

Estimating Costs for Veterans Health, Part 2

Day 2 – Overview of Scenarios

Jamie Taber, PhD, Commission on Care
Gideon Lukens, PhD, Commission on Care
Merideth Randles, FSA, MAAA, Milliman, Inc.
March 22-23, 2016

Comprehensive Assessment of Total Costs

- A comprehensive assessment of the total costs of a dramatic transformation of the VA health care system requires a systematic planning process, such as the Capital Asset Realignment for Enhanced Services (CARES) process
 - The total cost of the system transformation will depend on VA's mission
 - Does VA continue its educational, research, and emergency preparedness missions?
- Today we are providing order-of-magnitude estimates that do not consider
 - The total costs and/or savings associated with reducing any unneeded staffing and infrastructure
 - Costs and/or savings of repurposing the infrastructure and staff to meet the projected growth in ambulatory services for enrolled Veterans
 - Impact on the viability of existing operations at VA medical centers
 - Impact on VA's teaching, research, and emergency preparedness missions

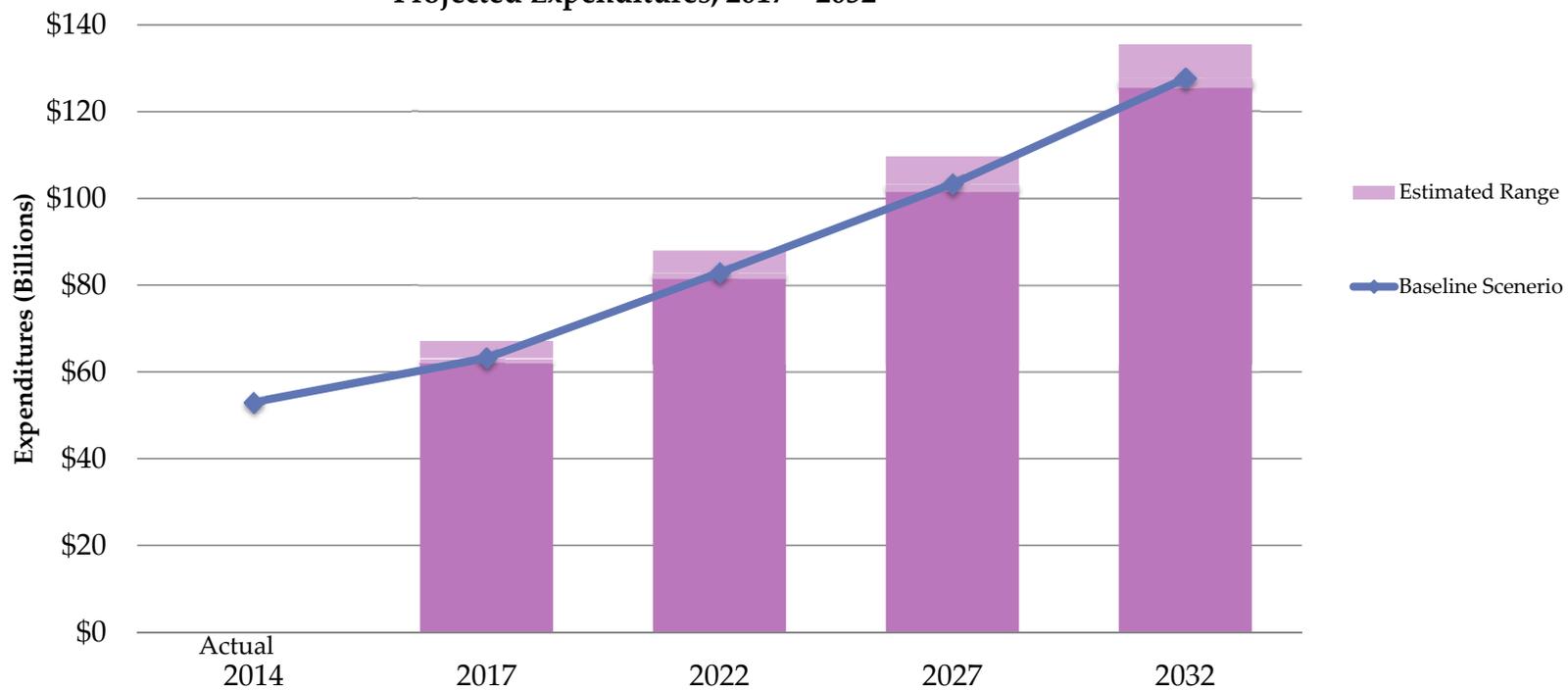
Overview of Scenarios

- Close Select Facilities [Milliman]
- Keep Select Services [Commission on Care]
- VA Purchases Insurance and Subsidizes Cost Sharing [Milliman]
- Enrollees Must Choose VA Care or a Subsidized Insurance Premium [Milliman]
- VA Opens Eligibility to all Priority 8 Veterans [Milliman]

Close Selected Facilities

- VA closes selected sites of care and purchases care for the affected enrollees in the community
 - 22 medical centers without inpatient acute services close
 - 50 medical centers with occupancy rates of 60% or less for acute inpatient medicine, surgery, and psychiatric in total, and those with a total Average Daily Census of less than 30 close their acute inpatient beds
 - 40% of VA medical centers are impacted
- All displaced care is provided in the community when available
- Enrollee reliance for services moving to the community is assumed to increase to 50%
- Health care services moving to the community are priced at VA's historical community costs
 - Identifies costs associated with providing these services in VA so assumptions can be made about potential facility offsets

2015 VA Enrollee Health Care Projection Model
Closing Select Facilities
Compared to Baseline Scenario
Projected Expenditures, 2017 – 2032



See previous slide for details on the key assumptions supporting the expenditure projections

Scenario: Keep Select Services

- All care moved to the community except for VA special-emphasis and primary care
- Illustrative comparisons of 2014 costs
 - Assumes policy has been fully phased-in
- \$22.4 billion of care moved out of VA
 - Assumes full VA “facility offsets,” i.e. care leaving VA priced at average unit costs
- \$30.6 billion of care assumed to stay in VA
 - Assumes no change in average unit costs for remaining service categories
- Does not include costs and/or savings from realigning VA physical footprint

Scenario: Keep Select Services (2)

- Priced at 2014 Care in the Community rates, \$22.4 billion => \$17.7 billion
 - Assumes historic national average care in the community rates are representative of the future rates negotiated under the scenario.
 - Actual rates are uncertain and would depend on policy choices and on what rates are feasible in local areas.
 - This does not provide a comparison of VA costs versus costs in the private sector for numerous reasons.
- \$53 billion => \$48.3 billion if no change in reliance or enrollment and full VA facility offsets
 - Captures the change in national level unit costs, weighted by health service category, when the select services are priced at 2014 Care in the Community rates. However, no change in reliance is unlikely.

Scenario: Keep Select Services (3)

- \$53 billion => \$48.3 billion if no change in reliance or enrollment
- \$53 billion => \$50.1 billion if reliance increases by 10% for care provided in the community (reliance is constant for care provided in the VA and enrollment is constant)
 - A reliance increase entails increases in both costs and benefits (i.e. health care services)
- \$53 billion => \$57.2 billion if reliance increases by 50% for care provided in the community (reliance is constant for care provided in the VA and enrollment is constant)

VA Purchases Insurance and Subsidizes Cost Sharing

- VA subsidizes commercial insurance and Medicare premiums and cost sharing for current and future enrollees, including currently non-eligible Priority 8 Veterans
- For Veterans under age 65
 - VA purchases a silver plan within each state's individual insurance market exchange
 - In addition, VA covers enrollees' cost sharing
 - Silver plans cover approximately 70% of claims costs, resulting in a significantly higher enrollee cost sharing than in VA
- For Veterans age 65 and over
 - VA pays the enrollees' Medicare premiums
 - In addition, VA covers enrollees' cost sharing
 - Medicare Parts A, B, and D cover approximately 80% of claims costs, resulting in a significantly higher enrollee cost sharing than in VA
- This policy is expected to increase enrollment in VA, particularly if VA subsidizes the Veteran's cost sharing
 - Therefore, cost estimates are provided for the current enrollee population as well as the non-enrolled Veteran population to provide a range of potential costs

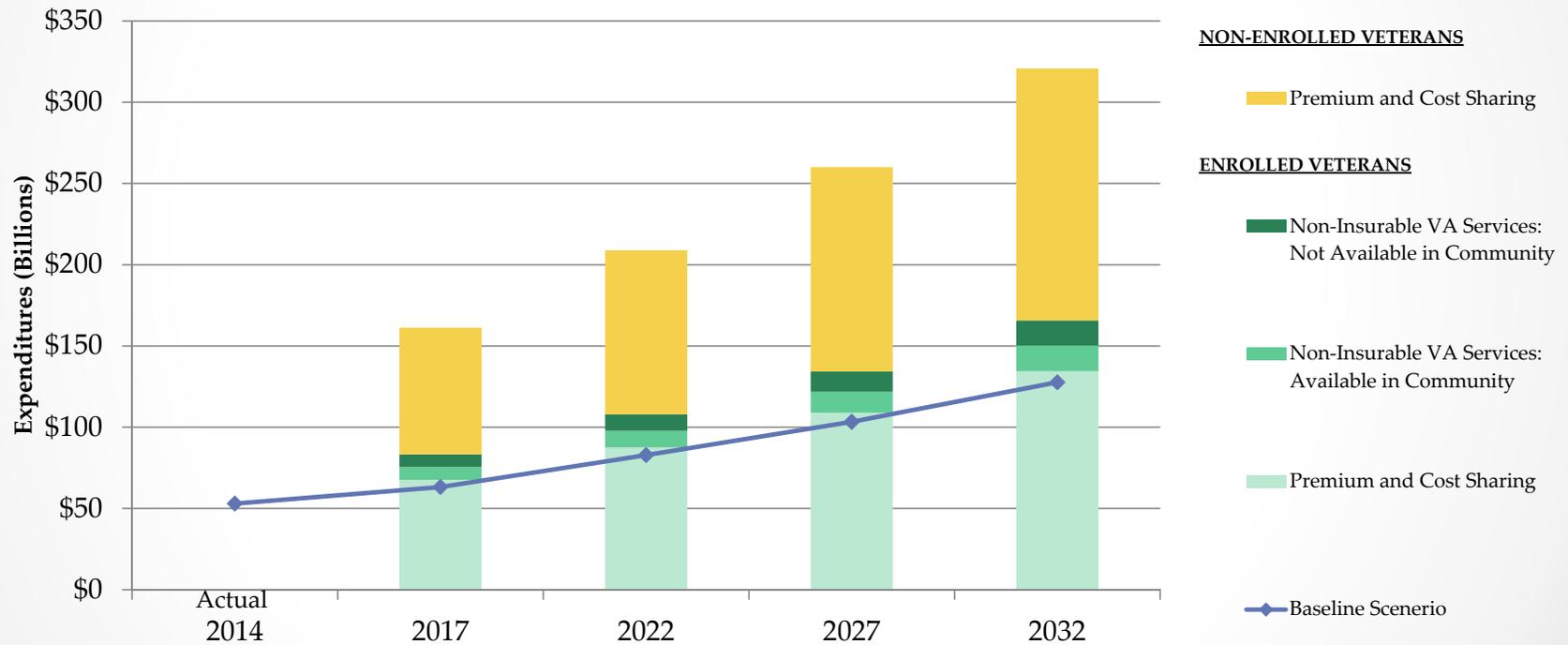
VA Purchases Insurance and Subsidizes Cost Sharing

- This analysis also includes cost estimates for services that are not provided through commercial insurance or Medicare or not covered at the level that VA provides
- Non-Insurable Services Available in the Community
 - Services rarely covered by commercial insurance or Medicare: institutional long term services and supports, dental care, hearing aids, over the counter pharmacy, state-based long term services and support programs
 - Services not covered at the level VA provides: outpatient mental health and substance abuse services, prosthetics, Hepatitis C drugs
 - These services are priced at VA's historical contract prices
 - Reliance for these services could increase if provided in the private sector closer to where the enrollee lives, but this has not been estimated

VA Purchases Insurance and Subsidizes Cost Sharing

- Non-Insurable Services Not Available in the Community
 - VA unique services and products: specialized mental health services, residential rehabilitation treatment programs, work therapy programs, homeless programs, spinal cord injury treatment, blind rehabilitation treatment and blind aids, home based primary care
 - Non-modeled services: readjustment counseling, non-medical homeless programs, Caregivers, Comprehensive Emergency Medical Program, Health Professions Educational Assistance Program, Income Verification Match, Rural Health Outreach Initiatives, Sharing Agreements, CHAMPVA, Spina Bifida, Foreign Medical Program, Children of Women Vietnam Veterans
 - These services are priced at VA's historical costs. However, if these services are delivered independently of the VA health care system, their cost basis may change significantly

**2015 VA Enrollee Health Care Projection Model
VA Purchases Insurance and Subsidizes Cost Sharing Scenario
Compared to Baseline Scenario
Projected Expenditures, 2017 – 2032**



See previous slides for details on the key assumptions supporting the expenditure projections

Enrollees Must Choose VA Care or a Subsidized Premium

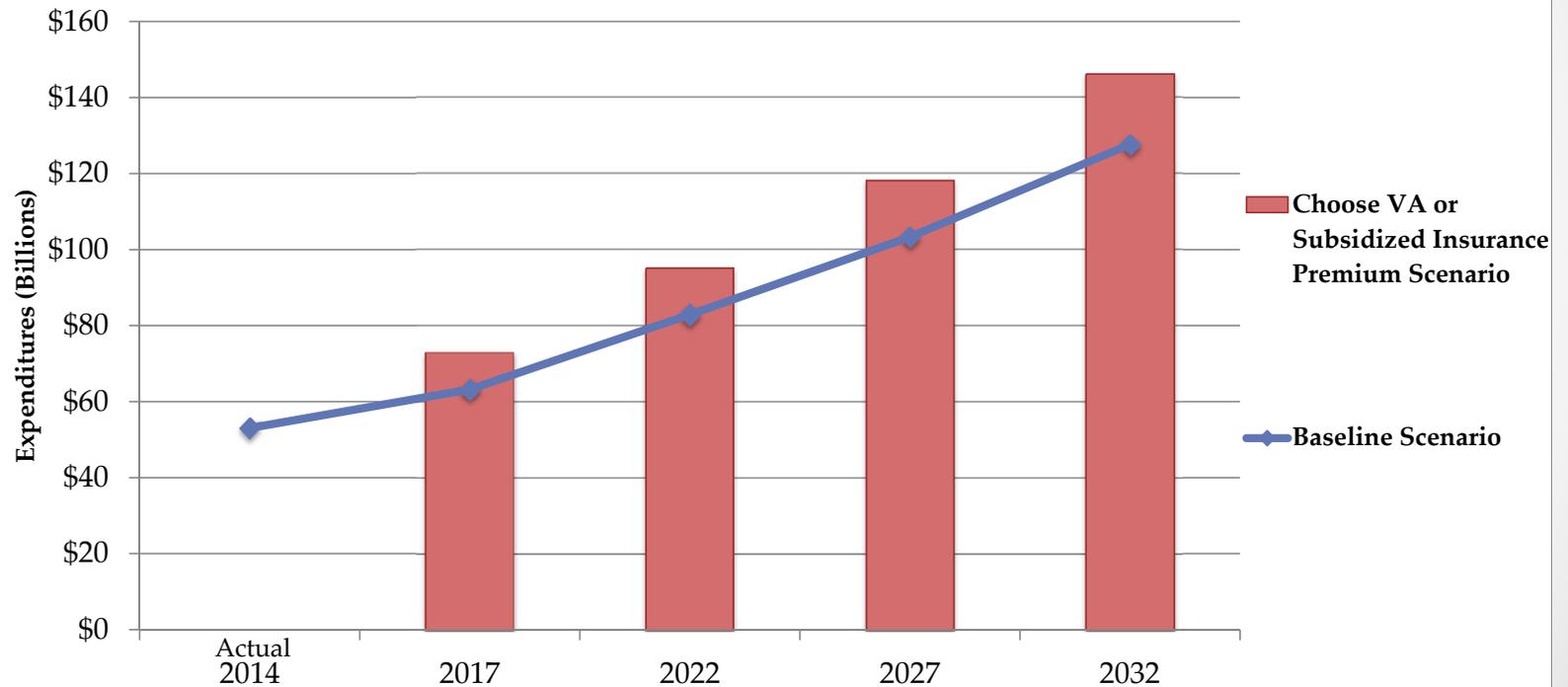
- All current and future enrollees under age 65 must choose between VA and a subsidized insurance premium and cost sharing
 - Assumes enrollees electing the premium and cost sharing subsidy no longer have access to any VA services, including the special services VA offers
- There is an annual election period, and VA actively engages with enrollees to make a decision
- Cost sharing varies by priority
- Silver policies are bought on the state individual insurance exchanges, and VA provides additional cost sharing assistance to meet the target subsidy
- The subsidized premium plan serves as a primary payer and does not supplement other coverage

Cost Sharing by Priority

- Priority 1: 10% cost sharing, on average this equates to \$1,600/year
- Priority 2: 10%, \$900/year
- Priority 3: 20%, \$1,800/year
- Priority 4: 20%, \$6,850/year*
- Priority 5: 30%, \$3,500/year
- Priority 6: 30%, \$900/year
- Priority 7: 40%, \$3,700/year
- Priority 8: 40%, \$3,400/year

*Maximum cost sharing under ACA exchange plans

2015 VA Enrollee Health Care Projection Model
Enrollees Must Choose VA Care or a Subsidized Insurance Premium
Compared to Baseline Scenario
Projected Expenditures, 2017 – 2032



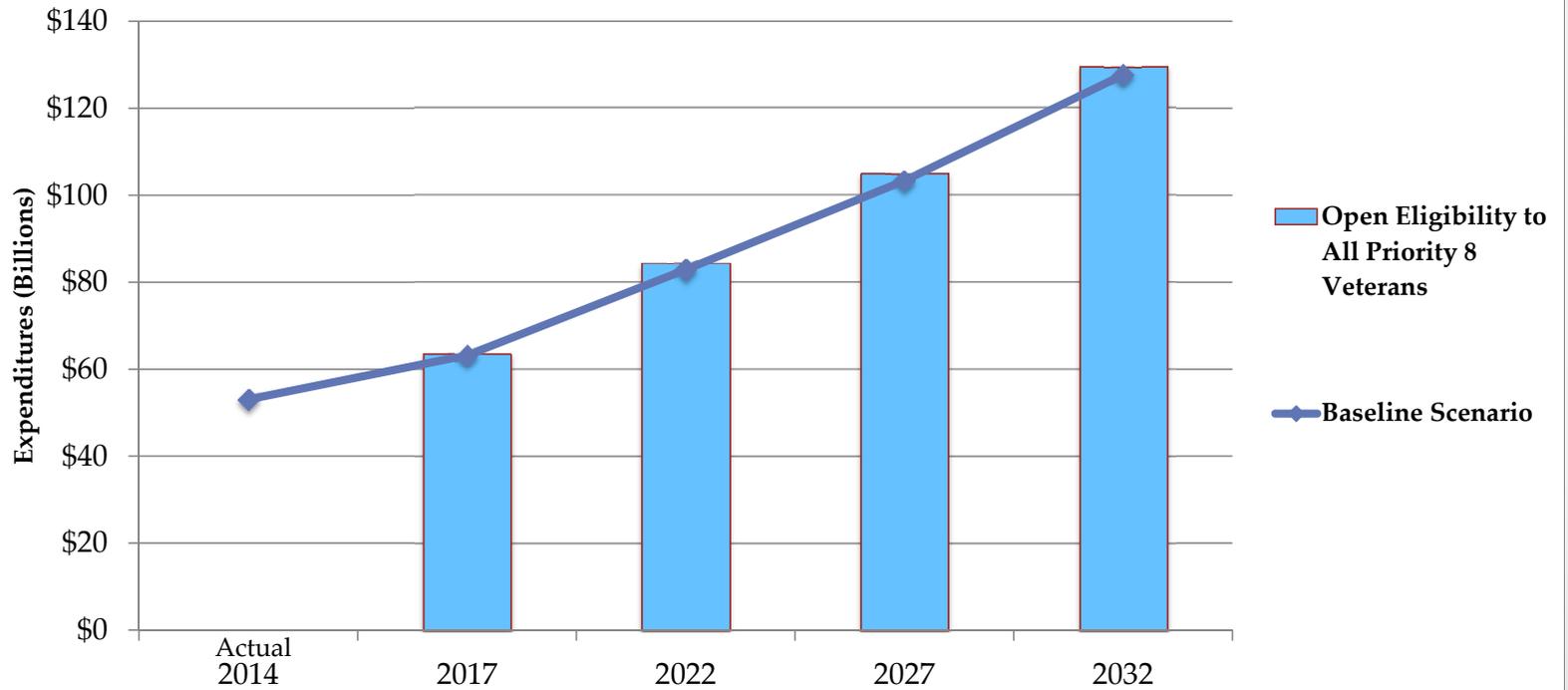
See previous slides for details on the key assumptions supporting the expenditure projections

VA Opens Eligibility to All Priority 8 Veterans

- The VA health care system expands to allow all Veterans to enroll in VA health care
 - Assumes the historical proportion of care provided in VA facilities and purchased in the community continues into the future
 - VA will need to grow internal capacity to provide services to these new enrollees
 - Current access issues indicate that VA ambulatory capacity is limited, and utilization for currently eligible enrollees is projected to grow by approximately 20% over the next five years
 - Opening the VA health care system to family members/beneficiaries would also require VA to grow internal capacity*
 - This estimate does not include capital infrastructure costs
- Newly eligible Priority 8 Veterans are assumed to have the same morbidity and reliance as current Priority 8 enrollees
 - By 2032, this scenario estimates an additional 375,000 enrollees with an additional \$1.8 billion in costs, reflecting this population's lower morbidity and reliance

*This scenario does not estimate the costs associated opening the VA health care system to Veterans' family members/beneficiaries. We have not previously conducted analyses of this population and would need time to acquire the necessary data and necessary assumptions

**2015 VA Enrollee Health Care Projection Model
Open Eligibility to All Priority 8 Veterans
Compared to Baseline Scenario
Projected Expenditures, 2017 – 2032**



See previous slide for details on the key assumptions supporting the expenditure projections