Date: May 23, 1996 VAOPGCPREC 3-96

From: General Counsel (021)

Subj: Application of Health Insurance Payments to Veterans' Copayment Obligations

To: Chief Financial Officer (174)

QUESTION PRESENTED:

How should reimbursements for the cost of VA furnished medical care received from health insurance policies of insured veterans be applied to their obligation to pay VA a portion of the cost of that care?

DISCUSSION:

1. Under Public Law 99-272, effective April 7, 1986, certain categories of veterans, in order to become eligible for Department of Veterans Affairs (VA) medical care, must agree to pay the lesser of the cost of that care or the so-called "means test" copayment for the type of care received; i.e., inpatient/nursing home or outpatient care. 38 U.S.C. §§ 1710 and 1712. The copayment for inpatient or nursing home care is based on the inpatient Medicare deductible in effect under section 1813(b) of the Social Security Act (42 U.S.C. § 1395e(b)). The copayment for outpatient care is an amount equal to 20 percent of the estimated average cost of that care as determined by VA. 38 U.S.C. § 1712(f). Thus, under Public Law 99-272, the means test copayments for inpatient or nursing home care and outpatient care are directly related to the cost of that care.

2. General Counsel Precedent Opinion 13-90 (May 21, 1990) addressed the application of reimbursement from a third party health insurer when there is also a Category C "means test" (now "discretionary patient") copayment debt. Nevertheless, uncertainty has arisen regarding the application of health insurance reimbursements to satisfy the additional copayment obligations of certain categories of veterans imposed by legislation enacted subsequent to that General Counsel Opinion, prompting this request for an additional opinion. As will be developed below, with respect to the application of reimbursements from veterans' health insurance policies, we see no basis to treat these subsequently imposed copayments any differently than the similar obligations originally imposed by Public Law 99-272. We would be pleased to assist you in drafting new implementing instructions to VA medical facilities on the application of this opinion.

3. Public Law 101-508, effective November 5, 1990, expanded VA's authority to charge certain categories of veterans for a portion of the cost of their medical care by

obligating them to pay $2 for outpatient medications (38 U.S.C. § 1722A), and by requiring that they agree to pay $10 for each day of inpatient hospital care and $5 for each day of nursing home care (38 U.S.C. § 1710(f)(2)). We will refer to the $2 copayment as a prescription copayment and the $5 and $10 copayments as per diem copayments.

4. As in the case of the copayments enacted under Public Law 99-272, the prescription copayment is related to VA's cost since the Secretary may not require a veteran to pay an amount in excess of that cost. 38 U.S.C. §§ 1722A(a)(2). However, unlike other copayment obligations of veterans which are capped at VA's cost of care, the per diem copayments do not have a cap. Pursuant to 38 U.S.C. §§ 1710(f)(2)(A) and (B), veterans are responsible for the per diem copayments in addition to the means test copayments imposed under Public Law 99-272. The legislative history of Public Law 101-508 expressly states Congress' intent not to cap the per diem copayments. The House Conference Report No. 101-964, Oct. 27, 1990 [to accompany H.R. 5836], at page 991, discussed the copayments established under Public Law 99-272 which established an overall cap on the amount a veteran may be required to pay for hospital, nursing home, and outpatient care, and then discussed the new per diem copayments:

> House bill
>
> Section 11013(b) would delete the caps on copayments. This section would require the current copayments to be paid by nonentitled veterans (formerly Category B and C veterans) in addition to the copayments per day of care. There would be no cap on the per day copayment charges.

5. Since the per diem copayments are "in addition" to the copayments enacted under Public Law 99-272, which are capped by the cost of VA's charges, an argument could be made that they are not health care charges and, therefore, should not be offset by reimbursements from health insurance. This argument overlooks the fact that they are charges assessed certain veterans only for health care. Avoidance of exposure to personal liability for health care costs is the very reason health insurance is purchased in the first instance. In the Maryland Blue Cross case, the court disagreed with Blue Cross' argument that a Medigap policy was not a health-plan contract, stating: "A health-plan contract need do only one of two things--provide health services or reimburse the expenses of such services. 38 U.S.C. § 1729(i)(1)(A)." U.S. v. Blue Cross and Blue Shield of Maryland, Inc., 989 F.2d 718 (4th Cir. 1993), cert. denied, 11 S. Ct. 302 (1993).

Veterans assessed per diem copayments clearly incur an "expense" for obtaining health care from VA that would be covered by their health insurance. Those veterans should be allowed to offset VA health care expenses from their health insurance coverage. The 1990 General Counsel Opinion addressed this very issue:

> It could be argued that the basic purpose of both provisions is to collect funds for the Treasury and that, therefore, the interest of the Government should prevail over that of the veteran. The better view, in our judgment, however, is that in enacting section 629 [now section 1729] Congress did not intend to prevent Category C veterans with health insurance from satisfying their means test obligations with the proceeds from their insurance.

6. Neither the legislative history of Public Law 101-508 nor the statute itself provides much guidance regarding the application of recoveries from veterans' health insurance carriers to the new copayments established under the Act. The House Budget Committee, in its report on H.R. 5835, appeared to indicate that the copayments imposed by the new bill were merely an extension of the same type of payment required of certain categories of veterans originally imposed under Public Law 99-272, by captioning the explanatory statement of the new per diem copayments, "Modification of Health-Care Categories and Copayments." House Report (Budget Committee) No. 101-881, Oct. 16, 1990 [to accompany H.R. 5835], at pages 219-220. The Conference Report's section on the new per diem copayments bears the same title as the Budget Committee's report. House Conference Report No. 101-964, Oct. 27, 1990 [To accompany H.R. 5835], at pages 988-991. That report noted that the House bill would require that all veterans not entitled to care pay the current copayments for inpatient and nursing home care and, in addition, the $10 and $5 per day copayments. It contains no discussion, with respect to the application of reimbursements from veterans' health insurance carriers, distinguishing the character of the existing and new copayments. In fact, we have found no indication in either the applicable legislative history or the statutes themselves that Congress intended the new copayments to be treated any differently in that regard than the similar obligations originally enacted under Public Law 99-272.

7. The above-mentioned 1990 O.G.C. Precedent Opinion, in analyzing Public Law 99-272, noted that, while the available legislative history did not directly address the issue, it was indicative of an attempt to permit veterans to have the benefit of their health insurance to the extent of its coverage. This interpretation is consistent with section 1729(e) (formerly 629(e)), which provides that no veteran eligible for care may "be denied such care or services by reason of this section." To require a veteran to make

an out-of-pocket payment, when there is insurance for which premiums have previously been paid available to cover the copayment, would place an additional condition of

eligibility on those veterans subject to the means test who also have insurance. With respect to the issue of the application of insurance reimbursements to veterans' obligations, we found no indication in the statutory language or legislative history evidencing Congress' intention to treat this class of veterans differently from those without insurance. We recognized that the issue was not free from doubt, but that to the extent it was a question of policy rather than of law, the Secretary had settled the policy issue in a letter to Chairman Montgomery dated October 10, 1989. We find no provision in Public Law 101-508 that refutes such policy decision nor alters its application by extension to the new per diem copayments.

8. We conclude, therefore, that in those instances where a veteran has an obligation to pay VA for a portion of his or her medical care and also has health insurance, payments to VA from the veteran's health insurer should satisfy the veteran's copayment (whether inpatient, outpatient, per diem, or prescription) obligation to VA to the extent of the available coverage under the policy.

9. Thus, for example, payment by a carrier of the full amount of VA's charges for inpatient medical care should satisfy the veteran's obligation to pay the Medicare deductible and, in most cases, should also satisfy the per diem copayments for that episode of care. (Since the per diem copayments are not limited by the cost of VA's care, even payment in full by a carrier of VA's charges for that episode of care may not extinguish a veteran's per diem copayment obligation in all cases, however.) Likewise, payment in full by an insurer of VA's charges for outpatient care should satisfy the veteran's obligation to pay the copayment for outpatient care as well as any prescription copayments related to that care since VA's charges for such care include the cost of medication(s). In the case of prescription refills (not related to an episode of outpatient care), payment in full by an insurer of VA's charge for a prescription refill should similarly satisfy the veteran's prescription copayment.

10. Non-Medigap health insurance policies, however, rarely provide coverage for the full amount of providers' charges. Rather, such policies commonly have both deductibles, representing the amount above which the insurer provides coverage, and policy copayments, representing the portion (usually a percentage) of the remainder of allowable charges for which the insured is responsible. (Frequently, the policy copayment is 20 percent, leaving the insurer's liability at 80 percent of the remainder of allowable charges.)

11. In these non-Medigap cases, the 1990 opinion stated that VA should apply the insurer's payment to so much of the veteran's means test copayment as corresponds to the veteran's responsibility for any deductible and copayment amounts under the policy. This requirement, as some have pointed out, results in a different application of

insurance proceeds than occurs in the private sector. While this undoubtedly is true, we find the distinction justified, nevertheless.

12. The liability of a veteran for the cost of hospitalization in the private sector is in no way analogous to that of a veteran hospitalized in the VA system. In the former, the patient is responsible for the entire, and same, cost of care as that billed to the insurer. In the latter, the veteran's only health care cost liability is limited to his or her VA copayment obligations. In either case, the veteran unquestionably should have the benefit of the health insurance he or she purchased for such eventuality. Accordingly, upon review, we hereby reaffirm our 1990 opinion on this issue.

13. To restate, insurance proceeds under a non-Medigap policy should be applied to the veteran's VA copayment debt, after subtracting the policy deductible, by applying the same percentage factor of payment as corresponds to the insurer's liability for the remainder of allowable charges. For example, if the veteran has an $800 VA copayment debt (including the means test deductible and per diem copayments) for an inpatient stay, an insurance policy with a $200 deductible and a 20 percent copayment for inpatient care, the veteran would be responsible for the first $200 of the $800 VA copayment debt, plus 20 percent of the remaining $600, for a total of $320. The insurance proceeds would cover the remaining $480 of the veteran's VA copayment debt, corresponding to the insurer's 80 percent liability after the policy deductible.

14. Finally, we note that the 1990 General Counsel opinion expressed the view that, in the case of Medigap coverage, the entire amount of any reimbursement from a supplemental policy should first be applied to the veteran's copayment obligation to VA. (This is due to the nature of such policies--they are designed generally to cover deductibles and copayments not covered by Medicare.) Nevertheless, paragraph 9 of the opinion went on to explain that "some medigap plans cover more than the Medicare deductible, in which case some additional payment from the insurer should be forthcoming and applied to the third party debt." The latter statement on application of the additional proceeds apparently caused some confusion when Public Law 101-508 added the per diem and prescription copayments. Accordingly, we want to clarify that any such "additional payment" from a Medigap insurer first should be applied to the veteran's copayment liability, including per diem copayments, outpatient copayments, and prescription copayments, before application of any remainder of insurance proceeds to the insurance receivable.

15. Of course, appropriate application of insurance proceeds, pursuant to this opinion (as well as the 1990 General Counsel opinion previously mentioned), requires that Medical Care Cost Recovery (MCCR) personnel obtain sufficient information as to the deductible and copayment provisions of the veteran's policy. The MCCR office has advised that this information is readily available from the carrier's Explanation of Benefits which normally accompanies insurance payments.

16. Thus, this opinion should be applied as follows:

(1) All veteran's copayment obligations for VA furnished medical care or medications established on or after the date of this opinion will be adjudicated by applying this opinion to such veteran's debt.

(2) All veteran's copayment obligations for VA furnished medical care or medications pending before the date of this opinion subject to a timely request for appeal, will also be adjudicated by applying this opinion to the veteran's debt.

(3) On or after the date of this opinion, all veteran's copayment obligations for VA furnished medical care or medications referred for enforced collection action, including IRS offset, VA administrative offset, or litigation, whether by VA Regional Counsels or the Department of Justice and United States Attorneys, will first be adjudicated or readjudicated as necessary, by applying this opinion to such veteran's debt before any enforced collection action is taken.

HELD:

1. Veterans covered by health insurance policies who are obligated to VA for a portion of the cost of their nonservice-connected medical care should be allowed to satisfy their obligation(s) to VA to the extent of coverage available under their policies.

2. Non-Medigap insurance proceeds should be applied to the veteran's VA copayment debt, after subtracting the policy deductible, by applying the same percentage factor of payment as corresponds to the insurer's liability for the remainder of allowable charges.

3. Reimbursements from Medigap carriers should first be applied to the veteran's copayment debt(s), including "means test" copayments, per diem copayments, outpatient copayments, and prescription copayments before application of those proceeds to the carrier's debt.

Mary Lou Keener