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Prepared remarks of

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Mr. Chairman and Members of the Committee, I am pleased to testify today on the subject of long-term care for America¡¦s veterans. I am Joshua M. Wiener, Ph.D., senior fellow and program director for aging, disability, and long-term care at RTI International, a nonprofit research organization headquartered in Research Triangle Park, North Carolina. I am the author or editor of eight books and over 100 articles on long-term care, aging, Medicaid, disability, end-of-life care, and health reform in the United States and abroad. In 1997 and 1998, I was a member of the Federal Advisory Committee on the Future of Long-Term Care in the VA. The opinions that I express today are my own and do not necessarily represent the views of RTI International.

Like the rest of America, the veteran population is aging, and with it, the prevalence of disability is increasing. In 2002, there were approximately 10 million veterans age 65 or older (Department of Veterans Affairs, undated). Even more important for long-term care is that the veteran population age 85 or older is projected to increase from 640,000 in 2002 to 1.3 million in 2012 (U.S. General Accounting Office, 2003). Disability and the need for long-term care services are closely linked to age, with much higher needs at older ages. For example, almost half of the nation¡¦s nursing home population is age 85 or older.

In addition, the population served by the Department of Veterans Affairs has a high level of disability. According to the 2002 survey of veterans enrolled with the Department of Veterans Affairs for health care, 51 percent of older people reported problems with the activities of daily

living or instrumental activities of daily living, and 6 percent reported problems with three or more activities of daily living, a prevalence level far higher than that of the general population (Department of Veterans Affairs, 2003; Manton and Gu, 2001). A large research literature finds that people with disabilities have higher levels of acute care and long-term care use than persons without disabilities (Alecxih, Corea, and Kennell, 1995).

Against the backdrop of increasing need for long-term care services, the Administration¡¦s FY 2006 budget proposes cutting back on Department of Veterans Affairs long-term care services. These proposals include a reduction in the number of Department of Veterans Affairs¡Vprovided nursing home beds, as well as a plan to limit geriatric nursing home care to service-connected conditions, catastrophically disabled persons (e.g., spinal cord injured veterans), and veterans who are at least 70 percent service-connected disabled. In addition, per diem payments and new grants for state veterans¡¦ homes would be further limited.

If enacted, these changes will reduce the availability of long-term care services in the Department of Veterans Affairs; veterans will have to obtain services in the general community and use other financing mechanisms or go without services. The key policy question is: Outside of the Department of Veterans Affairs, what long-term care services are available and how are they financed, and what are the implications for veterans and third-party payers of using services outside of the Department of Veterans Affairs system?

Background

To help meet the long-term care needs of veterans with disabilities, the Department of Veterans Affairs has a long history of providing long-term care services. Long-term care is the help needed to cope, and sometimes to survive, when physical or mental disabilities impair the capacity to perform the basic tasks of everyday living, such as eating, bathing, dressing, and housekeeping (Wiener, Illston, and Hanley, 1994). Although not as extensively provided as other services, the Department of Veterans Affairs provides nursing home care (in Department of Veterans Affairs¡Voperated units, contract community nursing homes, and state veterans¡¦ homes), home-based primary care, contract home health care, adult day health care, homemaker and home health aide services, community residential care, respite care, home hospice care, and domiciliary care (Department of Veterans Affairs, 2005b).

In FY 2005, the Department of Veterans Affairs will spend about $3.6 billion on long-term care, approximately 91 percent of which is for nursing home services (Department of Veterans Affairs, 2005a). Although the supply of VA-financed home and community-based services has increased in recent years, a General Accounting Office (2003) study found substantial variation across the country in the availability of services. Variation in availability of services and restrictions on the amount of services make it difficult for these home and community-based services to function as alternatives to nursing home care. Overall, the Department of Veterans Affairs finances about 3 percent of the nation¡¦s spending on long-term care services for older people and accounts for about 2 percent of the nation¡¦s nursing home population (American Health Care Association, 2005a; Congressional Budget Office, 2004). A majority of veterans receive their care outside of the Department of Veterans Affairs system.

Non-VA Long-Term Care Services

In terms of services, there are approximately 1.7 million nursing home beds in 16,000 facilities in the United States (American Health Care Association, 2005b). Current occupancy rates are at unprecedented low levels, averaging about 85.5 percent nationally (although rates vary greatly across geographic areas). In recent years, there has been a substantial growth in assisted living facilities, which are residential settings that provide personal care (e.g., help with eating, bathing, dressing, and other services); approximately 800,000 persons now live in these facilities (National Center for Assisted Living, 2001). These facilities are overwhelmingly financed by private payments, although some participate in Medicaid. They are expensive, costing approximately $1,900 a month in 2000. Due to overbuilding, occupancy rates for assisted living are also relatively low.

Approximately 6,900 home health agencies participated in Medicare in 2003 (Centers for Medicare & Medicaid Service, undated). An unknown number of other home care agencies provide a range of skilled and unskilled services, including personal care, housekeeping, respite care, adult day care, nursing, and other services.

Both institutional and noninstitutional services face difficult problems of recruitment and retention, which will only get worse over time as the imbalance between long-term care demand and the supply of workers increases. These workforce problems are due to low wages and benefits, lack of training, the nature of the work, and the organizational culture (Stone and Wiener, 2001).

Non-VA Long-Term Care Financing

Outside of the Department of Veterans Affairs, the major sources of financing long-term care for older people and younger persons with disabilities are out-of-pocket payments, private insurance, Medicare, Medicaid, the Older Americans Act, and state-funded programs (table 1).

Table 1: Long-Term Care Expenditures for Older People, by Source of Payment and Type of Service, 2004 (in billions of dollars)

Payment Source	Institutional Care	Home Care	Total
Medicaid	36.5	10.8	47.3
Medicare	15.9	17.7	33.6
Private insurance	2.4	3.3	5.6
Out-of-pocket	35.7	8.3	44.0
Other	2.0	2.5	4.4
Total	92.4	42.5	134.9

Source: Congressional Budget Office, 2004.

?X Out-of-pocket expenditures are a major source of financing for long-term care services. This is a consequence of the lack of either public or private insurance programs for long-term care that would otherwise cover the cost. Because services are expensive, they are a financial burden to most persons who use them. For example, the average private charge for a year in nursing home care was approximately $62,000 in 2002 (MetLife, 2004).

?X Private long-term care insurance has been growing steadily since the mid-1980s but finances less than 5 percent of total long-term care expenditures. About 9 percent of the population age

55 or older has long-term care insurance, as does far less than 1 percent of the younger population (Johnson and Uccello, 2005). A key barrier to the growth of private long-term care insurance is its high cost. For example, the average cost of a good quality policy bought at age 65 was $2,862 per year in 2002 (America¡¦s Health Insurance Plans, 2004). A variety of studies suggest that only about 10 to 20 percent of older people can afford private long-term care insurance, a proportion that will not change greatly over the next 20 years (Rivlin and Wiener, 1988; Wiener, Illston, and Hanley, 1994). Thus, private long-term care insurance is unlikely to be a major source of financing for long-term care.

?X Medicare, the federal health insurance program, provides nearly universal coverage for older people and some younger people with disabilities. Although primarily an acute care program (i.e., hospital and physician care), Medicare covers some nursing home and home health services, but generally of a short-term nature; long-term care is not covered. Specifically, Medicare covers skilled nursing facility services only when a beneficiary has spent 3 days in a hospital, is admitted to the nursing facility within 30 days of the hospitalization, and needs skilled nursing or rehabilitation services. Coverage is limited to 100 days, but the average length of Medicare-covered stay was only about 33 days in 2002 (Centers for Medicare & Medicaid Services, undated). The home health benefit is available to homebound beneficiaries who need intermittent or part-time skilled nursing or rehabilitation services. Although the home health benefit was evolving into a long-term care benefit during the early 1990s, the Balanced Budget Act of 1997 sharply reestablished the home health benefit as a skilled, short-term service. There is no coinsurance for home health; in 2005, there is a required copayment of $114 a day for skilled nursing care after the 20th day in the facility.

?X Medicaid is by far the dominant source of funding for long-term care services. It provides funding for persons who have low incomes or have been impoverished by the high costs of acute and long-term care. While the majority of Medicaid funds come from the federal government and there are some national requirements (especially for quality of care in nursing homes), states are responsible for administration and have substantial flexibility in determining eligibility and covered benefits.

Although nursing home and home health care are mandatory services and must be provided on an open-ended, entitlement basis, states vary greatly in their coverage of home and community-based services. Approximately 32 states and the District of Columbia cover personal care services as part of the regular Medicaid program (Burwell, Sredl, and Eiken, 2004). At their discretion, states may provide long-term care services under so-called home and community-based services waivers. Under waivers, states can provide a broad package of services that Medicaid does not routinely cover, and they can exert far greater fiscal control than they can under the regular Medicaid program. Unlike the rest of the Medicaid program, states can limit the number of waiver beneficiaries, and some states have waiting lists. Nonfinancial eligibility for waiver services is limited to persons who need a nursing home care.

In all but a few states, the vast majority of Medicaid funds are spent on institutional care rather than noninstitutional services; nationally, in 2004, approximately 23 percent of Medicaid long-term care spending for older people was for home and community-based services (Congressional

Budget Office, 2004). This is, however, a substantially higher percentage than in the Department of Veterans Affairs programs.

Financial eligibility standards for Medicaid are strict, complicated, and vary by state (Bruen, Wiener, and Thomas, 2003). Medicaid nursing home residents must contribute all of their income toward the cost of care, except for a small personal needs allowance of about $30 a month. Individuals may keep only $2,000 in nonhousing financial assets, although the home is generally an exempt asset in determining eligibility. However, states are supposed to recover the cost of Medicaid expenditures for long-term care from the estate of Medicaid beneficiaries, including the home. The community-based spouse of Medicaid nursing home residents may keep more of the couple¡¦s income and assets than is allowed single individuals.

Due to the high cost of long-term care services, a significant proportion of Medicaid beneficiaries in nursing homes ¡§spend down¡¨ and are impoverished by the cost of nursing home care. Approximately two-thirds of nursing home residents have their care paid by the Medicaid program. Thus, Medicaid long-term care services provide a safety net for the middle class as well as for the poor.

Medicaid financial eligibility standards for persons in the community generally require beneficaries to be eligible for the federal Supplemental Security Income program, the cash welfare program for the aged, blind, and disabled. This program provides benefits at about two-thirds of the federal poverty line and limits nonhousing assets to $2,000. A relatively few number of persons in the community ¡§spend down¡¨ to Medicaid eligibility because of high medical care costs. Depending on state choices, persons receiving Medicaid services under home and community-based services waivers may have incomes up to 300 percent of the Supplemental Security Income level (about twice the federal poverty level).

?X Other federally funded government programs include home and community-based services financed through the Older Americans Act, the Rehabilitation Act, and the Social Services Block Grant. In addition, many states use their own funds to provide home and community-based services to persons who do not qualify for Medicaid. In general, these federal and state programs have financial eligibility levels that are slightly above Medicaid but are small in terms of total expenditures.

Conclusions

Several implications can be drawn for veterans (and the general population) from this review of long-term care services and financing:

?X For both the veteran population and the general population, the demand for long-term care is certain to increase sharply over time. The United States does not have a coherent plan for dealing with the aging of the population.

?X Overall, many current nursing homes have excess capacity that could absorb the reduced demand by Department of Veterans Affairs¡Vfunded facilities. Whether the excess capacity and the reduced Department of Veterans Affairs capacity are in the same locations is unknown. Overall, the growth of long-term care services is likely to be impeded by a workforce shortage

that will almost certainly grow dramatically worse over time.

?X Although the supply of home and community-based services has been increasing, there is a stronger institutional bias in the Department of Veterans Affairs programs than in the general community. However, the overall long-term care system has a strong institutional bias.

?X Current financing for long-term care and acute care services is highly fragmented with multiple funding sources and a lack of integration between acute and long-term care services. While the extent to which Department of Veterans Affairs services achieve a high level of service integration is unknown, it provides a potential for integration that may be better than in the general community.

?X Current financing of long-term care is dominated by public programs, and that is likely to remain so in the future. While private sector initiatives will play a larger role in the future, they are likely to remain a relatively small source of financing for long-term care.

?X Medicaid is the dominant source of funding for long-term care. It is a strictly means-tested program. Initiatives to reduce Department of Veterans Affairs funding for long-term care will likely increase Medicaid expenditures, at least marginally, and are likely to be resisted by the states. This will occur at a time when states are still experiencing fiscal difficulties.

In conclusion, Americans have not yet begun a serious debate about the future of our aging society and the role of long-term care within it. The demand for long-term care will only grow dramatically over time, within both the veteran population and the general population. It is time to begin that debate.

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