

The Future of Health Care for Military Personnel and Veterans

Summary

The health care programs of the Department of Defense (DoD) and the Department of Veterans Affairs (VA) provide insurance and direct care to about 14 million people at a combined cost in 2011 of \$104 billion. The DoD program, Tricare, serves active duty personnel, military retirees, and their dependents. Tricare includes several insurance options that provide services directly in DoD facilities and also offer access to contracted networks of civilian providers. The VA health program generally functions as a delivery system, rather than as insurance. Care is provided through a network of hospitals, medical centers, and community-based outpatient clinics. Preference is given to veterans who have a service-connected disability or low income, and, for a limited period, to those who have served in combat in Afghanistan and Iraq.

Many active duty personnel and recent veterans who have served in combat have mental health problems, including post-traumatic stress disorder, major depression, or traumatic brain injury. As a result, access and quality of mental health care in both the DoD and VA have been a focus of policy discussion. Active service members may avoid care because of concerns about career effects or doubt about the efficacy of mental health services. Those who do obtain care may have their treatment disrupted when they return to civilian life. The DoD and VA have been working to improve transitions

between the two systems, but progress has sometimes been slow. Within the VA, there are numerous programs to improve access to mental health care, but recent veterans still report delays in obtaining needed services and lack of continuity. The problems have been the subject of a federal court case and have received considerable congressional attention.

Although the relevant provisions of the Affordable Care Act are ambiguous, it appears possible that many veterans, retirees, and their families will have a choice between obtaining insurance through the ACA exchanges (or, for lower-income families, ACA-expanded Medicaid) or using Tricare or VHA services. For potential Tricare enrollees, the choice could depend on the relative costs of Tricare or ACA coverage. The Administration has proposed new means-based enrollment fees for military retirees; this could shift the balance for lower-income participants. The effects of the ACA on VA users might be larger. Many will now qualify for Medicaid, while others might see lower costs for exchange coverage than for VA services. Some people are arguing that—if most nonelderly VHA users could get low-cost insurance elsewhere and older users have Medicare—it may no longer make sense to go on operating a separate health system for veterans, especially those without service-connected problems.

Genesis of this Report:

This report is drawn, in part, from a panel discussion on the same topic held on February 13, 2012, at AcademyHealth's National Health Policy Conference in Washington, D.C. Panelists were Karen Guice, Principal Deputy Assistant Secretary for Health Affairs, Department of Defense, Sonja Batten, Deputy Chief Consultant for Specialty Mental Health, Veterans Health Administration, and James D. McDonough, Jr., President and CEO, Veterans Outreach Center, Inc., Rochester, NY. Terri Tanielian, Director, Center for Military Health Policy Research, RAND Corporation, served as moderator. Opinions in this paper are those of the author and not of the panel participants or their employers.

Introduction

The health care programs of the Department of Defense (DoD) and the Department of Veterans Affairs (VA) provide insurance and direct medical care to about 14 million people, including active duty and retired military personnel and their dependents and specified populations of eligible veterans. (About 1 million people are served by both systems; see the discussion of overlap, below.)

Because the DoD and VA systems serve narrowly defined populations, they are rarely considered in discussions of federal health policy. However, they account for a significant share of federal health spending: a combined total of \$104 billion in fiscal year 2011, or nearly 11 percent of all federal health outlays.¹ Most of the people served by the programs are civilians, and most also have other forms of health insurance coverage—Medicare, Medicaid, or employer or other private plans—that give them access to care outside the DoD and VA systems. There is, then, a complex interplay between the programs and the broader medical care delivery and financing systems.

This brief provides an overview of the DoD and VA health systems and considers some of the policy issues facing the programs, including measures to improve care for recent combatants with mental health problems, budget constraints faced by the DoD health programs, and the potential effects of the Affordable Care Act (ACA) on the populations served by the DoD and VA.

Background on the Military Health Programs

Tricare

The DoD’s medical programs are collectively known as Tricare—so called because originally the system offered most participants three coverage options. All active duty military and activated members of the National Guard and reserves, along with their dependents, are eligible, as are military retirees and their dependents. (Military retirees generally must have served for at least 20 years and are thus only a subset of all veterans.)

Most Tricare beneficiaries are enrolled in the *Tricare Prime* program, which functions like a health maintenance organization (HMO). Active duty military and some reserve personnel are automatically enrolled in Tricare Prime at no cost. Dependents of active duty personnel may choose Tricare Prime. Retirees and their dependents also have this option, but must pay an annual premium (currently \$520 a year for a family). Enrollees generally obtain primary care from military health facilities, including 56 hospitals worldwide and 363 medical clinics. Specialty and referral services may be obtained either through military facilities or through a contracted network of civilian providers. Retirees and their dependents pay copayments for in-network services. They may sometimes opt for out-of-network care, but may be liable for much higher cost-sharing.

Participants other than active duty personnel may instead opt for *Tricare Standard*. (About one-third of non-active duty participants live in areas without access to the Tricare Prime network and must use the Standard plan.²) This is a fee-for-service program, with no enrollment fee, but a deductible, coinsurance of 20-25 percent, and the possibility of paying more if providers do not accept Tricare’s allowed charge. An optional Tricare Extra system within the Standard program functions like a preferred provider organization; participants may pay lower coinsurance if they use a contracted network provider.

Military retirees age 65 or older were excluded from Tricare until 2001, but those with Medicare are now covered by *Tricare for Life*, a wraparound plan that covers required Medicare cost-sharing as well as services not covered by Medicare Parts A and B (notably prescription drugs).³

DoD health programs perform several functions other than direct service delivery and health insurance coverage. On bases they perform public health functions such as environmental surveillance and community health. DoD funds an education and training system that includes an accredited medical school and graduate medical education programs. It spends \$600 million a year on comprehensive medical research and development. Many of the techniques developed to address military health concerns—in areas such as trauma care, plastic surgery, and burn care—have carried over into civilian medical practice.⁴

Veterans Health Administration

The Veterans Health Administration (VHA) within the VA will spend an estimated \$52 billion providing medical care to veterans in 2012. (This amounts to 40 percent of the VA budget, with most of the rest going to disability compensation.) The VHA program generally functions as a health care delivery system, rather than as an insurance plan. (There is a relatively small insurance program, CHAMPVA, for survivors and dependents of certain groups of veterans.) Care

Table 1. Tricare Beneficiaries by Program, September 2011

	Beneficiaries (millions)
Tricare Prime	
Active duty and activated Guard/ Reserve	1.8
Retirees and dependents	3.6
Tricare Standard/Extra	2.1
Tricare for Life	1.9
Other programs	0.2
Total	9.6

Source: Tricare data, available at: http://www.tricare.mil/pressroom/press_facts.aspx

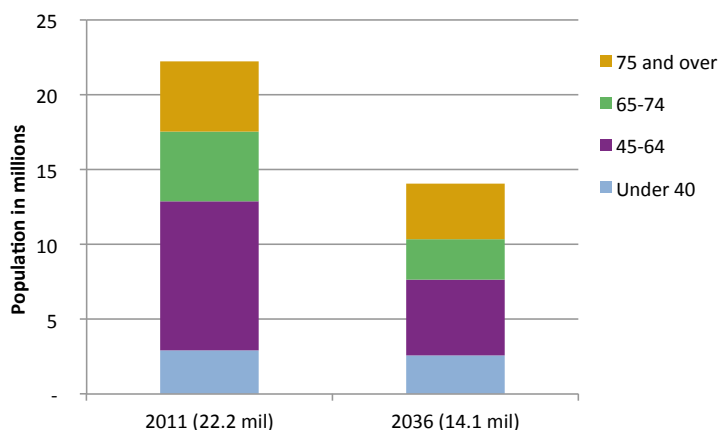
is provided through a network of hospitals, medical centers, and community-based outpatient clinics. The community-based clinics may be operated by the VHA or by contracting providers.

Veterans who were on active duty in the military for at least 24 months and were honorably discharged, as well as some reservists and National Guard members who were called up under federal orders, are potentially eligible for VHA services. However, because of limited resources, VHA uses a priority system to establish which veterans can actually receive care. Preference is given to those who have a service-connected disability or low income, and lower-priority veterans may have to pay copayments for services. Veterans who have served in combat in the “overseas contingency operations” (OCO)—the conflicts in Afghanistan and Iraq—since 2001 are automatically eligible for VHA services for five years after leaving the military. After that time, their eligibility is subject to the standard priority classifications.

VHA care for service-connected problems is free. However, veterans with income exceeding specified thresholds must pay copayments for most nonservice-connected care. These can be substantial: the “copay” (more like a deductible) for the first 90 days of inpatient hospital care during a year is \$1,560. Income thresholds are based on family size and locality. The national threshold for a single veteran was \$29,402 in 2011, or 268 percent of the federal poverty level.

Overall, of 24 million living veterans, about 5.5 million receive care through the VHA during a year.⁵ Overwhelmingly, these are veterans of World War II and the wars in Korea and Vietnam. Although 2.4 million personnel have been deployed in the OCO, many are still

Figure 1. Estimated Population of Living Veterans, by Age, 2011 and 2036



Source: VA estimates available at www.va.gov/VETDATA/docs/Demographics/11.xls

on active duty. In 2010, OCO veterans accounted for just \$2 billion in VHA spending, or about 4 percent⁶

The population of living veterans is expected to drop to about 14 million over the next 25 years (barring some new conflict). The age breakdown of this smaller population will be about the same as it is now, with nearly half the population aged 65 or older.

Overlap of Tricare, other public and private coverage, and VHA services

Figure 2, based on the Medical Expenditure Panel Survey (MEPS), shows the sources of insurance coverage for veterans as of December 2008. Veterans are classed as VHA users if they reported any VHA-paid inpatient or outpatient service during 2008. (Note that

Table 2 summarizes key features of the Tricare and VHA programs.

Program	Who Is Eligible/Covered	What Is Provided	Costs to Enrollees
Tricare Prime	Active duty military and some reservists and their families covered	HMO with primary care from military facilities or specialty care from military or contracted civilian providers	No cost
	Retirees (generally with 20+ years service) and their dependents eligible.	HMO with primary care from military facilities or contracted civilian providers	Enrollment fee of \$260/year for individuals and \$520/year for families plus copayments for in-network use. Deductibles and 50% coinsurance apply to out-of-network care.
Tricare Standard	Participants other than active duty personnel eligible	Fee-for-service plan with care from military facilities or civilian providers; reduced cost-sharing when participants use Tricare Extra contracted network	No enrollment fee, but deductible, 20-25% coinsurance and potential provider balance-billing.
Tricare Extra	PPO-like option for all Tricare Standard participants		Same as Standard except lower coinsurance and no balance-billing for in-network providers.
Tricare for Life	Medicare-enrolled retirees with 20+ years service and dependents eligible	Medicare wrap-around	Services covered by Tricare but not by Medicare subject to deductible and coinsurance
Veterans Health Care	Honorably discharged veterans with 24+ months of active service and some reservists/National Guard members called up under federal orders. Priority for low-income veterans and those with service-connected disabilities.	Inpatient and outpatient care, prescription drugs, and some long-term care.	Some classes of veterans pay cost-sharing for treatment of nonservice-connected conditions.

the MEPS shows many more VHA users, 6.8 million, than the 5.5 million reported by VHA. This may be the result of sampling error or the methods used to impute VHA utilization.)

Among all veterans, 79 percent were covered by Medicare or by employer or other private coverage. Just 10 percent had Tricare, while 9 percent were uninsured in December 2008. Veterans who used VHA services were more likely to have Medicare or Tricare and much less likely than other veterans to have private coverage. Data from the March 2010 Current Population Survey indicate that veterans whose military service ended after September 2001 are much more likely to be uninsured than veterans whose service ended earlier, although the sample is too small for reliable estimates. If the rate of uninsurance for recent veterans is actually higher, possible factors could include lack of access to employer coverage and the availability of free VA services for up to five years after separation.

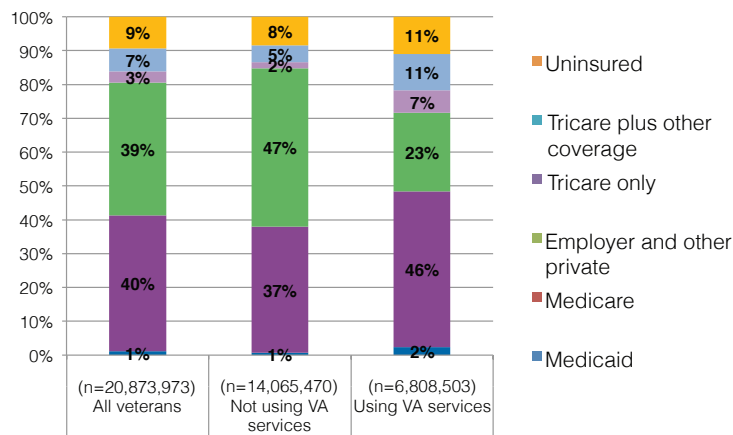
When enrollees obtaining services through Tricare have other coverage, Tricare is generally the primary payer: the other insurance is billed only for required copayments. The major exception is Medicare, which is primary for Tricare for Life enrollees. When VHA users have other coverage, VHA will bill for any applicable copays. VHA usually does not bill Medicare, except for emergency services. Medicare-eligible veterans—close to half the VHA population—may choose to use non-VHA services paid by Medicare or VHA services paid by the VHA. Proposals over the years to allow VHA facilities to bill Medicare have been strongly resisted by veterans' groups, who perceive such a move as a first step toward dismantling the separate VHA system.

Some VHA users are also enrolled in Medicare Advantage plans, private plans that contract with Medicare to provide all Medicare-covered services in return for a fixed monthly payment. These plans receive the monthly payment even if an enrollee is obtaining all of his or her care through the VHA. One analyst has estimated that the VHA spent \$3.2 billion on care for Medicare Advantage enrollees in 2009.⁷ Meanwhile Medicare was paying the private plans billions in premiums for comprehensive care of the same individuals.

Mental Health Care

Access to mental health care for active duty military personnel and recent veterans, and the quality of that care, have been a central focus of DoD and VHA policy discussion in recent years. An influential 2008 study by the RAND Corporation, *Invisible Wounds of War*, estimated that about one-fifth of service members deployed in the OCO met criteria for a probable diagnosis of either post-traumatic stress disorder (PTSD) or major depression, with percent reporting

Figure 2. Health Insurance Coverage of Veterans, by Use of VA Services, December 2008



Source: Author's estimate, based on 2008 Medical Expenditure Panel Survey (MEPS). Excludes institutionalized veterans. Respondents with multiple sources of non-Tricare coverage are classed according to the hierarchy: Medicare, employer and other private, Medicaid.

symptoms consistent with a diagnoses of both conditions. Only half (53 percent of those with a probable diagnosis of PTSD or depression had sought help in the last year, and of those who had sought help only about half received minimally adequate care. The study also documented that 19.5 percent reported experiencing a probable traumatic brain injury, but 57 percent of service members with symptoms of TBI had not been evaluated by a physician.⁸

The following discussion briefly examines three of the major concerns about DoD/VHA mental health care: barriers to care for active duty personnel, transitions from DoD to VHA care, and availability and quality of VHA services.

Barriers to DoD services. The RAND study identified a number of barriers to care for returning service personnel, including concerns about confidentiality, stigma attached to mental illness and potential negative career effects, beliefs that care would not be effective, and limited availability of services in some areas.

The DoD has begun numerous initiatives to promote earlier identification of mental health problems, encourage service members to obtain recommended care, and improve quality. Some progress has been reported. For example, when screening indicates that a service member may have PTSD, about 50 percent are now referred for care, up from about 20 percent in 2005. Of those referred for care, close to 70 percent now follow through, possibly suggesting a reduction in stigma.⁹

Still, a more recent RAND study finds continuing problems.¹⁰ The many programs to address mental health—the study counted 211 different programs across service branches—are fragmented and not well integrated into normal service delivery. There are still concerns about career consequences of mental health diagnoses

and inadequate support from leadership. There are continuity problems: mental health treatment can be disrupted when personnel are deployed or transferred. And most mental health programs have not been subject to rigorous evaluation.

Transition from DoD to VHA care. Another ongoing concern has been continuity of care for service members who receive DoD care while on active duty and then transition to VHA services. One study in 2003 found that only 52 percent of service members discharged with serious mental illness made their way into the VHA system.¹¹ The National Defense Authorization Act for FY 2008 contained a number of provisions intended to improve coordination of DoD and VHA services for physical as well as mental service-related problems.

DoD and VHA were required to develop a joint comprehensive care management and transition policy for service members recovering from a serious injury or illness, including development of recovery plans and the assignment of a recovery care coordinator for each service member. Special attention was to be paid to those with warning signs of PTSD or suicide. The two programs were also required to set standards for transition from DoD to VHA, including patient tracking and expedited enrollment for VA benefits. Finally, DoD and VA were to develop an electronic health records (EHR) system that would allow full exchange of personal health care information between the two agencies.¹²

Some of these requirements have proved easier to meet than others. DoD and VHA have developed a joint “inTransition” program, under which service members are assigned a “support coach” to provide one-on-one assistance with the transition process. VHA has a number of additional programs to get recent veterans into mental health care, such as a program for family members of veterans who are reluctant to seek services. Veterans who come into the VHA for other reasons are screened for PTSD and depression.¹³

On the other hand, the shared EHR system, which was originally supposed to be operational by late 2009, is still in the early stages of development. DoD and VA agreed on a framework for the system only in May 2011, and development was expected to take up to four more years.¹⁴

Care in the VHA. The Congressional Budget Office (CBO) has estimated that 28 percent of OCO veterans treated by the VHA between 2004 and 2009 had a diagnosis of PTSD, TBI, or both. The average cost of services for this group in their first year of treatment was four to six times higher than for other OCO veterans.¹⁵ The size of the veteran population in need of mental health services is likely to increase as the overseas operations wind down and deployed service members return to civilian life.¹⁶

To deal with the mounting burden of mental health problems among returning veterans, the VHA has developed numerous programs to improve access to health care and to integrate mental health in physical health care settings. Among the initiatives highlighted at the February meeting were a Veterans’ Crisis Line for suicide prevention; a national awareness campaign (Make the Connection) to encourage veterans to seek care; and telemental health in community based clinics.

The RAND *Invisible Wounds of War* study found that the VHA had made significant progress in improving the quality of mental health care. Still many OCO veterans reported difficulty obtaining services, while others felt uncomfortable in VA facilities largely populated with the elderly and chronically ill. A RAND study in 2011 found that the VHA had increased service capacity at many facilities. Still, one recent survey by the Wounded Warriors Project, an advocacy group, found that two out of five veterans who sought mental health services had some difficulty in obtaining them. Reported problems included lack of available providers, inability to see the same provider on multiple visits, inability to schedule appointments outside working hours, and distance to available clinics or hospitals.¹⁷

In May 2011, ruling on a suit brought by veterans’ advocacy groups, a panel of the 9th Federal Circuit of Appeals found that the VA had failed to take appropriate steps to reduce delays in evaluating and treating mental health problems. The court ordered the District Court to work with the VA and the plaintiffs on solutions or, if necessary, impose its own corrective action plan.¹⁸ The full Circuit Court overturned this decision, on the grounds that only Congress had the authority to issue guidelines for the VA. In April 2012, the VA announced an increase of nearly 10 percent in mental health staffing levels.¹⁹ Congressional critics contend that staffing is still insufficient, pointing to a finding by the VA Inspector General that the VA’s performance measures are inadequate and understate access problems.²⁰

Military Health Services Budget

Federal spending for the DOD health programs grew 7.9 percent per year from 2003 to 2011. (2003 is used as the starting year here, because there was a sharp one-time spike in spending in 2002, with the start-up of the Tricare for Life program.) The DOD growth rate is almost exactly the same as the growth in total federal health outlays during the same period.²¹ As with other health programs, most spending growth has stemmed from unit price inflation and increased volume and intensity of services. Only 4 percent of spending growth in the years 2000-2010 was related to the overseas contingency operations. A larger share, about 8 percent was attributable to growth in the enrolled population.²²

Veterans Outreach Center

Along with support furnished to veterans by the VA, state and county veteran service agencies and Veteran Service Organizations (VSOs), many veterans are helped by local, community-based nonprofit organizations. One example is the Veterans Outreach Center, Inc. in Rochester, NY. Founded in 1973 by returning Vietnam veterans and organized as a 501(c)(3), the Center provides comprehensive employment counseling and job placement services, housing and emergency shelter, wellness programs, readjustment counseling, temporary financial assistance, and peer mentoring services. All services are coordinated through case management practices designed around individual need and at no cost to veterans and family members, regardless of their discharge characterization. A recent recipient of the VA's "Supportive Services for Veteran Families" (SSVF) funding, the Center established a its "Steps To Enable Positive Solutions" (STEPS) program to reduce the risk of homelessness among eligible veterans and family members facing immediate financial and housing crises. The Center makes many other services available through partnerships with community resources, such as veterans' benefits and financial counseling and legal services. About two-thirds of the Center's \$3.4 million budget is supported by federal, state, and local grants; the rest comes from public donations and revenues from a series of fundraising events and an on-campus flag store.

Much of the enrollment growth has reflected a shift of nonelderly retirees and their families from private insurance to Tricare. The DoD has suggested that this shift reflects the fact that Tricare enrollment fees were held steady for many years, while premiums for employment-based and nongroup coverage more than doubled in the last decade.²³ There could be other factors as well, including a general drop in the availability of employment-based coverage and even sharper erosion in access to employer-sponsored benefits for pre-Medicare retirees.

While DoD health spending growth is not disproportionate in comparison to the rest of the federal health budget, it is outpacing overall defense spending—rising from 7 percent of DoD outlays in 2004 to 10 percent today.²⁴ This trend could be exacerbated if health costs grow at their current rate but overall DoD spending is constrained, either by an automatic sequester stemming from last year's budget agreement or by alternative budget-cutting legislation. As one DoD adviser put it: "We in the Department of Defense are on the same path that General Motors found itself on... General Motors did not start out to be a health care company that occasionally built an automobile. Today, we're on the path in the Department of Defense to turn it into a benefits company that may occasionally kill a terrorist."²⁵

Former Secretary Gates offered a similar analogy in testimony in 2011. "The current TRICARE arrangement... is simply unsustainable. And, if allowed to continue, the defense department runs the risk of the fate of other corporate and government bureaucracies that were ultimately crippled by personnel costs, in particular, their retiree benefit packages."²⁶ In response, enrollment fees for Tricare Prime were increased last year for the first time in 15 years.

The Administration's budget proposal for FY 2013 includes further increases in Tricare Prime enrollment fees for retirees and their families, and would impose enrollment fees for the first time for the other major Tricare programs. There would also be increases in deductibles, out-of-pocket limits, and pharmacy copayments. An important feature of the proposal is that enrollment fees for retirees

would be based on retirement pay. This might have some implications for the possibility of coverage shifts resulting from the Affordable Care Act, as discussed in the next section.

Not surprisingly, these changes are opposed by organizations representing military retirees. They argue that the increased costs to current retirees represent a breach of faith, while recruitment and retention of active duty personnel would become more difficult if long-term military service becomes less attractive. One organization, the Military Officers Association of America, has expressed particular concern about the use of means-testing. They point out that civilian retirees enrolled in the Federal Employees Health Benefits program pay premiums based solely on their choice of plan, not their income.²⁷

DoD also hopes to achieve further savings through greater efficiency. For example, reliance on civilian providers has increased steadily, to the point that 60 percent of services are furnished in the private sector, at the same time that occupancy rates in military facilities have declined. DoD plans to reverse that trend and operate military hospitals at full capacity.²⁸

Effects of the Affordable Care Act

Section 1501 of the ACA uses the term "minimum essential coverage" to describe the public programs and private plans that qualify as acceptable insurance for the purpose of compliance with the individual coverage mandate. The list of acceptable plans includes Tricare as well as "coverage under... the veteran's health care program," although most VHA participants are not really receiving insurance.²⁹

The definition of minimum essential coverage has implications beyond the individual mandate. Most important, no one who is eligible for any type of minimum essential coverage during a month can receive the ACA premium tax credits for that month. (These are provided to families with incomes below 400 percent of

Table 2. Proposed Enrollment Fees for Tricare Prime

TRICARE Prime Annual Family Enrollment Fees (Individual Fees = 50%)						
Retired Pay	FY 2012	FY2013	FY2014	FY2015	FY2016*	FY2017
Tier 1: \$0 – \$22,589	\$460/\$520	\$600	\$680	\$760	\$850	\$893
Tier 2: \$22,590 – \$45,178	\$460/\$520	\$720	\$920	\$1,185	\$1,450	\$1,523
Tier 3: \$45,179 & above	\$460/%20	\$820	\$1,120	\$1,535	\$1,950	\$2,048

Source: Department of Defense, Feb. 2011, available at: http://www.defense.gov/DODCMSShare/NewsStoryPhoto/2012-02/hrs_120214-D-SS9999-001.jpg

poverty who join a health plan through the new health exchanges.) So people found by the exchanges to be eligible for Tricare or for VHA services will be unable to opt for subsidized coverage through the exchanges, regardless of their income.

“Eligible” is a tricky word in this context. Many people are legally qualified for Tricare or for VHA services, but have never participated. Would each exchange be expected to conduct its own determination of individuals’ potential access to these programs? This seems unlikely, particularly in the case of the VHA, for which eligibility determination includes an assessment of service-connected disability. More plausibly, only actual participants would be treated as eligible and hence excluded from premium subsidies.³⁰ If this view is correct, then many veterans, retirees, and their families will have a choice between obtaining insurance through the ACA exchanges (or, for lower-income families, ACA-expanded Medicaid) or using Tricare or VHA services.

For potential Tricare enrollees, the choice could depend on whether the Administration’s proposed means-based enrollment fees are enacted. Under the proposal, a family of four with income up to \$22,589 would pay \$680 a year in 2014. This family is below the federal poverty level for its family size and would qualify for Medicaid at no cost under the ACA. A family with income of \$32,000 in 2014 would pay \$920 for Tricare. The same family would pay about \$960—3 percent of family income—for subsidized coverage through an exchange plan. This seems almost a toss-up, except that the exchange plan could charge much higher cost-sharing the family would pay for in-network services under Tricare Prime. On the other hand, Tricare participants without access to the Prime network—and hence paying the higher cost-sharing under Tricare Standard—or those preferring non-network care, might find the exchange plan more attractive.

The effects of the ACA on VHA users might be larger. Among currently uninsured veterans, about one-fourth had incomes below 138 percent of poverty in 2009 and would therefore have qualified for Medicaid under the new ACA standards.³¹ Another half of uninsured veterans had incomes between 138% and 400 percent of poverty, and would have qualified for subsidized coverage under the health exchanges. It seems reasonable to predict that the lowest-income users of VHA care will be getting Medicaid. (A pilot project in the state of Washington is already shifting veterans into Medicaid

to reduce the cost of state-funded veterans’ benefits.³²) For middle-income users, the decision about whether to shift from the VHA to an exchange plan may again turn on cost-sharing comparisons. Those with nonservice-connected conditions, and hence paying high VA copayments, could find the exchange plans more favorable.

If the vast majority of nonelderly VHA users could qualify for free or low-cost insurance elsewhere, and close to half of VHA users have Medicare, does it make sense to go on operating a separate health system for veterans—especially those without service-connected problems? One participant at the February meeting argued that the VHA is most attractive to older users. A RAND Corporation survey of newer veterans in New York state found that 54 percent of those needing mental health care preferred the VA, while 46 percent preferred civilian providers.³³ Another participant responded that, even among more recent veterans, more than half of those eligible have accessed the VHA. However, this could reflect a lack of alternatives, which would be largely addressed by the ACA.

Not all countries maintain a distinct veterans’ health care system. In England, for example, veterans obtain care through the National Health Service (NHS) like everyone else. They have priority when there is a waiting-list for services, and there are some programs within the NHS to address veterans’ special needs, but there is no separate system.³⁴ However, it may be easier to make special provisions for veterans in a single-payer system than in one with numerous public and private payers. And there are concerns that civilian providers lack the expertise to identify or treat service-related problems, especially mental health problems. So it seems likely that the VHA will have a continuing role.

Finally, whether the ACA results in shifts into or out of Tricare and the VHA, it is expected to increase the number of Americans with insurance by some 30 to 33 million in 2016.³⁵ Some people have expressed concern that increased access to services by the newly insured will strain the nation’s health resources—in particular, the already limited capacity of primary care physicians. One effect could be to exacerbate the existing difficulties, for the VHA especially, in recruiting enough qualified personnel. The problem might be reduced if some current users move to non-VHA care, but this is uncertain, as VHA staffing needs are not directly related to utilization.³⁶

About the Author

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