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FOR PRESENTATION BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

VA MISSION ACT: IMPLEMENTING THE VETERANS COMMUNITY CARE PROGRAM

APRIL 10, 2019

Good afternoon, Chairman Isakson, Senator Tester, and distinguished Members of the Committee. I am pleased to be here today to discuss Milliman's role in the development of the Department of Veterans Affairs' (VA's) expenditure estimates associated with the MISSION Act community care access standards.

ABOUT MILLIMAN

My name is Merideth Randles and I am a principal and consulting actuary with Milliman, an international firm of actuaries and consultants. Milliman has been evaluating financial risk for clients since 1947. Our firm is broadly acknowledged to be the leading consulting firm to health care insurers and providers in the United States. Health care utilization and expenditure projections are at the core of the actuarial consulting that we, as health actuaries, provide to our clients. As a firm, we have served thousands of clients in the area of health care modeling, and with each effort accounting for the specific needs, characteristics, and health care delivery environment of the population at risk.

Our health care clients consist of the majority of the health insurers in the nation, including Blue Cross Blue Shield plans, health maintenance organizations (HMOs), and health insurance companies. In addition, our consultants provide cost modeling services to many health care providers, including hospitals, physician groups, pharmacy benefit managers, and other provider organizations. Our firm contracts with a number of governmental agencies to assist them with health care cost forecasting, including state Medicaid programs, state mental health agencies, state employee plans, state insurance departments, numerous county and municipal entities, and federal agencies, such as the Department of Defense, Centers for Medicaid and Medicare Services (CMS) and notably, the Department of Veterans Affairs.

I have 24 years of health actuarial experience and I have been consulting with Milliman for the entirety of my career. I am a Fellow in the Society of Actuaries (FSA) and a member of the Academy of Actuaries (MAAA). I have been involved with the Veterans Health Administration (VHA) as a consultant since 1995 when they first began exploring ideas on how to plan for and estimate the impact of eligibility reform legislation. I was involved with the inception of the Enrollee Health Care Projection Model (EHCPM), VA's actuarial health care forecasting model, in 1998, and continued this involvement as the EHCPM became integral to VHA's budget formulation process and was used to support other key initiatives, such as Capital Asset Realignment for Enhanced Services (CARES) and the President's Commission on Care. I have supported VA in the evaluation of a multitude of legislation, policies, and program initiatives, as well as briefings to veteran service organizations (VSOs) and governmental stakeholders such as the Office of Management and Budget (OMB), Government Accountability Office (GAO), Congressional Budget Office (CBO), Executive Office of the President (EoP) and congressional staff.

Over the years, VA and Milliman have developed a strong partnership. Milliman brings specialized expertise, access to extensive amounts of data, and first-rate research to the modeling effort. VA experts provide valuable input, analysis, and subject matter expertise used to develop the model assumptions and related projections. In addition, VA experience data is incorporated into many of the analyses. This partnership of subject matter experts and data from both VA and Milliman is a powerful combination that provides VA with the best resources to develop utilization and cost estimates for the veteran enrollee population. In particular, this collaborative experience has led to a deep and extensive understanding of the veteran enrollee population and the dynamics driving their use of health care, both inside and outside of VA.

The remaining testimony presents an overview of the Enrollee Health Care Projection Model (EHCPM) as well as a brief section defining the concept of veteran reliance on VA, which is foundational to the evaluation of the proposed MISSION standards. The discussion then proceeds into specific details regarding the methodology and assumptions used to estimate the expenditure impacts associated with MISSION.

VA'S ENROLLEE HEALTH CARE PROJECTION MODEL

The VA EHCPM was used to estimate the costs of care for the MISSION Act access standards. The EHCPM is a health care demand projection model and uses actuarial methods and approaches to project veteran enrollment, utilization of VA health care (VA facility and community care), and the associated expenditures of providing that care. The modeling approaches underpinning the EHCPM are similar to approaches used by private insurers, Medicare, and Medicaid. The EHCPM incorporates detailed demographic data specific to the VA enrollee population, health care trends, economic conditions, and other drivers of change in health care costs and utilization. As the

EHCPM was first begun in 1998 with the onset of VA's enrollment eligibility reform and adoption of a comprehensive medical benefits package, the current model is now informed by 20 years of VA experience and the expertise of VA's actuarial consultants at Milliman. The EHCPM is updated with emerging experience data annually and used to produce multiple enrollment, utilization, and expenditure scenarios each year. These scenarios are widely used by VA for important stakeholder needs, such as

- Supporting 90% of VA's medical care budget (some budget elements are external to the model, such as construction and equipment).
- Informing strategic planning, including the Market Assessments.
- Use by the Commission on Care to cost proposed system changes.
- Generating key data provided to Congressional Budget Office to support independent costing.
- Producing projections integral to programmatic planning, policy development, and legislative costing.

Currently, the EHCPM projects utilization and costs for more than 120 health care services. In addition to the full range of services provided under a typical commercial or Medicare health plan, VA offers several specialized services without direct counterparts in most health care systems including specialized mental health services, other VA programs, and longer-term nursing home care or home-based care, known as long-term services and supports (LTSS).

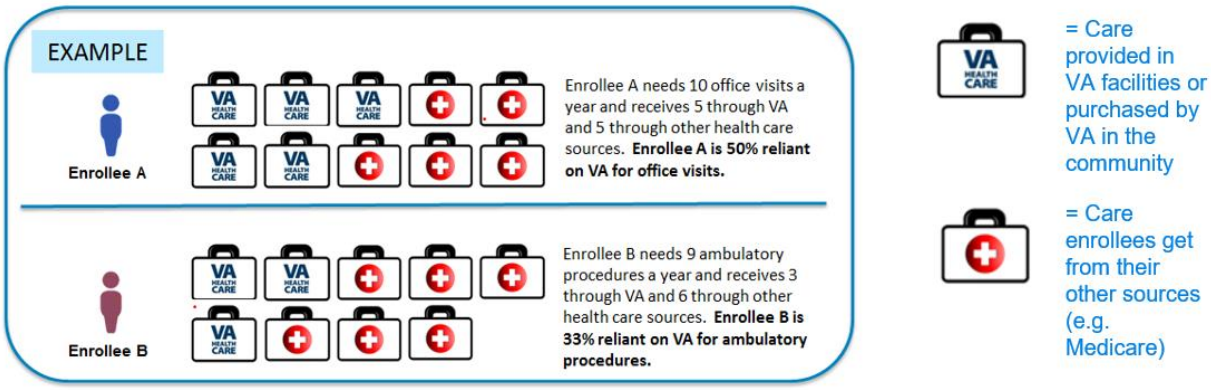
The EHCPM projections are based on the expected utilization of health care services for veteran enrollees. Therefore, the projections start by first estimating who is expected to enroll each year from the veteran population. These projections are made at a detailed level, including age band, gender, priority level, county of residence, and special conflict status. These detailed enrollee projections then become the membership base upon which estimates of total health care utilization are built. Similarly, the utilization and cost estimates are then built specifically for VA facility and community care at a detailed demographic and service level. Future projections reflect the expected demographic changes in the enrollee population, health care trends, VA program implementation, and current policy decisions.

Within the EHCPM utilization is projected for each service using units particular to each service, such as visits, procedures, bed days, etc. In addition, each service is represented using relative value units (RVUs). RVUs are an industry standard metric used to represent the relative intensity of resources required to provide a service as compared to another. For example, a flu shot has fewer associated RVUs than an outpatient surgery, though both are counted as a VA appointment. Therefore, RVUs provide a more accurate representation of workload and cost impact than appointments. Moreover, they provide an accurate way for different services to be aggregated and measured over time. Throughout this testimony, many of the system-wide assessments of workload trends and VA use are measured based on RVUs.

VETERAN ENROLLEE RELIANCE ON VA

The VA system is different from most health care programs in that veteran enrollees generally do not obtain all of their health care through VA because most enrollees have other health care insurance (OHI). In fact, over 80% of veteran enrollees have other health insurance in addition to VA health care. This is mainly comprised of coverage via Medicare, commercial insurers, TRICARE, Medicaid, and Indian Health Service (IHS). Given that most veterans are able to choose among multiple health care providers, this means that VA often is called upon to provide only a portion of a veteran's health care needs. The term ***reliance*** in this context refers to the portion of an enrollee's total health care need that he or she is expected to receive through VA at either a VA operated facility or through community care, rather than through other health care sources. Reliance is measured at the enrollee and service level, as enrollee reliance behavior varies from enrollee to enrollee as well as from service to service for any given enrollee. Figure 1 illustrates the measurement of reliance for a particular type of service for two enrollees.

FIGURE 1 – MEASURING ENROLLEE RELIANCE ON VA HEALTH CARE

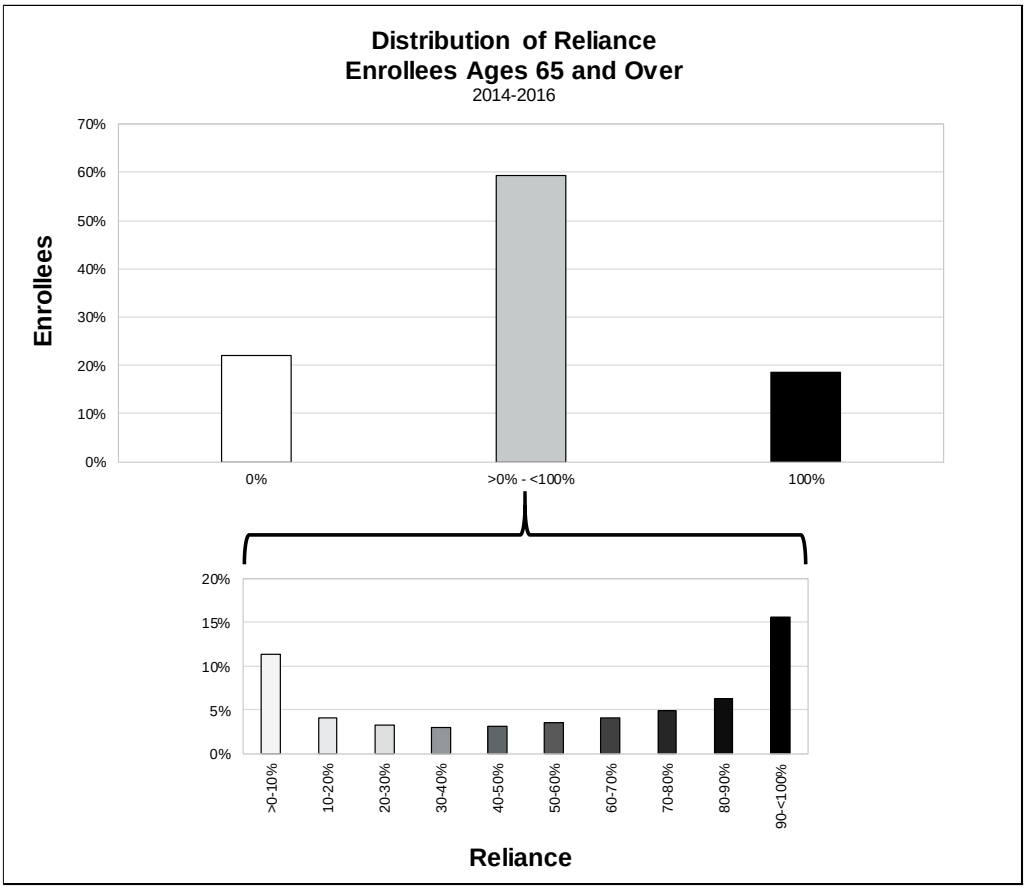


Reliance refers to the portion of an enrollee's total health care need that he or she is expected to receive through VA (facility or community care) rather than through other health care sources

Formal enrollment for VA eligibility began in fiscal year (FY1999). Since that time, VA's master enrollment file (MEF), as well as the comprehensive set of all health care encounters recorded within the VA system has been analyzed on an annual basis. In addition to this, several years ago, VA collaborated with CMS to merge the Medicare fee-for-service (FFS) claims experience for veteran enrollees with VA's encounter data, allowing for a complete capture of enrollee health care between the two health care systems. The resulting dataset provides an invaluable insight into the level of overall health care utilization demanded by enrollees, as well as the portion of this care provided by VA and the portion provided by Medicare.

While some enrollees use VA exclusively for all of their health care needs, roughly half of the Medicare eligible enrollee population accesses health care services from both VA (either a VA facility or community care) and Medicare during the same year. Over the three-year period from 2014 to 2016, nearly 60% of enrollees ages 65 and over (approximately half of the enrollee population) used both VA care and non-VA care, while approximately 20% did not use any VA care and an additional 20% used VA exclusively for all of their care. Further, for those enrollees who utilize both sources of care, there is a wide range of partially reliant users, as some enrollees only obtain a few services from VA and others get almost all of their health care services from VA. The range of these outcomes is presented in Figure 2.

FIGURE 2 – RANGE OF ENROLLEE RELIANCE FOR AGES 65 AND OVER



Why do Veterans Choose VA?

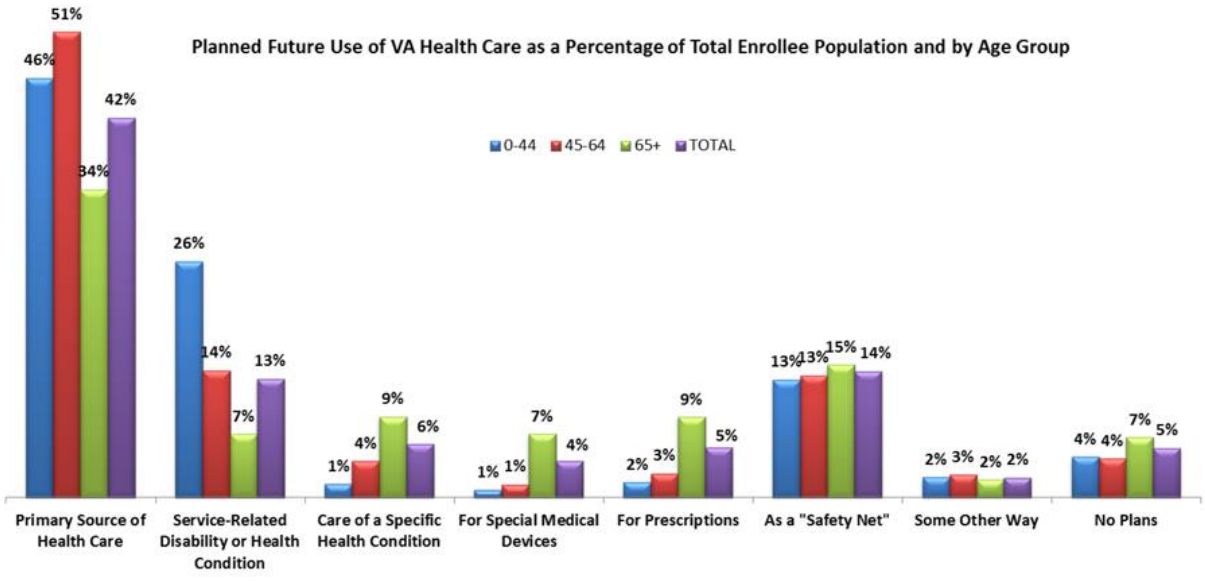
Upon separation from the military, most veterans navigate the U.S. health care system in a fashion similar to the general population, with the notable exception that they also have access to VA. Given this choice, current reliance levels are a testament to how many veterans value the care and services that VA has to offer. Many factors influence

a veteran's decision to choose VA. Some reasons why veterans may choose VA as their source of health care include

- The no copay or small copay cost (depending on priority level) of obtaining services, medical equipment, and prescriptions, which is a richer benefit than Medicare fee-for-service (FFS) or the average commercial plan.
- Specialized treatment and care coordination for a service-connected disability.
- Specialized programs and supplies, such as residential rehabilitation and compensated work therapy, bed-based blind rehabilitation, post-traumatic stress disorder (PTSD) and military sexual trauma treatment, and hearing aids (most of these services are non-existent outside of VA).
- Dedicated veteran providers and facilities.
- The fellow veteran patient population.
- For approximately 20% of veterans, VA plays a critical role as their only source of health care. For the remaining 80% VA plays a safety net role during loss of OHI.

Even small changes in enrollee reliance behavior represent significant changes in the level of care provision and resource requirement for VA. In recognition of this, VA includes a series of questions related to veteran access of VA within its annual Survey of Enrollees. Figure 3 demonstrates the diversity of ways that enrollees plan to use VA health care in the future.

FIGURE 3 – PLANNED FUTURE USE OF VA HEALTH CARE SYSTEM

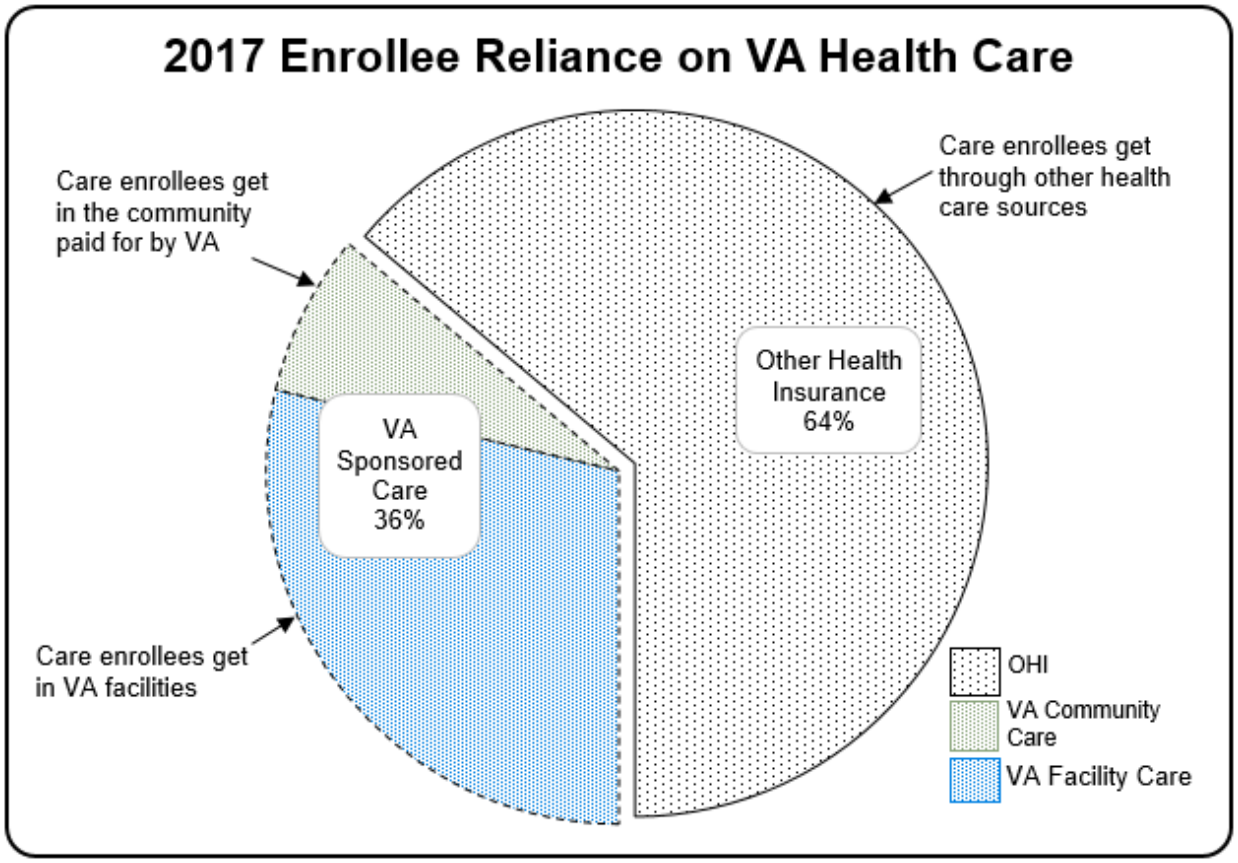


Source: 2017 Survey of Enrollees

Current VA Enrollee Reliance

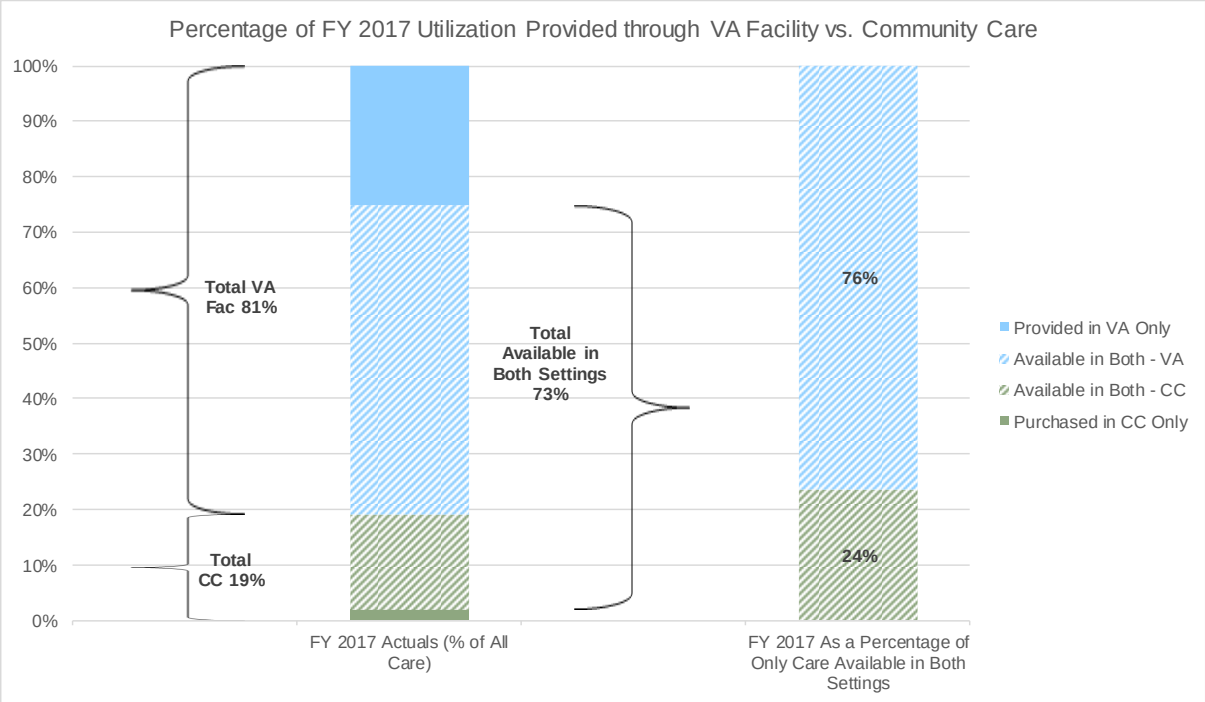
The VA data match with CMS, as well as annual survey data collected across the veteran population, allows us to measure reliance at a health care service level. Aggregating services based on their relative resource requirements using RVUs, it is estimated that overall veteran reliance on VA was 36% in FY2017. This estimate indicates that VA provided 36% of the health care services used by enrollees and other health insurance provided 64%.

FIGURE 4 – 2017 ENROLLEE RELIANCE ON VA



The VA sponsored care shown in Figure 4 includes care enrollees get in VA facilities as well as community care. Figure 5 presents the percentage of utilization provided through VA facility care and community care. In FY 2017, 73% of all VA sponsored care used by enrollees was for services available through both VA facilities and community care. Within these services, 24% of health care was purchased in the community and 76% was provided in VA facilities.

FIGURE 5 – FY 2017 UTILIZATION PROVIDED THROUGH VA FACILITY VS. COMMUNITY CARE



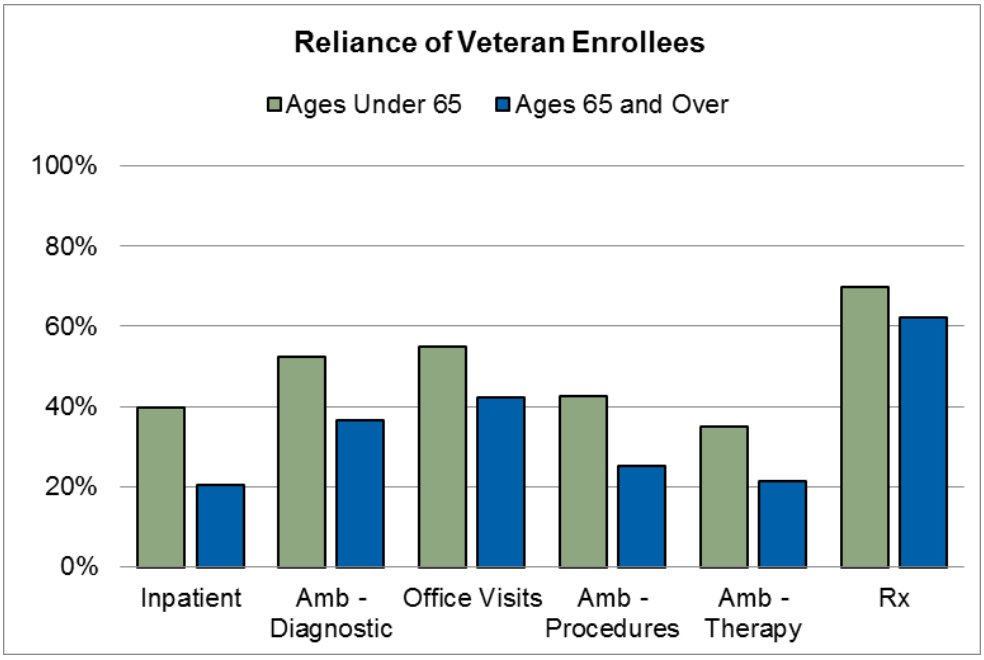
Services only provided in VA accounted for 25% of utilization in FY 2017. These services include services unique to VA such as VA special mental health outpatient and inpatient programs, blind rehabilitation and spinal cord injury programs, recreational therapy, case management, nutritional counseling, and prosthetics and orthotics services, as well as home and community based LTSS and pharmacy and prosthetics products which VA does not purchase in the community.

Services only purchased in the community accounted for 2% of utilization in FY 2017. These services include home and community based LTSS: community adult day health care, home hospice care, home respite care, homemaker/home health aide programs, purchased skilled home care, maternity care and ambulance.

It also is important to note that reliance behavior varies significantly within the veteran enrollee population. Here are some examples from recent reliance studies:

- Average reliance for priority 1a enrollees (70% or more service-connected disability rating) is 50%, while it is 18% for priority 8 (high income, no service connected disabilities).
- For enrollees under age 65, average reliance on inpatient services is 40%, while reliance on office visits is 55%. For ages 65 and over, average reliance on inpatient services is 20%, while reliance on office visits is 40%.
- Average reliance is 47% for enrollees under age 65, while it is 32% for those ages 65 and over

FIGURE 6 – RELIANCE OF VETERAN ENROLLEES BY SERVICE



In conclusion, the above information regarding enrollee reliance behavior demonstrates why legislation, policies, or initiatives that have the potential to impact enrollee reliance must be carefully considered. Even a relatively small shift in reliance represents a substantial increase in VA's budget. Under the current budget environment, every percentage point increase in reliance represents significant resource requirements. For example, doubling reliance from 36% to 72% would necessitate a doubling of VHA's current resource requirements. Given this dynamic, experience has shown that policies that increase access to VA provided care will increase veteran reliance and VA's resource requirements.

MISSION ACCESS STANDARDS COST ESTIMATES

With the passage of the MISSION Act, VA was compelled to establish several standards for implementation. To estimate the impact of these standards, VA and Milliman started with the 2018 VA EHCPM. Thus, the estimates take into account enrollee demographics, health care trends, current enrollee reliance, and other drivers accounted for within the model.

VA evaluated several MISSION Act provisions allowing enrollees access to community care. Two of the standards are when the VA facility does not offer the care required by the enrolled veteran, and the best medical interest provision. For purposes of estimating

cost impacts associated with the access standards, these two standards were considered by VA to be a continuation of current practice, so no new expenditures were indicated. The remaining MISSION access provisions are expected to incur new costs. The proposed access standards were published in the Federal Register on February 22, 2019. The Regulatory Impact Analysis that accompanies this proposed rule can be found as a supporting document at http://www.regulations.gov and is available on VA's website at http://www.va.gov/orpm/, by following the link for "VA Regulations Published From FY 2004 Through Fiscal Year to Date." This notice includes reference to Milliman's expenditure impact analysis of the proposed standards. The projected additional expenditures associated with these standards resulting from the actuarial analysis are repeated below in Figure 7 for reference.

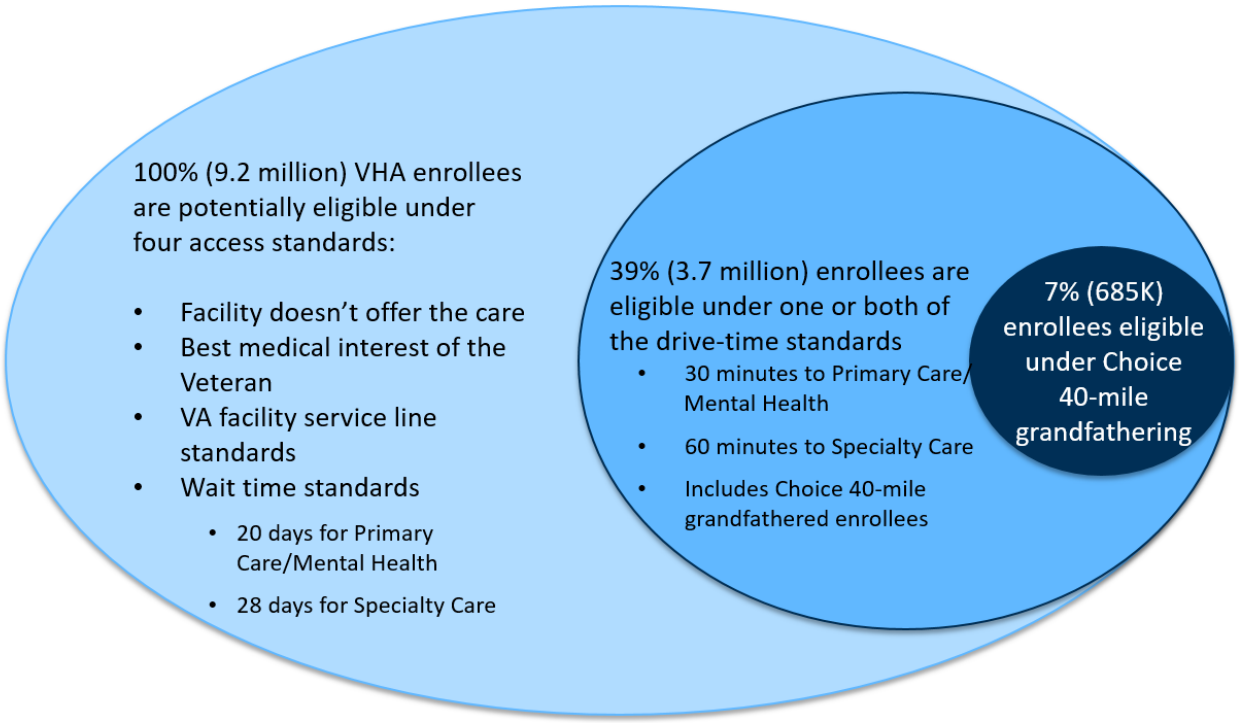
FIGURE 7 – ACTUARIAL PRICING OF PROPOSED VA MISSION ACCESS STANDARDS

Projected Additional Expenditures Under Scenario LAV7 (in billions)

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Total FY19-23
Grandfathered Choice Enrollees	$0.5	$0.8	$1.0	$1.1	$1.2	$4.5
Cost for CC Due to Deficient VA Facility Quality / Timeliness	$0.0	$0.0	$0.1	$0.1	$0.1	$0.3
Cost Due to Implementing Drive Time/Distance Standards	$0.6	$1.5	$3.0	$3.2	$3.4	$11.6
Cost Due to Implementing Wait Time Standards (applies only to enrollees not already eligible under drive distance standards)	$0.1	$0.3	$0.6	$0.6	$0.7	$2.3
Increase in Expenditures due to MISSION Act Access	$1.1	$2.6	$4.7	$5.0	$5.3	$18.7

An overview of the proportion and count of VA enrollees who are potentially eligible for each standard is provided in Figure 8.

FIGURE 8 – VA ENROLLEES ELIGIBLE FOR EACH MISSION STANDARD



Grandfathered Choice Enrollees

The MISSION legislation allows the grandfathered Choice enrollees to continue to receive community care. These grandfathered enrollees include those eligible under the 40-mile distance access standard as well as enrollees who live in a state with no full-service medical facility. Approximately 685,000, or 7%, of enrollees will be eligible under this provision.

While the explicit grandfathering provisions in the MISSION Act for this population are restricted to a five-state subset after two years, VA assumed that the additional language, allowing for community care when "in the best medical interest of the covered veteran," would effectively allow for a continuation of the 40-mile provision for all those currently eligible under Choice. Therefore, the increases in reliance assumed in FY 2019 and beyond for these enrollees were attributed to the MISSION Act and included in the estimates above.

VA assumes that existing 40-mile enrollees will continue to increase their reliance on VA beyond the increased levels seen under the Choice program. These enrollees are expected to reach approximately 50% reliance on VA for their health care, which is similar to the reliance level for priority 1 enrollees. Further, these enrollees are expected

to continue to get care from VA facilities, but growth in reliance due to the 40-mile provision is entirely in community care.

The actual VA health care utilization experience of the grandfathered Choice enrollees since the onset of the Choice program has provided invaluable insight into the reliance changes that are expected to continue for this population into the future. This experience also informed the expectations for the defined group of enrollees that will become eligible for similar community care access under the new drive-time standards. Several of these relevant similarities and outcomes are discussed within the ensuing drive time standard section.

Drive Time Standards

The proposed drive time standards are 30 minutes to primary care/ mental health (PC/MH) and 60 minutes to specialty care (SC). To estimate the enrollees eligible under this standard, VA established where each enrollee lives and their average drive time to primary, secondary, and tertiary VA facilities (using geographic information software), resulting in the following:

- 12% of enrollees are eligible under both standards.
- 20% of enrollees are eligible under the PC/MH standard.
- 31% of enrollees are eligible under the SC standard.
- 39% of enrollees are eligible under one or both standards.

Costs for the drive time standards were produced using the population size of each group and their anticipated increases in the use of different categories of health care services. A detailed discussion of the approach and assumptions taken to estimate the expenditures associated with the drive time standards is included as Attachment A within this testimony. This discussion highlights the commonalities between the proposed drive time standard population and the grandfathered Choice population which informed the utilization and reliance assumptions for these estimates, some of which are presented in Figure 9.

FIGURE 9 – USING CHOICE EXPERIENCE TO INFORM MISSION ESTIMATES

Grandfathered Choice Enrollees	Drive Time Eligible Under Both Standards (but not grandfathered)
• Distance eligible (40-miles)	• Drive time eligible (30 min/60min)
• Enhanced access to community care	• Enhanced access to community care
• 7% of enrollee population	• 8% of enrollee population
• Ambulatory utilization increased 46% from FY 2015 through 2018 and is expected to increase further based on recent experience	• Ambulatory utilization expected to increase 50% in total
• Inpatient utilization increased 29% from FY 2015 through 2018 and is expected to increase further based on recent experience	• Inpatient utilization expected to increase 25% in total
• Ultimate reliance levels expected to be approximately 50%	• Ultimate reliance levels expected to be approximately 50%
• Ambulatory and inpatient utilization within VA facilities from FY 2015 through 2018 was stable and did not decline	• Ambulatory and inpatient utilization within VA facilities will continue as projected by the EHCPM (no decline due to MISSION)
• No material impact on enrollment	• No enrollment impact anticipated

Wait Time Standards

The proposed wait time standards are 20 days for primary care/ mental health and 28 days for specialty care. Further, all enrollees may become eligible under the wait time standard because any enrollee may potentially face a wait time for necessary care.

To produce the cost estimates, VA estimated the number of providers that would be required to reduce the primary care/ mental health wait times to the standard. This workload these providers would generate was then translated into community care workload, and then costed at community care rates for the portion of enrollees not already eligible under drive time standards (to avoid double-counting). The 28-day standard for specialty care was determined to be sufficiently close to the current 30-day standard that no additional costs were assumed.

The estimates of the impact of wait time eligibility criteria under the MISSION Act are national level estimates. VA capacity and wait times vary significantly by service and by facility and can change throughout the year, and from year to year, due to the loss of providers, hiring of new providers, increases in productivity, and expansion or renovation of space. Therefore, it is not possible to project the specific services triggering the wait time criteria at the local facility level. However, the national estimates

provide credible estimates of the type and volume of services that will need to be purchased in the community. Finally, no adjustments were made to the projected levels of care that these enrollees are expected to receive from VA facilities. It is expected that these enrollees will continue to use VA facility care as projected by the EHCPM.

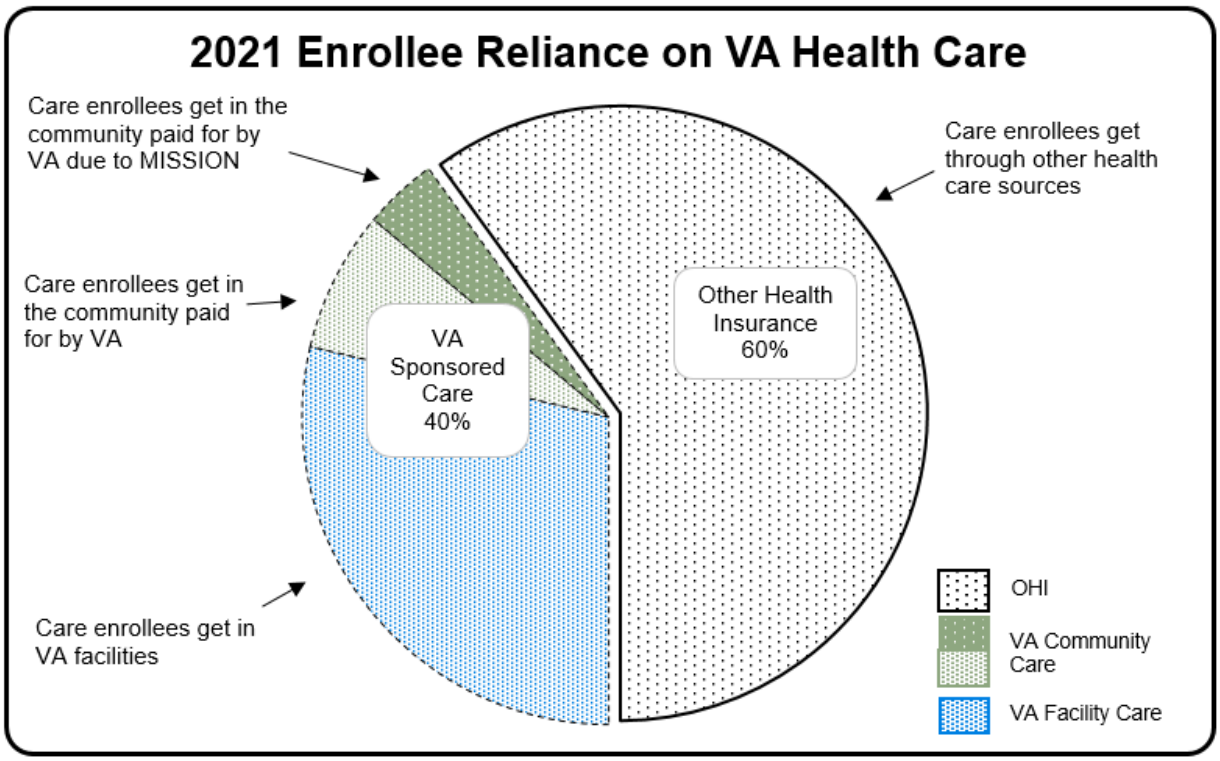
Deficient VA Facility Quality/Timeliness (VA Facility service line quality standards)

Under this provision, enrollees can access community care if they need specific care from a facility and the service line responsible for this care does not meet the quality standard. Thus, all enrollees are potentially eligible for this access. However, the provision will be restricted to a limited number of facilities and service lines each year. VA estimated this provision by assuming it impacts 12 primary care service lines per year (in reality, it would be a mix of service lines). These estimates will change when quality standards are finalized, though as seen in Figure 7 they represent a small fraction of the total estimated MISSION cost impact.

MISSION Standards Impact on Reliance

Implementation of all MISSION access standards is expected to bring the average reliance for the entire enrollee population from 36% to 40% by 2021.

FIGURE 10 – MISSION STANDARDS IMPACT ON RELIANCE



The recent experience of those eligible for community care under the Choice 40-mile provision provides valuable insight into the expected utilization response under community care eligibility. Again, referring back to the previous discussion on reliance, most enrollees currently get a significant amount of their health care from the community via other health insurance. To the extent that VA community care eligibility poses little disruption to the care that they are already receiving in the community, VA's low cost sharing compared to their current OHI becomes an incentive to have VA cover the cost of these claims.

The estimates assume VA's Community Care Network (CCN) contract will be implemented in accordance with VA's estimated contract pricing and schedule. If the implementation timing of the contract changes, that change would impact the cost estimates. Administrative costs for the CCN and first-party and third-party collections offsets are not included in the EHCPM-based MISSION estimates.

ATTACHMENT A – DRIVE TIME DISTANCE STANDARD METHODOLOGY DISCUSSION

To give the Committee an understanding of the process and methodology used to arrive at the drive time standard cost estimates, the following section details the development of the projected expenditures of $3.0 billion in FY2021.

The proposed drive time standards for primary care, preventive care, and mental health are that access be within a 30 minute drive. If this type of care is not available at a VA facility within a 30 minute drive, then the care could be provided within the community — referred to as community care. The equivalent standard proposed for specialty care is 60 minutes. As a point of reference, in FY2018 the average drive time to a VA facility was 21.6 minutes for primary care and 48.7 minutes for specialty care.

The number of enrollees in each county eligible under each provision were measured by VA. Milliman then calculated the percentage of enrollees nationwide that would be eligible for care under either the primary care or specialty care drive time standards (excluding those currently eligible for community care access under the Choice 40-mile provision), resulting in these estimates for the following five groups of enrollees:

- Group 1: 7% of enrollees, eligible for community care due to the Choice 40-mile provision. The expenditure impact of continued community care provisions for these grandfathered Choice enrollees was evaluated separately.
- Group 2: 8% of enrollees, eligible for community care due to residing 30 minutes or more from primary care and 60 minutes or more from specialty care.
- Group 3: 7% of enrollees, eligible for community care due to residing 30 minutes or more from primary care but not 60 minutes or more from specialty care.
- Group 4: 18% of enrollees, eligible for community care due to residing 60 minutes or more from specialty care but not 30 minutes or more from primary care.
- Group 5: 60% of enrollees, who are not eligible for community care due to residing within 30 minutes of primary care and within 60 minutes of specialty care.

Naturally, the eligible population increases as the drive time standards (or equivalent distance standards) are reduced. The eligible population was stratified in this manner to allow for estimation of community care utilization impacts in major service categories. For example, Group 2 is expected to increase their use of both primary and specialty care within the community, while Groups 3 and 4 will increase their utilization more intensively in just one of the two areas.

Using Group 2 as an example of the evaluation process, FY2017 actual workload experience for these enrollees was analyzed to allocate workload into major categories of service, including primary care, specialty care, inpatient and residential care,

institutional long-term services and supports (LTSS), home and community based services (HCBS), prescription drugs, and prosthetics. Group 2 will gain access to both primary and specialty care under the drive time standards, making their qualification for community care access similar to the grandfathered Choice enrollees under the 40-mile provision.

At 7% of the enrollee population, the grandfathered Choice enrollees group also is of similar size to Group 2 and the benefits offered to Group 2 enrollees are essentially the same as the 40-mile benefit. Therefore, the utilization and expenditure experience of this population for community care services under the Choice Act is an appropriate reference point for anticipating the expenditures for Group 2 enrollees under MISSION. VA's community care claims experience shows that the Choice 40-mile enrollees increased their overall ambulatory service utilization by 46% from FY2015 (the onset of Choice) through FY2018, with the vast majority of this care being provided in the community. However, it also is important to note that VA facility care utilization for this population has not declined over this time. In other words, these enrollees are not transferring VA facility services to the community under the Choice program; rather, VA is covering the claims for care they were already receiving in the community from other health insurers. Further, access to community care under MISSION is expected to be similar to Choice, in that use of community care will be authorized by VA for each episode of care and VA will continue to coordinate overall care for the veteran enrollee.

Given Group 2's similarity to the 40-mile population in terms of community care access for both primary and specialty care, setting Group 2's expected ambulatory care expenditure impact at a 50% increase was deemed appropriate. For primary and secondary care, it is assumed that their current VA utilization, as represented by expenditures, would increase 50%, and that all of this increase would be serviced via community care. The increase in inpatient care expenditures (25%) was set equal to half of the increase in ambulatory specialty care and would also be serviced in the community. The lower increase in inpatient care is because approximately half of inpatient admissions begin as emergency room admissions, so they are not attributable to episodes of care referred to community care. The increase in prescription drug care was set equal to 20% of the increase in ambulatory specialty care. The relatively lower increase reflects the already high levels of reliance on VA for prescription drugs. Evaluation of Groups 3 and 4 were performed similarly, but with varying assumptions regarding the assumed increase in health care service expenditures. The resulting assumed percentage increase in expenditures by enrollee group are presented in the table in Figure 11.

FIGURE 11: ASSUMED PERCENTAGE INCREASE IN EXPENDITURES BY ENROLLEE ELIGIBILITY AND SERVICE

Assumed Percentage Increase in Expenditures by Enrollee Eligibility and Service

	Group 1	Group 2	Group 3	Group 4	Group 5
Eligibility					
40-Mile	Yes	No	No	No	No
30 Minutes to Primary Care	Yes/No	Yes	Yes	No	No
60 Minutes to Secondary Care	Yes/No	Yes	No	Yes	No
Estimated % of Enrollees	7%	8%	7%	18%	60%
Utilization Increase by Service Category Grouping (in FY 2021 and beyond, relative to FY 2017)***					
Primary Care	*	50%	30%	0%	0%
Ambulatory Specialty Care**	*	50%	10%	20%	0%
Inpatient and Residential**	*	25%	5%	10%	0%
Insitutional LTSS	*	0%	0%	0%	0%
HCBS**	*	25%	5%	10%	0%
Prescription Drugs	*	10%	2%	4%	0%
Prosthetics	*	0%	0%	0%	0%

* Enrollees eligible for 40-mile benefit under Choice increase reliance by 3 percentage points in FY 2019, 2 percentage points in FY 2020 and 1 percentage point in FY 2021 in aggregate across all services. The increase varies by service category.

** Services provided only through VA Facility care are not assumed to increase

*** Increase in FY 2019 is 1/6 of FY 2021 values. Increase in FY 2020 is 1/2 of FY 2021 values.

Workload increases in FY2019 were set equal to one-sixth of the FY2021 percentage increases shown in Figure 11 to reflect that these provisions will only be in effect for four months in FY2019 and assuming that not all enrollees will immediately use these provisions at their ultimate level. Workload increases in FY2020 were set equal to one-half of the FY2021 percentage increases to recognize that enrollee behavior patterns will not change immediately even if all processes have been fully implemented within VA. The estimated expenditure increases result in an expenditure impact of $3.0 billion in FY2021 for the proposed drive time standard for Groups 2, 3, and 4 (no expenditure impact was assumed for Group 5 enrollees, who do not qualify for community care under the proposed drive time standards).

From a reliance perspective, these projected expenditure impacts are equivalent to increasing reliance to approximately 130% of starting levels. If the starting reliance for these enrollees matches the overall non-40-mile enrollee reliance of 36% in FY2017 (exact measures of MISSION enrollee reliance have yet to become available), then this

growth would lead to a projected reliance of 47% in FY2021 (11% additive increase). Including projected enrollee demographic changes, reliance is expected to be approximately 48% in FY2021. Further, the reliance growth for the populations eligible for just primary or just secondary care (Groups 3 and 4) is estimated to increase reliance to approximately 110% of starting levels by FY2021. Again, assuming the starting reliance for these enrollees is also 36% in FY2017, the expected reliance would be approximately 39% in FY2019 due to the MISSION provisions. Including demographic changes would further increase this to approximately 40%.

Limitations and Considerations

This analysis relies in part on data and other listings provided by various personnel at VA. That data has been reviewed for reasonableness and compared to past data submissions and other information, when possible. The information has not been audited by Milliman for accuracy. If the data or other listings are inaccurate or incomplete, this analysis may also be inaccurate or incomplete.

Some of the information in this analysis is based on modeling assumptions and historical data. Estimates presented in this report will only be accurate if future experience exactly replicates those data and assumptions used in this analysis. Actual experience will likely vary from this analysis to a degree for a number of reasons. In addition, many of the modeling variables are assumed to be constant over time. Therefore, emerging experience should be continually monitored to detect whether expectations based on this analysis are appropriate over time.

The results contained in these reports are projections. Actual results will differ from those projected here for many reasons. For example, it is impossible to determine how world events will unfold. Those events that impact the economy and the use of the nation's military may have a profound impact on enrollment and expenditure projections into the future. It is important that actual enrollment and costs be monitored and the projections updated regularly based on this changing environment.

This report and associated databases were prepared solely to provide assistance to the Department of Veterans Affairs. Neither the Department of Veterans Affairs nor Milliman assume any duty or liability to other parties who receive this work. Milliman recommends any recipient be aided by its own actuary or other qualified professional when reviewing the Milliman work product. Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I, Merideth Randles, am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.