   Local number: _____

   _____

   Name of plan: _____

   _____

   Plan or group number (if known):

   _____

   2. ☐ No—No coverage by a union

APPENDIX III

6. During the period you were hospitalized, did your spouse have employment-related health insurance coverage under which you were also covered? *(Check one.)* (13)

   1. ☐ Yes—Name of spouse's employer:

      _____

      _____

      Plan or group number (if known):

      _____

   2. ☐ No—No coverage, separated or not married.

7. During the period you were hospitalized were you covered by any of the following? *(Check all that apply.)* (14-21)

   1. ☐ Medicare
   2. ☐ Insurance to supplement Medicare
   3. ☐ Medicaid
   4. ☐ Champus/Champva
   5. ☐ Health insurance as part of your retirement plan
   6. ☐ Insurance coverage which paid you cash while hospitalized
   7. ☐ Other health plan(s) not mentioned (specify)

      _____

      _____

   8. ☐ No—None of the above

If you checked any of the above, please list plan(s) and group number(s), if known.

Plan	*Group Number*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If you answered "NO" to Questions 4, 5, 6, and 7 (all four), on pages 1 and 2, GO TO QUESTION 10 on page 3.

If you answered "YES" to at least one of them GO TO QUESTION 8 on page 3.

8. If you checked a "YES" box for Questions 4, 5, 6, or 7, do you know of any reasons why each plan you had would not cover the nonservice-connected medical care you received at the VA hospital? *(Check one.)* (22-25)

   1. ☐ Yes—Please indicate which plan(s) and the reason(s) why the health insurance plan would not cover the care.

Plan	*Reason*
_____	_____
_____	_____
_____	_____

   (Attach additional sheet if necessary)

   2. ☐ No

9. If there were no cost to you, would you have any objections if the VA could *collect* some payment from your health insurance company to help defray the cost of nonservice-connected medical care that your health insurance may cover? *(Check one.)* (26-29)

   1. ☐ Yes—I would object because: _____

   _____

   _____

   _____

   (Attach additional sheet if necessary)

   2. ☐ No objection

10. In case we have a question on the information provided, please give a telephone number and time of day when we could call you. This can be a work or home number where we could contact you during the day or evening.

	(Home)	(Work)
Telephone number:	( ) _____ (Area Code)	( ) _____ (Area Code)
Time of day:	_____	_____

(OVER)

11. If you have any additional comments related to this questionnaire or would like to provide us with any other information related to your health insurance coverage, please use the space below.

Please return this questionnaire in the enclosed reply envelope.

APPENDIX IV

U.S. GENERAL ACCOUNTING OFFICE

SURVEY OF VETERANS' HEALTH INSURANCE COVERAGE

1. Was the person named on the label above employed by your company immediately prior to or during the period shown above? *(Check one)* (6)

   1. ☐ Yes—GO TO QUESTION 2
   2. ☐ No—Please return the questionnaire in the enclosed envelope. There is no need to continue.

2. Does your company offer health insurance coverage (including coverage in conjunction with a labor union) to employees? *(Check one)* (7)

   1. ☐ Yes, health insurance coverage is offered to all employees.
   2. ☐ Yes, however, health insurance coverage is offered to some but not all employees.
   3. ☐ No

3. Does the employee belong to a labor union that provides health insurance coverage to its members? *(Check one)* (8)

   1. ☐ Yes:
      Name of Union: _____
      Local #: _____
   2. ☐ No
   3. ☐ Don't know

If your company does not offer a health insurance program for your employees, no further questions apply. Please return the questionnaire in the enclosed envelope.

4. Was the employee named above covered under one of your employees' health insurance plans during the period indicated above? *(Check one)* (9)

   1. ☐ Yes
   2. ☐ No

5. What is the name of the insurance company which issued the plan covering this employee and the plan or group identification number?

   Insurance company: _____

   Plan or group number: _____

If your company has printed information describing this health insurance plan which you provide to employees, please send us a copy.

THE REMAINING QUESTIONS RELATE TO THE PLAN MENTIONED IN QUESTION 5. EACH SHOULD BE ANSWERED AS IT RELATES TO THE PLAN'S PROVISIONS FOR HOSPITAL ROOM AND BOARD CHARGES IN A SEMI-PRIVATE ROOM.

6. Consider the provisions of the insurance plan for hospital room and board charges in a semi-private room. During the period of time mentioned in the label what were each of the following provisions under this plan?

   1. The annual deductible amount payable by the insured employee. $_____ (10-13)
      (If none, enter "0")

   2. The coinsurance percent payable by the insurance company. _____% (14-16)

      If the rate changes after some total of charges, please indicate—e.g., "100% up to $1,500, 80% thereafter."

      _____

      _____

7. After the deductible and the insured's share of coinsurance have been satisfied, is there a limit to the daily charge payable by the insurance plan for hospital room and board in a semi-private room? *(Check one)*

   1. ☐ No limit, if charge is reasonable. (17)

   2. ☐ Yes—What is the daily limit? $_____(18-21)

8. What is the maximum number of days that the plan will pay something towards the hospital room and board in a semi-private room? *(Check one)* (22)

   1. ☐ No limit

   2. ☐ 30 days or less

   3. ☐ 31-60 days

   4. ☐ 61-90 days

   5. ☐ 91-180 days

   6. ☐ More than 180 days

9. Please provide the name, title, and telephone number of the person in your company we can contact if we have any further questions related to your responses:

   Name: _____

   Title: _____

   Telephone number: (___) _____
   Area code

10. If you have any further comments related to our questions or you believe other provisions of the plan should be highlighted for our consideration, please do so in the remaining space.

MASSACHUSETTS STATE VETERANS' HOME

RECOVERIES FROM PRIVATE HEALTH INSURANCE

This appendix discusses actions taken by the Commonwealth of Massachusetts to enable its state-operated veterans' hospitals to recover costs of medical services provided to insured veterans. Because of the similarities between VA and state home hospitals, this appendix provides further insight into such issues as potential recoveries, administrative costs, effects on premiums, and billing procedures.

BACKGROUND

State homes are state-operated hospitals, nursing homes, and domiciliaries providing care primarily to disabled veterans incapable of earning a living. As of April 1984, there were 46 homes in 33 states.

VA helps the states defray the costs of operating and constructing state home facilities through a program of per diem payments and construction grants. Although VA administers the per diem and construction grant programs and conducts annual inspections of state home facilities, VA has no direct management control over state home operations.

Each state establishes the eligibility requirements for admission to its home(s). VA has no direct control over admissions, and the homes may admit both veterans and nonveterans. However, VA pays per diem to a state only for care provided to veterans who meet the eligibility requirements for admission to a VA health care facility. Generally, a veteran is eligible for care if he or she has (1) a service-connected disability or (2) a non-service-connected disability and is unable to defray the expenses of necessary hospital, nursing home, or domiciliary care (38 U.S.C. 610(a) and (b)).

Massachusetts state homes

Massachusetts operates two state homes, the Massachusetts Soldiers Home in Chelsea and the Massachusetts Soldiers Home in Holyoke. The homes provide hospital, nursing home, and domiciliary care to veterans with non-service-connected disabilities. Under Massachusetts law, veterans cannot be admitted for treatment of

--any condition if they have a service-connected disability rated at 100 percent,

--a service-connected disability,

--an injury or illness resulting from an industrial accident, or

--an injury resulting from an automobile accident involving insurance and liability of a third party.

In fiscal year 1983, the Chelsea home operated 82 hospital, 84 nursing home, and 305 domiciliary beds. In addition, the home provided care to about 48,000 outpatients. The Holyoke home operated 27 hospital, 259 nursing home, and 50 domiciliary beds, and it provided care to about 15,000 outpatients. According to home officials, the fiscal year 1983 operating costs of the Chelsea and Holyoke homes were approximately $12.9 million and $7.4 million, respectively.

Like VA, the homes provide care to an aging population of veterans, many of whom exhausted their resources before turning to the state homes. Although authorized by state law (1970 Massachusetts Acts, ch. 523) to charge residents (from income from all sources in excess of $40 per month) for their care, neither home charges veterans.

According to state officials, all of the homes' patients meet VA eligibility requirements, and the state receives VA per diem payments to help defray the costs of their care.

MASSACHUSETTS LEGISLATION BARS EXCLUSIONARY CLAUSES

In April 1960, Massachusetts enacted legislation (Mass. Ann. Laws, ch. 175, sec. 22 (1984)) which invalidated any provisions in an insurance contract which excluded liability on the part of an insurance company for care provided in the state homes at Chelsea and Holyoke. Specifically, the act provided that:

> "No policy of insurance issued by a company . . . shall contain a provision excluding liability on the part of the insurance company or health and welfare fund for hospital, medical or surgical expenses if the insured is hospitalized or receives medical or surgical treatment in a soldiers' home established by the commonwealth. Any such provision shall be void."

The act has been amended twice, in 1975 and 1978. The 1975 amendment added the following clarifying statement.

> "Expenses as used in this paragraph shall mean the charges of such soldiers' homes for the services rendered and such charges shall be deemed to have been legally incurred by persons insured under such policies not withstanding that such person is entitled to benefits under chapter one hundred fifteen A or that no bill is, or would otherwise be, rendered by such soldiers' homes with respect to such persons. The foregoing provisions shall apply to any group or non-group policy of insurance delivered, issued or renewed, by any domestic insurer under the authority of this chapter, or by any alien or foreign insurer to the extent such policies cover persons having a residence within the commonwealth."

According to the chief accountant at the Chelsea home, the 1975 clarifying amendment was added because of a claim by one insurance carrier that it should not have to pay for care at the state homes because patients have no personal obligation to pay for their medical care.

MASSACHUSETTS HOMES COLLECT FROM PRIVATE HEALTH INSURANCE

As shown by the table below, the two state homes collected about $5.7 million from private health insurance during fiscal years 1979-83.

State home	Recoveries from private health insurance					
	FY 79	FY 80	FY 81	FY 82	FY 83	Total
Chelsea	$ 724,373	$493,101	$661,364	$1,234,300	$1,202,045	$4,315,183
Holyoke	327,560	313,414	272,204	219,006	255,086	1,387,270
Total	$1,051,933	$806,515	$933,568	$1,453,306	$1,457,131	$5,702,453

The $1.5 million recovered in fiscal year 1983 represented about 7 percent of the homes' operating costs, although most of the recoveries were for services provided in the homes' 109 hospital beds.

In the narrative for its fiscal year 1983 budget submission, the commandant of the Chelsea home noted that:

". . . There is a substantial change in that the majority of our patients in the acute care section of the hospital are now paying a substantial portion of their expenses through third party reimbursements while a minority in the chronic care hospital [nursing home] are doing the same . . . These people are mindful of these changes. They are no longer to be considered recipients of the 'charity' of a generous government. They recognize that, they themselves, are paying for the services that they receive and, therefore, are becoming more sophisticated in what they expect."

STATE RELIES ON ADMISSION FORMS TO IDENTIFY VETERANS' INSURANCE

Like VA, the Chelsea and Holyoke homes' admission forms contain questions about veterans' employment and insurance coverage. According to home officials, the homes rely entirely on the admission forms to identify employment and insurance. Veterans who have health insurance are asked to sign a form assigning their benefits to the state home and authorizing direct payment of benefits to the home.

PER DIEM BILLINGS HAVE NOT CREATED MAJOR PROBLEMS

Like VA, both homes bill primarily on an all-inclusive per diem basis. However, unlike VA, the per diem rates do not include services provided by physicians (other than staff physicians), surgeons, and anesthesiologists who bill insurers directly. In 1982, the medical/surgical per diem charges were about $361 ($269 for room and board and $92 for ancillary services) for care provided by the Chelsea home, and about $223 ($141 for room and board and $82 for ancillary services) for care provided by the Holyoke home. The rates are established by a state rate setting commission based on the homes' cost data. By comparison, VA's fiscal year 1982 medical/surgical per diem rate was $285, including physicians', surgeons', and anesthesiologists' services.

According to the Holyoke home's chief accountant, the home uses the per diem rates in billing all insurance carriers. He said that although the carriers prefer itemized bills, the home has had no significant problem collecting from the carriers based on the per diem charges. He said that the only problem they have experienced is in collecting from out-of-state carriers. According to the chief accountant, a few out-of-state carriers ignore

billings and follow-up letters. He said that the home writes them off as uncollectible without further effort.

The Chelsea home's director of Business Services said that the home uses the per diem rate in billing Blue Cross (over 75 percent of the billings), but prepares itemized bills for other insurance carriers using a general hospital insurance form. He said that the itemized bill requires more clerical time to prepare than do the Blue Cross billings in which per diem rates are used.

Like Holyoke, the Chelsea home has experienced difficulty only in collecting for a small number of billings submitted to out-of-state carriers. The home's director of Business Services said that it periodically writes such billings off as uncollectible.

Blue Cross billing and review procedures

In fiscal year 1981, Blue Cross of Massachusetts, Inc., paid for about 78 percent of the care reimbursed by private insurers at the Chelsea and Holyoke homes. According to home officials, through a contractual agreement with the homes, the homes submit a batchbilling to Blue Cross once a month. A separate Blue Cross billing form is submitted for each case, and a transmittal form is prepared listing the cases and the amount claimed for each case.

At the same time the homes mail the monthly billing to Blue Cross, they prepare a bank draft against a Blue Cross account for the total amount of the billings. Blue Cross makes a post-payment audit of the monthly billings, and any needed adjustments are made based on the audit findings.

Under terms of the contract, the homes must provide Blue Cross detailed cost data on hospital operations and submit to a utilization review by Blue Cross.

According to a Blue Cross official, the billings from the state homes have created no significant problems, although they are the only billings Blue Cross accepts which are based on an all-inclusive per diem rate. He said that the billings from the state homes account for only about $700,000 out of $1 billion in annual billings processed by Blue Cross, and as such are not very noticeable.

The Blue Cross official said that Blue Cross prefers to receive itemized billings because its audits and analysis of the billings are computerized. He explained that the audits include a review of the reasonableness of the charges and services relative to the conditions being treated and the age and sex of the patient. According to the official, the per diem billings may be very reasonable, but they do not fit into Blue Cross' automated audit and cost control system.

ADMINISTRATIVE COSTS ARE NOT EXCESSIVE

Neither the homes nor the insurance carriers were experiencing excessive administrative costs associated with the recovery efforts.

The Chelsea home's director of Business Services said that the preparation and processing of the insurance billings costs about $80,600 a year, or about 13 percent of the average annual collections ($626,279) for fiscal years 1979 through 1981. He said that the insurance billings require about 4.9 staff years, including 10 percent of his time. He estimated the salary cost to be about $70,600 (including 24 percent for fringe benefits). According to the director, another $10,000 should be added to administrative costs to cover the indirect cost of space and utilities. He said that there are no other costs for the billing effort since all of the home's bookkeeping is performed manually and no legal assistance has been used for billings or collections.

The Holyoke home's chief accountant estimated the cost of preparing and processing insurance billings to be $36,400, or about 12 percent of the average annual collections ($304,000) for fiscal years 1979-81. He said that the billings require about 1.2 staff years, including about 30 percent of his time. He estimated the salary cost to be about $36,400 including fringe benefits.

According to a Blue Cross official, the insurer's costs to process the state home's per diem rate billings are slightly higher than its costs to process other hospitals' bills. He said that the higher costs occur because clerks must transfer certain data from the old Blue Cross form used by the homes for their per diem billings to another form used for data entry into the computer. According to the Blue Cross official, the extra cost is not readily measurable because so few state home billings are processed and the clerks fit the work into their normal work schedule.

NO NOTICEABLE EFFECT ON PREMIUMS

Although about 78 percent of the homes' fiscal year 1981 recoveries were from Blue Cross of Massachusetts, a Blue Cross official told us that the amount of state home billings was too small to have a noticeable effect on premiums. He said that the billings from the state homes accounted for only about $700,000 (.07 percent) of $1 billion in annual billings processed by Blue Cross. He noted, however, that all Blue Cross costs are considered in setting premium rates and that the state home billings would therefore have some minute effect on premiums.

96TH CONGRESS
1ST SESSION

S. 759

To amend title 38 of the United States Code to provide for the right of the United States to recover the costs of hospital, nursing home, or outpatient medical care furnished by the Veterans' Administration to veterans for non-service-connected disabilities to the extent that they have health insurance or similar contracts or rights with respect to such care, or have entitlement to private medical care under workers' compensation or automobile accident reparation statutes of any State, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 26 (legislative day, FEBRUARY 22), 1979

Mr. CRANSTON (by request) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38 of the United States Code to provide for the right of the United States to recover the costs of hospital, nursing home, or outpatient medical care furnished by the Veterans' Administration to veterans for non-service-connected disabilities to the extent that they have health insurance or similar contracts or rights with respect to such care, or have entitlement to private medical care under workers' compensation or automobile accident reparation statutes of any State, and for other purposes.

II—E

APPENDIX VI

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 610 of title 38, United States Code, is amended by adding at the end thereof new subsection (e) as follows:

"(e)(1) Where a veteran is furnished hospital or nursing home care for a non-service-connected disability pursuant to subsection (a) of this section or outpatient medical care for a non-service-connected disability pursuant to subsections (b)(5), (f), (g), and (h) of section 612 of this chapter—

"(A) and such veteran is entitled to care, or reimbursement for the expenses of care under an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement for the purpose of providing, paying for, or reimbursing expenses for health services; or

"(B) the veteran's illness or injury is so related to his or her employment as to provide entitlement for payment of hospital, nursing home and medical care by the employer, insurance carrier, or other sources under workers' compensation, or employers' liability, or where entitlement to health care is provided under automobile accident reparation acts, or similar laws of any State,

the United States shall have the right to recover the reasonable value of the care and treatment so furnished or to be

furnished to the extent of coverage and/or entitlement described in clauses (A) and (B) of this paragraph and shall, as to this right, be subrogated to any right or claim that the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors has under such coverage and/or entitlements to the extent of the reasonable value of the care and treatment so furnished or to be furnished.

"(2) No contract, arrangement, or entitlement described in the above clauses (A) and (B) entered into, renewed, or accrued after the effective date of this subsection and no State law shall after such effective date exclude the right of the United States to recover the charges or reasonable value for hospital, nursing home, and outpatient care furnished for non-service-connected disabilities pursuant to subsection (a) of this section, and subsections 611(b) and 612(b)(5), (f), (g), and (h) of this title, if such care or charges would be covered under such contract, arrangement, or entitlement when furnished by private facilities.

"(3) The renewal of a contract or arrangement within the meaning of this subsection includes the exercise of an insurer's rights to modify the premiums or coverage of such contract or arrangement and the first opportunity to exercise that right after the effective date of this subsection.".

SEC. 2. This Act shall take effect on the first day of the first month which begins ninety days after the date of its

approval: *Provided, however,* That this Act shall not prejudice any existing rights of the United States under the contracts, arrangements, and entitlements described in clauses (A) and (B) of section 1 of this Act.

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U.S. Department of Justice

Washington, D.C. 20530

January 28, 1985

Mr. William J. Anderson
Director
General Government Division
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Anderson:

This letter responds to your request to the Attorney General for the comments of the Department of Justice (Department) on your draft report entitled "Legislation to Authorize VA Recoveries from Private Health Insurance Could Save Millions."

We have reviewed the General Accounting Office's (GAO) draft report and have only a few minor comments to offer. Generally, we find no constitutional difficulties with the GAO recommendation that Congress enact legislation to enable the Veterans Administration (VA) to recover the costs of care provided to privately insured veterans for nonservice-connected medical conditions. As the draft report indicates, the Department has opined previously, with respect to analogous legislative proposals, that Congress constitutionally may legislate to prohibit exclusionary clauses in private health insurance policies, and that the elimination of such clauses concerning the coverage of costs of treatment for veterans would neither violate due process nor abrogate existing federal obligations. (See letter to Honorable Alan Cranston, Chairman, Senate Committee on Veterans' Affairs, from Patricia M. Wald, Assistant Attorney General, Office of Legislative Affairs (April 10, 1979); and letter to Paul H. O'Neill, Associate Director for Human and Community Affairs, Office of Management and Budget, from Robert G. Dixon, Jr., Assistant Attorney General, Office of Legal Counsel (June 11, 1973)). The letters cited above are referenced on pages 48 and 55 of the draft report.

The three comments noted below are provided to improve the clarity or accuracy of statements made in the report:

1. In the third paragraph on page 48, we suggest amending the sentence beginning "Because the use . . ." to read as follows: "Because the use of exclusionary clauses in health insurance contracts relates to health care provided in VA facilities in any state and involves insurance companies doing business across state lines, we believe it affects interstate commerce and is therefore subject to federal regulation."

2. On page 50, line 1, replace the reference to "page 4" to read "page 5."

3. On page 56, delete the second line beginning with the word "retroactive" and ending with the word "due." The deleted words already appear in proper context as the last line on page 55.

We appreciate the opportunity to respond to your report while in draft form. Should you have any questions, please feel free to contact me.

Sincerely,

Anthony C. Liotta
Assistant Attorney General
for Administration

GAO note: Page references may not agree with page numbers in this final report.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

FEB 12 1985

Mr. Richard L. Fogel
Director, Human Resources Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

Your December 12, 1984 draft report "Legislation to Authorize VA Recoveries from Private Health Insurance Could Save Millions" has been reviewed. The General Accounting Office (GAO) recommends that

> -the Congress should enact legislation similar to S.759 to enable the Veterans Administration (VA) to recover the costs of nonservice-connected care provided to privately insured veterans.

While the VA is cognizant of the objections raised when similar legislation was proposed earlier, and fully expects considerable litigation should such legislation be enacted, I am cautiously optimistic that it would enhance VA recoveries. I would note that the President's budget for Fiscal Year 1986 provides for legislation which is consistent with GAO's recommendation. Although the VA supports the recommendation, I have reservations concerning the administrative costs developed by GAO to implement a billing program of this magnitude because the total costs cited in the report appear to be seriously underestimated.

Earlier this year the VA commented on a draft bill amending 38 U.S.C. 629 such as GAO recommends. In May 1984, extensive cost estimates were developed for this draft bill. I believe these estimates of administrative costs to run the program are more accurate than those developed in the GAO report.

The report states that the "costs to prepare and process billings should be about $27 for each claim processed, or less than 2 percent of recoveries projected in this report." We question GAO's use of the Department of Veterans Benefits' disposition cost from closed Centralized Accounts Receivable System cases as an appropriate cost per claim processed for the Department of Medicine and Surgery. The report also assumes 100 percent recoveries on all cases covered by health insurance. This is unrealistic since the majority of health insurance policies have deductible and/or coinsurance clauses.

Finally, GAO's estimate of $1.7 million in administrative costs is based solely on inpatient medical/surgical care and assumes that only 18 percent of nonservice-connected veterans have health insurance. The 1979 National Survey of Veterans shows that 38.2 percent of nonservice-connected veterans using VA facilities had health insurance and that 53 percent of all policies covered outpatient care. This means that by considering only episodes of inpatient care, GAO has underestimated the total workload, inpatient care plus outpatient visits, that would be involved in implementing this program.

APPENDIX VIII

Mr. Richard L. Fogel

Start-up costs would be incurred for the additional personnel, automated data processing equipment, and software needed to initiate the cost recovery program. There would also be continuing personnel and software maintenance costs to keep the program in operation. A copy of the estimates prepared by the VA on a similar recovery program are enclosed for your information.

Enclosure I contains suggested corrections or additions to your draft report which I believe would more fully and accurately present VA's position. Thank you for the opportunity to review this report.

Sincerely,

Harry N. Walters

HARRY N. WALTERS
Administrator

Enclosures

VETERANS ADMINISTRATION SUGGESTED CORRECTIONS OR ADDITIONS TO THE DECEMBER 12, 1984 DRAFT REPORT, "LEGISLATION TO AUTHORIZE VA RECOVERIES FROM PRIVATE HEALTH INSURANCE COULD SAVE MILLIONS"

Page 1, under the heading "Who Can Get Care at a VA Hospital?": These paragraphs are misleading in their overview of eligibility. For example, a veteran who is less than 50 percent service-connected and needs treatment for a condition not related to his/her service-connected disability must require treatment that would obviate the need for hospital care. If the condition needing treatment does not meet these medical criteria, the veteran is not eligible for care even though he/she is service-connected.

Page 4, line 8: Delete "uninsured motorist" and substitute "no-fault insurance."

Page 5, line 11: Should read "November 1983 - September 1984." New rates have been published by the Office of Management and Budget and were effective October 1, 1984. (See Volume 49 of the November 15, 1984 Federal Register, page 45280.) The breakdown of rates into separate components for room and board, physicians' services, and ancillary services has not yet been published.

Page 9, first paragraph: Our legislative program files do not reflect that the VA proposed recovery legislation in 1981. In May 1981, the VA did testify on two bills, S.1058 and S.636, but they were not proposed by this Agency. No final action was taken with respect to S.1058; however, S.636 was enacted as section 106 of Public Law 97-72, clarifying the VA's authority to collect for the cost of nonservice-connected care in the workers' compensation, no-fault insurance, and crime-victim situations. Therefore, it is suggested that the first sentence be amended to read, "The Congress has not given serious consideration to enactment of recovery legislation since 1981." The second sentence should be deleted.

Pages 29, 30, and 31: On page 29, the assumption is made that the "VA already identifies veterans' private health insurance coverage." Page 30 contains the statement "Accordingly, additional administrative costs would not be incurred to identify potential billings." Department of Medicine and Surgery (DM&S) Circular 10-82-245 is cited on page 31 as the policy requiring VA medical centers to gather such information. This circular was rescinded by a February 28, 1984 DM&S Circular 10-84-33 which specifically prohibits VA medical center personnel from asking veterans with service-connected disabilities and former prisoners of war for information on health insurance coverage.

GAO has assumed that the provisions of Public Law 96-330 will be implemented and that all administrative costs associated with gathering information from veterans applying for care on health insurance coverage would be absorbed by that program. It is an erroneous assumption for two reasons: (1) determination of ability to pay, implementing Public Law 96-330, has not been accomplished, and (2) even if Public Law 96-330 were implemented, it would apply only to certain nonservice-connected veterans under age 65. New administrative costs would still be incurred in collecting health insurance information from service-connected veterans, nonservice-connected veterans over age 65, those in receipt of VA pension, former prisoners of war, those needing care for a condition possibly

related to exposure to Agent Orange or to ionizing radiation, and those in receipt of Medicaid, all of whom are exempt from having to complete any sort of ability-to pay statement.

Page 37: The statement that "VA officials have begun working on solutions to the procedures problems" (to include medical care debt collection in the Centralized Accounts Receivable System (CARS)) is not true. Inclusion of the medical care cost recovery program in CARS or in any automated system would require additional ADP equipment and personnel to program and maintain it.

Page 49: paragraph 1 under the heading "VA Can Seek Reimbursement of Costs Veterans Are Not Obligated to Pay": Add the following sentence at the end of the paragraph: "This rationale was recently adopted by the U.S. Court of Appeals for the Ninth Circuit in United States v. Metropolitan Life Insurance Co."

Page 67: VA does not agree with the suggestion to use the system being developed for payment of non-VA hospital care based on Medicare s diagnosis related group (DRG) prospective payment system. The Medicare rates are based on costs in the private sector and not on costs incurred by the VA in operating VA facilities. VA is mandated by law to recover its costs. Under Medicare's DRG payment system, physicians, nonphysician anesthetists, and others are paid separately by Part B coverage. VA billings are all inclusive, and we would have no way of generating separate physician costs on a case-by-case basis associating costs with any particular diagnosis.

Page 71: VA disagrees with the implication that it would be proper to allow private insurance companies to conduct utilization reviews on VA cases.

The remaining comments relate to the statements made on pages iii, 2, and 32 concerning the effect of section 401 of Public Law 96-330.

The GAO draft report characterizes the pertinent provisions of that law as authorizing--but not requiring--VA to establish specific ability-to-defray criteria and to verify veterans' ability to defray the expenses of nonservice-connected medical care before providing that care to all but specified beneficiaries. These statements are somewhat misleading. In essence, chapter 17 of title 38, United States Code, confers authority on the Administrator to provide certain care to nonservice-connected veterans under the age 65 "which the Administrator determines is needed . . . if such veteran is unable to defray the expenses of necessary . . . care." (See 38 U.S.C. section 610(a)(1)(B). Also see 38 U.S.C. sections 610(b)(2), 624(c), and 632(a)(2).) Prior to the enactment of Public Law 96-330, section 622(a) of title 38 provided that a "statement under oath of an applicant on such form as may be prescribed by the Administrator shall be accepted as sufficient evidence of inability to defray necessary expenses." In Public Law 96-330, the Congress amended section 622 to provide that for purposes of determining a veteran's eligibility for VA care based on his "inability to defray" in 38 U.S.C. sections 610(a)(1)(B) 610(b)(2) 624(c), and 632(a)(2):

The fact that an individual is—

(1) eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(2) a veteran with a service-connected disability; or

(3) in receipt of pension under any law administered by the Veterans' Administration;

shall be accepted as sufficient evidence of such individual's inability to defray necessary expenses.

It is true that the pertinent provisions of the public law do not expressly direct the VA to establish and impose ability-to-defray criteria on applicants for nonservice-connected care. Nevertheless, the clear effect of that amendment is to require the Agency to determine the "inability to defray" of veterans whose eligibility for care is "needs-based," unless such individuals are within the class described in section 622. Such a conclusion is inescapable given the condition precedent reflected in VA's basic medical eligibility provisions: "if such veteran is unable to defray the expenses of necessary . . . care." (38 U.S.C. sections 610(a)(1)(B), 610(b)(2).) Certainly this provision gives VA broad latitude as to the criteria used to establish an applicant's inability to pay for care and the means by which those criteria are implemented. Clearly, though, VA does have an obligation and not simply authority to make these case-by-case determinations.

APPENDIX VIII

COST ESTIMATES

The following assumptions are made with respect to additional billing would be required if this legislation is enacted:

a) That billing will be made only for medical care furnished to the following categories of veterans having health care insurance:

   1) Nonservice-connected veterans less than age 65 and not receiving VA pension.

   2) Service-connected veterans less than age 65 treated for nonservice-connected disabilities.

b) That only 38.2% of nonservice-connected veterans and 30.8% of service-connected veterans have health care insurance.

c) That such health care insurance would cover approximately 50% of billed charges:

   1) Many of our patients have used up most of their coverage before coming to a VA facility.

   2) Insurance companies provide only limited coverage for outpatient treatment and psychiatric care.

   3) Coinsurance and deductibles have been increasing each year.

d) Of the 50% of services covered, the VA will recover 60 cents on each dollar billed:

   1) Many policies do not provide coverage the first 2 years for pre-existing conditions.

   2) Insurance companies insist that the average length of stay of VA patients exceeds the average in the community.

   3) Insurance companies will decline to pay for some charges in the absence of itemized bills which the VA is presently unable to provide.

e) That the following all-inclusive per diem rates, approved by OMB for tort cases, will be used, and these will be increased at 5% increments for subsequent years:

GM&S Inpatient	-	$319
Psychiatric Inpatient	-	$185
Outpatient Visit		$ 71

APPENDIX VIII

f) That the statistical information on page 176 of the Administrator's Annual Report 1982 be used for determining the approximate number of patients and resultant number of days of inpatient care for which billing would be made.

g) That inpatient and outpatient workloads and the percent of veterans with health insurance will remain constant.

h) That legislation enacted would have an effective date of January 1, 1985, and that exclusionary clauses would be "phased-out" over a 2-year period as policies are renewed.

2. Based on random sampling information recorded in the Administrator's Report 1982, the number of hospitalized veterans on any given day for whom billing would be indicated, is as follows:

a) Nonservice connected without pension - 29,712
Less those age 65 or older - -7,164
22,548

b) Service connected treated for non-service-connected disabilities - 9,854
Less those age 65 or older - 3,155
6,699

c) This represents 8,230,020 patient days of care per year for nonservice-connected veterans without pension under age 65 (22,548 x 365) and 2,445,135 patient days of care for service-connected veterans treated for nonservice-connected disabilities under age 65 (6,699 x 365).

d) According to the "1979 - National Survey of Veterans", 38.2% of nonservice-connected veterans and 30.8% of service-connected veterans hospitalized in VA medical centers had private, group or health maintenance organization health insurance coverage. This means that for non-service-connected veterans, 3,143,867 patient days of care (8,230,020 x 0.382) and for service-connected veterans, 753,101 patient days of care (2,445,135 x 30.8) for a total of 3,896,968 patient days of care would be covered by such insurance for which billing could be done.

3. Latest information indicates that 64% of the patient mix is GM&S, while 36% is psychiatric. Applying these percentages to 3,896,986 days of care indicate the number of days of care for which billing would be made at the respective rates:

a) 3,896,968 x 64% = 2,494,059 GM&S days

b) 3,896,968 x 36% = 1,402,908 Psychiatric days

4. The "1979 - National Survey of Veterans" indicates that only 53.2% of the health insurance policies held by veterans provided outpatient coverage. Approximately 38.7% of all outpatient visits are made by veterans with a service-connected disability. Projected outpatient visit workloads are as follows for each fiscal year based on the budget workload estimate for Fiscal Year 1985:

Total	SC Veterans	NSC Veterans
18,692,000	7,233,804	11,458,196

A constant workload is assumed.

5. Another assumption is that exclusionary clauses are "phased-out" over a 2-year period from the effective date of the legislation (assumed to be January 1, 1985) so that 37.5% of policies would be converted in Fiscal Year 1985, 87.5% in Fiscal Year 1986 and 100% by Fiscal Year 1987.

6. A final assumption is made that the respective reimbursement rates wall increase at 5% each year. With that assumption, the following tabulation represents the amounts the VA would bill and the amount we would collect if we collected 60% of charges billed:

Total Potential Billing (in dollars)

	FY 1985 (Jan-Sept)		FY 1986
GM&S Inpatient	313,231,888		438,524,657
Psychiatric Inpatient	102,193,079		143,070,311
Outpatient	96,234,065		137,526,962
	511,659,032		719,121,330
Collections	64,282,629 *		346,300,240
	FY 1987	FY 1988	FY 1989
GM&S Inpatient	460,450,890	483,473,434	507,647,105
Psychiatric Inpatient	150,223,827	157,735,018	164,621,768
Outpatient	144,403,241	151,623,508	159,204,683
	755,077,958	792,831,950	831,473,456
Collections	448,061,443	475,459,170	498,884,073

* Even assuming that funding is made immediately available with passage of the legislation to hire additional personnel and ADP equipment, it is unrealistic to think that the VA could implement changes quickly enough to bill for or collect more than 25% of the amount for Fiscal Year 1985.

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7. Certain administrative costs would be associated with implementing a billing program of this magnitude. Estimates of expenditures that would be needed for the acquisition of computer hardware for each of 28 medical districts, installation, training, and other costs, and approximately 2,495 necessary FTEE, are summarized as follows:

	FY 1985 (Jan-Sept)	1986	1987	1988	1989
Hardware:					
CPU $100,000 x 28	$2,800,000	-	-	-	-
Burster & Stuffer $40,000 x 172	6,880,000	-	-	-	-
Terminals 2 CRT's @ $800 and 2 Printers @ $1200 x 172	688,000				
Software (Development)	500,000				
(Royalties & Maintenance)	1,086,800	1,086,800	1,086,800	1,086,800	1,086,800
Installation and Training	3,000,000	-	-	-	-
Staffing (ADP) 1 GS-7, 2 GS5s x 28 FTEE *	1,199,772	1,599,696	1,599,696	1,599,696	1,599,696
Staffing (MAS) ** 994 FTEE, GS 5*	13,151,365	17,535,154	17,535,154	17,535,154	17,535,154
Staffing (Fiscal) ** 1380, FTEE GS-6 *	20,352,240	27,136,320	27,136,320	27,136,320	27,136,320
Staffing (District Counsel) ** 19 FTEE, GS 13 * 18 FTEE, GS 7	951,800	1,269,067	1,269,067	1,269,067	1,269,067
Billing Forms **	26,893	98,835	98,835	98,835	98,835
Mailing **	262,200	874,000	874,000	874,000	874,000
Photocopying **	51,300	171,000	171,000	171,000	171,000
	50,950,370	49,690,872	49,690,872	49,690,872	49,690,872

* Costs are based on current salary levels plus 12.5%.

** Staffing and cost estimates are based on an additional workload of 3.8 million bills prepared by the VA annually. An increase in the cost of first class mail to 23 cents is assumed beginning in Fiscal Year 1985.

8. The following table summarizes collections, costs, FTEE, and net financial impact to the VA.

	Reimbursements to VA	Administrative *** Costs	FTEE	Net Financial Impact to VA
FY 1985 (Jan-Sept)	16,070,657	50,950,370	1871	(34,879,713)
FY 1986	346,300,240	49,690,872	2495	296,609,370
FY 1987	448,061,443	49,690,872	2495	398,370,571
FY 1988	475,459,170	49,690,872	2495	425,768,298
FY 1989	498,884,073	49,690,872	2495	449,193,201

*** The true administrative costs are probably higher than these figures since no adjustment was made for annual cost of living or step increases for employees salaries or for increases in other costs. If these factors were to be taken into account, the net gain to the VA would be reduced. Remember, too, that one of the assumptions was that there would be a 5% increase in our billing rates each year.

GOE costs: FY 1985 = $951,800; FY 1986-1989 = $1,269,067
Medical Care Appropriation: FY 1985 = $49,998,570; FY 1986-1989 = $48,421,805

It should be noted that one additional assumption was made in the derivation of these estimates. That assumption is that the provision of P.L. 96-330 authorizing the VA to "look behind the oath" is not implemented and that the veteran's certification of inability to defray the cost of medacal care continues to be accepted to establish VA eligibility without further scrutiny. When this provision of P.L. 96-330 is implemented, the VA will consider for certain veterans whether their health insurance and other assets are adequate to enable them to obtain medical care in the community making them ineligible for VA care. This means that those nonservice-connected veterans with adequate health insurance will not be receiving care from the VA and so there will be no recovery from the insurance companies to be made. Recovery from health insurance policies would then be possible only for treatment rendered to service-connected veterans for nonservice-connected disabilities. Veterans with service-connected disabilities are eligible for VA care without regard to their ability to pay.

9. The following cost estimate assumes that the VA has implemented "looking behind the oath" so that recovery is to be made only from service-connected veterans receiving care for nonservice-connected disabilities. The other assumptions remain the same.

APPENDIX VIII

Billings (in dollars)

	FY 1985(Jan-Sept)	FY 1986	FY 1987	FY 1988	FY 1989
GM&S Inpatient	60,549,240	84,768,936	89,007,382	93,457,751	98,130,639
Psychiatric Inpatient	18,808,672	26,332,141	27,648,748	29,031,185	30,482,744
Outpatient	31,558,665	44,182,132	46,391,238	48,710,800	51,146,340
	110,916,577	155,283,209	163,047,368	171,199,736	179,759,723
Collections	13,864,567	74,482,239	95,375,767	102,719,842	107,855,834

Administrative Costs
(based on workload of 1.2 million bills/year)

	FY 1985(Jan-Sept)	FY 1986	FY 1987	FY 1988	FY 1989
Hardware:					
CPU $100,000 x 28	$2,800,000	-	-	-	-
Burster & Stuffer $40,000 x 172	6,880,000	-	-	-	-
Terminals 2 CRT's @ $800 and 2 Printers @ $1200 x 172	688,000				
Software (Development)	500,000				
(Royalities and Maintenance)	1,086,800	1,086,800	1,086,800	1,086,800	1,086,800
Installation and Training	3,000,000	-	-	-	-
Staffing (ADP) 1 GS-7, 2 GS-5s x 28	1,199,772	1,599,696	1,599,696	1,599,696	1,599,696
Staffing (MAS) 314 FTEE, GS-5s	4,154,455	5,539,274	5,539,274	5,539,274	5,539,274
Staffing (Fiscal) 436 FTEE, GS-6s	6,430,128	8,573,504	8,573,504	8,573,504	8,573,504
Staffing (District Counsel) 6 FTEE, GS-13s 6 FTEE, GS-7s	305,743	407,658	407,658	407,658	407,658
Billing Forms	8,498	31,232	31,232	31,232	31,232
Mailing	82,855	276,184	276,184	276,184	276,184
Photocopy	16,211	54,036	54,036	54,036	54,036
Total Cost	27,152,462	17,568,384	17,568,384	17,568,384	17,568,384

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	Reimbursements to VA	Administrative Costs *	FTEE	Net Financial Impact to VA
FY 1985 (Jan-Sept)	3,466,143	27,152,462	634	(23,686,319)
FY 1986	74,482,239	17,568,384	846	59,913,855
FY 1987	95,375,767	17,568,384	846	77,807,383
FY 1988	102,719,842	17,568,384	846	85,151,438
FY 1989	107,855,834	17,568,384	846	90,287,450

* GOE Costs: FY 1985 = $305,743; FY 1986-1989 = $407,658

Medical Care Appropriation Costs: FY 1985 = $26,846,719; FY 1986-1989 = $17,160,726

ACTIONS REQUIRED TO IMPLEMENT LEGISLATION ABOLISHING EXCLUSIONARY CLAUSES

1. Prepare a notice of proposed rulemaking and a regulatory impact analysis for publication in the Federal Register allowing 60 days comment period. (MAJOR RULE) (9 months from passage)

2. Analyze comments and prepare final regulation for necessary concurrence and publication. (15 months from passage)

3. Develop and publish changes to the DM&S and Finance Operations Manuals. (9 months from passage)

4. Develop or adopt forms for billing and billing control, including form letters to facilitiate liaison with insurance companies. (9 months from passage)

5. Coordinate development of an AMIS Report on billing activities and collection results. Coordinate with (04), (02) and (70). (9 months to 1 year from passage)

6. Develop training programs for Medical Administration Service, Fiscal and District Counsel employees - perhaps a Program Guide. (1 year from passage)

7. Hire additional personnel. (1 year from passage)

8. Conduct training programs - perhaps through RMEC. (1 year from passage)

9. Revise space criteria for Medical Administration and Fiscal Services and District Counsels to accommodate the additional personnel and necessary equipment. (1 year from passage)

10. A program of this magnitude requires computerization. Specifications and RFP's have to be developed for hardware and software. Cost of these factors would be dependent upon the degree of sophistication considered necessary for effective control. (2 years from passage)

11. If the decision were made to base billings by the VA on DRG rates rather than our present all-inclusive rates, we would have to publish in the Federal Register an explanation of the VA's method for deriving our DRGs and associated rates. Also, the VA would have to develop and publish in the Federal Register an interim billing system for patients who remain hospitalized. DRG systems are based on discharges and are not geared to generate costs for patients who remain hospitalized. These Federal Register publications would be Major Rules. (15 months to 2 years from passage)

* Time frames listed assume that no major problems arise during any of these steps, that adequate funding is available and that the project is given a high priority by all concerned.

GAO note: Page references may not agree with page numbers in this final report.

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