CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

May 29, 1998

H.R. 3828
Veterans Medicare Access Improvement Act of 1998

As ordered reported by the House Committee on Ways and Means on May 14, 1998

SUMMARY

H.R. 3828 would require the Secretaries of Health and Human Services (HHS) and Veterans Affairs (VA) to establish two systems—a program and a demonstration project—in which Medicare pays the VA on a capitated basis for Medicare-covered services furnished to certain veterans who are entitled to Medicare. The program would involve veterans who are entitled to certain types of free health care from the VA (Category A veterans), and the demonstration project would involve veterans who are not entitled to free health care from the VA (Category C veterans).

CBO estimates that H.R. 3528 would increase Medicare spending by about $20 million in fiscal year 1999 and by about $500 million during the 1999-2003 period. Because the proposal would affect direct spending, pay-as-you-go procedures would apply. The bill does not contain any intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act.

Demonstration Project and Program

Both the demonstration project and program would operate in up to three geographic areas for a period of three years. The demonstration project would begin on January 1, 1999, and the program would begin on January 1, 2000. During these three-year periods, Medicare payments to VA would be subject to annual caps, with a cumulative limit of $150 million for the demonstration project and $225 million for the program.

The demonstration project for Category C veterans would be discontinued after 2001. The program for Category A veterans may be continued after 2002, with Medicare payments to VA capped at $100 million a year. However, the program may be expanded to additional sites, without caps on payments to VA, if the HHS Inspector General certifies that VA has

established and is using a data system that can reliably and accurately measure the costs incurred by VA in providing Medicare-covered services to Medicare-eligible veterans.

Participating Sites

The bill defines a site as a geographic service area of the Department of Veterans Affairs, which CBO interprets to mean a Veterans Integrated Services Network (VISN). The Secretaries would jointly designate three sites to participate in the program and three sites to participate in the project. The same or different VISNs may be selected for the program and the project. At least one of the VISNs selected as a project site must include the catchment area of a military medical facility that was closed pursuant to a base closure and realignment act.

In general, VA sites participating in the program or demonstration project would be required to qualify as Medicare+Choice plans. However, the Secretary of HHS would be allowed to waive such requirements if the waiver reflects the unique status of VA and is necessary to carry out the program or demonstration project.

Eligibility and Enrollment Rules

Veterans must be enrolled in both Part A and Part B of Medicare to be eligible for either the program or the demonstration project. To participate in the program, a Category A veteran must live in an area that is geographically remote from the closest VA hospital.

Enrollment in either the program or the demonstration project would be voluntary. As with other Medicare+Choice plans, CBO assumes that veterans who enroll in the program or demonstration project would give up the ability to have Medicare pay for services furnished by providers outside the network established by VA.

Basis of Payments

Medicare's payments to VA would equal 95 percent of the applicable payment to a Medicare+Choice plan, less amounts related to Medicare's medical education payments, disproportionate share payments, and part of capital-related payments to hospitals for inpatient services.

Maintenance of Effort

The proposal is intended to have no net effect on Medicare spending. It would require the Secretaries to specify how VA's health care efforts for Medicare-eligible veterans would be monitored. The proposal would also require several analyses of VA's level of effort and the effect of the program and demonstration project on Medicare spending. If the Secretaries conclude that the program or demonstration project has caused Medicare spending to increase, the proposal would require VA to pay Medicare for increased spending already incurred by Medicare, and would require adjustment of the capitation rates paid to VA to avoid future increases in Medicare spending.

The proposal would require VA to develop data systems to measure the Medicare-covered services that VA furnishes to Medicare-eligible veterans. The first step would be the identification by October 31, 1998, of veterans who are eligible for Medicare. By October 1, 2001, VA would be required to develop a data system that would be able to identify the costs VA incurs in furnishing Medicare-covered services to Medicare-eligible veterans. The caps on the number of program sites and on annual Medicare payments to VA would be eliminated if the HHS Inspector General certified by June 1, 2002, that VA is able to identify those costs in a reasonably reliable and accurate manner.

Relation to Compensation for Use of Tobacco

The bill makes implementation of the program and demonstration project contingent on enactment of legislation that restricts entitlement to VA service-related compensation for a disability that is the result a veteran's use of tobacco products and on a determination by the Director of the Office of Management and Budget that available savings from that legislation are sufficient to offset the increase in Medicare spending.

The restriction on entitlement to VA service-related compensation that is necessary to permit implementation of H.R. 3828 is included in H.R. 2400, the Transportation Equity Act for the 21st Century, which has been passed by both the House and Senate.

ESTIMATED BUDGETARY IMPACT

CBO estimates that the proposal would increase Medicare spending through two mechanisms:

- Favorable selection—that is, Medicare capitation payment rates for enrollees in the VA program or demonstration project that would be higher than what

Medicare would spend if the participants received all of their care from non-VA providers; and

- Changes in VA's level of health care efforts for Medicare-eligible veterans that result in higher Medicare spending for services furnished by providers eligible for Medicare payment.

The combined effect of favorable selection and changes in VA's level of effort would increase Medicare spending by about $10 million in fiscal year 1999, $500 million during the 1999-2003 period, and $1.8 billion over ten years. Changes in VA's level of effort would contribute more to higher Medicare spending than would favorable selection. (See Table 1.)

The estimate of the increase in Medicare spending due to favorable selection is based on the assumption that, compared to Medicare payments for enrollees in the fee-for-service sector, selection in VA plans would be at least as favorable as selection in Medicare+Choice plans.

The conclusion that Medicare spending would rise due to erosion of VA's level of effort is based on the inherent tension between VA's mission and satisfaction of the maintenance of effort requirement, the inability to establish a reliable measure of effort during the base period, and the lack of an effective mechanism to monitor and enforce compliance with that requirement. Because measured effort is likely to exceed the level-of-effort target, the proposal would permit a substantial increase in Medicare spending while enabling the Secretaries to find that the level-of-effort criteria have been met. Erosion of VA's level of effort would be slowed, however, following implementation of a new data system to measure the costs VA incurs in furnishing Medicare-covered services to Medicare-eligible veterans.

VA has been unable to provide relevant data on the cost to VA of the Medicare-covered services furnished to Medicare-eligible veterans in the base year. CBO's estimate assumes that the base-period cost was $8 billion, or about half of the VA's health appropriation, and that, under current law, this cost would remain constant throughout the projection period. The estimate also assumes that VA initially would reallocate from its core mission nearly all (90 percent) of the incremental resources necessary to maintain its level of effort in the preceding year but that this proportion would decline in subsequent years. The estimate assumes that the proportion of incremental resources allocated to maintenance of the previous year's level of effort would return to 90 percent following implementation of the new data system.

Table 1. Increases in Medicare Spending Due to Favorable Selection and Erosion of VA Level of Effort

	By calendar year, in millions of dollars											
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	1999-2003	1999-2008
Increase in Medicare Spending due to:												
Favorable Selection	a	10	10	10	10	20	30	50	70	110	40	320
Erosion of Level of Effort	20	60	100	150	190	200	210	210	220	220	510	1,580
Total												
By Calendar Year	20	60	110	160	200	220	240	260	290	330	550	1,890
By Fiscal Year	10	50	100	130	190	210	250	230	280	320	480	1,780

NOTES: Numbers may not add to totals because of rounding.

a. Less than $5 million

The costs of this legislation fall within budget function 570 (Medicare).

BASIS OF ESTIMATE

The following sections elaborate on CBO's analysis of the effect of this proposal on Medicare spending. This analysis uses calendar years.

Costs of Favorable Selection

The estimate assumes that Medicare+Choice payment rates would be adjusted to remove half of the capital-related component, and that the resulting payment rates would average 92 percent of rates normally paid to Medicare+Choice plans. Average capitation payment rates for participating veterans would grow from about $5,500 in 1998 to $9,200 in 2008. (See Table 2.)

Table 2. Summary of Projected Enrollment and Medicare Spending in Proposed VA Program and Demonstration Project

	By calendar year, in millions of dollars									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Spending Cap										
Category A Program	0	50	75	100	b	b	b	b	b	b
Category C Demonstration Project	50	50	50	0	0	0	0	0	0	0
Average Capitation Rate (Dollars)	5,500	5,700	6,000	6,300	6,700	7,200	7,700	8,200	8,700	9,200
Enrollment (Thousands)										
Category A Program	0	9	13	16	23	33	50	80	110	160
Category C Demonstration Project	5	8	8	0	0	0	0	0	0	0
Total Enrollment	5	17	20	16	23	33	50	80	110	160
Total Capitated Payments to VA	30	95	122	100	150	240	390	640	970	1,450
Change in Medicare Spending due to Favorable Selection	a	10	10	10	10	20	30	50	70	110

Notes: Details may not add to totals due to rounding.

a. Less than $5 million.

b. The $100 million cap on annual Medicare payments to VA would be removed if the HHS Inspector General certifies that VA can reliably and accurately calculate cost of Medicare-covered services furnished to Medicare-eligible veterans.

CBO assumes that VA would establish a separate Medicare+Choice plan in each region. Because of the caps on total capitated payments to VA, CBO also assumes that Medicare would waive the minimum enrollment requirement (5,000 enrollees for Medicare+Choice plans in urban areas) for at least the first four years of operation. CBO assumes that enrollment in the program for Category A veterans would grow from about 9,000 in 1999 to about 160,000 in 2008. CBO assumes that enrollment in the Category C project would rise from about 5,000 in 1999 to about 8,000 in 2001. CBO assumes that enrollment of Category C veterans would not be impeded by the prospect of the demonstration ending, because VA and many Category C veterans would act on the expectation that the project would be continued and expanded after 2001.

CBO assumes that selection of enrollees would be at least as favorable as selection in other Medicare+Choice plans under current law.[1] The increase in Medicare spending due to favorable selection would increase from less than $5 million in 1999 to about $110 million in 2008.

Erosion of Level of Effort

Three factors contribute to CBO's conclusion that Medicare spending would rise due to erosion of VA's level of effort: an inherent tension between VA's mission and satisfaction of the maintenance of effort requirement, the inability to establish a reliable measure of effort during the base period, and the lack of an effective mechanism to monitor and enforce compliance with that requirement. Despite these impediments, CBO assumes that VA will allocate substantial resources to maintain its level of effort. In addition, the estimate assumes that erosion of VA's level of effort would be slowed substantially following implementation of a new data system.

Tension Between VA's Mission and Satisfaction of the Maintenance of Effort Requirement. According to VA, "The mission of the veterans healthcare system is to serve the needs of America's veterans. It does this by providing specialized care for service-connected veterans, primary care and related medical and social support services. To accomplish this mission, VHA (Veterans Health Administration) needs to be a comprehensive, integrated healthcare system that provides excellence in healthcare value, excellence in service as defined by its customers, and excellence in education and research, and needs to be an organization characterized by exceptional accountability and by being an employer of choice."

VA does not have sufficient resources to satisfy the health care demands of all eligible veterans. To carry out its mission within the resources available, the Congress and VA have established seven priority groups to specify the order in which veterans may stake a claim to VA health care services. The VA also allocates care by determining which services it offers, where it offers them, and the quantity it offers. Only by managing the set of services VA provides, and by managing the distribution of those services across the veteran population

1. Enrollees in Medicare risk plans have been estimated to cost 10 percent to 12.4 percent less than Medicare enrollees with similar demographic characteristics who remain in the fee-for-service sector. See R.S. Brown, et al., The Medicare Risk Program for HMOs--Final Summary Report on Findings from the Evaluation, Princeton, N.J.: Mathematica Policy Research, Inc., February 1993; and G. Riley, et al., "Health Status of Medicare Enrollees in HMOs and the Fee-for-Service Sector in 1994", Health Care Financing Review, 17(4), Summer 1996. Selection tends to be substantially more favorable for new enrollees in Medicare risk plans. In the six months before joining an HMO, new HMO enrollees have been estimated to cost Medicare only 63 percent as much as beneficiaries who remained in the fee-for-service sector. See "Geographic Adjustment of Medicare Payments", Annual Report to Congress, Physician Payment Review Commission, 1996.

can VA best serve the needs of America's veterans within the constraints imposed by limited resources.

The VA provides a full spectrum of medical care. However, some veterans have medical needs that are not well served by community providers. To satisfy these needs, the VA has developed special expertise in certain areas, including provision of low-cost pharmaceuticals and, for patients with chronic disabilities, rehabilitation and substance abuse/mental health services.[2]

To improve the VA's ability to carry out its mission, the Veterans Health Administration is pursing a "30-20-10" strategy: to increase efficiency by 30 percent, to increase the number of veterans served by 20 percent, and to generate 10 percent of funding from non-appropriated sources.

One method by which VA intends to carry out its mission is by allocating more resources to those services in which it has special expertise. If the proposal did not require that VA maintain a level of effort out of nonMedicare funds, Medicare payments for Medicare-covered services would enable VA to redistribute some appropriated funds to provide more of the services in which VA has special expertise. Medicare spending would increase as Medicare pays VA or community providers for the Medicare-covered services that would no longer be funded out of VA appropriations.

By contrast, implementation of an effective mechanism to enforce maintenance of a level of effort out of nonMedicare funds would require that VA shift resources away from the services in which VA has special expertise to pay for providing additional Medicare-covered services to Medicare-eligible veterans who do not participate in the program or project. Because of the resulting tension between carrying out VA's mission and satisfaction of the maintenance-of-effort requirement, CBO believes it is unlikely that a fully effective maintenance of effort mechanism could be implemented.

Level of Effort during the Base Period and in Baseline. The level of VA outlays for Medicare-covered services furnished to Medicare-eligible veterans is currently unknown. VA staff have guessed that it is in the range of one-third to two-thirds of VA health outlays. CBO used the midpoint of this range as the basis for estimating that VA outlays for Medicare-covered services furnished to Medicare-eligible veterans were about one-half of the $17 billion in VA health outlays in 1997, or about $8 billion. Under current law, CBO assumes that these outlays will be constant during the 1998 through 2008 period.

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2. In general, the services in which the VA has developed special expertise are not covered by Medicare. Medicare does cover some services in which VA has developed special expertise, and Medicare does not cover some services in which VA has not developed such expertise. The estimate refers to services in which VA has developed special expertise as Medicare-noncovered services.

On a per-person basis, CBO assumes that VA will shift more of its appropriated resources to pay for the services in which VA has special expertise. However, this change in the allocation of VA's effort between Medicare-covered and noncovered services will be offset by growth in the share of veterans eligible for Medicare. The proportion of veterans who are at least 65 is projected to increase from 36 percent in 1997 to 41 percent in 2008.

Although CBO assumes that VA will spend $8 billion on Medicare-covered services furnished to Medicare-eligible veterans in 1998, the estimate assumes that Medicare would spend less than $8 billion if those veterans were to receive all Medicare-covered services from nonfederal providers eligible for payment by Medicare. CBO estimates that the value to Medicare of each dollar of VA outlays for Medicare-covered services furnished to Medicare-eligible veterans is about 85 cents in 1998. This assumption is based on research findings that VA delivers a substantial amount of nonacute care in relatively high-cost acute care settings.[3] CBO assumes that the gap between VA outlays and the value to Medicare of those outlays will close over six years, as VA implements its strategy to increase efficiency by 30 percent. Thus, CBO projects that the value to Medicare of VA outlays will increase from $6.8 billion in 1998 to $8 billion per year in 2004 through 2008.

Measuring, Monitoring and Enforcing Level of Effort. The proposal attempts to avoid increasing Medicare's costs by establishing a requirement that VA maintain a level of effort for Medicare-covered services furnished to Medicare-eligible veterans. The mechanism intended to achieve budget neutrality for Medicare requires that VA compensate Medicare for any change in Medicare spending for veterans compared to the amount Medicare would have spent for such veterans if the program and demonstration project had not been conducted. However, this change in Medicare spending cannot be measured.

CBO assumes that the agreement between the Secretaries would establish a mechanism for approximating VA's level-of-effort during the 1999 through 2003 period. CBO also assumes that the VA would develop a data system that would be able to identify the costs VA incurs in furnishing Medicare-covered services to Medicare-eligible veterans, and that this data system would be used to recalculate the base level of effort during 2002 and to monitor compliance with the level of effort requirement in 2003 and subsequent years.

Until the new data system is implemented, attempts to measure level of effort would be hampered by weaknesses in VA data systems. In addition, using existing VA data systems

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3. A recent VA study found that 38 percent of admissions to acute medical and surgical services were nonacute, and that 32 percent of inpatient days of care in these acute settings were for nonacute patients. (Smith, et al., "Overutilization of Acute-Care Beds in Veterans Affairs Hospitals", Medical Care, 34(1), 1996, p85-96.) These findings are consistent with the results of earlier studies. See, for example: Booth, et al., "Nonacute Inpatient Admissions to Department of Veterans Affairs Medical Centers", Medical Care, 28(8 supp.), 1991, p. AS40-AS50; and General Accounting Office, Better Patient Care Practices Could Reduce Length of Stay in VA Hospitals, GAO/HRD-85-92, 1985.

for monitoring compliance with the level of effort requirement—a purpose for which they were not initially designed—would produce substantial "measurement creep," that is, a tendency for measured effort to grow faster than real effort.

Weaknesses in VA Data System. Based on extensive discussions with staff from VA, HHS, and the General Accounting Office, CBO has concluded that VA does not have and could not quickly develop and implement data systems that would permit reliable measurement and monitoring of VA's level of effort. Without reliable measures of VA's effort, budget neutrality for Medicare cannot be enforced.

VA is only beginning to convert to industry-standard systems of categorizing many of the services and procedures it furnishes. Thus, VA cannot reliably distinguish the services that would be covered by Medicare from those that would not be covered. In many situations, VA would use the setting in which a service is furnished as a proxy for whether the service is Medicare-covered. In some settings, the costs of services are estimated using methods designed to allocate budgets. This cost-estimating methodology, in conjunction with VA's inability to categorize services adequately, prevents VA from measuring the costs of those services reliably.

Measurement Creep. Until the new data system is implemented, the Secretaries would use existing data systems as the basis for measuring, monitoring, and enforcing VA's level of effort, and for generating and justifying Medicare payments to VA. Data that are not required to generate payments are reported less completely than data that are audited and used for payment. When those data begin to be used for payment, the elements that qualify for higher payment will be reported more completely than when the data system was developed. Thus, the reported output will grow more rapidly than actual output. Based on Medicare's experience with "DRG creep" following introduction of the prospective payment system for hospital inpatient services in fiscal year 1984, CBO assumes that measurement creep would inflate VA's level of effort by 3 percent in 1999 but that the rate of inflation would gradually decline to 0.5 percent in subsequent years. This measurement creep would permit VA to satisfy level of effort requirements with little or no need to reallocate appropriated resources away from the Medicare noncovered services central to its mission.

Despite the inherent tension between carrying out VA's mission and satisfying the maintenance of effort requirement, and despite the contribution of measurement creep to reducing or eliminating the apparent need for VA to satisfy that requirement by reallocating appropriated resources away from services not covered by Medicare, CBO assumes that VA would reallocate substantial resources from its core mission to provide Medicare-covered services to Medicare-eligible veterans who do not participate in the program or demonstration project. Initially, VA would reallocate from its core mission 90 percent of the resources necessary to maintain the level of effort. In subsequent years, however, measured

effort would substantially exceed the level-of-effort target, and VA would gradually reduce to 50 percent the reallocation of resources necessary to maintain the previous year's level of effort. After implementation of the new data system, VA would again reallocate from its core mission 90 percent of the resources necessary to maintain the level of effort. How erosion of VA's level of effort would affect Medicare spending is summarized in Table 3.

Table 3. Changes in VA Level of Effort and Medicare Spending

	By calendar year, in billions of dollars									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
VA Level of Effort, Baseline										
Cost to VA	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
Value to Medicare	6.8	7.0	7.2	7.4	7.6	7.8	8.0	8.0	8.0	8.0
Relative Value of VA Effort to Medicare (Percent)	85.0	87.5	90.0	92.5	95.0	97.5	100.0	100.0	100.0	100.0
Measurement Creep (Percent)	3.0	2.5	2.0	1.5	1.0	1.0	0.8	0.6	0.5	0.5
Proportion of Increment in Measured Effort Used to Maintain Effort (Percent)	90	80	70	60	50	90	90	90	90	90
VA Level of Effort, Proposed Law										
Cost to VA	8.2	8.4	8.5	8.6	8.6	8.7	8.8	8.8	8.8	8.9
Value to Medicare	7.0	7.1	7.3	7.5	7.6	7.8	7.8	7.8	7.8	7.8
Increase in Medicare Spending due to Erosion of VA Effort	a	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2

NOTES: Details may not add to totals due to rounding.

a. Less than $50 million

PAY-AS-YOU-GO CONSIDERATIONS:

The Balanced Budget and Emergency Deficit Control Act establishes pay-as-you-go procedures for legislation affecting direct spending or receipts. The projected changes in direct spending under H.R. 2912 are shown in the table below for fiscal years 1999-2008. For

purposes of enforcing pay-as-you-go procedures, however, only the effects in the current year, budget year, and the succeeding four years are counted.

Summary of Pay-As-You-Go Effects

	By fiscal year, in millions of dollars									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Change in outlays	10	50	100	130	190	210	250	230	280	320
Change in receipts	Not applicable									

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 3828 does not contain any intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would impose no costs on state, local, or tribal governments.

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