Veterans and the Affordable Care Act

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ARMED CONFLICT HAS BEEN A FREQUENT OCCURrence throughout US history. During the last century, the United States has fought 8 wars that together span more than 35 years, not counting numerous conflicts that are not officially considered wars. In view of the many health consequences of war, the potential effect of the Affordable Care Act (ACA) on health care for veterans warrants careful consideration.

In 2011, there were 22.2 million veterans of service in the US Armed Forces. Veterans are a highly diverse population but can be grouped into 3 categories from a health insurance perspective. Approximately 37% are enrolled in the Department of Veterans Affairs (VA) health care system in accordance with a congressionally mandated eligibility system based on having a service-connected disability, low income and net worth, or other prescribed circumstances. More than 80% of VA enrollees older than 65 years are also covered by Medicare and about 25% of enrollees are beneficiaries of 2 or more non-VA federal health plans (eg, Medicare, Medicaid, TRICARE, or Indian Health Service). Another 56% of veterans have private health insurance or are covered by a non-VA federal health plan, while 7% have no health insurance. These latter veterans are poor or near poor but have incomes or net worth that exceed the mean test thresholds for VA health care eligibility.[1]

The ACA will not affect health care for the majority of veterans differently than it will affect nonveterans, and the ACA will not change eligibility for VA health care, covered benefits, co-payment for services, or how the VA health care system is administered or operated. Nonetheless, the ACA may affect health care for many veterans through its effects on access, fragmentation and quality of care, utilization of services, the health care work force, and federal expenditures.

The ACA will expand health insurance coverage for low-income persons through Medicaid and state health insurance exchanges, which should make health insurance available to uninsured veterans. The new insurance coverage options will also be available to many VA health care enrollees, expanding their health care choices and potentially increasing convenience and timeliness of care but also fragmenting care. Fragmentation of care is of concern because it diminishes continuity and coordination of care, resulting in more emergency department use, hospitalizations, diagnostic interventions, and adverse events. The VA serves an especially large number of persons with chronic medical conditions or behavioral health diagnoses—populations especially vulnerable to untoward consequences resulting from fragmented care.

Veterans with dual or multiple health plan eligibility are known to have more fragmented care, although associated untoward effects have not been well studied. Some data suggest that veterans receiving care from both VA and non-VA sources are more likely to be rehospitalized and to die within a year compared with VA-only users, although the reasons for the disproportionate mortality have not been studied.[2] VA/Medicare dual-eligible veterans with myocardial infarctions who use both plans undergo more invasive cardiac procedures without gaining a survival advantage over VA-only users, but adverse events associated with greater use of invasive procedures by non-VA clinicians have again not been analyzed.[3]

More health care choices may adversely affect the quality of care for some veterans in ways other than fragmenting care. Physicians in private practice may not be prepared to treat conditions prevalent among veterans. For example, the Reaching Rural Veterans Initiative in Pennsylvania found that private practice primary care clinicians lacked knowledge of posttraumatic stress and other mental health disorders prevalent among veterans and were unfamiliar with VA treatment resources for such conditions.[4] Additionally, numerous studies have shown that VA enrollees are significantly more likely than persons receiving care from non-VA clinicians to receive evidence-based treatment and recommended services for prevention and early diagnosis of cancer, cardiovascular disease, diabetes, and infectious diseases.[5-7]

VA enrollees with non-VA health insurance are known to use less VA care than those having only VA coverage, so expanding health care insurance for veterans may decrease use of VA facilities. Volume-sensitive services (eg, intensive care or complex surgery) at some smaller VA hospitals

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currently have marginally sufficient volumes from a quality-of-care perspective, and maintaining such services in the face of decreased utilization may be ill advised. However, such facilities are typically located in rural and medically underserved areas, where 40% of VA enrollees reside, and closure of underused services may adversely affect local access to both the affected services and others that rely on them, as well as some health care worker training programs.

Furthermore, like similarly located non-VA hospitals, some VA facilities in rural and medically underserved areas struggle with health care worker shortages, especially specialist physicians. The increased demand for care stemming from more than 30 million newly insured persons in 2014 may exacerbate workforce shortages at such facilities. If more veterans have insurance options, then they may seek care outside the VA system and ameliorate some staffing needs; however, past experience has shown that the relationship between health care workforce issues and demand for services in the VA system is difficult to predict.

About a third of dual- or multiply eligible VA enrollees concurrently use non-VA care that is paid for by non-VA federally funded health plans. Increasing health insurance options for VA health care enrollees (eg, Medicaid coverage) will increase redundant spending for veterans' health care, the cost of which will be partially borne by the government. For example, in 2009, VA spent $3.2 billion to care for 774 970 veterans who were also enrolled in Medicare Advantage plans (Amal Trivedi, MD, MPH, written communication, September 29, 2011). VA expenditures were overwhelmingly for routine inpatient and outpatient care covered by the Medicare Advantage plan, but federal law precludes VA from being reimbursed for services provided to Medicare Advantage beneficiaries, meaning that the federal government paid twice for care of the same person in many instances.

The overall net effect of the ACA on health care for veterans is uncertain at this time, although the act will likely have a number of intended positive and unintended negative effects. Several steps should be taken to better define and quantify these before the coverage expansions take effect in 2014.

First, the effects of multiple health plan eligibility on access to and quality of care for VA health care enrollees should be comprehensively evaluated to prioritize solutions for coordinating VA and non-VA health care coverage for veterans. For pragmatic reasons, this evaluation might focus on California, Texas, and Florida because 24% of US veterans live in these 3 states and they represent a broad spectrum of health care environments.

Second, a systematic assessment of current and projected VA health care workforce needs and service utilization vulnerabilities should be completed and options for addressing them reviewed, including expansion of VA's already well-developed tele-health and home care capabilities. This assessment should also consider effects on VA's postgraduate medical education and other health care worker training programs.

Third, a shared vision of the VA health care system in post-ACA US health care should be developed that considers the effects of increased health insurance coverage for veterans on VA's role as a safety net provider,[8] declining numbers of World War II and Vietnam War veterans, the increasing number of female veterans, and measures that may be taken to address federal budget problems.

Developing a shared vision for veterans' health care will likely engender a spirited and protracted debate because of the complexity of the issues and divergent views about the VA health care system. This debate should be mindful of the important roles of the VA in health care professional training and research, the large public investment that has been made in the system, and the special status of veterans in US culture. Perhaps above all else, it should be based on the recognition that providing health care for veterans is an ongoing cost of foreign policy and national defense strategies and that the nation has a long-standing social contract with veterans to ensure that those who have experienced harm during military service have ready access to health care.

Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Kizer reports that he has served as an independent consultant for the Alaska VA health care system and Booz Allen Hamilton and has been a paid speaker at meetings of various VA networks or services.

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