Authorizing the VA to Recover Payments from Medicare Advantage Plans for Dually Enrolled Veterans' Care

Up to 19%
of the VA's Health Care Appropriation (0.4% of Total Health Spending)

Published: September 2026

Authors: Amal N. Trivedi, Brown University; Jean Yoon, University of California, San Francisco; David J. Meyers, Brown University; Aaron L. Schwartz, University of Pennsylvania; Erin Fuse Brown, Brown University; Kenneth W. Kizer, Stanford University

Issue Summary: In 2023, more than 1.2 million veterans were enrolled simultaneously in the Veterans Affairs Health Care System (VA) and a Medicare Advantage (MA) plan. MA plans receive full capitated payments from Medicare for these dually enrolled beneficiaries, even when veterans receive some or all their care through the VA. Because federal law prohibits the VA from billing Medicare or MA plans for veterans' use of VA services, taxpayers finance care for veterans enrolled in MA twice: once through Medicare payments to a MA plan and again through annual medical care appropriations to the VA.

From 2019 to 2023, the VA spent an estimated $86.9 billion caring for veterans enrolled in MA plans. In 2023 alone, VA spending on MA enrollees reached $22.7 billion, equal to 19% of the VA's Congressional appropriation for health care in that year and highlighting the magnitude of potentially wasteful spending.

Policy Recommendation: Congress could authorize the VA to recover payments from MA plans for Medicare-covered services delivered directly by the VA or purchased by the VA in the community. This policy would align MA with other private insurers, which the VA can already bill under existing law.

Potential Savings: In 2023, the VA delivered $22.7 billion in health care services to veterans enrolled in MA, expenditures that MA plans were concurrently paid to deliver and that VA could potentially recover from MA plans. From 2026-2035, allowing the VA to bill MA plans for care provided to veterans has been estimated to generate $357 billion in recouped payments, under conservative assumptions that the proportion of veterans enrolled in MA and the proportion of dually enrolled veterans receiving VA care remain constant over this time period.

Related Literature and Evidence:

Center for Advancing Health Policy through Research. 2024. "Potential Excess Federal Spending on Dual Medicare Advantage and Veterans Health Administration Enrollees." Center for Advancing Health Policy through Research. Accessed April 30, 2026. https://repository.library.brown.edu/studio/item/bdr:cc9brqve/.

Dorneo, Allison, Yanlei Ma, Melissa M. Garrido, Steven D. Pizer, Paul R. Shafer, Thomas C. Tsai, Austin B. Frakt, and Jose F. Figueroa. 2025. "Characteristics and Benefit Design of Veteran Medicare Advantage Affinity Plans." *JAMA Health Forum* 6 (3):e250159.

Ma, Yanlei, Jessica Phelan, Kathleen Yoojin Jeong, Thomas C. Tsai, Austin B. Frakt, Steven D. Pizer, Melissa M. Garrido, Allison Dorneo, and Jose F. Figueroa. 2024. "Medicare Advantage Plans with High Numbers of Veterans: Enrollment, Utilization, and Potential Wasteful Spending." *Health Affairs* 43 (11):1508-1517. Erratum in: *Health Affairs* 43(12):1734.

Meyers, David J., Aaron L. Schwartz, Lan Jiang, Jean Yoon, and Amal N. Trivedi. 2024. "Spending by the Veterans Health Administration for Medicare Advantage Dual Enrollees, 2011-2020." *JAMA* 332 (16):1392–1394.

Meyers, David, and Andrew Ryan. 2025. "RE: Response to Request to Estimate Spending Impact of Proposed VA/MA Legislation." Center for Advancing Health Policy through Research. Accessed April 18, 2026. https://doggett.house.gov/sites/evo-subsites/doggett.house.gov/files/evo-media-document/cahpr-vha-ma-spending-estimates-6202025.pdf.

Trivedi, Amal N., Regina C. Grebla, Lan Jiang, Jean Yoon, Vincent Mor, and Kenneth W. Kizer. 2012. "Duplicate Federal Payments for Dual Enrollees in Medicare Advantage Plans and the Veterans Affairs Health Care System." *JAMA* 308 (1):67-72.

Trivedi, Amal N., Lan Jiang, David J. Meyers, Aaron L. Schwartz, Kenneth W. Kizer, Jean Yoon. 2025. "Spending by the Veterans Affairs Health Care System for Medicare Advantage Enrollees." *JAMA Health Forum* 6(12):e255653.

Background

More than half of Medicare beneficiaries are now enrolled in a Medicare Advantage (MA) plan. Under MA, private insurers receive prospective monthly payments that are adjusted for each enrollee's expected health care needs. These federal payments, which totaled $494 billion in 2024, are intended to finance all Medicare-covered services for enrolled beneficiaries. Veterans, like the general population, can enroll in Medicare based on age and disability eligibility, and they may also be eligible for care in the Veterans Affairs Health Care System (VA) due to disabling conditions developed from military service, exposure to toxins during service, low incomes, or meeting criteria for other special categories. Many veterans enrolled in MA are also enrolled in the VA which operates an integrated public health system of VA hospitals, clinics, pharmacies, and the VA Community Care Network of private providers. Veterans may choose to receive care through the VA, through their MA plan, or through both systems based on preferences for providers, cost-sharing for services, and geographic and wait time barriers to accessing care.

Individuals who have served in the armed forces are entitled, like all Americans, to government-funded health care through Medicare when they meet age or other qualifying requirements, and many have also earned VA health care benefits through their service. However, dual enrollment in an MA plan and the VA generates redundant federal spending. When a veteran enrolled in MA receives care through the VA, the MA plan continues to receive its full capitated Medicare payment even if it finances little or none of that veteran's care. At the same time, the VA bears the cost of delivering those services under a separate Congressional appropriation.

Unlike other private insurers, MA plans are exempt from standard third-party recovery rules that otherwise allow the VA to bill insurers for care it provides. As a result, the VA cannot recover payment from MA plans for services delivered to their enrollees. This statutory prohibition dates to the creation of Medicare in 1965 and was originally intended to prevent fee-for-service Medicare from paying for VA-covered care. However, the provision was never updated to account for the creation of Medicare+Choice (now MA) in 1997. This created a loophole through which MA plans receive capitated payments for each veteran enrollee, irrespective of whether the enrollee's care is provided by the VA.

Dual enrollment in the VA and MA therefore creates two significant policy problems:

1. Duplicate federal spending through simultaneous MA capitation payments and VA appropriations for the same beneficiary, including full MA payments for veterans whose care is financed and delivered by the VA.

2. Distorted incentives for MA plans to market coverage to veterans and shift their use of services to the VA to absorb health care costs.

More broadly, this arrangement undermines a foundational principle of managed care: that a single accountable entity should bear responsibility for financing, coordinating, and delivering care for a defined population. Instead, MA plans receive capitated payments while the VA, a separate federally funded delivery system, often bears the cost of providing that care.

One might ask whether the simplest remedy would be to bar veterans who rely on the VA from enrolling in MA. We do not recommend this. Medicare is an earned entitlement, and veterans who qualify for it should not be treated differently from other beneficiaries; excluding them from MA would claw back an earned benefit and constrain their coverage choices. Many veterans also value MA's supplemental benefits and access to non-VA providers, particularly in rural areas, and enrolling in a $0-premium plan marketed to them is a rational choice when the premium does not fall on the veteran. This subset of Americans is uniquely and legitimately eligible for care from two federally funded programs.

In sum, any solution should preserve and not penalize that hard-earned dual eligibility. At the same time, limited federal health care dollars should not be paid twice for the same care or used to inappropriately enrich private plans. The challenge is to manage these concurrent benefits in a way that makes prudent use of limited federal funds without disadvantaging the veterans who earned them.

Evidence Base

Our team has conducted a series of studies that link national VA and Medicare enrollment and claims data to quantify the number of veterans concurrently enrolled in an MA plan and the VA, the magnitude of spending for dual VA-MA enrollees, and the proportion of VA's federal appropriation that was spent on care for MA enrollees. Key findings are as follows:

Rapid Growth in Dual Enrollment

Between 2011 and 2023, the number of veterans concurrently enrolled in both VA and MA who used VA services approximately doubled, from 634,000 in 2011 to over 1.28 million in 2023. Thus, in 2023, approximately 21% of all users of VA health care were simultaneously enrolled in an MA plan.

Rising VA Costs for MA Enrollees

From 2019 to 2023, the VA spent $86.9 billion caring for MA enrollees. Inflation-adjusted annual spending rose from $12.8 billion in 2019 to $22.7 billion in 2023, a 77% increase. Outpatient services were the largest spending category, while community care—private-sector care paid for by the VA—was the fastest-growing component, increasing 221%.

Significant Share of VA Budget

By 2023, spending on veterans enrolled in MA accounted for 19% of the VA's total Congressional

appropriation for health care. In practical terms, nearly one dollar of every five appropriated for VA health care supported beneficiaries whose insurers were already receiving Medicare payments for their care.

Policy Recommendation

Two potential policies could reduce duplication of payments to MA plans for veterans enrolled in the VA. They include:

1. Permit the VA to recover payments from MA plans for VA-delivered health care

Congress could amend current law to allow the VA to bill MA insurers for Medicare-covered services delivered to enrolled veterans, just as the VA bills private commercial insurers. Reimbursement rates could be tied to traditional Medicare fee-for-service payment rates for comparable services, while retaining the prohibition on traditional fee-for-service Medicare reimbursement for VA-covered services.

2. For Medicare-covered services provided in the community, designate MA as the primary payer with VA as a potential secondary payer.

VA Community Care, in which the VA finances care for veterans who receive services from private-sector providers, was the fastest growing component of spending among veterans enrolled in MA, reaching $3.2 billion in 2023. These include services that MA plans have been paid prospectively to cover for their enrollees. Currently, however, MA plans do not pay for VA Community Care provided to dually enrolled veterans. Congress could require MA plans to be the primary payer of care received outside the VA, with the VA covering cost-sharing for veterans as a secondary payer. Under such a policy, MA plans could either be required to treat all VA Community Care providers as in-network for covered episodes of care or reimburse these providers under existing MA regulations governing out-of-network care.

The goal of these reforms is payment neutrality, not to penalize plans for enrolling veterans. Just as MA plans are paid to cover Medicare-covered services for other enrollees, they should bear the same responsibility for veterans. In other words, a plan should be no better and no worse off enrolling a veteran than a comparable non-veteran. The aim is to end payment for care the plan did not provide, not to make veteran enrollment unprofitable or to discourage plans from serving veterans. Whether veterans are, on balance, more or less costly than their MA payments reflect is ultimately an empirical question that can be monitored as reforms take effect. If needed, policymakers have other tools to modify the size of capitation payments paid to MA plans for covering veterans, e.g. the risk adjustment system.

Potential Savings

In 2023, VA spending for MA-enrolled veterans totaled $22.7 billion, which comprised about 19% of the VA's congressional appropriation for health care in Fiscal Year 2023 and 0.4% of total health care spending in 2023. Not all of this spending would be recoverable from MA plans, since some services may not be covered under Medicare. However, $22.7 billion excludes categories that aren't covered by Medicare (e.g., long-term services and supports) and includes covered categories like hospital care, post-acute care, outpatient care, and prescription drugs.

Further, in response to reimbursing the VA for care provided to dually enrolled veterans, MA plans may increase their bids to enroll Medicare beneficiaries. MA plans may also change practices related to marketing coverage to veterans, since allowing the VA to recover payments from MA insurers may reduce plans' incentives to enroll veterans. In 2022, there were known to be 188 veteran MA "affinity plans" marketing to VA-Medicare dually-enrolled veterans. These estimates also assume the current structure of MA payment. CMS already adjusts the fee-for-service costs underlying MA county benchmarks to account for veterans' lower Medicare utilization (CMS 2020). Were CMS to price veterans' VA reliance more directly into capitation or risk adjustment, the recoverable savings could be smaller.

An estimate for the GUARD Veterans' Health Care Act projects $357 billion in savings over ten years from 2026-2035, again suggesting that these reforms could produce substantial savings. Recovered payments would supplement the VA's appropriation through the VA Medical Care Collections Fund, an account that holds money the VA collects from private health insurance companies (other than MA insurers) as well as veteran copayments. These funds are then used to provide medical care and services to veterans. Savings to taxpayers accrue to the extent these collections reduce future VA appropriations, or if recoveries fund VA care that would otherwise require new appropriations. Across the federal government as a whole, the logic is straightforward: today the government pays twice for these veterans, once through MA capitation and again through VA appropriations, so allowing the VA to recover MA payments for VA-delivered care lowers net federal outlays for this population.

Existing Policy Proposals

As referenced above, the GUARD Veterans' Health Care Act—introduced in June 2025 in the US House of Representatives and US Senate—would authorize the VA to recover payments from MA plans for care delivered to dually enrolled veterans, among other provisions beyond the scope of this brief. The bill was introduced by members of the House Ways & Means Committee, House Veterans' Affairs Committee, and Senate leadership from both parties, reflecting bipartisan concern over duplicate payments.

References

Center for Advancing Health Policy through Research. 2024. "Potential Excess Federal Spending on Dual Medicare Advantage and Veterans Health Administration Enrollees." Center for Advancing Health Policy through Research. Accessed April 30, 2026. https://repository.library.brown.edu/studio/item/bdr:cc9brqve/.

Centers for Medicare & Medicaid Services. 2020. "Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part II." https://www.cms.gov/files/document/2021-advance-notice-part-ii.pdf.

Dorneo, Allison, Yanlei Ma, Melissa M. Garrido, Steven D. Pizer, Paul R. Shafer, Thomas C. Tsai, Austin B. Frakt, and Jose F. Figueroa. 2025. "Characteristics and Benefit Design of Veteran Medicare Advantage Affinity Plans." *JAMA Health Forum* 6 (3):e250159.

Ma, Yanlei, Jessica Phelan, Kathleen Yoojin Jeong, Thomas C. Tsai, Austin B. Frakt, Steven D. Pizer, Melissa M. Garrido, Allison Dorneo, and Jose F. Figueroa. 2024. "Medicare Advantage Plans with High Numbers of Veterans: Enrollment, Utilization, and Potential Wasteful Spending." *Health Affairs* 43 (11):1508-1517. Erratum in: *Health Affairs* 43(12):1734.

Meyers, David J., Aaron L. Schwartz, Lan Jiang, Jean Yoon, and Amal N. Trivedi. 2024. "Spending by the Veterans Health Administration for Medicare Advantage Dual Enrollees, 2011-2020." *JAMA* 332 (16):1392–1394.

Meyers, David, and Andrew Ryan. 2025. "RE: Response to Request to Estimate Spending Impact of Proposed VA/MA Legislation." Center for Advancing Health Policy through Research. Accessed April 18, 2026. https://doggett.house.gov/sites/evo-subsites/doggett.house.gov/files/evo-media-document/cahpr-vha-ma-spending-estimates-6202025.pdf.

Trivedi, Amal N., Regina C. Grebla, Lan Jiang, Jean Yoon, Vincent Mor, and Kenneth W. Kizer. 2012. "Duplicate Federal Payments for Dual Enrollees in Medicare Advantage Plans and the Veterans Affairs Health Care System." *JAMA* 308 (1):67-72.

Trivedi, Amal N., Lan Jiang, David J. Meyers, Aaron L. Schwartz, Kenneth W. Kizer, Jean Yoon. 2025. "Spending by the Veterans Affairs Health Care System for Medicare Advantage Enrollees." *JAMA Health Forum* 6(12):e255653.

Disclaimer:

The views expressed in this brief are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs, the Department of Health and Human Services, or the US Government.